

Management of tocophobic women

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INTRODUCTION

Having a baby is usually an exciting time for women, one that is full of joy and happiness. This is not the case for some mothers-to-be, however, as they are encumbered by a morbid dread, and fear, of pregnancy and the birthing process. Although many overcome their anxiety with the help of their partner, family or friends and the support of those caring for them, for others the fear and anxiety remain intense and can best be described as 'a morbid dread of childbirth'. To enter pregnancy with such a degree of apprehension is an obvious detriment to the mother and her unborn child.

Little has been published about why some women fear childbirth, aside from that in Nordic countries and the UK. Sjogren from Sweden followed up 72 women with severe anxiety of childbirth and the support offered to them¹. Hofberg and Brockington described 26 cases in the UK and cited an 1858 definition by Marce which applied to the women in their study:

'If they are primiparous, the expectation of unknown pain preoccupies them beyond all measure, and throws them into a state of inexpressible anxiety. If they are already mothers, they are terrified of the memory of the past and the prospect of the future'².

Despite being initially documented in the medical literature over 150 years ago, tocophobia still remains largely unrecognized within the obstetric community as well as the wider health profession. During the past

decade, however, interest in fear of childbirth has expanded.

TOCOPHOBIA

The word tocophobia comes from the Greek word tokos, meaning 'childbirth' and phobos, meaning 'fear'. Tocophobia is an intense anxiety or fear of pregnancy and childbirth, with some women avoiding pregnancy and childbirth altogether³. Women who suffer from tocophobia often feel alone in their angst. Swedish researchers explored the phenomenon of anxiety and fear in childless women as well as in those with children. Childbirth fear was more frequent amongst primigravidas than multigravidas^{3,4}. Tocophobia can be divided into primary and secondary components⁴.

Primary tocophobia

Primary tocophobia may have its onset in adolescence, affecting nulliparous women to such a degree that some women never bear a child². This dread has led women to avoid pregnancy for fear of dying, despite their desperately wanting children². Many of these are never able to overcome this fear² scrupulously use contraception², often using one or more methods simultaneously 'just in case'.

Although a few women remain childless³, others decide to adopt a child³. Occasionally tocophobia is culturally associated, such as

negative feelings towards childbirth which can be passed between mother and daughter², a result of sexual abuse², or arises after seeing a film depicting childbirth early in life with no support or explanation. Although some women are able to overcome the avoidance of pregnancy, mainly due to a huge desire to become a mother, they still harbor a deep fear². This may result in a decision to terminate the pregnancy³ or to seek an elective cesarean section as their only alternative².

Secondary tocophobia

Secondary tocophobia may be associated with a previous traumatic birth experience² such as stillbirth, termination of pregnancy, an obstetric event such as unexplained stillbirth or delivery of a malformed child, or even a normal delivery³. Women may also be concerned with pain, their own incapability, possible obstetric injuries, lack of control, lack of partner or familial support and, finally, loss of the baby's, or their own, life^{2,3}.

SYMPTOMS

Primigravidas and multigravidas display similar symptoms, their fear being so intense that it forces them to request a cesarean section, as labor and vaginal birth are too difficult to contemplate³. Behavioral, emotional or physical symptoms⁴ may also be present in the form of sleeplessness, crying episodes, restlessness or nervousness. Health professionals should be astute to these manifestations, as they can provide an indication that the woman's underlying distress and anxiety may be greater than it appears.

IMPLICATIONS

Raphael-Leff states that a woman's mental state, particularly her anxiety level during

pregnancy and labor, may contribute to complications of labor and the degree of interventions that are required. After delivery, the woman's self assessment of how she has coped is likely to have postnatal psychological repercussions for her, the baby and, in turn, the whole family⁵. Anxiety during the antenatal period has been associated with an increased risk of postnatal depression; bonding and attachment towards the baby can also be affected^{6,7}. Additionally, anxiety can lead to an increased number of requests for cesarean and instrumental deliveries³. In one Scandinavian study, anxiety and fear were associated with premature birth, post-term delivery, low birth weight and intrauterine growth retardation (IUGR) of the fetus⁷.

High levels of anxiety, expressed early or during pregnancy, should alert health professionals to acknowledge the women's distress, react in a supportive manner, and, if necessary, obtain appropriate consultation⁷.

PERTINENT LITERATURE REVIEW

Wijma suggests that tocophobia differs from other phobias in that many women's fear of childbirth only increases to a phobic level after they have become pregnant. However, unlike people with different phobias who may be able to have some control over their situation by means of avoidance, the pregnant woman cannot avoid what she fears. She is caught in a situation for 9 months until she is forced to approach the unknown, uncontrollable and unavoidable delivery.

According to a study published in 1981, approximately 6% of pregnant women have an intense, complex and multifaceted fear of childbirth, in which pain is not a dominant factor¹⁰. A more recent study of 8000 women showed that the rates of intense fear of childbirth affected about 1 in 20 women⁶; of those affected, approximately 50% feared for the baby's health and 40% feared the pain itself⁶.

Clearly, how the questions are posed has an effect on the answers given, the literature cites different fears within different reports but what appears to be constant is that intense fear is always present for some women.

In Sweden, fear and a prior bad birth experience represent major reasons for women desiring a cesarean section¹¹, whereas British obstetricians note that their patients are more likely to ask for a cesarean section on 'maternal request', as opposed to fear of giving birth⁹. When no medical indication is present, debate continues amongst the obstetric community regarding the woman's right to choose how her baby is delivered⁹, but very little thought is given to why women choose to have a cesarean section and how to help them to overcome the fear of vaginal birth⁹.

A UK cesarean section audit in 2000 found that 7% were for maternal request³. However, the exact number of women requesting an elective cesarean section for tocophobia was not known³. This is in contrast to Finland and Sweden where fear of childbirth or maternal request represents the reason for about 7–22% of cesarean section births⁹.

The findings highlighted above show the importance of antenatal strategies⁹ to identify women with intense fear related to childbirth. In Sweden, nearly all obstetric departments have specialized teams to deal with patients exhibiting intense anxiety; these teams include experienced midwives, obstetricians, psychologists, social workers and occasionally a psychiatrist¹¹. The value of such efforts underscores the finding of Saisto *et al.*, who found that about half of the women in their study who requested a cesarean section because of anxiety accepted a vaginal delivery after psychological support was offered⁹. One-third who wanted a cesarean section chose not to accept help⁹.

Although all women have some degree of anxiety in relation to childbirth, the quality and intensity of the fear is different for women with tocophobia. For many women talking

through their fears is helpful, despite the fact that talking through difficult and painful feelings is not an easy thing to do¹³. Under these circumstances, a 'birth reflection' experience can help considerably by allowing the women to think back to a previous birth, clarify events, obtain a greater understanding of what happened, why intervention was necessary and the implications for future births. By allowing women the opportunity to go through their maternity records and discuss their birth experiences, women who felt traumatized (secondary tocophobia) can be identified and, where necessary, offered support. This listening and working through of a previous birth allows the mother (and partner, if present) to verbalize feelings, identify fearful moments and find ways of strengthening her self-confidence.

Women can be informed of the birth reflection service by their general practitioner (GP), midwives based within the hospital and community, physiotherapists and health visitors. Women can also self refer, with women recommending the service to other women. Involvement with family social workers, community mental health teams, psychiatrists and obstetricians can also support women where necessary. For some, this may be the first time they are able to verbalize the trauma they felt and express their views about future childbirth. Others are able to say that although they wanted more children, they felt their previous experience and the fear surrounding it prevented them from doing so. In allowing women further sessions to explore their feelings, many are able to consider further pregnancies. Having a greater understanding of intense fear and anxiety surrounding pregnancy and childbirth can enable health professionals to identify women¹³ who are distressed at an initial or early appointment or who immediately request a cesarean section. Such women may have broken down at an antenatal appointment or walked out of a parent education class in tears, unable to stay.

CASE STUDY

A woman presenting with secondary tocopobia was referred by the community midwife to the Birth Reflection Service following the initial appointment. The community midwife recognized her distress and offered her support. The woman sobbed uncontrollably as she remembered the events of her first birth. On reviewing the maternity notes, the delivery appeared to have been a normal straightforward vaginal birth. However, the woman's perspective was one of a traumatic experience where she felt no one had listened to her or involved her in the decision making. She suffered with postnatal depression for 2 years following the birth and was treated with medication.

The second pregnancy was unplanned, and the woman had an appointment to terminate at 9 weeks, but decided, at the last minute, that she could not go through with it. She felt caught, because she also felt she could not go through labor again. As a result, she was late in seeking antenatal care (18 weeks).

At the initial meeting, she was able to begin to share her feelings with the midwife counselor. She hated the thought of an 'alien' being inside her, the feeling of 'it' moving around inside of her, and felt sickened when anyone acknowledged her bump. Although support was provided it was not until the 36th week of pregnancy that she dared think about 'the alien' as her baby. Only then did she allow herself to walk past baby items and purchase something for the baby.

Sharing and acknowledging her feelings was not an easy process and involved much emotion and pain as she recalled the last birth. She was petrified of her forthcoming birth and felt that the professionals had not taken her seriously.

In preparation for the birth, meetings were arranged once a month, gradually increasing to fortnightly and then weekly from approximately 36 weeks. When these appointments were made, it was understood by the midwife

counselor that if the woman felt content and able to cope, then she could cancel an appointment if she so wished, thus allowing the woman to feel more in control and giving her flexibility and trust. Meetings included visits to the labor ward and obstetric theaters, and introducing the woman (and partner, if present) to members of staff. As part of the management, an early epidural was discussed which enabled the woman to feel more in control.

On admission, an epidural was administered at 4 cm dilation. The woman labored well and achieved a spontaneous vaginal birth. On later reflection of her birth, her experience was completely different to her first one, as she felt that people had listened to her and included her in the decision making.

AN EXAMPLE OF SOME PRIMARY TOCOPHOBIA EXPERIENCES

Although there are similarities between primary and secondary tocopobia, distinct differences also exist. In our experience, primigravida had not shared their fear with anyone, even when breaking down at the midwife or general practitioner's (GP) appointment. It was only when pressure from a partner to start a family was applied that they were able to confide that they had a fear of childbirth, and in some cases this did not happen until well into the pregnancy. The common factor that they all shared was that in the process of giving birth and in dilating during the second stage to deliver the baby, they thought that they would die. They were unable to disclose this fear other than to ask for a cesarean section simply saying they had a fear of childbirth.

Because this fear is profound and terrifying women find it difficult to express and share their true feelings or seek preconception advice. When sharing their intense anxiety (they did not share their real fear) with a health professional, these women were often told 'this is normal, all women are afraid'. The

fear, however, was so dominant that they knew this was not the case and often felt undervalued, unable to share their real fear of dying. It was not so much about the pain of childbirth but more about the dilating during the second stage being described, as like trying to get 'something the size of a melon through an opening the size of a small orange'. They felt that in the process they would die.

Many women knew that their fear was not rational, but were unable to feel differently. They felt that a cesarean section was their only option. This fear was so great that they also appeared to be in denial of their pregnancy. In meeting with these women over a number of years, although few in numbers, they all presented with a similar history, disclosing that they had this fear for as long as they could remember and, while they really wanted a baby, they delayed starting a family for as long as possible. Eventually with pressure from their partner, they agreed to have a baby and, while they stopped contraception, they did not plan for it to happen either. Whereas their partners were overjoyed by the pregnancy, the women were struck by fear and in denial, seeking care late and wearing clothes that concealed the pregnancy. They often avoided antenatal classes or only attended some of them. They also disclosed, in the attempt not to confront their pregnancy, that they were often unable to enter baby shops to look at baby equipment or clothes, and often were unable to buy any of the items required to create a nursery. Frequently it was the partner who did this and in some instances the women did not allow anything into the house that could remind them of the pregnancy. They disliked discussing the pregnancy with friends or relatives. There was also a reluctance to share their fears with medical professionals as their perception was one of being judged for not wanting the baby, which was not the case; the baby was very much wanted.

These women's thoughts were very positive regarding the baby and there was a feeling of

great excitement in thinking about the baby once born. However, there was a strong sense of wanting to fast forward the whole process and to be able to hold and nurture their baby. By attending regular sessions to explore their fear they were able to share something that was so profound to them, this fear and dread of death. They understood that their fear was not logical and sharing it was profound, as they felt they would be judged as being 'mad'.

Regular sessions with these women helped build the trust between the midwife counselor and the women who were able to learn how their bodies responded and to gain a greater understanding of the labor process. The midwife counselor, with the permission of the women, shared with the staff the women's fear of dying during labor. In doing this, it raised the staff's awareness of tocophobia and while most staff were keen to learn and be supportive, there were staff who felt that all women have anxieties about birth and that this was no different. This included some doctors as well as midwives. Although these members of staff were in the minority, one cannot ignore the fact.

Over the weeks, women started to explore the idea of a vaginal birth as opposed to a cesarean section and as the due date approached, the midwife counselor discussed with the women the possibility of a vaginal birth. These women often stated that they really wanted a vaginal birth but that a cesarean section was the option for them to get through their specific fear.

The next step was to prepare a robust care plan with the women. With their agreement, details pertaining to their fears, issues and needs were documented in the case notes and within their care plans. One of their wishes was often that they could 'bale out' at any time and have a cesarean section. Although they wished to have a vaginal birth, they had a deep-rooted need to feel that they could have a cesarean section. This gave them a sense of control. As only a consultant can agree a cesarean section,

an appointment was made with a consultant, including the midwife counselor, where all three could discuss this issue. Most consultants agreed to write in the woman's labor notes that she could have a cesarean section at any time in her labor should she request it and the note also stated clearly that the woman suffered from tocophobia. This 'safety net' is often not used. It cannot be over emphasized how important this was to these women; however, it was also explained that on a busy labor ward a cesarean section could not always be performed to order. The women understood that if there was an obstetric emergency that it would take priority and they would have to wait. This was also the case regarding an epidural and women accepted this.

Whilst one-to-one care is highly recommended, carers must not promise women support that cannot be delivered. Honesty and trust is very important in the relationship between members of the multidisciplinary team caring for these women.

The midwife counselor should meet all the obstetric registrars who will be working on the labor ward and should explore the individual woman's birth plan with them, explaining the extent of the fear. For many, this may be the first time they have heard of tocophobia, so educating and sharing is paramount. It is hoped that in meeting with the registrars, the registrars will have a greater understanding if the woman feels the need to request a cesarean section in her labor that the consultant has agreed can be performed.

These women, often remaining in denial regarding their pregnancy, would remain in denial when they went into labor and would avoid the hospital and remain at home for as long as possible, often coming into hospital well into established labor. With the support of the multidisciplinary team, women with the phenomenon of fear of death at the time of cervical dilation achieved a vaginal birth. Aided by the therapeutic process, these women were able to share this deep-rooted fear, despite feeling at the beginning of their

pregnancy that the only option for them was a cesarean section.

There was also a high level of commitment by the midwife counselor to constantly ensure that communication was effective and the support was constant. Every possibility was meticulously covered to ensure that they received the one-to-one care and support they felt they needed to achieve a vaginal birth. Obviously this approach is labor intensive and throws into question the realism of the commitment with larger numbers of women in busy labor wards. However, with the right support these women were able achieve a vaginal birth and confront their fear. One could argue therefore that this kind of involvement is indeed cost-effective. Psychologically and emotionally the women feel listened to and supported, which may have long-term effects for the individual woman and her family.

Not all consultants agreed to documenting that a cesarean section could be carried out at anytime during labor, with what was perceived to be no medical indication. If this was the case for those women, they felt that their only option was to have an elective cesarean section on 'maternal request'. In our experience, none of the women who had the cesarean section option documented in their notes needed to use the option.

In our practice, over a period of time, women with tocophobia have returned to have a second baby and been able to have a vaginal birth; they no longer needed the previously required support. Having had a vaginal delivery the first time, seemed to have confronted their fear and enabled them to enjoy a next pregnancy. During their second pregnancies these women embraced all aspects of maternity care and advice which placed them in a healthier position.

SUMMARY OF THE MANAGEMENT OF WOMEN WITH TOCOPHOBIA

Health professionals need to be able to recognize what may be classic symptoms of

tocophobia in women such as vague distress unrelated to anything specific, excessive nervousness or anxiety, bouts of crying, odd behavior and early requests for cesarean section. Such women should be brought into contact with a health professional(s) who can give expert advice where possible and create an atmosphere where the women can feel safe to disclose their fear(s), where they can feel heard and listened to without feeling judged. The building of a trusting relationship involves the midwifery team, the obstetric team and psychological support. These women need practical help rather than 'labeling'. Although some women feel relief that tocophobia is acknowledged and they are not alone in their fear, for some the 'label' may be reassuring. Health care workers need to realize that working closely as a team is imperative for these women, to ensure that the appropriate professional is available for advice and support.

It is important to develop a plan of care that documents information provided to help support the team caring for these women, including the extent of the women's fear and, ensuring that the women are part of the decision-making process. Women may wish to have a vaginal birth, but may have been sexually abused as a child and want minimal vaginal examinations, or only female attendants; these requests can be built into the birth plan. In the authors' experience, the more women are able to share with the professionals caring for them, the happier they are with the birth experience. One-to-one care is also important for these women, as is an early epidural which provides more control from a psychological perspective.

Taking the women to the labor room and obstetric theater for an explanatory tour can help dispel any preconceived ideas about how they imagine the rooms to be, especially for the nullipara or for the multipara who has previously delivered at another institution. Introductions to members of staff who may be on duty can also be helpful. For some women, the

fear is so intense that it may take several visits to the hospital before they feel secure and safe enough to enter the labor ward. As trying as this may be for some health professionals, the multiple visits can be a powerful experience for some women that allows emotions and fears to be worked through as well as clarifying any distorted notions of what the room might contain. This is especially true for the primigravida, whereas for the multigravida, it may be about lost expectations, or dreams of how they imagined the birth.

SUPPORTING WOMEN

It is important that women with fear of childbirth have access to professionals who are qualified to support them. The NICE guidelines regarding counseling women in relation to cesarean section state that women who have a fear of childbirth should be offered counseling to help them address their fear in a supportive manner¹⁴. Counseling support is an effective way to help women experience birth in a way they find acceptable¹¹.

Midwives occasionally undertake counseling roles beyond their training and abilities⁹. It is necessary for midwives and health professionals to work within their remit and not press for information that may open painful past experiences, for example those in childhood that may not be able to be fully worked through such as sexual abuse. Health professionals need to be aware of boundaries. Respect for the women at this vulnerable time is paramount.

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