Antenatal

Routine screening of all pregnant women at first contact with maternity services. See NWC pathway for antenatal and postnatal mental health.

Anxieties around child-birth raised at any point. This may include pre-conception advice and requests for elective caesarean section or termination of pregnancy due to anxieties.

Has the woman given birth previously?

No

As part of routine antenatal care, ask the Tokophobia screening questions:
• How do you feel about the pregnancy?
• What are your thoughts and plans for childbirth?
• What are your feelings towards the baby?

Yes

As part of routine antenatal care, ask the Tokophobia screening questions:
• How do you feel about the pregnancy?
• What are your thoughts and plans for childbirth?
• What are your feelings towards the baby?
• What was your previous experience of childbirth like?

Based on the questions above, have any concerns relating to the mother and/or the parent-infant relationship been identified?

No

Follow routine antenatal care and continue to monitor and screen in accordance with the NWC pathway for antenatal and postnatal mental health.

Yes

With the woman’s consent, refer to Specialist Perinatal Mental Health Midwife or Consultant Midwife at earliest possible date (ideally between 20-24 weeks gestation).

At the same time, consider referral also for additional mental health intervention (right) based on severity of symptoms, with the woman’s consent. Consider the use of a screening tool (see notes) and/or liaison with Specialist Perinatal Mental Health Service to inform clinical decision making.

Augmented and tailored package of care to be offered including:
• Tokophobia information
• Psychoeducation on childbirth
• Familiarisation visit to place of birth
• Specialist appointments as appropriate
• Information on childbirth options provided
• Option for elective caesarean section discussed and remains open if relevant
• Complimentary therapies as appropriate
• Optimise continuity of care in maternity team

Multi-disciplinary birth planning by 32 weeks of pregnancy.
• To include both psychological and obstetric/maternity aspects of care
• Include birth plan in notes and communicate with multi-disciplinary team

Mental health services input

Birth – implement birth plan as appropriate.

Monitor mental health postnatally as per NWC Antenatal and Postnatal pathway for Mental Health.

Pathway ends
Women should be asked about their mental health and well-being, in accordance with NICE Quality Standards and the NWC pathway for antenatal and postnatal mental health.

**Tokophobia and birth trauma pathway V2.2 02/21**

**Postnatal**

Routine screening for birth trauma during post-natal care, as per NWC Antenatal and Postnatal Mental Health Pathway (minimum: at discharge from hospital, from Community Midwife and at 6/8 week check).

**Note:** risk of PTSD is elevated for parents of babies requiring neonatal care.

**Mild to moderate symptoms of birth trauma identified**

- Midwife or Health Visitor to:
  - Provide information on childbirth / birth trauma association leaflet
  - Watchful waiting / listening visits during first 6-8 weeks postnatal
  - Monitor parent-infant relationship

**Symptoms resolve**

- With the woman’s consent, refer for a birth reflections appointment with Specialist Perinatal Mental Health Midwife / Consultant Midwife / Obstetrician

**Symptoms persist**

- With the woman’s consent, consider referral for mental health assessment based on severity of symptoms and/or parent infant mental health services if significantly impacting on parent-infant relationship. Refer to Specialist Health Visitor for Perinatal and Infant Mental Health (where available)

  Consider the use of screening tools such as GAD/PHQ to aid decision making, as per NWC pathway for antenatal and postnatal mental health.

**Severe symptoms of birth trauma identified**

**Symptoms resolve**

- With the woman’s consent, refer for a birth reflections appointment with Specialist Perinatal Mental Health Midwife / Consultant Midwife / Obstetrician

**Symptoms persist**

- With the woman’s consent, consider referral for mental health assessment based on severity of symptoms and/or parent infant mental health services if significantly impacting on parent-infant relationship. Refer to Specialist Health Visitor for Perinatal and Infant Mental Health (where available)

  Consider the use of screening tools such as GAD/PHQ to aid decision making, as per NWC pathway for antenatal and postnatal mental health.

**Mild to moderate mental health symptoms**

- Main impact on parent-infant relationship.

- Evidence based psychological intervention in the maternity setting (where available). Consider referral for peer support.

- Refer to Parent Infant Mental Health Services and/or Specialist Health Visitor for Infant and Perinatal MH.

**New severe or complex mental health symptoms**

- Main impact on mother.

- Refer to IAPT services.

**Already open to secondary care**

- Refer to Specialist Perinatal Mental Health Services. To include assessment and intervention for both perinatal and parent infant MH needs.

**Interventions provided by Secondary Care Mental Health.**

Pathway ends
Most women report some degree of concern, apprehension or fear about pregnancy and childbirth. However, for a minority of women the fear becomes a phobic response that affects pregnancy, childbirth choices and mental health. These guidelines are intended to help clinicians accurately screen for (primary and secondary) tokophobia, and make decisions about what is needed next. Where decisions about next steps remain unclear, services should work together with a focus on shared decision-making, collaborative treatment planning and enabling choices.

**Key questions for the screening of Tokophobia (expanded):**
- How do you feel about the pregnancy? (look for ambivalent or negative emotions, anxiety symptoms)
- What are your thoughts and plans for childbirth? (if she requests a caesarean section but there is no medical indication for it, explore the reasons why)
- What are your feelings towards the baby? (ask during pregnancy as well as postnatally; tokophobia and/or birth trauma are likely to make it more difficult to form a bond with the baby)
- What was your previous experience of childbirth like? (where applicable; look for symptoms of post-traumatic stress disorder such as frequent thoughts/images of the birth, flashbacks, nightmares, avoiding reminders of the birth).

**Consider the following risk factors for Tokophobia:**
- Previous childbirth that was experienced as traumatic: this relates to a woman’s subjective experience of childbirth independently of whether or not there were any obstetric complications; it can include not only perceived risk of medical events such as maternal or infant death, but also perceived threats to integrity such as feeling violated, out of control or abandoned.
- Previous adverse medical/surgical experience.
- Previous traumatic experience of witnessing childbirth either personally (e.g. family member) or professionally (e.g. as healthcare staff).
- Pre-existing anxiety or mood disorder.
- History of sexual abuse or rape.
- History of sexual dysfunction.
- Previous miscarriage, stillbirth or neonatal death.
- Previous adverse experience of being a parent of a baby requiring neonatal care.

**Screening tools**
- There are few validated measures of tokophobia. The following measures were found to have reasonable reliability and validity:
  - Wijma Delivery Expectancy Questionnaire (WDEQ-A) by Wijma (1998) (most extensively validated, yields detailed information).
  - Fear of Birth Scale (FOBS) by Haines (2011) (quick and easy to use, good for initial screening).
- For secondary tokophobia, there may be symptoms of post-traumatic stress from a previous birth. Using a measure such as the Impact of Events Scale-Revised (Weiss & Marmar, 1996) in relation to this previous birth may provide a useful indication of the severity of these symptoms. The City Birth Trauma Scale (Ayers, Wright & Thornton 2018) is also a promising Birth Trauma specific measure.

**Key post-traumatic stress (PTSD)/birth trauma symptoms**
- Re-experiencing: frequent thoughts or images of the birth, nightmares, flashbacks, high levels of distress or anxiety.
- Avoidance: avoiding reminders of childbirth e.g. hospitals, TV programmes about birth, friends who are pregnant, avoiding talking about or thinking about childbirth.
- Hyperarousal: hypervigilance, exaggerated startle response, sleep problems.

**References and further information**
- NICE CG192 Guideline for Antenatal and Postnatal Mental Health
- NICE CG132 Guideline for Caesarean Section
- NICE QS115 Quality Standard for Antenatal and Postnatal Mental Health
- NICE QS32 Quality Standard for Caesarean Section
- North West Coast Antenatal and Postnatal Mental Health Pathway, NWC Perinatal Mental Health Network
- RCOG leaflet ‘Choosing to have a caesarean section’: https://www.rcog.org.uk/en/patients/patient-leaflets/choosing-to-have-a-caesarean-section/
- Your Rights in Childbirth http://www.birthrights.org.uk/
- Birth Trauma Association http://www.birthtraumaassociation.org.uk/
- Birth Trauma Association Advice Leaflet https://www.birthtraumaassociation.org.uk/for-parents/leaflets-for-parents
- Stillbirth and Neonatal Death (SANDS) https://www.uk-sands.org/