UNDERSTANDING TOKOPHOBIA PHENOMENON AS A KEY TO PROPER MANAGEMENT

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RUNNING TITLE
Tokophobia

KEYWORDS
tokophobia, fear of childbirth, analgesia, anxiety

WORD COUNT
1043

CONFLICT OF INTERESTS
no conflicts of interest

ABSTRACT
Tokophobia also known as fear of childbirth (FOC) becomes a frequent psychiatric indication to Caesarean section which makes it a rising problem of current obstetrics. Patients with FOC may suffer from additional psychiatric conditions such as depression. Women with higher risk of developing tokophobia are those with immense levels of fear of pain, young, with low educational level, poor socio-economic status, low self-esteem and lack of proper knowledge concerning peripartum period. History of unfortunate events during previous deliveries or illness of the older child are also associated with more frequent occurrence of FOC. Adequate management of FOC focuses on implementing psychotherapy. Symptoms of FOC can be decreased by means of qualified and trustworthy medical staff during labor or support from a closely related person. Secondary tokophobia can be prevented by minimalisation of negative experience during the first birth. If tokophobia is the symptom of depression, the underlying illness should be treated. Tokophobic patients are more prone to experience higher levels of pain during labor, which makes peripartum pain management harder for clinicians. FOC is one of the main reasons for performing caesarean delivery on maternal request (CDMR), which may lead to post-operative complications. Research shows that FOC is related to anxiety concerned with lower self-esteem due to changes occurring in women’s body during pregnancy and delivery. Learning and understanding the reasons behind tokophobia might lead to reducing the number of patients suffering from this condition and in consequence minimalizing the number of performed CDMR.
okophobia (from Greek toko meaning "birth" and phobos meaning "fear") is a fear of childbirth (FOC) and a variety of aspects related to it. Since the anxiety in the antenatal period is presented by up to 80% of women, tokophobia is defined as a pathological fear, exceeding the level observed in majority of patients, forcing 6-10% of women to avoid vaginal delivery and search for the possibility of Caesarean section (CS) [1].

So far, three types of this condition have been described: primary tokophobia, secondary tokophobia and tokophobia coexisting with depression. Primary tokophobia is characterized by an early onset, predating the pregnancy by years, sometimes as early as in adolescence, referring not only to the childbirth, but quite often to the pregnancy itself. Secondary tokophobia develops as a result of traumatic experience during earlier pregnancies (i.e. emergency CS, failure of analgesia). Patients suffering from tokophobia coexisting with depression present obsessive thoughts about risk of fatal complications during peripartum period or about being unable to give birth [1,2]. Women with tokophobia experience fear of possible pain and trauma they could be exposed to, but also of not being able to physically cope with the new experience, not receiving enough support or even perinatal death [1,3,4,5,6]. Tokophobia is one of the main reasons for performing caesarean delivery on maternal request (CDMR) and is described in the literature as psychiatric indication for performing CS [1,7,8,9]. The growing number of CSs is becoming the matter of concern for clinicians and governments. Only in Poland the percentage of the CSs doubled between 1999 (18.1%) and 2012 (37.0%) [10,11].

CHARACTERISTICS OF PATIENTS WITH TOKOPHOBIA

Studies show that there are several features predisposing patients to development of tokophobia, among which are fear of pain, young age, low educational level, poor socio-economic status, low self-esteem, lack of proper knowledge, unfortunate events during previous deliveries or illness of the older child [1,4]. The fear of pain strictly correlates with sensitivity to it, which was proven by Saisto et al. – tokophobic patients are experiencing more intense pain than patients form control groups. Authors concluded that fear experienced by tokophobic patients leads to higher level of pain from which they suffer during delivery [12]. It was also observed that patients with FOC present lower levels of norepinephrine in response to painful stimuli than women from the control group [13]. In addition, tokophobia also leads to the labour lasting longer, with lengthening of the both first and second stage of labour up to 1/3 (10.5 vs 7.8 h, p=0.016 of the first stage and 42 vs 47 min., p=0.002 of the second stage) [14]. Moreover, women who needed surgical intervention during earlier pregnancies or those who required forceps or vacuum assistance during delivery, were more prone to developing tokophobia during next pregnancies [14].

In 2016 Hammama-Raz et al. compared intrapersonal and interpersonal factors which might have an impact on developing tokophobia. The data was collected from the Internet survey. 577 women over 18 years old with no serious mental or medical conditions completed online questionnaire. The demographic section of the survey included age, marital status, number of children and years of education. Participants were asked to provide information regarding relationship satisfaction, body image, self-esteem, life satisfaction, attitude towards pregnancy and birth, and FOC. Participants were divided into two groups, regarding whether they had or had not given birth before. None of the demographic factors was associated with tokophobia in the group of nulliparous women. Intra- and interpersonal characteristics were also insignificant in accordance to tokophobia. However, fear of body change and preventing body change by undergoing CS were positively associated with tokophobia and negatively with importance of pregnancy and birth. Attitude regarding the presence of the spouse during labour was not associated with FOC [15].

Among the parous group of participants, neither demographic, nor the inter- and intrapersonal characteristics were significant. The presence of the spouse during labour was also insignificant. However, attitudes toward pregnancy and birth, fear of body change, and considering adoption instead of natural birth were positively associated with tokophobia [15].

The fear of body change presented by women from both groups and its association with tokophobia might be linked with the beauty standards which are imposed by modern culture [16]. Women after pregnancy and birth are often less satisfied with their body image and feel less sexually attractive. Their identity changes from female to maternal [17]. The perspective of not fitting the strict beauty standards may cause anxiety, fear and lead to development of tokophobia [15].

Another important risk factor for FOC is history of abuse as women who reported sexual or physical abuse in childhood were more prone to higher levels of fear during birth, operative vaginal delivery and emergency CS [18].

Spice et al. examined the relationship between FOC and anxiety sensitivity (AS) [19]. 9% of women in their sample suffered from FOC which was comparable to rates of other researchers using the same method for FOC diagnosis - Wijma Delivery Expectancy/Experience Questionnaire [20,21]. Results showed that primiparous women were at higher risk of FOC than multiparous which confirmed previous findings [5,19,22,23]. Moreover, elevated trait anxiety was identified as a risk factor for experiencing FOC [19]. Eventually, AS was recognized as a significant predictor of FOC, separately from trait anxiety [19].

MANAGEMENT OF PATIENTS WITH TOKOPHOBIA

Both physical and psychological examination of patients with FOC is essential [19]. Physical complaints of women suffering from FOC may be symptomatic for fear and increased sensitivity to physical stimuli [2,13,19]. As Spice et al. suggests FOC can be predicted primarily in accordance to AS and is more strongly related to fear of pain rather than social consequences of anxiety.
symptoms [19]. Therefore, adequate quality and availability of peripartum analgesia is recommended. The need of analgesia and length of labour can be decreased due to presence of qualified medical staff and support from familiar person [24,25]. Fundamental method of FOC management is psychotherapeutic intervention [1,2,6]. Establishing specialized teams including the physician, the midwife and the psychologist increases focus on early identification of patients at risk of developing FOC and implementing prophylaxis or proper management depending on patient’s individual needs [6]. Effective therapy leads to decrease in labour length, fear levels and prevents negative experience associated with childbirth in women with FOC [18,26].

CITE THIS AS
MEDtube Science 2016, September 3(4), 12 - 14

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