

Tokophobia: Fear Of Pregnancy And Childbirth

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Abstract

Tokophobia is a pathological fear of pregnancy and can lead to avoidance of childbirth. It can be classified as primary tokophobia or secondary tokophobia. Fears are more intense and more common in primigravidae than in the multigravidae. Women with tokophobia can have increased psychological morbidity during both antepartum as well as postpartum period. Increased incidence of caesarean section is found in this group of women. Management in terms of proper childbirth education and counselling should be implemented in modern obstetrics.

INTRODUCTION

Pregnancy is a major physical, psychological as well as social event in every woman's life. Instead of being a joyful and exciting time pregnancy may become a worrisome event in few patients and these fears may assume a pathological dimension and becomes a medical disorder worth recognition and treatment. It is understandable that women may have some apprehension because of lack of experience and upcoming responsibilities of motherhood. Increasing awareness and education may make them knowledgeable and at the same time apprehensive regarding the morbid accompaniments of labour and its sequel. Some amount of fear is therefore rational and acceptable. Majority of women are able to cope up with these fears and anxieties by self help efforts, social support and help of medical attendants. But when it becomes pathological dread it is called tokophobia.

TOKOPHOBIA CLASSIFICATION

Tokophobia (from the Greek tokos, meaning childbirth and phobos, meaning fear) is classified as follows:-

Primary – Morbid fear of childbirth in a woman, who has had no previous experience of pregnancy. The dread of childbirth may start in adolescence or early adulthood. Although sexual relations may be normal, contraceptive use to delay the pregnancy is often scrupulous (1). Generally pregnancy is avoided because of fear of labour. In some cases women may be so terrified that they may terminate a wanted pregnancy rather than go through childbirth. Some patients may already seek an obstetrician who could perform an elective LSCS even before becoming pregnant for first time. Some patients are never able to overcome this fear

of childbirth and remain childless throughout life and some adopt children, instead of going through pregnancy and labour. Some women enter into the menopause having never delivered a much desired baby and grieve this loss into old age.

Secondary – Morbid fear of childbirth developing after a traumatic obstetric event in a previous pregnancy. But it could also occur after an obstetrically normal delivery, a miscarriage, a stillbirth, or a termination of pregnancy.

Secondary to depressive illness in pregnancy – Less commonly, prenatal depression may be present with tokophobia. With this, there is no morbid dread of childbirth and this fear is in stark contrast to the women's prepregnancy and predepression beliefs (2).

PREVALANCE OF TOKOPHOBIA

Fears related to pregnancy and childbirth is common. In 1941 Sonrag stated that a woman emotional state could affect her pregnancy and its outcome (3). He stated that deeply disturbed maternal emotions produce a marked increase in the physical activity of the foetus. A variable number of 20% to 78% of pregnant women report fears associated with the pregnancy and childbirth (4, 5). However 13% of nongravid women report fear of childbirth sufficient to postpone or avoid pregnancy (4). Fears are more common and more intense in nulliparous than in parous women (6, 7). Women who experience fear and anxiety in previous pregnancy are likely to suffer again in subsequent pregnancy. Incidence of demand LSCS is also gradually increasing due to the fear of childbirth (8).

PHARMACOLOGICAL BASIS

The theory that anxiety during pregnancy can interfere with the delivery process has been supported by some prospective studies (9, 10, 11, 12). Such interference can occur directly by psychophysiological pathways. Pharmacologically, epinephrine has been associated with enervated uterine contractility, and norepinephrine with intensified uterine contractility (13). Self-reported anxiety during labour was found to be correlated with the concentration of epinephrine in plasma (14). Longer duration of the second stage of labour has been observed in women with higher catecholamine concentrations (13). Women with antenatal fear of childbirth have also been found to run an increased risk of dissatisfaction with their delivery experience (15). They also tend to have an increased rate of caesarean section and operative vaginal delivery (16).

AETIOLOGY OF PRIMARY TOKOPHOBIA

The aetiology of primary tokophobia is multifactorial.

Social culture – Fear of childbirth may transmit over generations (17) and this can produce a second generation effect of a mother's own unresolved frightening experience (18). It is suggested that women's reproductive adaptations are like that of their mother's. This suggests a psychological heredity (18).

Anxiety theory – A phobia is an avoidance response and it is learnt through a frightening experience or seeing other person's fearful responses or through instruction (19). Zar (20) and Lazarus (21) have investigated fear of childbirth and postulate that majority of problems are because of the expectations from the delivery. Fear of the childbirth has been associated with proneness to anxiety in general or may occur to a person who has familial predisposition to anxiety disorder.

Trauma and abuse – A history of childhood sexual abuse could be associated with an aversion to a gynaecological examination. The trauma of vaginal delivery or even contemplation of it, may cause a resurgence of distressing memories. This can lead to dread and avoidance of childbirth (1).

CLINICAL IMPLICATION

It is important to detect maternal anxiety and fears during pregnancy as it may have a deleterious effect on the course as well as outcome of pregnancy. Antenatal stress and anxiety has been associated with preterm and post-term

delivery, foetal growth restriction and low birth weight (22, 23). Women with antenatal fear of childbirth have been found to have not only an increased risk of dissatisfaction with their birthing experience, but also an increased rate of caesarean section and operative vaginal delivery (15,24). Fear of pain is associated with more pain and distress during labour. Women suffering from fears during pregnancy are also at increased risk of emotional imbalance after childbirth. Anxiety, distress and depression during pregnancy are associated with postpartum depression and impaired bonding with the child. Stress during pregnancy may also be a risk factor for delay in motor and mental development in infants (25), development of colic's in the neonates (26).

CAUSES OF FEAR

The most common fears associated with pregnancy and childbirth are concerned with the baby's well being, the course of pregnancy and childbirth (6). A large study of more than 8000 pregnant women revealed that the most frequent fears mentioned were fear for the child's health as pregnancy outcome (50%) and fear of pain (40%) (27). Primiparous women experience more fear than multiparous women (6, 7), more so about labour pain, responsibilities of motherhood and injuries during childbirth. Other studies have suggested that the fears of delivering a congenitally malformed or physically damaged child are the common ones (28, 29). Fears concerning the behaviour and conduct of healthcare staff during labour are common in studies reported from west (5). Sjogren studied the reasons for anxiety about childbirth in 100 pregnant women referred to a psychosomatic outpatient clinic because of extreme fear of childbirth. He found that anxiety over the delivery was related to lack of trust in the obstetrical staff (73%), fear of own incompetence (65%), fear of death of mother, infant or both (55%), intolerable pain (44%) or loss of control over self (43%) (30). In parous women, negative experiences of previous childbirth such as pain, complications during pregnancy or childbirth, having an injured or malformed child, delivery by an unanticipated caesarean section or postpartal problems have also been reported to cause fears in subsequent pregnancies. Previous good childbirth experiences and knowledge about childbirth significantly increases women's confidence and allays fears. However, emergency CS and operative interventions during previous deliveries are associated with secondary fear of childbirth (15). Negative information obtained from other people's stories or alarming publications may originate fears in some women. Even knowledge gained during childbirth

education programmes or professional education may aggravate fear in some ((₃₁)). Medically high risk women have high levels of anxiety and distress concerning the course and outcome of pregnancy (₃₂).

MANIFESTATIONS OF FEARS

The pregnancy related fears may result in anxiety and stress manifesting as changes in emotions, behaviour or physical symptoms (₆). Symptoms of stress include restlessness, nervousness, and sleeplessness, crying episodes or even tachycardia, change in eating habits or physical activity. Some women feel paranoid and unable to enjoy pregnancy, while other may wish to have a caesarean section because of fear of vaginal delivery (₅).

COPING UP STRATEGIES

There is negative correlation between antenatal stress and social support (₃₃). Better the support system, lesser is the antenatal stress load. Most of the women with fears seek support from their spouses, mothers, sisters and/ or other family members, while some look to friends and colleagues for support (₃₁). Support may be in the form of emotional support, seeking information or simply sharing experiences. Research has shown professional support to be very important in dispelling or alleviating fears associated with pregnancy and childbirth. Sjogren and Thomassen have shown in 100 women that psychosomatic support for women with severe fear of delivery resulted in a 50% reduction in the rates of caesarean section births for psychosocial indications (₃₄). Childbirth education is a good way to alleviate fears. The information or knowledge may be obtained either from books, specialists or antenatal classes. Although knowledge may partly be responsible for the origin of some of the fears, the way in which information is given determines whether it will cause or alleviate fears. Knowledge and information delivered positively are helpful in alleviating fears. Antenatal screening tests certifying normalcy have also been shown to be effective in reducing the level of fear and anxiety experienced throughout pregnancy (₃₅).

CONCLUSION

Pregnancy and anxiety related to childbirth are very common in women. These fears and anxiety have individual variations. Healthcare professionals should try to make an attempt and explore the positive as well as negative influences around the pregnant women and at the same time encourage her to use the easily available social support system as a source of help. Programmes of diagnosis and

management of pregnancy related fears should be implemented in modern obstetrics. This would facilitate satisfactory delivering experience as well as may be able to decrease the high caesarean section rate.

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