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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

GUIDELINE FOR TOKOPHOBIA

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Introduction: What is tokophobia?

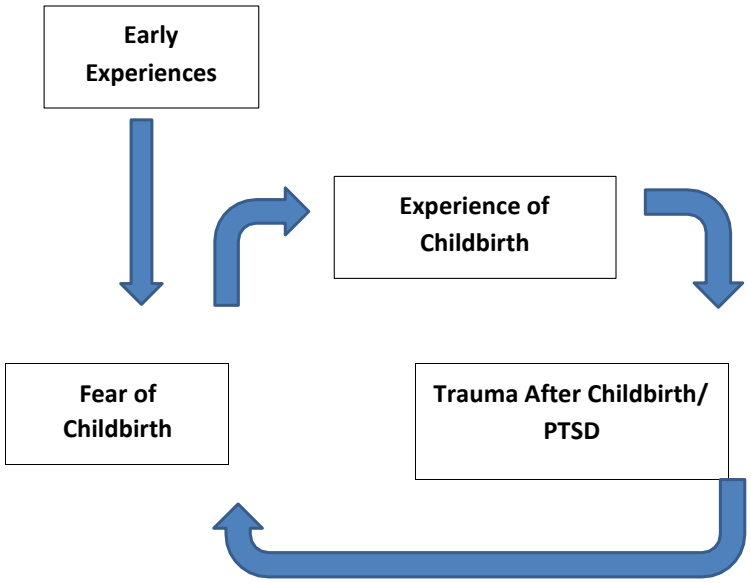
Aims:

- Early identification of fear of childbirth (antenatally) and post-traumatic stress disorder after childbirth (postnatally)
- Increased signposting to timely interventions for fear of childbirth and/or post- traumatic stress disorder after childbirth.

Tokophobia refers to a **marked fear of childbirth** (and sometimes fear of pregnancy) that gives rise to anxiety symptoms. There is usually avoidance of anything related to childbirth, such as talking about childbirth, watching programmes about childbirth and pregnancy itself is often avoided. Sometimes, women with tokophobia contemplate a termination of pregnancy because they are so distressed about the prospect of giving birth, or they may have undergone a termination of pregnancy in the past. When planning for birth, many (though not all) of these women request a caesarean section, even where there is no medical indication for it. A recent metanalysis (O'Connell et al., 2017) estimated that approximately 14% of women may experience severe tokophobia: many more will have mild to moderate anxieties about childbirth.

A woman with tokophobia is likely to experience severe anxiety symptoms during pregnancy that will impact on her birth experience and the care that she requires.

Fear of childbirth is usually categorised into **primary tokophobia**, which is longstanding often since childhood, and **secondary tokophobia**, which is subsequent to a previous childbirth that was experienced as traumatic. Secondary tokophobia is therefore commonly conceptualised and treated as a specific form of post-traumatic stress disorder (PTSD). It is much more common than primary tokophobia. The diagram demonstrates how fear of childbirth can arise as a result of early childhood experiences and/or from a traumatic experience of childbirth.



Fear of Childbirth and the Relationship between Primary and Secondary Tokophobia

January 2018

1 Timeline care pathway

The recommended care pathway for women presenting with fear of childbirth is summarised in the table below.

Timeline of care	Preconception	Booking 8-12 weeks or at 16 week midwife appointment	Antenatal Care 12-32 weeks	Antenatal Care 32 weeks	Intrapartum Care	Postnatal Care

Interventions	Access to consultation e.g. Specialist Mental Health Midwife/ Consultant Midwife. Information about tokophobia and care pathways. Access to discussion about previous delivery. If necessary, refer for psychological therapy in IAPT (if mild to moderate) or Community Mental Health/Psychology Services (if severe/complex).	Routine assessment of fear of childbirth. Appointment with Specialist Mental Health Midwife/Consultant Midwife or other perinatal mental health professional. If necessary refer for psychological therapy in Maternity, IAPT or Perinatal Community Mental Health Services (see text for guidance). Information leaflets. Tokophobia/trauma clearly identified on notes e.g. coloured sticker.	Early appointments with obstetrician. Specialist appointments (e.g. with anaesthetist) if appropriate. Birth/care plan collaboratively formulated. Continuity of carer (midwifery caseloading). Continue psychological therapy in Maternity/IAPT/Perinatal Community Mental Health Services.	Individualised birth care plan finalised, including medical and psychological aspects of care. Familiarisation visit to labour ward/birth centre. Psychoeducation about childbirth and relaxation may be helpful. Continue psychological therapy in Maternity/IAPT/Perinatal Community Mental Health Services.	Implementation of birth care plan. Handover includes birth care plan.	Postnatal follow up e.g. with Specialist Mental Health Midwife/ Consultant Midwife. Screen for birth trauma/PTSD. Assess mother- baby relationship. Access to information about birth/birth reflections appointment. If there are PTSD symptoms relating to the birth, refer for trauma-focused CBT or EMDR in IAPT (if mild to moderate) or in Perinatal Community Mental Health Services (if severe/complex).

Timeline of care	Preconception	Booking 8-12 weeks or at 16 week midwife appointment	Antenatal Care 12-32 weeks	Antenatal Care 32 weeks	Intrapartum Care	Postnatal Care
Information	Tokophobia information leaflet.	Page in maternity notes on tokophobia pathway. Tokophobia information leaflet RCOG leaflet 'Choosing to have a Caesarean section'.		Birth/care plan placed in notes and circulated to relevant professionals.		Birth Trauma Association Information. Information about IAPT/perinatal community mental health services/birth reflections.

2 Identification and assessment of tokophobia

Early identification of tokophobia is crucial in order to allow time to access appropriate treatment before childbirth.

On questioning, most women will report some degree of anxiety in relation to childbirth and the challenge is to ascertain whether they require intervention. This is further complicated by the fact that many of the risk factors for tokophobia are highly sensitive topics (e.g. history of sexual abuse or rape), which women may hesitate to disclose.

Key questions

- **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:

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

There are few properly validated measures of tokophobia. A simple indication can be given by asking the woman to rate her feelings about childbirth on a 0 to 10 scale, where 0 is not at all anxious and 10 is extremely anxious. The higher the score, the more significant the 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 will 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.

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.
- Some people report emotional numbing.

3 Risk

When working with women experiencing tokophobia there are specific risks to both mother and baby which should be considered.

Baby/fetal risk: During the early stages of a pregnancy, women with primary tokophobia are likely to be at increased risk of terminating pregnancies, including those which were previously wanted and planned, or resulting from assisted conception. During all stages of pregnancy there is evidence that ongoing anxiety as in primary and secondary tokophobia can impact on emotional and developmental outcomes for the baby in the longer term. Women are likely to find it difficult to form a bond with their baby (known as the attachment relationship), both during pregnancy and postnatally. Sometimes they may develop negative thoughts or feelings towards the baby, because the baby links to their experience of childbirth.

Maternal risk: There is a very high risk of severe levels of anxiety and depression during pregnancy for women with primary tokophobia. There will be symptoms of post-traumatic stress in secondary tokophobia and sometimes also in primary tokophobia. The risk of self-harm and suicide may be raised once a pregnancy progresses beyond 24 weeks' gestation (the legal limit for termination of pregnancy), as women may then feel trapped. It is also the case for many of these women that increasing proximity to the delivery is associated with increasing anxiety.

4 Interventions for tokophobia

These are summarised in the care pathway table

NICE CG192 Guideline for Antenatal and Postnatal Mental Health recommends: Primary and secondary tokophobia:

7.7.1.11 For a woman with tokophobia (an extreme fear of childbirth), **offer an opportunity to discuss her fears with a healthcare professional with expertise in providing perinatal mental health support.**

Secondary tokophobia:

Traumatic birth, stillbirth and miscarriage

7.7.1.18 Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends.

7.7.1.19 **Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR])**.

7.7.1.20 Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth.

In addition, expert clinical opinion suggests the following general principles of care:

- Clear care pathways for women with tokophobia allowing for local configurations of Maternity and Mental Health Services.

- Routine assessment of fear of childbirth by midwives at booking or at 16 week appointment, using the questions and measures given above.

- Early identification and signposting: Where tokophobia is identified, ensure that the woman is offered appointment(s) with a specialist mental health midwife, consultant midwife or other perinatal mental health professional.

This is usually the person who carries out a full assessment, decides whether it is necessary to refer on for psychological therapy or multidisciplinary perinatal mental health support, and who can co-ordinate and implement the other interventions described below.

When to refer on

Tokophobia can be assessed and diagnosed by any professional with perinatal mental health knowledge, including specialist midwives and obstetricians. Many women with mild or moderate anxiety may be managed by tailored support in maternity i.e. through a Specialist Mental Health Midwife/Consultant Midwife. A significant proportion will benefit from psychological therapy if they are referred early enough in pregnancy. Only the most severe and complex presentations will need to be seen by Perinatal Mental Health Services.

Is there an indication for psychological therapy? e.g. secondary tokophobia, post-traumatic stress disorder or other mental health problems such as anxiety or depression.

If so, refer to Clinical Psychology in Maternity if available. If not, for mild to moderate problems refer to IAPT; for problems that are severe, complex, with comorbidities or significant risk, refer to Psychology in Perinatal Community Mental Health Services.

Early referral is particularly important for psychological therapy so that the necessary work can be done within the timescale of the pregnancy.

Is there an indication for multidisciplinary mental health input? i.e. if the tokophobia is very severe, complex has multiple other mental health comorbidities which are also severe, or there are high levels of risk to mother and baby.

If so, refer to Perinatal Community Mental Health Services (or Community Mental Health Services in areas without specialist perinatal provision).

Any onward referral for psychological therapy and/or mental health support is in addition to providing tailored support in Maternity in the ways described below.

Interventions that can be provided in maternity

- Provide information about fear of childbirth and about the risks and benefits of different types of delivery (see Appendix for a Tokophobia Information Leaflet; Royal College of Obstetricians and Gynaecologists leaflet ‘Choosing to have a caesarean section’)

- Tokophobia/trauma should be clearly identified on the maternity notes e.g. a coloured sticker so that staff are immediately aware that anxiety about the birth needs to be taken into account.

- Early appointments with obstetrician/midwife to discuss anxieties and plans for the birth. Specialist appointments (e.g. with anaesthetist) if appropriate.

- Collaborative informed decision-making between the woman and her obstetrician/midwife about plans for birth and mode of delivery, which
- include clear information about the likely risks and benefits (medical and psychological) of different types of delivery for the woman and her baby.

- A clear birth care plan that has been collaboratively worked through with the woman and takes account of her anxieties about and preferences for childbirth i.e. makes recommendations for both medical and psychological components of care (see Appendix for an example). This includes close liaison between Maternity and Mental Health Services (e.g. IAPT/Perinatal Community Mental Health Services).

- Continuity of carer (caseloading) wherever possible.

- Groups offering psychoeducation about childbirth and relaxation may be helpful.

- Familiarisation visit to labour ward/birth centre.

- Peer support may be beneficial where available.

Postnatal follow-up

Postnatal follow-up is important in order to ascertain what the woman's experience of childbirth has been. This should be with the same professional seen antenatally wherever possible. It should include screening for traumatic experience of childbirth/PTSD and assessment of the mother-baby relationship. If there are PTSD symptoms relating to the birth, refer to IAPT (mild to moderate) or to Psychology in Perinatal Community Mental Health Services (if severe, complex, there are comorbidities or significant risk) for trauma-focused CBT or EMDR.

5 Guidance about caesarean section by maternal request or for psychological/psychiatric reasons

All interactions with women with tokophobia should be based on a shared understanding that should be made explicit to women from the earliest stages of pregnancy (even pre-conception):

- Appropriate support from Maternity and/or Mental Health Services will be offered to address her anxieties (see above).

- Maternity Services will work together with her towards a plan for the birth that takes account of both the physical and mental health of her and her baby.

- Ultimately, if the woman feels that a caesarean section is the best choice for her, it will be offered to her.

- The decision about mode of birth is likely to be made later in pregnancy. Often, the decision about mode of birth will be made in the third trimester, recommended as being at 32 weeks. Where it is clear that the psychological impact of a vaginal birth would be detrimental to the woman's mental health and it is considered that her anxiety is unlikely to respond to treatment in the time available, it may be helpful to work towards a planned caesarean section that is agreed upon at an earlier stage of pregnancy. Where the tokophobia is very severe, this certainty may allay some of the woman's anxieties with better outcomes for her and her baby.

If a woman requests a caesarean section and there is no medical indication for it, she should be seen by a Specialist Mental Health Midwife, Consultant Midwife or other perinatal mental health professional who can explore her concerns and screen for tokophobia (see above). Follow the care pathway referring for intervention in Maternity, IAPT or perinatal mental health services as above.

Following this (or if it is too late in pregnancy for the woman to access intervention in time), **if the Obstetrician is satisfied that the woman is suffering from primary or secondary tokophobia, it is acceptable to offer an elective caesarean section, which is usually carried out after 39 weeks of gestation.** Prior to this there is a significant risk of breathing difficulties of the new-born necessitating admission to special care baby unit.

In exceptional circumstances, an obstetrician may carry out an earlier planned caesarean delivery following discussions with the parents and neonatologist if the mother's mental health is felt to be significantly at risk.

NICE CG132 Guideline for Caesarean Section

1.2.9 Maternal request for CS

1.2.9.1 When a woman requests a CS explore, discuss and record the specific reasons for the request.

1.2.9.2 If a woman requests a CS when there is no other indication, discuss the overall risks and benefits of CS compared with vaginal birth and record that this discussion has taken place (see box A). Include a discussion with other members of the obstetric team (including the obstetrician, midwife and anaesthetist) if necessary to explore the reasons for the request, and ensure the woman has accurate information.

1.2.9.3 When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner.

1.2.9.4 Ensure the healthcare professional providing perinatal mental health support has access to the planned place of birth during the antenatal period in order to provide care.

1.2.9.5 For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS.

1.2.9.6 An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS.

6. Psychological therapy for tokophobia

Along with high quality maternity care that takes account of mental health, psychological intervention is the mainstay of treatment for many women with tokophobia. Regardless of whether this takes place in Maternity, in IAPT (for mild to moderate problems) or in Perinatal Community Mental Health Services (if severe tokophobia or with comorbidities or significant risk), it should be informed by the following principles (British Psychological Society, 2016):

- Prompt assessment and treatment (assessment within 2 weeks, treatment within 6 weeks of referral, NICE CG192).

- Close working relationships between psychological therapies and Maternity with regular two-way communication about mental health, obstetric needs and care planning.

- Specialist knowledge of pregnancy, childbirth and the postnatal period, including maternity care.

- Specialist perinatal psychology supervision.

- A weighing up of the likely costs and benefits of treating or not treating each individual woman at a given stage of pregnancy or postnatally and tailoring of treatment accordingly.

- Usually, trauma work should be initiated within the first or second trimester when the likely benefits of treatment will probably outweigh the risks of a temporary exacerbation of symptoms (Arch et al., 2012).

- After 30 weeks of pregnancy, treatment is usually restricted to stabilisation, postponing trauma focused treatment until after the birth. This is in order avoid higher levels of symptomatology at the time of giving birth.

- Intervention in pregnancy should include planning for the birth that takes account of the likely psychological impact, in conjunction with Maternity Services.

- After the birth, trauma-focused therapy can usually be commenced as soon as is practicable. Although there is no evidence specifically of the risk of treating trauma during breastfeeding, the known benefits of both breastfeeding and psychological intervention for PTSD are likely to outweigh any potential disadvantages. The exception to this is where there is a diagnosis of bipolar disorder or psychosis (particularly post-partum psychosis) where the woman is at very high risk of relapse postnatally: in these cases trauma focused work is contraindicated in the first 6 months postpartum.
- Interventions should take account of the relationship with the baby (both during pregnancy and postnatally) and the ways in which fear of childbirth and/or traumatic experience of birth may impact on this.

- Where tokophobia is severe, with comorbidities and/or with significant levels of risk, a multidisciplinary approach is required in the context of a Perinatal Community Mental Health Team.

7. Partners

Partners are often able to support women with tokophobia by listening to and containing their worries and offering a balanced view of childbirth. However, partners may also experience their own anxieties about childbirth, in particular where they have had a previous traumatic experience of birth, and may need to be signposted for their own support.

8. REFERENCES and APPENDICES

Tokophobia resource list

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

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 page for Fathers/Partners http://www.birthtraumaassociation.org.uk/help-support/fathers-partners-page

Birth trauma Facebook page closed group https://www.facebook.com/groups/TheBTA/

Birth Trauma and PTSD information and support http://www.unfoldyourwings.co.uk/

Maternity Experience http://matexp.org.uk/

NHS Choices PTSD information https://www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd/

PTSD UK http://www.ptsduk.org/

EMDR support and Information http://emdrassociation.uk/

Baby Buddy app https://www.bestbeginnings.org.uk/baby-buddy

Stillbirth and Neonatal Death (SANDS) https://www.uk-sands.org/

Fear of childbirth (tokophobia) information leaflet

What is fear of childbirth?

Fear of childbirth is also known as tokophobia. It is a severe (or phobic) fear of giving birth, with high levels of anxiety about birth, even if your desire is to have a child. Some women also feel very anxious and uncomfortable or even repulsed about pregnancy. Many women experience some uncertainty or anxiety about giving birth. More severe fear of childbirth may affect up to 14% of women.

Primary tokophobia refers to women who have had no previous experience of birth but who nevertheless have a strong fear of childbirth. In these cases, the feelings of dread associated with childbirth may link to early experiences and can start in adolescence.

Secondary tokophobia is the most common form of tokophobia and occurs in women who have already had a baby. This is where the woman has had a previous traumatic experience of childbirth. It is considered to be a form of post-traumatic stress disorder (PTSD).

Why might I have fear of childbirth?

Risk factors and causes include:

- A previous birth that you experienced as traumatic
- A previous traumatic medical experience
- Experience of sexual assault or rape
- A history of childhood abuse
- A history of mood disorders, anxiety disorders (including PTSD)
- A strong need to be in control
- Hearing, reading or witnessing negative experiences of childbirth

How might tokophobia make me feel?

- Distress and heightened anxiety when a pregnancy is confirmed
- Feelings of being out of control and trapped, agitation, irritability, stress, restlessness and nervousness
- Feelings of isolation, loneliness, being misunderstood and unsupported
- Negative thoughts about being abnormal and different to the people around you, especially those who are pregnant
- Thoughts about having an abortion, even though you want to have children
- Self-doubt about your ability to go through labour and birth
- Repeated negative thoughts around labour and birth
- Intrusive thoughts and memories (sometimes images) of a previous traumatic birth
- Fear of pain during labour and birth
- Fear of harm or death as a result of birth (in relation to both mother and baby)
- Increasing distress and anxiety throughout the pregnancy and especially in the last trimester
- Symptoms of anxiety, which can include: altered sleep pattern, nightmares, rapid heartbeat, tension, abdominal pains, and panic symptoms, difficulty relaxing
- Avoidance of talking about/thinking about birth
- Avoidance of antenatal education

How can I help myself?

The earlier you can get help the better:

- Speak to your partner and family/friends if you feel comfortable doing so.
- Speak to your Consultant Obstetrician and/or midwife and enquire what options and services are available for women with tokophobia.
- You should be offered an appointment with a specialist mental health midwife or consultant midwife or other mental health professional to discuss your concerns.
- You may benefit from psychological therapy such as cognitive behaviour therapy (CBT) or Eye Movement Desensitisation Reprocessing (EMDR) either in an IAPT service or in a perinatal mental health service. Your midwife, obstetrician or GP can refer you or you can self-refer to your local IAPT.
- Read relevant sources of information – don't rely on information from blogs or internet forums. The Royal College of Obstetricians and Gynaecologists has a leaflet called Choosing to have a Caesarean section: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-choosing-to-have-a-c-section.pdf
- Write a detailed birth plan in partnership with your birth partner and midwife.
- Arrange to visit the labour ward or birth centre so that you can become familiar with the environment.
- If you are concerned about coping with pain, request an appointment with an anaesthetist to discuss pain relief options.
- Ask about the availability of continuity of carer (sometimes called caseloading) where you see the same midwives throughout pregnancy.
- Take care of yourself with a balanced diet, exercise, relaxation.
- Consider yoga and mindfulness.
- It can be difficult to hold your baby in mind when you are feeling very anxious about childbirth. Using an app such as Baby Buddy (https://www.bestbeginnings.org.uk/baby-buddy) can offer regular information about how your baby is growing and developing and help you to start to form a bond with him or her.

Can I request a caesarean section?

If you feel strongly that a caesarean section would be the best birth option for you, let your midwife or obstetrician know this as soon as possible.

- Appropriate support will be offered to address your anxieties, including some of the options discussed above.
- Maternity services will work together with you towards a plan for the birth that takes account of both your physical and mental health.
- Often, the decision about mode of birth will be made in the third trimester (recommended at around 32 weeks).
- Ultimately, if you feel that a caesarean section is the best choice for you, it must be offered to you.

What about after the birth?

Discuss your experience of the birth with a health professional. This could be someone you saw antenatally such as a specialist mental health midwife, consultant midwife, a perinatal mental health professional or your psychological therapist. Alternatively, it might be your midwife, health visitor or GP. If you need further support, you may be able to access a birth reflections appointment, support from a perinatal mental health team or psychological therapy (e.g. in IAPT).

Sample birth care plan

Name: **DOB:**
Address: **Telephone:**
EDD: *Include details if planned induction or elective caesarean section (date)* **Maternity Service:**
Perinatal Mental Health Service: *where applicable*

IDENTIFIED PROBLEMS/NEEDS/RISKS
e.g. Severe fear of pregnancy and childbirth since adolescence; Post-traumatic stress disorder following traumatic experience of childbirth with first child; Emotional instability; High need for control and predictability; History of childhood sexual abuse; History of vaginismus/sexual dysfunction; Risk of escalating anxiety in later stages of pregnancy; Distrust of health professionals based on previous experience; Specific fear of perineal trauma.
Psychiatric diagnosis: *e.g. Mixed anxiety and depression; Generalised anxiety disorder, PTSD; Emotionally Unstable Personality Disorder.* **Medication:**

CARE PLAN
During pregnancy *e.g. regular appointments with perinatal mental health midwife, appointment with Consultant Obstetrician to discuss mode of delivery; appointment with anaesthetist to discuss early anaesthesia; psychological therapy within IAPT/Perinatal mental health services; pre-birth planning meeting at 32 weeks; continuity of midwifery care; familiarisation visit to labour ward/birth centre.*
During labour/delivery e.g*. Wishes to try vaginal birth with early pain relief. Requests minimal numbers of staff present (no students). Requests to limit/avoid vaginal examinations wherever possible. To use techniques learned in therapy to differentiate this birth from the previous one. To use relaxation/hypnobirthing techniques learned in antenatal classes. Procedures to be discussed in advance in detail wherever possible to instil a sense of control. OR planned caesarean section at 39 weeks due to severe primary tokophobia. If labour onsets before 39 weeks, to consider caesarean section according to her mental state and the progress of labour: Caesarean section may be indicated where vaginal delivery is considered to pose a significant risk to the mother's mental health.*
Postpartum Period e.g*. Review by liaison psychiatry prior to discharge (for severe tokophobia with comorbid mental illness). Monitoring the newborn for withdrawal (where mother was on medication). 28 day midwife follow up. Postnatal review with perinatal mental health midwife. Screen for birth trauma/PTSD. Assess mother-baby relationship. Completion of psychological therapy.*

Crisis Plan:
Professionals involved: Obstetrician/Midwife/GP/HV/Psychologist/Perinatal Mental Health Services/IAPT Practitioner Note *contact details*
Social Care: Previous safeguarding concerns/involvement; current safeguarding concerns; Social Worker