



## Tokophobia: “An Unsolved Dread of Childbirth”

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### ABSTRACT

Pregnancy is a life-changing event for every woman in her lifetime. In many women, due to various factors like psychology, environment, social, and etc., certain unwanted clinical manifestations arise which further develops into fear of pregnancy and childbirth. When a psychiatric disorder is associated with or exacerbated by breastfeeding, the topic requires expert experiences from several areas in medicine. This essay examines the relationship between pregnancy, depression, eating disorders, and irrational fear of childbirth, known altogether as tokophobia. Although literature in this area is scarce, an attempt is made to collect what is available and compile them together.

**Keywords:** Tokophobia, Psychiatric disorder, Childbirth, Breastfeeding, Anxiety disorder.

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### INTRODUCTION

This article avoids discussing medical and psychological descriptions of "normal" pregnant woman, focusing only on certain pathological mental conditions that can impair pregnant women. Pregnancy anxiety and childbirth anxiety have been identified with signs of eating disorders, mood swings, obsessive fear and avoiding childbirth, also known as tokophobia.

International Classification of Diseases-11 (World Health Organization, 2019) included Tokophobia as an unspecified phobic anxiety disorder<sup>1</sup>. Anxiety disorders during pregnancy, especially those in the first trimester, were first medically recognized in the 18th century by Louis Victor Marcé, a French psychiatrist and exhibit profound tumultuous characteristics<sup>2</sup>. Surprisingly, some individuals that suffer from fetal anxiety can report a decrease in symptoms during the first trimester.

#### Pregnancy and childbirth related depression

While depressive illness is often associated with postpartum mothers, it is also prevalent in pregnant women. Postnatal depression has been a source of worry, with potential adverse effects. Additionally, research indicates that infants can experience mental or behavioral disorders and developmental delays throughout childhood.<sup>3</sup> Indeed, it has long been believed that pregnancy protects from depression. Antenatal

psychopathology research has focused chiefly on antenatal mood as an indicator of postnatal depression. Watson et al. discovered that 23% of women with postnatal depression developed it during birth.<sup>4</sup> There is extensive literature, going back to Esquirol's in 1818 work, documenting all forms of mental disease associated with pregnancy. He coined the term "puerperal psychosis" to describe the condition, which involved chronic maternal depression. More modern research conducted by Menzies and Knauer has confirmed the prevalence and seriousness of fetal depression.<sup>5</sup> They imply that postnatal depression is not a separate clinical entity. According to their findings, delivery is less likely than pregnancy activities to be accompanied by distress in people who are not depressed.<sup>6</sup> Additionally, depressed people are more prone to recover after birth. Ramrakha et al. discovered an elevated likelihood of "risky sex" in individuals with various mental health diagnoses. Clinical disorder was often correlated with an elevated likelihood of engaging in "risky sex," sexually transmitted disorders, and early sexual experience. Other issues occur when it comes to sexual initiation, such as the role of sexual harassment, which is a significant precursor to mental health disorder.<sup>7</sup> Mothers' depression is seldom insignificant. The seriousness of the condition has the potential to be fatal. It is tragic because several people die after childbirth.

#### INFANTICIDE

While the intentional killing of a child by a mother has been recorded since ancient times, it is perhaps more appropriate to view this activity in two ways. This includes the customary neonaticide of unwanted newborns and the intentional killing of infants.<sup>8</sup>

The term "neonaticide" has also been used to refer to the selective killing of female infants. This has resulted in a



significant change in the proportion of registered male births to female births, with ratios sometimes reaching 3:1. This essay aims not to discuss the psychopathological factors of infanticide or the legal framework around it.<sup>9</sup>

## EATING DISORDERS

### Anorexia nervosa

Anorexia nervosa is described as a phobic fear of average body weight. There are frequent references in the literature of an "antagonism" between anorexia nervosa and fertility, owing to menstruation cessation in committed instances of anorexia nervosa.<sup>10</sup> Pregnancy is uncommon in active anorexia nervosa and cases of induced ovulation.

Numerous trials have been conducted to determine the result of breastfeeding after treatment from the condition.<sup>11</sup> Additionally, there are case records of pregnant people that have not yet healed. Following birth, the babies born to these women have an abnormally low birth weight as a category.<sup>12</sup> There is evidence of a greater prevalence of stillbirths.<sup>13</sup> These women may experience a higher rate of preterm births and caesarean sections. As a predictor, research indicates little distinction for people with active and remitted signs of anorexia nervosa.

### Bulimia nervosa

Bulimia nervosa is described as an inability to regulate one's diet and self-perpetuating patterns of bingeing and purging. Pregnant women who suffer from this disease usually recover. However, some evidence indicates that bulimic mothers' infants are premature and underweight. While most women's bulimic symptoms increase as pregnancy continues, more than half reported worse symptoms after pregnancy. Severe bulimia signs after breastfeeding, a history of anorexia nervosa, gestational diabetes, and unintended pregnancy both expected relapses. Postpartum depression resulted in one-third of the group. Although the reported research results are contradictory, they indicate that both anorexia nervosa and bulimia nervosa may have a detrimental impact on fetal outcome. Taken together, the data indicate that having a history or current eating disorder may predispose a mother and her child to pregnancy complications.

### Sexuality and eating disorders

Sexuality and anorexia nervosa studies indicate a relationship with body mass index, but their findings are constrained by cross-sectional or retrospective sample formats. Additionally, the above research indicated that sexual behavior in anorexia nervosa does not often represent sexual desire or pleasure. This disjunction between motivation and behavior parallels the disjunction between appetite and eating behavior of anorexia nervosa, highlighting the fundamental subversion in appetitive behavior.<sup>14</sup> Purging anorectics have a more substantial background of sexual activity than conservative anorectics. Simultaneously, people with bulimia are typically more sexually involved and mature than women

without an eating disorder, with more lifelong sexual partners and a higher risk of induced abortion. In the case of frequent self-induced vomiting, oral contraceptives are ineffective and unreliable. Sexual violence in childhood has been linked to eating disorders.

## MISCARRIAGE

Historically, correctly estimating the incidence of miscarriage concerning completed births has been highly challenging. Before readily accessible closure, research has explored the approximate values between 1845 and 1933. More recently, radioimmunoassay-based pregnancy diagnosis revealed that 43% of all pregnancies ended in spontaneous abortion, with a significant proportion of these unrecognized by the mother. Seven per cent of all miscarriages result in women who have had repeated accidental abortions.<sup>15</sup>

## TERMINATION OF PREGNANCY

Termination's social and medical consequences are nuanced and often linked to the cause for termination. In his extensive research, Ekblad reached the following conclusion: Additionally, it should be recognised that any postpartum psychiatric complications can arise after pregnancy termination. For over a year, certain women had extreme and vivid dreams of "murdering the boy." According to others, "almost every woman who considered the idea of terminating her pregnancy, albeit momentarily, became distraught during or after birth." Two participants ended their pregnancy in one sample because they were too afraid to survive childbirth. Termination could be sought by women who have tokophobia and desperately want a child but cannot comprehend their anti-parturition feelings. Without an empathic trained ear or access to relevant medical literature, their only option would be to end the pregnancy and deal with the psychological consequences. It has been proposed that the previous psychiatric status among people with unintentional pregnancies is similarly indicative of future distress regardless of if they terminate or bring to term.<sup>16</sup> Reardon and Cogle take issue with this. They believe that married women who take unintended pregnancies to time faceless depression risks than married women abort. Independent of the result, single mothers, on the other hand, had elevated depression levels.

## PATHOLOGICAL DREAD AND AVOIDANCE OF CHILDBIRTH (TOKOPHOBIA)

### Prevalence of fear of pregnancy and childbirth

Fear of childbirth is normal in pregnant nulliparous women and is more severe than in pregnant parous women. About 20% of pregnant women express anxiety, and 6% identify a fear that is hindering. In total, 13% of non-gravid women say apprehension of childbirth to the extent that they delay or prevent pregnancy.

Pregnancy is widely established to be an anxious period, with signs worsening in the third trimester.<sup>17</sup> Women continue to experience apprehension of death during



childbirth." Tokophobia can affect women throughout their lives, from childhood to old age.

### Prevalence of anxiety

Sontag speculated in 1941 that a woman's mental condition might have an impact on her birth." Numerous scholars have researched the origins and effects of maternal distress and paranoia in the years since. Thus, in Western culture, "fear of pain" can be a psychologically acceptable means of describing something more nuanced. Current research indicates that pregnant women who are afraid of childbirth underestimate faith in the obstetric staff, fear of their failure, and fear death.<sup>17,1</sup> According to other surveys, the most considerable risk was giving birth to a visually disabled or congenitally malformed infant. Women who have experienced sexual assault or rape as a child worry that the experience of childbirth will bring back the pain and helplessness associated with abuse. Women that have already experienced trauma through childbirth fear re-traumatization.

### Treatment studies for fear of childbirth

Studies on the alleviation of childbirth anxiety stretch back to the 1920s. In the 1950s, psychoprophylaxis was studied, as were the benefits of hypnosis.

Psychoprophylactic planning for pregnant women fearful of childbirth has a little discernible effect on obstetric outcomes. Psychological consequences were not examined. Ryding, an obstetrician and psychotherapist, provided counselling or brief psychotherapy to pregnant women who demanded an unwanted caesarean section. At the word, approximately half of these women opted for vaginal delivery. Sjogren examined people who were experiencing extreme fear around childbirth. Psychotherapy or additional obstetric care was provided to them. Following it, several women opted for vaginal delivery. These women had the same good experience with delivery as a comparison sample. Tokophobia women who requested a surgical delivery but were denied had a higher rate of psychiatric morbidity than those who received their preferred delivery form. It is unknown how many women request elective caesarean sections due to tokophobia. In October 2001, the National Sentinel Caesarean Section Audit was released. The audit discovered that one in every five births (21.5 per cent) in England and Wales occurred by caesarean section; 7% of these occurred at the mother's request with no medical cause.

### TOKOPHOBIA CLASSIFICATION

Tokophobia has been classified as follows:

- Primary—nulliparous.
- Secondary—previous traumatic deliveries.
- Secondary to depressive illness in pregnancy.

### (1) Secondary tokophobia

Women who fear childbirth are more likely to need surgical intervention and suffer psychiatric problems as a result. Studies on the alleviation of childbirth anxiety stretch back to the 1920s. In the 1950s, psychoprophylaxis was studied, as were the benefits of hypnosis. Psychological consequences were not examined. Sweden also did significant studies. Ryding, an obstetrician and psychotherapist, provided counselling or brief psychotherapy to pregnant women who demanded an unwanted caesarean section.<sup>18</sup> At the word, approximately half of these women opted for vaginal delivery. Sjogren examined people who were experiencing extreme fear around childbirth. Psychotherapy or additional obstetric care was provided to them. Following it, several women opted for vaginal delivery. These women had the same good experience with delivery as a comparison sample. Tokophobia women who requested a surgical delivery but were denied had a higher rate of psychiatric morbidity than those who received their preferred delivery form. It is unknown how many women request elective caesarean sections due to tokophobia. In October 2001, the National Sentinel Caesarean Section Audit was released. The audit discovered that one in every five births (21.5 %) in England and Wales occurred by caesarean section; 7% of these occurred at the mother's request with no medical cause.

### Secondary tokophobia and the relation to post-traumatic stress disorder (PTSD)

PTSD is becoming more widely recognized due to childbirth and is linked with a morbid fear of pregnancy and childbirth. Savage referred to a "startling and horrible dream" after conception in 1875, followed by a "melancholy stupor."<sup>19</sup> They identified ten cases of "névrose traumatic post-obstétricale" in women who had difficult deliveries.

They hypothesized that the post-delivery trauma was amplified during a subsequent pregnancy. These traumatised women choose to abstain from childbirth. In 1995, four cases of postpartum PTSD were identified. PTSD may occur due to deliveries that "did not need to be irregular from the clinician's perspective." In rare and catastrophic situations, women will end highly desired pregnancies due to their inability to cope with another delivery. In the first year of delivery, almost 2% of people had a "post-traumatic stress symptom profile" linked to childbirth. Additionally, one-third of women experience "severe post-traumatic invasive stress responses" two months after undergoing an immediate caesarean section.

### Secondary tokophobia and the "vicious cycle principle."

A subsequent pregnancy's apprehension of childbirth rises after an immediate caesarean section or oral, vaginal delivery. Additionally, pregnant people who experience anxiety of childbirth have a higher rate of immediate caesarean section or instrumental vaginal delivery. Ryding et al. found that women delivered by emergency caesarean section or instrumental vaginal delivery had



more detrimental psychological responses than women who delivered via elective caesarean section or regular vaginal delivery.<sup>20</sup>

As a result, the assumption a pregnant woman has regarding her impending delivery can significantly impact her experience and behavior during delivery. That is, her assessment before delivery can affect her subsequent appraisal—"a vicious loop concept." For certain women, the anxiety lasts an extended period.

## (2) Primary tokophobia

Fear of childbirth may begin as early as puberty or early adulthood. To stop parturition, pregnancy is discouraged. In certain unfortunate circumstances, a woman is so fearful of childbirth that she chooses to end the desired pregnancy rather than undergo birth. Before being pregnant for the first time, certain patients would deliberately search out an obstetrician to administer an elective caesarean section. Some people can never transcend their fear of childbirth and will stay childless, while others will adopt. Many people experience guilt as a result of their perceived inadequacy.

### Aetiology of primary tokophobia

The main tokophobia is likely to have several etiologies. Psychological and social factors have been hypothesised.

#### A. Social culture

Fear of childbirth can be passed on across generations resulting in a second-generation influence of a mother's unresolved terrifying encounter. This reflects the existence of psychological heredity.<sup>20</sup> This is compounded for girls whose parents have a dismissive outlook about sexuality. Women correctly remember childbirth information twenty years apart.

#### B. Anxiety theories

Phobias are avoidance reactions. It may be acquired by terrifying encounters, vicariously seeing others' frightened reactions or training. Zar examined the terror of childbirth through the lens of Lazarus. She indicated that a pregnant woman's aspirations for the childbirth process are essential to her perceptions and behaviour during labour and delivery.

Fear of childbirth has been linked to an increased susceptibility to distress in general and can be classified as an anxiety condition.

#### C. Trauma and abuse

According to Baker and Duncan, 13% of women confirmed being sexually assaulted by psychological morbidity associated with adolescent sexual assault may be enormous and complex, including elevated rates of sexual dysfunction, anorexia, and posttraumatic stress disorder (PTSD).

## (3) Tokophobia as a symptom of depression

Prenatal distress is less often associated with tokophobia.

## CONCLUSION

Tokophobia is a specific and harrowing condition that needs acknowledging psychological morbidity is prevalent in females during their reproductive years. However, certain diseases, such as PTSD and tokophobia, can have no apparent antecedent and therefore go undiagnosed. All of the problems examined in this article had a worse result than most mothers. Psychiatrists and obstetricians must collaborate to better the lives of this under-recognized and under-treated population of women and infants.

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