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Editorial

Fear of childbirth, postnatal post-traumatic stress disorder and midwifery care

The impact of maternal mental health disorders on women and their children is significant. Stress and psychological problems during pregnancy are associated with preterm labour, poor infant outcomes and greater cognitive, behavioural and interpersonal problems in young children (Glasheen et al., 2010). Similarly, postnatal psychological problems have an adverse impact on the woman, child, and relationships. The World Health Organisation lists psychological illness as a significant indirect cause of maternal death in the first year after birth (WHO, 2008). This has led to an international call for the integration of maternal mental health into maternal and child health care programmes (Rahman et al., 2013).

In the UK, the importance of women's mental health during pregnancy and after birth has been the focus of a number of recent reports from organisations such as the NSPCC (Hogg, 2013), Royal College of Midwives, Institute of Health Visitors and charities (Boots Family Trust, 2013), and a cross-party parliamentary manifesto (Leadsom et al., 2013). In November 2013 the Maternal Mental Health Alliance published a report on the importance and role of specialist mental health midwives (MMHA, 2013) and the UK Government announced specialist perinatal mental health staff would be trained for all birthing units by 2017 (Department of Health, 2013).

In this context, recognition of the range of mental health problems that women can suffer from becomes even more important. Historically, research has focused on the most common or severe psychological disorders that occur, namely postnatal depression and puerperal psychosis, which has raised public awareness of these disorders. However, evidence is clear that women can suffer from a range of disorders at this time including anxiety disorders such as panic, generalised anxiety, phobias and adjustment or stress-related disorders, such as post-traumatic stress disorder (PTSD). Collectively, anxiety disorders appear to be as common as depression. For example, a meta-analysis of postnatal depression suggests it affects up to 19% of women (Gavin et al., 2005). Similarly, a Canadian study found 16% of women had postnatal anxiety disorders (Wenzel et al., 2005).

Two, less recognised disorders are particularly relevant to midwifery care because they directly affect women's perinatal experiences or arise as a result of birth experience. These are fear of childbirth (tokophobia) in pregnancy and PTSD in response to difficult or traumatic births. These disorders can have an impact on women throughout pregnancy and after birth. They can also negatively affect women's relationships with their partner and infant (Nicholls and Ayers, 2007; Parfitt et al., 2013). These disorders can be inter-related in that fear of childbirth can arise as a result of a previous traumatic birth experience. The important point for midwifery is that both disorders are potentially preventable or reducible through appropriate midwifery and perinatal mental health care.

This special issue of *Midwifery* focusses on fear of childbirth and postnatal PTSD in order to inform our understanding and hence prevention and treatment. As a relatively new area of research there are still many gaps in our knowledge. However, research is rapidly increasing and this journal includes papers on key issues as well as reviews synthesising the evidence. The first section focusses on fear of childbirth and includes papers on the aetiology of fear of childbirth, women's perceptions of morbidity, and midwives views on antenatal management. The second section focusses on postnatal PTSD and includes papers examining diagnostic criteria, the role of support, the impact on women, and treatment. Consideration of fear of childbirth, PTSD, and how papers in this issue contribute to our knowledge is provided below.

Fear of childbirth

Intense fear of childbirth occurs in 7–26% of pregnant women (Fenwick et al., 2009; Laursen et al., 2009), with a smaller proportion developing extreme fear or tokophobia (Nieminen et al., 2009). The BIDENS study of 7200 women in six European countries found significant differences between countries with prevalence ranging from 1.9% to 14.2% (Van Parys et al., 2012). Symptoms include high levels of anxiety about pregnancy and birth, fear of harm or death during birth, poor sleep and somatic complaints.

As with most psychological problems the cause of fear of childbirth is multifactorial. It has been associated with factors such as nulliparity (Rouhe et al., 2009), increased gestation (Rouhe et al., 2009), poor mental health (Laursen et al., 2008; Storksen et al., 2012), a history of abuse (Nerum et al., 2006; Lukasse et al., 2011), younger age (Laursen et al., 2008), lower education (Laursen et al., 2008), and low self-efficacy (Salomonsson et al., 2013). Although fear of childbirth is more common in nulliparous women, women who have a negative or traumatic experience of birth are almost five times more likely to report fear of childbirth in a subsequent pregnancy (Storksen et al., 2013).

The importance of fear of childbirth for midwifery is apparent from the impact it has on women's preferences for intervention during birth. There is good evidence from large epidemiological studies that women with fear of childbirth are more likely to want interventions such as epidural analgesia and caesarean sections (Nieminen et al., 2009; Rouhe et al., 2009). Evidence on the

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relationship between fear of childbirth and birth outcomes is inconsistent, however the balance of evidence suggests fear of birth is associated with negative outcomes such as increased labour duration (Adams et al., 2012) and caesarean section (Waldenstrom et al., 2006; Laursen et al., 2009; Sydsjo et al., 2013). Where studies do not find this relationship (e.g. Sluijs et al., 2012) it may be due to confounding factors such as parity. For example, Fenwick et al. (2009) found fear of birth was associated with emergency caesarean section but this relationship was no longer significant when parity was controlled for.

One question that remains is *why* women are afraid of childbirth, particularly nulliparous women and men who have not had previous negative or traumatic experiences of birth. This is examined in this issue by **Stoll and colleagues** who carried out a survey of 3680 Canadian students and found that fear of birth was highest in students who reported the media shaped their attitudes towards pregnancy and birth, suggesting an important role of the media in contributing to fear of birth. Consistent with previous research, students with fear of birth were more likely to want epidural anaesthesia and caesarean section. However, interestingly, students who reported the media was the *only* influence on their attitudes to pregnancy and birth were more likely to want caesarean sections than those with multiple sources of influence (Stoll et al., 2014). In a related paper, **Faisal and colleagues** examine why primigravidae in Iran with a normal pregnancy request caesarean section. Qualitative interviews with 14 women found requests for caesarean sections were related to fear of childbirth (in particular pain), concern about complications after vaginal birth, and trust in obstetricians compared to mistrust of maternity ward staff (Faisal et al., 2014).

Combined, these two studies provide interesting insights into what processes underlie why nulliparous/primiparous women are afraid of birth. They confirm previous work showing that women are predominantly frightened of pain and injury during vaginal birth, and that these women would prefer caesarean sections. These studies also indicate the importance of social context in terms of family, friends and the media shaping women's attitudes and fear of childbirth; as well as social relationships in terms of trust in different health care professions influencing women's preferences and choices about type of birth.

The care provided by midwives and other health care professionals during pregnancy and birth therefore has the potential to reduce or increase fear of childbirth. In this issue **Fontein-Kuipers and colleagues** look at midwives' intentions with regard to screening and managing women's distress in pregnancy in a survey of 112 community midwives in the Netherlands. They show that the main predictors of whether midwives intend to support women with distress are whether midwives find psychological distress interesting and have a positive attitude towards it (Fontein-Kuipers et al., 2014). This supports the recent move in the UK to training specialist mental health midwives, who will presumably be those who are interested and positively inclined towards managing women's mental health in pregnancy.

Finally, the impact of pregnancy and birth on men's fear of childbirth and psychological well-being is an area which has not been widely examined. The few research studies that have been carried out suggest between 10% and 13% of men report intense fear of childbirth (Eriksson et al., 2005; Bergstrom et al., 2013; Hildingsson et al., 2014). In this issue, **Hildingsson and colleagues** report results from a study of 1047 expectant fathers in Sweden. Similar to previous research, this study confirms 13% of men report fear of birth and fear is associated with worries about complications in pregnancy and birth, less attendance at antenatal classes, a preference for caesarean birth, poor physical and mental health, and parenting stress one year after birth (Hildingsson et al., 2014). This suggests fear of childbirth in fathers has a similar pattern to women in terms of an overlap with other mental health problems. It also shows the impact of fear of childbirth on men, their engagement with the pregnancy, and parenting stress; highlighting the importance of addressing fathers' fear of childbirth as well as mothers.

PTSD

PTSD can affect women in pregnancy and after birth. PTSD in pregnancy is usually due to non-obstetric events such as abuse or other trauma. After birth, a substantial proportion of PTSD is associated with the events of birth itself. Research on PTSD in pregnancy and post partum is relatively new but clearly demonstrates the importance of recognising and treating women with PTSD at this time. Women with PTSD in pregnancy are at greater risk of pregnancy complications and poor health behaviours that can have a negative impact on the woman and fetus. In community studies, up to 7% of women report PTSD in relation to birth (Ayers et al., 2008). Rates of PTSD are higher in high risk groups such as women who have preterm or stillborn infants or life-threatening complications during pregnancy or labour (Turton et al., 2001; Elklit et al., 2007; Kersting et al., 2009). Unlike other post partum psychopathology, this is therefore an area where there is clear potential to prevent or minimise post partum PTSD through changing maternity care and services.

The impact of postnatal PTSD on women is substantial. A number of qualitative studies have illustrated the wide ranging effects postnatal PTSD can have on women and their relationships with their partner, infant and future reproductive choices (Gottvall and Waldenström, 2002; Beck, 2004; Nicholls and Ayers, 2007). In this issue **Fenech and colleagues** provide a meta-synthesis of the qualitative evidence on the impact of traumatic birth on women. Their synthesis identifies three main impacts on women: intense negative emotions after birth, a sense of loss of self and family ideals, and shattered relationships (Fenech et al., 2014). The quotes in this paper illustrate the profound cascade of negative effects this can have on some women and shows the importance of preventing and treating postnatal PTSD to prevent such long-term negative impacts.

As with fear of childbirth, the causes of PTSD are likely to be due to a combination of a woman's vulnerability and risk factors during and after birth. To date, there is evidence for women being more vulnerable if they have current or previous psychiatric problems, a history of PTSD and/or fear of childbirth in pregnancy (Ayers and Ford, in press). The events of birth are critical in causing post partum PTSD and the diagnostic criteria require that the event (birth) involves perceived threat of serious injury or death (American Psychiatric Association (APA), 2000). Previous diagnostic criteria also specified that women had to respond with intense fear, helplessness or horror but this was removed in the 2013 revision of diagnostic criteria. This has obvious repercussions for events such as birth where it might be relatively common for women to perceive a threat of injury. In this issue **Boorman and colleagues** examine this further. In a survey of 890 women they found that 29% thought they or their infant would die or be seriously injured during birth. However, only half these women (14% overall) responded to this with intense fear. Boorman and colleagues therefore argue that, for postnatal PTSD, intense fear during birth may be more diagnostically accurate than perceived threat of injury or death (Boorman et al., 2014). This has important implications for screening and identifying women who had traumatic births and might benefit from early intervention in the postnatal period.

A long-standing debate in this field has been around the relative importance of obstetric events or morbidity compared to women's subjective experience. On the one hand, there is