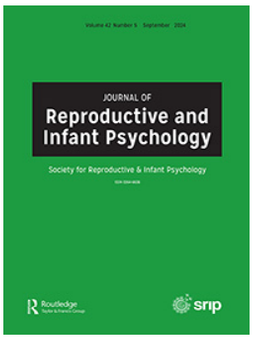

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Journal of Reproductive and Infant Psychology

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/cjri20

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To cite this article: Elisabet Rondung, Emma Lier & Elin Ternström (15 Oct 2024): Psychologists' experiences of working with fear of childbirth: implications and advice for care providers, Journal of Reproductive and Infant Psychology, DOI: 10.1080/02646838.2024.2415106

To link to this article: https://doi.org/10.1080/02646838.2024.2415106

Published online: 15 Oct 2024.

JOURNAL OF REPRODUCTIVE AND INFANT PSYCHOLOGY
https://doi.org/10.1080/02646838.2024.2415106

Psychologists' experiences of working with fear of childbirth: implications and advice for care providers

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ABSTRACT

Background and Aim: Fear of childbirth is a common problem that affects women's health and wellbeing. A variety of interventions have been used in research and clinical settings, but it remains unclear how interventions should be designed to be as effective and acceptable as possible. Additionally, the experiences of psychologists working to support women fearing childbirth are sparsely documented and therefore unavailable for researchers and clinicians. This qualitative study aimed to bridge this gap by exploring and describing the experiences of perinatal psychologists working clinically with women suffering from fear of childbirth.

Methods: Focus group interviews with eleven psychologists, analysed with reflexive thematic analysis with an inductive and semantic approach.

Results: We identified four main themes, with three to four subthemes each. It was described as essential to meet the woman where she stands: to listen, validate, explore, and tailor interventions. Depending on the needs of each woman, the psychologists had a smorgasbord of core interventions to offer. They also described how they could help the woman and her partner or support person to prepare for childbirth. Finally, they addressed the importance of multiprofessional engagement and cooperation. A list of recommendations based on the findings is presented.

Conclusion: The findings add to the existing literature on how to treat and support women with fear of childbirth and should be considered as one of many sources of information guiding the development of future interventions, care strategies, and clinical pathways for women fearing childbirth.

ARTICLE HISTORY
Received 3 June 2024
Accepted 3 October 2024

KEYWORDS
Fear of childbirth; tokophobia; interventions; clinical experiences; qualitative research; psychology

For many pregnant women, the time of pregnancy is not all about joy and positive anticipation; it can also be a time of worry, fear and anxiety when thinking of the approaching birth. While there is a common agreement on the lack of clarity and consensus regarding the concept of fear of childbirth or tokophobia (Jomeen et al., 2021; O'Connell, Martin, et al., 2021), the existence of such a phenomenon is internationally accepted (Dai et al., 2020). The reported prevalence in self-report questionnaire

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studies vary considerably depending on contextual factors and assessment tools, but pooled prevalence estimates suggest that 14–18% of pregnant women experience severe fear of childbirth (O'Connell et al., 2017; Sanjari et al., 2021). However, self-report symptom assessment often fail to consider important diagnostic features such as clinical distress and functional impairment (American Psychiatric Association, 2022) and therefore overestimate the prevalence of clinically significant cases. In the absence of clear diagnostic criteria for fear of childbirth, researchers have previously used the diagnosis of a specific phobia as a proxy to assess the prevalence of diagnostic cases, indicating a prevalence of 0.03–3.3% (Fairbrother et al., 2022, Nath et al., 2020). Considering that at least 12% of pregnant women receive fear of childbirth specific support from Swedish health care services (Skogsdal et al., 2023), diagnostic assessment based on the criteria for a specific phobia might instead risk underestimating womens suffering and need for support due to fear of childbirth.

Many differentiate between the primary fear of childbirth, experienced by women who have not given birth before, and the secondary fear of childbirth, arising from previous negative birth experiences (Hofberg & Brockington, 2000). Women fearing childbirth are also heterogeneous in terms of psychological aspects (Rondung et al., 2018). For example, while fear of childbirth has repeatedly been associated with previous traumas and psychiatric symptomatology (Lukasse et al., 2010; Nordeng et al., 2012), this is not at all the case for every woman fearing childbirth.

Over the years, a wide array of interventions have been developed and evaluated. In a recent systematic review, Webb et al. (2021) categorised scientifically evaluated interventions into six broad groups: cognitive behavioural therapy, other talking therapies, antenatal education, enhanced midwifery care, alternative interventions, and interventions during labour. The available evidence suggests that most interventions may reduce fear of childbirth to some extent (O'Connell, Khashan, et al., 2021; Webb et al., 2021), but the evidence gives little guidance on how to choose between interventions. It remains unclear which approaches are most effective and beneficial, and there seem to be room for further improvements to make interventions even more efficient.

In Sweden, maternal care services have a long tradition of offering women with fear of childbirth support at specific clinics. Typically, the woman meets a midwife or obstetrician on one to three occasions, with the aim to prepare for a positive birth experience regardless of birth mode. While this intervention has not been evaluated in any controlled trial, women have generally been satisfied with this support (Larsson et al., 2015; Ryding et al., 2003). Based on focus group interviews, Wulcan and Nilsson (2019) have described the work of midwives at these fear of childbirth clinics, emphasising the importance of building a trusting relationship, providing knowledge that match reality, giving inspiration and hope, strengthening the woman's believe in her abilities, and the collective formulation of a birth plan following an open discussion of different options. For women who have given birth before, they also stress the importance of going through previous birth experiences and using these to plan for the upcoming birth.

Women fearing childbirth can also receive support from perinatal psychologists, most commonly working in maternal health care services. Their support can take many forms, depending on the woman's or couple's needs. It typically builds on the general principles of psychological interventions but has not been described to the scientific community. Like Wulcan and Nilsson (2019) have illustrated the work of midwives supporting women

with fear of childbirth, we believe that the competence and experience of perinatal psychologists working with these issues can contribute to an increased understanding of how to treat and support women fearing childbirth and thereby inform the development of future care strategies and interventions. The aim of this study was thus to explore and describe perinatal psychologists' experiences of working clinically with women suffering from fear of childbirth.

Methods

This was a qualitative study with an inductive approach. Data were collected using focus group interviews and analysed with reflexive thematic analysis (Braun et al., 2019). Given the focus on professional experiences with no handling of sensitive personal data, Swedish legislation does not require an ethics review. The study was conducted in accordance with ethical principles of research, building on voluntary participation, informed consent, and protection of participants' privacy and confidentiality. To ensure the participants did not reveal any sensitive information about their patients, the importance of any clinical examples being fully anonymised was stressed in the interviews.

Recruitment and participants

For recruitment we used a Facebook post that was shared in two national yet private groups, one for psychologists in Sweden, and one for Swedish psychologists working in maternal and child health services. Interested psychologists could follow a link to an online registration form in the web-based survey software Qualtrics, where they received further information about the study and gave their formal consent to participate. The registration included an eligibility check (being a licenced psychologist working in maternal mental health services, with experience of meeting women fearing childbirth in daily work) and a few background questions (year of psychologist graduation, years working with fear of childbirth, and geographical region). Finally, potential participants shared their contact information (email and/or telephone).

Between November 18 and 14 December 2020, we received a total of 21 registrations, of which six were excluded due to ineligibility and one due to lack of contact information. All 14 remaining psychologists were contacted to book a focus group interview. One never responded, one could no longer participate, and one confirmed the invitation but did not show up for interview. Thus, 11 licenced psychologists working in maternal mental health services in eight Swedish regions (Dalarna, Kronoberg, Skåne, Sörmland, Västerbotten, Västmanland, Västra Götaland, and Örebro) were interviewed. They had been working as psychologists for five to 25 years, and with fear of childbirth for one to 18 years.

Data collection

The eleven participants were interviewed in four online focus groups, planned in accordance with participant time preferences and with the aim to maximise diversity in experience and geographical region in each group. Following a first pilot interview (not included in the dataset), the interviews were conducted in January 2021 using the video

conference platform Zoom. Interviewers were two master students in clinical psychology, supervised by the first author.

The interview commenced with an oral repetition of the research participant information, followed by an opportunity to ask questions. Participants were reminded that there are no correct or wrong answers, and that all perspectives are of importance. They were encouraged to speak freely, having their microphones and cameras on. After an oral consent from all participants, the interviews were recorded. The aim of the interviews was described as to explore psychologists' experiences of working professionally with women fearing childbirth, emphasising our interest in their daily work procedures: what they did, how they did it, and how they experienced it. The interview guide covered three content areas: successful work strategies, challenges, and cooperation with other professions. While guiding and monitoring the dialogue and posing follow-up questions, the interviewers also allowed the group to go its own way as long as the conversation was in line with the overall research question.

Data analysis

Interviews were transcribed verbatim, also including non-verbal expressions (e.g. nodding and laughter). We analysed our data inductively, using reflexive thematic analysis according to the stepwise guide by Braun et al. (2019). After familiarisation with the data and writing down spontaneous thoughts and ideas, we proceeded to a semantic and inductive coding of the complete dataset. We thereafter developed candidate themes that were checked in relation to the codes and the data, striving for coherence around a central organising concept within each theme, and minimising overlap between themes. When we were convinced we had found the final thematic map, the themes were named and defined, reported here in a combination of our analytic narrative and data extracts.

Results

In the analysis we identified four main themes, with three or four subthemes each, see Table 1. Based on the findings, we have also compiled a list of recommendations, presented in Table 2.

Meeting the woman where she stands: to listen, validate, explore, and tailor

The first theme resolved around general manners and advantageous approaches relevant for all professionals encountering women with fear of childbirth in their professional practice. From the psychologists' point of view, professional support should be offered and established in early pregnancy or as soon as possible after the need has been identified, not only because psychological change and acceptance processes may need considerable time but also to offer our support as pregnancy proceeds.

Listening, validating, and sharing the burden of fear

In all the focus group interviews, the psychologists stressed the importance of genuinely listening to each woman telling her story in her own way and offering her someone to share her fears with. It was fund central not to discount or

Table 1. Themes and subthemes identified in reflexive thematic analysis.

Themes and subthemes
Meeting the woman where she stands: To listen, validate, explore, and tailor
Listening, validating, and sharing the burden of fear
Creating a space for exploration and reflection
Acknowledging the unique needs and preferences of each woman
A smorgasbord of core interventions that could be matched to the woman's needs
Cognitive and educational strategies
Explorative problem solving
Dealing with uncertainty
Processing traumatic birth experiences
Preparing for birth
Planning and preparing for the birth
Involving a partner or support person
The issue of Caesarean Section
Working together to offer the best possible care
Signposting, referrals, and cooperation beyond maternal care
Continuity through documentation and follow-up
Acknowledging both medical and psychological needs in maternity care

trivialise her experiences, but take them seriously and acknowledge them as valid and understandable given the woman's unique circumstances. Many described validating the challenge of waiting for something frightening that cannot be escaped, sharing the uncertainty of not knowing, and giving hope as cornerstones throughout the contact. In this early stage, communicating an open mind by listening unconditionally, rather than advocating your own standpoints, was found essential. After first truly meeting the woman where she stands, the psychologists found it easier to carefully open up for other reflections.

> I think that what someone who is afraid needs, is really to be met by someone who listens and takes the fear seriously. I think a lot loosens up in being heard and being treated with empathy or understanding, that this is something that is very difficult for you, this fear is something that affects you in everyday life (. . .) it's a good thing to accept and hold their fear first, to be able to take the next step into interventions later.

Many participants testified of the detrimental effects of ignoring relational aspects when meeting women fearing childbirth. From their perspective, one single appointment with a specialist that was perceived as being uninterested or abrupt could nullify any achievements made in previous care contacts. Consequently, they emphasised that all care professionals must endeavour to treat every woman with empathy and respect.

Creating a space for exploration and reflection

After having established a trusting working relationship, the psychologists emphasised creating a space where the woman felt safe to approach, explore and reflect on her fears. Professionals were encouraged to help the woman put her thoughts and feelings into words, specify different fears, and explore what she found more or less frightening or manageable. This could help the woman realise that she is not afraid of everything and provide important information on how to proceed the intervention.

Table 2. Recommendations for practice based on the findings.

Recommendations for practice
(1) **Establish multiprofessional clinical routines and pathways for identification, assessment, support, referrals, and follow-up** Make sure to have clearly documented and communicated clinical routines to identify, assess, support, and conduct follow-up appointments with women experiencing fear of childbirth and traumatic birth experiences. Given the diverse needs experienced, this requires multiprofessional collaboration within maternity care. When the needs identified cannot be met as part of your services, make sure to have well-established pathways for referrals and signposting (e.g. to psychiatric care units, family counselling, and social services). Facilitate referrals by assisting in establishing a contact and prepare the receiving unit.
(2) **Offer support for fear of childbirth and traumatic birth experiences as early and as long as needed** Fear of childbirth and traumatic birth experiences can be identified at various stages: before pregnancy, at different stages of pregnancy, and in the postpartum period. Offer support as soon as possible after the need has been identified. If the need is identified during pregnancy, do not postpone support until late pregnancy. Make sure to offer postpartum follow-up that is of relevance to the woman. If traumatic birth experiences are identified in the postpartum period, offer assessment and intervention. Do not postpone this to a potential future pregnancy.
(3) **Meet the woman where she stands and treat her with empathy and respect** This is of central importance for all professionals that meet women with fear of childbirth and traumatic birth experiences. To build a trusting relationship, it is essential to listen unconditionally to each woman telling her story in her own way, acknowledge her experiences, and take them seriously. Health care professionals must provide a safe place where the woman can put her thoughts and feelings into words, explore them, and specify her fears together with you. Rather than assuming, ask the woman what she needs to feel safe and how you can be of help and support.
(4) **Adapt interventions to each woman's unique needs and preferences** Women can experience fear of childbirth for different reasons. They have different experiences, challenges, expectations, and needs. Adapt the interventions you offer to the needs and preferences identified in collaboration with the woman.
(5) **Acknowledge psychological needs and experiences** It is essential that all professionals that meet women with fear of childbirth prioritise psychological needs as well as medical in birth planning and follow-up. Psychological needs must also be acknowledged during all phases of the birth process, as well as in the postpartum period. Include and consider information of psychological nature in the medical records from pregnancy, childbirth, and the postpartum period.
(6) **Involve a partner and/or other support person and assess partners' need for own support** Involve a partner and/or other support person in fear of childbirth interventions according to the woman's (and partner's) preferences, if possible from an early stage. Explore how the partner can be of help and support during pregnancy and childbirth and encourage joint birth preparations together with partner and/or other support person. Since partners may also suffer from fear of childbirth and traumatic birth experiences, assess partners' need for individual support.
(7) **Offer trauma-focused support to women with traumatic birth experiences** Women who have had a traumatic birth experience should be offered trauma-specific support and interventions. This includes assessing and treating posttraumatic stress. When meeting women from this group, validate fear and anxiety as natural reactions to a difficult event, and work to relieve experiences of shame and guilt. Go through the course of events in detail, based on the woman's own story. If necessary, use information in medical birth records as support, while prioritising the woman's own experience. Try to concretise what the woman would have needed in that situation and use her experiences to plan for the current pregnancy and upcoming birth. If the woman is open to it, ask her if there are any positive experiences in the otherwise negative story. Offer trauma-focused interventions, as you would with other traumas and in line with the best available evidence and current guidelines. If needed and possible, offer support to the partner and/or other support person.
(8) **If you are in the position to discuss and make decisions regarding birth mode: offer an open and honest dialogue** If possible, avoid postponing a decision about birth mode to late pregnancy. When meeting with the woman, invite her to bring a partner or other support person if she wishes. Explore thoughts and feelings regarding the birth mode, including potential ambivalence, as freely as possible. Be open and honest in your information. Avoid persuasions and having a hidden agenda. Do not promise anything you can't guarantee. If a woman is not interested in psychological interventions, carefully consider the purpose of suggesting/pursuing such interventions. Do not use such interventions to postpone or condition a dialogue regarding birth mode.

Acknowledging the unique needs and preferences of each woman

The psychologists recommended asking what the woman needs to feel safe, and jointly explore how health care in general and you in particular can be of help and support. From their perspective, interventions should be adapted to each woman's unique needs and preferences. This may, for example, involve adapting one's own way of working or involving other health care professionals or agencies if the woman has such needs.

> As you hear, we encounter several different categories of women that all can have fear of childbirth, but for completely different reasons and who have been through different things. And then it is very important to first try to circle what it has looked like for her earlier in life, to understand together how we can help.

For psychological interventions to be of any use, the psychologists found it essential that the woman herself was motivated and engaged.

A smorgasbord of core interventions that could be matched to the woman's needs

Depending on the specific needs and preferences of each woman, further conversation and intervention could take different pathways. The second theme comprised several core interventions commonly used by the psychologists.

Cognitive and educational strategies

The psychologist described an array of cognitive and educational strategies, all of them striving to widen the women's knowledge, expectations, or perspectives. In practice, this could mean recommending good and trustworthy sources of information, giving psychoeducation about worry and anxiety, exploring and challenging catastrophic cognitions, offering alternative and more realistic pictures of the birth process, trying to strengthen the woman's confidence in her body and her ability to give birth, or trying to relieve performance-based demands.

Several psychologists mentioned working with mentalising strategies. Widening the focus from fear alone to thoughts, images and emotions of the expected child and oneself as a parent, was described as a possible way to find new entrances and move forward in the treatment.

Explorative problem solving

Another central intervention was to help the women identify if any of their worries could be solved or handled in a practical manner. One psychologist gave an example of how she could frame this to a woman: 'I'm thinking of trying to sort out, what are the problems that you might be able to find some kind of solution to and what are the things where you need to find something within yourself'. In these cases, problem-solving approaches were found useful, as were exploring and using strategies and resources the women had used to handle difficult situations previously in her life.

Dealing with uncertainty

Working towards finding acceptance for the uncertainties inherent in pregnancy and childbirth was addressed in all focus group interviews, especially when working with primiparas. At times, women sought reassurance that would take all their worries away.

This was found challenging to deal with, since no such guarantees could be given. Instead, the psychologist offered to share and explore the difficulty of having to deal with uncertainty. They suggested exploring why this aspect of childbirth was found difficult and look into the possibility of similar patterns in other situations or areas of life. Rather than getting stuck in the view that childbirth is totally unpredictable, they recommended going through possible scenarios to differentiate aspects that are perceived as more or less intimidating and manageable, and possibly use imaginary exposure techniques to approach the more fear-provoking scenarios. They also recommended helping the woman formulate what she needs to endure this uncertain situation and identify what parts of the birth situation the woman and her partner actually could have some control over: 'I agree (. . .) to endure or find acceptance, but also try to hold on to what you actually *can* do or influence'.

Processing traumatic birth experiences

Traumatic birth experiences could be encountered either in follow-up visits after birth or in a later pregnancy. If encountered after birth, the psychologists preferred dealing with this in the postpartum period, rather than waiting for them to reappear in a subsequent pregnancy.

When previous negative birth experiences are identified, the psychologists found it important to validate a woman's fear as a natural reaction to a difficult event and try to relieve any experiences of shame and guilt about what happened. They then agreed that the main intervention would be to give considerable time and effort to process the traumatic experience and use this experience to plan for the coming birth.

The first part of trauma processing was described as going through the course of events in detail, with support from the medical birth records. To capture both medical and psychological aspects, the psychologists found it helpful if both a psychologist and a midwife could take part of the woman's story at this stage. Psychological birth traumas were then suggested to be treated in the same way as other psychological traumas, preferably including imaginative exposure of the traumatic memory.

When working with the trauma, the psychologists laid great emphasis on including a focus on what the woman would have needed in that particular situation, what lessons could be learned when planning for giving birth again, and what she needs to feel safe during the current pregnancy. They also proposed asking about exceptions of positive experiences in the otherwise negative story, and examining whether there was a slight desire for revenge to build on.

Preparing for birth

As described in the third theme, part of the psychologists' job was to encourage the woman to prepare for childbirth, preferably together with her partner or another support person.

Planning and preparing for the birth

Although most psychologists were not involved in decisions about birth mode or the formal birth planning, they could engage women and partners in preparing in other ways, such as practicing relaxation or breathing, exploring different birth strategies (e.g.

welcoming contractions as a way to bring you closer to the goal), or by offering psychoeducation on anxiety management. They also saw that a visit to the maternity ward could be very helpful.

Their experience was that it could be difficult, especially for first-time mothers, to know how they wanted things to be when giving birth. In such cases, their role as psychologists was to help the woman formulate her fears and needs, and how these could be articulated before and during birth. They could also encourage women to write a birth letter and support them in what to include and how to write it. Similar preparations could be made with women who had an appointment with an obstetrician or midwife to discuss the birth mode or specify a birth plan or birth contract. Rather than holding on to fixed ideas about how a vaginal birth should go about, the psychologists called for more creative ways to meet a woman's needs while giving birth. As an alternative to commonly used strategies, such as planned induction of labour or a planned CS, the psychologist had noticed that many women expressed a desire to give birth with a known midwife for increased confidence.

Involving a partner or support person

The psychologists found it important to explore opportunities for support in the woman's network. In their view, partners and/or other support persons should be involved at an early stage and as much as possible to remind the woman that she does not have to face this alone. However, some mentioned that it could be a good idea to give the woman time to formulate the problems for herself first and to talk a bit about how the partner relationship worked before including a partner in the sessions.

Partners were found valuable in writing up the story of past experiences, but most of all, the partner or support person was seen as an invaluable resource in teaming up with the woman to prepare for the birth. This included working out the partner's role as support person during both pregnancy and birthfor example, by encouraging joint birth preparation classes, practicing relaxation together, or planning how the partner could facilitate communication with staff during birth.

Involving the partner was seen as important also for partner's own sake. Partners might need support to handle previous traumatic birth experiences or fear of childbirth, at times warranting a parallel contact of their own. Giving all future parents the possibility to prepare for parenthood was also discussed:

> I think it's such an incredibly neglected area, to really capture parenting processes for all those who are waiting to be part of childbirth. (. . .) In maternity care the woman is the medical patient, but it is so important for her and the baby that the partner is involved in the parenting process too".

The issue of caesarean section

In Sweden, decisions regarding an elective CS on maternal request are generally made in late pregnancy. While waiting for an opportunity to discuss the birth mode with an obstetrician, women are often referred for other interventions (e.g. psychological counselling). Most psychologists met women in this state and found that the work could be challenging. The psychologist did not support the idea of working from a hidden agenda, being yet another voice trying to persuade women into vaginal

birth. Instead, many preferred being a neutral part, finding it more feasible to address fear-related topics in a wider perspective (e.g. other worries and perceptions of a CS birth).

The situation was described as particularly challenging when meeting women who were completely determined to give birth by CS, prepared to fight for it no matter the cost, and uninterested in talking about the matter:

> Like I said, those who are so completely focused on wanting a Caesarean, I think it is a waste of time for them to come to me. I think there isn't very much I can do unless they are afraid of a Caesarean too. Those who are ambivalent, in that case I think you can explore relating to that.

The psychologist described their work as much easier when the woman expressed at least some level of ambivalence relating to birth mode. In these cases, they could explore and approach both alternatives in a more open way. Some had the experience of working with women where the question of birth mode was held open. While this could be difficult, there were experiences of successful managing when moving carefully forward, letting the process take its time.

Working together to offer the best possible care

The fourth theme circles the importance of collaborative efforts to meet the needs of women fearing childbirth.

Signposting, referrals and cooperation beyond maternal care

The psychologists found it challenging when a woman's (or couple's) need for support expanded beyond their own professional boundaries, either in terms of time or competence. A commonly mentioned example was severe or complex mental disorders, where they stressed the necessity of working in cooperation with a psychiatric unit. In these cases, the support often needs to be planned individually, and the perinatal psychologist might have to advocate the woman's need for further support or treatment. Signposting could also be necessary when the couple experienced relationship problems, where contact with family counselling could be suggested, or when the needs warranted cooperation with social services or facilities for addiction treatment. When the woman or couple could not communicate in Swedish, the psychologists had positive experiences of engaging a community-based bilingual doula.

Continuity through documentation and follow-up

The participants strongly suggested making follow-up appointments after birth and found that it could be very assuring for pregnant women to know they will receive postpartum support. If further support is offered at another care unit, their advice was to assist in establishing a contact and prepare the receiving unit.

Continuity was described as imperative to ensure effective care, requiring all professionals to make clear journal entries and truly consider the information entered by others. The psychologists encouraged not to forget documenting information that is of emotional rather than medical nature, e.g. information about a woman's birth experience.

> I often think I get this story that … it has been a really horrible birth experience, but in the medical record it looks tip top (. . . .) so the woman feels that 'this was not my birth, - why isn't there anything about how it felt and how I experienced it?' There is no psychological or emotional record, only a medical one;, showing that 'yes a child was born in the end'.

The psychologists also called for a feedback loop giving maternity ward personnel access to information about the birth experience that has been revealed by women in the postpartum period.

Acknowledging both medical and psychological needs in maternity care

All focus groups emphasised the importance of collaboration between all professions and units within maternity care, to the benefit of both professionals and patients. Ideally, the collaboration should be 'Unpretentious …. The patient in focus – in capital letters!'.

Many called for, or highlighted the strength of, working in inter-professional teams as a means to optimise care. They also stressed that it is critical to have clear routines for how to identify and assess women's need for support, and a clear structure for who should provide which support. Often, parallel support from different professions (e.g. practical birth preparations alongside emotional support) was found useful.

The psychologists described working in close collaboration with midwives in antenatal care. Unfortunately, many felt that their expertise was not as highly valued in specialist maternity care and obstetric settings. 'You really have to fight to get in' one psychologist said, describing how she and her colleagues repeatedly had invited themselves before finally being admitted to meetings where joint cases were discussed. At times, the lack of interaction between psychologists and obstetric specialists hindered the psychologist's work, e.g. when plans suddenly were remade or agreements were broken.

> What you have talked about with the patient, and what you've decided on and what you've said, it's suddenly not relevant. Or that completely different things are said and completely different answers are given.

The psychologists acknowledged that their limited knowledge of the medical aspects of pregnancy and childbirth could lead to challenges when meeting women with fear of childbirth, as the psychologist, for example, cannot assess medical risks or contribute to the practical planning of childbirth. To compensate for this to some extent, the psychologists considered it essential to have basic knowledge of the normal birth process, current routines, and everyday life at the labour ward.

Looking at it from the other perspective, the psychologists wished that psychological competence could be given higher priority in obstetric care. As the medical perspective always trumped all other perspectives, they found it difficult to convey women's psychological needs and convince medical staff to prioritise these matters. This was not unique to the profession of psychologists; midwives with high psychological competence were also described having to submit to the medical perspective. At the extreme, care procedures ignoring the psychological needs of women were considered posing a risk for unnecessary care-induced fear of childbirth.

Discussion

In this study, we set out to explore and describe perinatal psychologists' experiences of helping women with fear of childbirth. Central to the psychologists' work was to listen, validate and explore the fear together with the woman. These are common themes through studies describing both counsellors' and womens' perspectives of good fear of childbirth support (Larsson et al., 2019; Salomonsson et al., 2010; Wulcan & Nilsson, 2019). As concluded in a systematic review of different intervention strategies, it might be more important to give women with fear of childbirth a supportive space to explore their fear than to provide a specific approach in terms of reducing fear (Webb et al., 2021).

The psychologists in this study used several different techniques, chosen based on the unique needs and previous experiences of each woman. As described by Wulcan and Nilsson (2019), the psychologists found that women expecting their first child often have somewhat different needs than women who are haunted by previous negative birth experiences. However, rather than letting the distinction between primary and secondary fear of childbirth be the only guide to tailoring of interventions, the psychologists reached for a more detailed problem analysis and further individualisation. Individualised care has been advocated by others (Salomonsson et al., 2010), starting form a mutual understanding of each woman's wishes in relation to fear of childbirth (Jomeen et al., 2021).

The specific intervention techniques mentioned by the psychologists included cognitive and educational approaches, problem solving, dealing with issues of uncertainty, and trauma processing. When possible, the psychologists preferred offering trauma processing in the postnatal period, rather than in a subsequent pregnancy. Since trauma-focused psychological interventions during the postnatal period appear to be effective in reducing birth-related posttraumatic stress symptoms (Furuta et al., 2018), this striving seems reasonable and ethically sound.

As the most challenging part of their work, the psychologists mentioned meeting women who were completely determined not to give birth in any other way than by a CS. If the woman had some ambiguities or were open to explore her thoughts, feelings and preferences on the matter, the psychologists' work was found much easier. Few studies have evaluated the effect of fear of childbirth interventions on birth preferences. In their systematic review, O'Connell, Khashan, et al. (2021) identified two: Although the psychoeducative intervention presented by Boz et al. (2021) seemed successful in turning the 12 women in their intervention group towards wanting to give birth vaginally, more than 40% of the sample eventually gave birth by CS. In the other, two sessions of telephone counselling with a midwife prevented an increase in CS preferences from mid- to late pregnancy, rather than reduce the number of women preferring a CS birth during the same period (Fenwick et al., 2015; Toohill et al., 2014). Hence, the challenge of shifting women's minds does not seem unique to our sample. Available trials evaluating the effect of fear of childbirth interventions on the actual mode of birth also show inconsistent findings. In their meta-analysis, Webb et al. (2021) found that contextual factors of the study country had an impact on intervention outcomes in this regard, and that the intervention groups in Scandinavian studies generally showed a lower CS rate than their comparison groups. So, if the intention of an intervention is to reduce the actual rate of Caesarean sections, Scandinavian talking therapies seem (on a group level)

promising. On the individual level however, when acknowledging the unique circumstances of each woman or couple, this endeavour might be more or less adequate and fruitful.

To help women with fear of childbirth in the best way possible, the psychologists emphasised the necessity of inter-professional collaborations. While midwife led counselling build on the clinical expertise and credibility of the midwife, and for natural reasons emphasise sharing knowledge about the birth process and planning for the future birth, such interventions played a smaller role in the psychologists' work. They candidly admitted their limited knowledge of the physical birth process, risk assessment, and birth interventions, and highlighted the necessity of working together with midwives and obstetricians to give the women the information and practical planning they could not offer themselves. That said, they experienced that psychological perspectives of women's needs often were undervalued, both in the inter-professional dialogue and in meeting with the women. Advocating women's psychological needs during pregnancy and childbirth was described as challenging, yet highly important.

Although Striebich et al. (2018) argue that midwives, as primary care providers, are in the best position to identify and support women with fear of childbirth, they also point to the necessity of establishing cooperative local networks between midwives, psychologists and obstetricians as a complement to ensure timely and effective care for women with high or severe FOC. Similarly, Jomeen et al. (2021) advocate a multi-professional package of care combined with clear referral pathways. The results of this study point us in the same direction; multi-professional collaboration is imperative to optimise support for women with fear of childbirth. Integrated intervention programs, joint group sessions, or individual planning according to the woman's needs and preferences could be examples of strategies to implement shared multiprofessional interventions. Unfortunately, we are not aware of any scientific study evaluating such initiatives, making this an interesting area for future research. The strategies for implementing multidisciplinary treatment and support most likely need to be adapted to the contextual factors of each specific country. In Sweden, where fear of childbirth support is well-established and several professions are already being involved, a first step would be to bridge organisational gaps to facilitate coordination and collaboration. In countries where fear of childbirth support is less established, integrating the professional resources from the start might be an interesting way to go.

A limitation of this study was the relatively small number of participating psychologists. On the positive side, the participants represented eight different hospital regions, from the north to the south, including both rural and city regions. Most worked closer to maternal care services, but we also had participants working in specialist obstetric care services. Small groups were used for the focus group interviews, allowing everyone to share their perceptions without time constraints. The digital format facilitated participation despite busy work schedules and regardless of geographical location.

The findings in this study adds to the current knowledge on how to treat and support women fearing childbirth and should be considered as one of many sources of information guiding the development of future interventions, care strategies, and clinical pathways for women fearing childbirth.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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