National Institute for Health and Clinical Excellence

Review of Clinical Guideline (CG45) - Antenatal and postnatal mental health

Stakeholder Comments Proforma

Please enter the name of your registered stakeholder organisation below. **NICE is unable to accept comments from non-registered organisation or individuals. If you wish your comments to be considered please register via the NICE website or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.**	
Stakeholder Organisation:	Electivecesarean.com
Name of commentator:	Pauline McDonagh Hull

Stakeholder organisation	Agree / Disagree with prospo sal to update	Comments **Please insert each new comment in a new row.**	Comments on areas excluded from original scope	Comments on equality issues
Electivecesarean.com	Agree	The comments I have written in the adjacent column ("comments on areas excluded from original scope") relate to: 1) Clinical area 3:- Interventions for women with subthreshold symptoms of depression and/or anxiety 2) Clinical area 4:- Management of	**Pg.10 (1.1.1.2)** NICE: '*Providing and using information effectively …explore the woman's ideas, concerns and expectations and regularly check her understanding of the issues*' It would be useful to include a statement here on	

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		traumatic birth: Potential new evidence or concerns (relating to overall management of traumatic birth) that may need to be considered for inclusion in the guideline Therefore, in the adjacent column, I have noted the section and page number as they refer to the original NICE guideline, in order to help identify the areas. For some of the comments, it may be the case that the area IS included in the update proposal, and I am just suggesting some expansion to the coverage of these areas. Thank you.	the specific issue of tokophobia. Please look at this Royal College of Psychiatrists' press release from January 01, 2000: http://www.rcpsych.ac.uk/press/pressreleasearchive/pr55.aspx (Text:) *'Tokophobia' is an intense anxiety or fear of death which leads to some women dreading and avoiding childbirth despite desperately wanting a baby. A study of a series of 26 cases of women suffering from this condition is published in the January issue of the British Journal of Psychiatry. It concludes that:* *Tokophobia is a distressing psychological condition which may be overlooked* *It is associated with anxiety, depression, post-traumatic stress disorder (PTSD) and bonding disorders* *Close liaison between the obstetrician and the psychiatrist is imperative* *Subjects for the study were referred from obstetricians in the West Midlands and from psychiatrists on the mother and baby unit at the Queen Elizabeth Psychiatric Hospital in Birmingham. They were seen over a two-year period in their homes by the same psychiatrist who was not the treating doctor.* *24 of the women in the study were married and 24 had had all their children with the same*	

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			partner. *Primary tokophobia. Eight of the women had a dread of childbirth which pre-dated pregnancy and had begun in adolescence. Sexual relations were normal but contraceptive use was scrupulous. Four of these women planned their pregnancy despite their intense fears; and two had an overwhelming desire to be a mother which overpowered their avoidance but did not allay their fear.* *Most women with primary tokophobia strongly desired a Caesarian birth. Four achieved this, bonded well with their baby and enjoyed excellent psychological health. Three women endured vaginal deliveries against their will; all suffered postnatal depression, two suffered symptoms of PTSD and two had delayed bonding with their infants.* *Secondary tokophobia occurs after a traumatic or distressing delivery. 14 women in the study developed a dread of childbirth after a previous delivery. Their dilemma was that the family felt incomplete but they were terrified of a further delivery. Nevertheless 13 of them proceeded with further pregnancies, of whom three had miscarriages (and felt enormous relief that delivery was avoided). All 13 women were extremely anxious during their pregnancies.* *11 of the women in this study group arranged a Caesarian birth; one had a successful vaginal*	

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			delivery and a good psychological outcome; and the other suffered postnatal depression, PTSD and a bonding disorder with her baby. *Four women developed tokophobia as a symptom of depression in the prenatal period and believed that they were unable to deliver their baby – if made to, they would die. Two who tried to end their pregnancy were treated psychologically and recovered. One woman who responded well to antidepressants arranged a Caesarian birth and bonded well to her baby. By contrast, another women who declined antidepressant medication and was refused a Caesarian had a traumatic vaginal delivery, suffered from postnatal depression and felt detached from her baby.* *Five women in the sample reported sexual abuse in childhood and three a traumatic rape. The authors comment that a history of sexual abuse may be associated with an aversion to routine obstetric care associated with primary tokophobia or tokophobia as a symptom of depression. The trauma of a vaginal delivery may cause a resurgence of memories of abuse and contribute to secondary tokophobia.* *Two women in the study terminated a pregnancy because they could not face delivery, even though both babies were much wanted. This outcome may be the only choice in the absence of an empathic professional listener or access to*	

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			relevant medical literature. *There was a high rate of hyperemesis gravidarum in the study, and a psychological component to this has been postulated.* It refers to this study: K Hofberg and I Brockington, “Tokophobia: an unreasoning dread of childbirth. A series of 26 cases,” The British Journal of Psychiatry: The Journal of Mental Science 176 (January 2000): 83-85. http://www.ncbi.nlm.nih.gov/pubmed/10789333 In addition, the following studies might be useful to consider for background knowledge during the gathering of evidence: Mothers' Satisfaction with Planned Vaginal and Planned Cesarean Birth. Blomquist JL, Quiroz LH, Macmillan D, McCullough A, HandaVL. Am J Perinatol. 2011 Mar 4. http://www.ncbi.nlm.nih.gov/pubmed/21380993 Ingela Wiklund, Gunnar Edman, and Ellika Andolf, “Cesarean section on maternal request: reasons for the request, self-estimated health, expectations, experience of birth and signs of depression among first-time mothers,” Acta Obstetricia Et Gynecologica Scandinavica 86, no. 4 (2007): 451-456.	

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			http://www.ncbi.nlm.nih.gov/pubmed/17486467 E L Ryding, K Wijma, and B Wijma, "Psychological impact of emergency cesarean section in comparison with elective cesarean section, instrumental and normal vaginal delivery," Journal of Psychosomatic Obstetrics and Gynaecology 19, no. 3 (September 1998): 135-144. http://www.ncbi.nlm.nih.gov/pubmed/9844844	
			Pg.15 (1.3.1.3) NICE: '*Prevention of mental disorders*' It would be useful to include a statement here on the specific issue of tokophobia and its potential to lead to a psychological problem postpartum – if not recognised and supported (or perhaps deemed sufficient to be mentioned in CG13?). And given the example studies below, it appears that more research in this area is needed – in the sense that in order to prevent, we need to recognise what may lead to psychological problems: Risk factors in pregnancy for post-traumatic stress and depression after childbirth. Söderquist	

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			J, Wijma B, Thorbert G, Wijma K. BJOG. 2009 Apr;116(5):672-80. Epub 2009 Feb 10. Sweden http://www.ncbi.nlm.nih.gov/pubmed/19220236 …One month postpartum, 12 (1.3%) women had post-traumatic stress (met symptom criteria B, C, and D for post-traumatic stress disorder according to Diagnostic and statistical manual of mental disorders, 4th edition [DSM-IV]). The most important risk factors in pregnancy were depression in early pregnancy (OR=16.3), severe fear of childbirth (OR=6.2), and 'pre'-traumatic stress (in view of the forthcoming delivery) in late pregnancy (OR=12.5). The prevalence of depression was 5.6%. Post-traumatic stress and depression were positively related 1 month postpartum and were predicted by mainly the same factors… Risk factors for post-traumatic stress and depression after childbirth can be assessed in early pregnancy. Post-traumatic stress and depression also seem to share the same underlying vulnerability factors. Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth. Zaers S, Waschke M, Ehlert U. J Psychosom Obstet Gynaecol. 2008 Mar;29(1):61-71. Switzerland http://www.ncbi.nlm.nih.gov/pubmed/18266166 This study examined the course of psychological problems in women from late pregnancy to six	

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			months postpartum, the rates of psychiatric, especially depressive and post-traumatic stress symptoms and possible related antecedent variables. During late pregnancy, one to three days postpartum, six weeks and six months postpartum, 47 of the 60 participating women completed a battery of questionnaires including the General Health Questionnaire, the State-Trait Anxiety Inventory, the Edinburgh Postnatal Depression Scale, and the PTSD Symptom Scale. In general, most women recovered from psychiatric and somatic problems over the period of investigation. However, depressive and post-traumatic stress symptoms in particular were not found to decline significantly. Six weeks postpartum, 22% of the women had depressive symptoms, with this figure remaining at 21.3% six months postpartum. In addition, 6% of the women studied reported clinically significant PTSD symptoms at six weeks postpartum with 14.9% reporting such symptoms at six months postpartum. The most important predictor for depressive and post-traumatic stress symptoms was the block variable "anxiety in late pregnancy". Other predictors were the variables "psychiatric symptoms in late pregnancy", "critical life events" and the "experience of delivery". The results of our study show a high prevalence rate of psychiatric symptoms in women after childbirth and suggest, besides the experience of the	

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			delivery itself, a vulnerability or predisposing history that makes the development of psychiatric symptoms after childbirth more probable. Childbirth and the development of acute trauma symptoms: incidence and contributing factors. Creedy DK, Shochet IM, Horsfall J. Birth. 2000 Jun;27(2):104-11. Australia. http://www.ncbi.nlm.nih.gov/pubmed/11251488 Posttraumatic stress disorder after childbirth is a poorly recognized phenomenon. Women who experienced both a high level of obstetric intervention and dissatisfaction with their intrapartum care were more likely to develop trauma symptoms than women who received a high level of obstetric intervention or women who perceived their care to be inadequate. These findings should prompt a serious review of intrusive obstetric intervention during labor and delivery, and the care provided to birthing women. Post-traumatic stress disorder due to childbirth: the aftermath. Beck CT. Nurs Res. 2004 Jul-Aug;53(4):216-24. USA http://www.ncbi.nlm.nih.gov/pubmed/15266160 Childbirth qualifies as an extreme traumatic stressor that can result in post-traumatic stress disorder. The reported prevalence of post-traumatic stress disorder after childbirth ranges	

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			from 1.5% to 6%... Mothers with post-traumatic stress disorder attributable to childbirth struggle to survive each day while battling terrifying nightmares and flashbacks of the birth, anger, anxiety, depression, and painful isolation from the world of motherhood… This glimpse into the lives of mothers with post-traumatic stress disorder attributable to childbirth provides an impetus to increase research efforts in this neglected area. Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth. Reynolds JL. CMAJ. 1997 Mar 15;156(6):831-5. Canada. http://www.ncbi.nlm.nih.gov/pubmed/9084390 CHILDBIRTH CAN BE A VERY PAINFUL EXPERIENCE, often associated with feelings of being out of control. It should not, therefore, be surprising that childbirth may be traumatic for some women. Most women recover quickly post partum; others appear to have a more difficult time. The author asserts that post-traumatic stress disorder (PTSD) may occur after childbirth. He calls this variant of PTSD a "traumatic birth experience." There is very little literature on this topic. The evidence available is from case series, qualitative research and studies of women seeking elective cesarean section for psychologic reasons. Elective cesarean section exemplifies the avoidance behaviour typical of PTSD. There are many ways that health care professionals,	

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			including physicians, obstetric nurses, midwives, psychologists, psychiatrists and social workers, can address this phenomenon. These include taking a careful history to determine whether a woman has experienced trauma that could place her at risk for a traumatic birth experience; providing excellent pain control during childbirth and careful postpartum care that includes understanding the woman's birth experience; and ruling out postpartum depression. Much more research is needed in this area. Posttraumatic stress following childbirth: a review. Olde E, van der Hart O, Kleber R, van Son M. Clin Psychol Rev. 2006 Jan;26(1):1-16. Epub 2005 Sep 19. The Netherlands http://www.ncbi.nlm.nih.gov/pubmed/16176853 …Case studies and quantitative studies confirm that childbirth may be experienced as so emotionally intense that it can lead to the development of posttraumatic stress symptoms or even a PTSD-profile. Among the identified risk factors were a history of psychological problems, trait anxiety, obstetric procedures, negative aspects in staff-mother contact, feelings of loss of control over the situation, and lack of partner support. The conclusion of the current review is twofold. First, traumatic reactions to childbirth are an important public health issue. Secondly,	

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			studying childbirth offers opportunity to prospectively study the development of posttraumatic stress reactions. [Psychologic effects of traumatic live deliveries]. Pantlen A, Rohde A. Zentralbl Gynakol. 2001 Jan;123(1):42-7. Germany http://www.ncbi.nlm.nih.gov/pubmed/11385911 Psychological symptoms postpartum were reported frequently. Traumatically experienced childbirth can be responsible for specific short-term or long-term symptoms. In individual cases, a PTSD can develop after a traumatic delivery with long-term negative consequences for the health and mental condition of the mother, the mother-child-relationship and the desire for further pregnancy. In such cases, a specific psychotherapeutic treatment is always necessary. The longitudinal course of post-traumatic stress after childbirth. Söderquist J, Wijma B, Wijma K. J Psychosom Obstet Gynaecol. 2006 Jun;27(2):113-9. Sweden http://www.ncbi.nlm.nih.gov/pubmed/16808086 …In pregnancy, depression, severe fear of childbirth, 'pre'-traumatic stress, previous counseling related to pregnancy/childbirth, and self-reported previous psychological problems were associated with an increased risk of having	

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			post-traumatic stress within 1-11 months postpartum. Sum-scores of post-traumatic stress did not decrease over time among women who at least once had post-traumatic stress (criteria B, C, and D) within 1-11 months postpartum. Women with post-traumatic stress also showed a decrease in perceived social support over time postpartum.	
			Pg.16 (1.3.1.3) NICE: '*take into account the effect of the birth on the partner.*' Please include, in consideration of the evidence: Karen Nicholls and Susan Ayers, "Childbirth-related post-traumatic stress disorder in couples: a qualitative study," British Journal of Health Psychology 12, no. Pt 4 (November 2007): 491-509. Also, in addition to the effect on the partner, it might also be useful to look at the effect on the child too; here is an example study to be considered: Cristie Glasheen, Gale A Richardson, and Anthony Fabio, "A systematic review of the effects of postnatal maternal anxiety on children,"	

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			Archives of Women's Mental Health 13, no. 1 (February 2010): 61-74.	

Please add extra rows as needed

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Closing date: 5pm on 14 June 2011

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