Practitioner perspectives on the use of selected Fear of Childbirth screening tools within a clinical context.

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Abstract

Fear of childbirth (FOC), or tokophobia, can influence several medical and obstetric variables, and is a significant predictor of maternal and mental health outcomes and birth experiences. Current practice in the UK does not include initial screening for tokophobia, rather, assessment and support occur under extreme circumstances e.g., maternal requests for caesarean sections or pregnancy termination requests in order to avoid childbirth. Moreover, while there are several candidate outcome measures for FOC, none have been evaluated in terms of their perceived suitability by specialist practitioners within perinatal healthcare pathways. The present study explores the perceived barriers and facilitators reported by health professionals working within the maternity and mental health services for the use of FOC candidate outcome measures. Evaluated measures included the Fear of Birth Scale, the Oxford Worries about Labour Scale, The Wijma Delivery Expectancy Scale, the Slade-Pais Expectations of Childbirth Scale the Tokophobia Severity Scale. The Tokophobia Severity Scale, followed by the Slade-Pais Expectations of Childbirth Scales were the most favourable scales selected for use according to clinicians. The identification of preferred scales and how they can be used in the local maternity system is a step towards the application of these consistently in clinical practice, to aid in the identification and assessment of FOC. The use of the correct tool at each stage of contact with the local maternity system will improve clinician confidence in the identification of FOC and facilitate the efficient implementation of treatment and support through the development of pathways of care.

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Introduction

Background

Severe fear of childbirth (FOC), also referred to as tokophobia, is characterised as a fear of abandonment and isolation, fear of harm (to the women and/or their baby), and fear of not coping with pain. (Slade, Balling, Sheen & Houghton, 2019). The condition is considered distinct from anxiety at other points in life and is a significant predictor of infant outcomes and maternal health from pregnancy to delivery (Alderdice, Lynn & Lobel, 2012; Slade, Balling, Sheen & Houghton, 2020). Women with FOC are at heightened risk of future mental illness, including depression, anxiety and post-traumatic stress disorder (Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008; McKenzie-McHarg et al., 2015), and more severe FOC is associated with a negative childbirth experience and outcome (Chabbert, Panagiotou & Wendland, 2021; Ryding et al., 2015). Women with FOC may request termination of an otherwise wanted pregnancy to avoid childbirth (Elmir, Schmied, Wilkes & Jackson, 2010; Zar, Wijma & Wijma., 2002), overuse contraception, experience denial of a pregnancy, and avoid utilising and engaging with obstetric or sexual health services altogether. (Gutteridge & Richens, 2020). The prevalence of FOC varies extensively, ranging from 1.9 to 30% worldwide which, even at the lower margin, represents a significant proportion of birthing women and families (Ayers, 2014; O'Connell, Leahy-Warren, Khashan, Kenny & O'Neill, 2017).

Assessing FOC in clinical settings: Current practice and measures

For clinicians supporting women with FOC, it is crucial to discern between fear that can be managed within routine maternity services, and severe FOC that requires specialist support and

treatment (Wigert et al, 2020). At present in the UK, screening within maternity services is recommended for anxiety but not for FOC, and the point at which women receive professional help for FOC can depend upon local provision, in particular whether there are clinicians with specialist expertise in the region, and dependent upon multi organisational pathways of care being in place (Jomeen et al, 2021). Development of such pathways of care can be complex and require significant negotiation across the various care providers within this context (Jones et al, 2020). While there are a number of screening materials available to healthcare professionals for identifying and assessing FOC, these are often utilised inconsistently, and due to differences in their length and content, their respective suitability for implementation at each stage of patient care is unknown. The present issue for current UK practice in perinatal mental health care is therefore twofold; a system is required to help practitioners to identify and assess FOC at initial stages of the patient journey, and the outcome measures used for FOC must be regarded by healthcare professionals as effective and suitable for implementation within a dedicated perinatal mental health pathway.

A number of measurement tools appropriate for screening have been developed, ranging from single items to questionnaires. We identified five of the most frequently cited tools for use in this study. The most commonly used FOC measure is The Wijma Delivery Expectancy Questionnaire Version A (WDEQ-A) (Wijma, Wijma & Zar, 1998), however this tool is rarely used in clinical practice (e.g., Healthy London Partnership, 2022). Other clinical outcome measures include the Fear of Birth Scale (FOBS) (Haines, Pallant, Karlstro, & Hildingsson, 2011), the Oxford Worries about Labour Scale – Antenatal (OWLS) (Redshaw, Martin, Rowe & Hockley, 2009), the Slade-Pais Expectations of Childbirth Scale (SPECS) (Slade, Pais, Fairlie,

Simpson & Sheen, 2016) and the Tokophobia Severity Scale (TSS) (Wootton, Davis, Moses, Moody & Maguire, 2020). See Table 1.

(Table 1 here)

Assessing FOC in a dedicated perinatal mental health pathway: Benefits for patients

Effective screening measures are crucial for clear referral processes, and patient access to the correct resources and specialised perinatal care (Khan, 2015). Utilising outcome measures, practitioners can initiate discussions about anxieties and concerns regarding pregnancy, labour and childbirth. The questions within the measures may encourage the woman to contemplate, identify and consider aspects of their experience that are otherwise difficult to discuss.

Ensuring that the measures used for identifying and assessing FOC in clinical settings are both patient-centred and practitioner-approved is crucial for supporting women's active engagement in making decisions about their care and ensure that interventions and services are efficiently implemented.

Present study

The present study measured the perceived efficacy of 5 screening questionnaires for assessing FOC for its use within a local maternity system and perinatal mental health pathway, which includes a pathway of care for women with severe FOC, launched in September 2019 by the Humber Teaching NHS Foundation Trust, Specialist Perinatal Mental Health Team, Hull University Teaching NHS Trust, the University of Hull and partner agencies. The pathway follows a stepped model of care, implemented to ensure that women can access support, and that their psychological and pregnancy needs were met. Services included advice and information

from midwifery, the development of individualised birth plans, and psychological interventions such as cognitive behaviour therapy and support from primary care mental health services.

Materials and Methods

Participants

Participants were recruited by sharing and cascading information through the Local Maternity and Neonatal Systems meetings. Twenty specialist practitioners, including those from a perinatal mental health team (11), midwifery (5), and primary care mental health providers (4), from Humber 4 region, Hull, East Yorkshire, North and Northeast Lincolnshire. Participants were invited to take part if they provided either maternity or mental health care to pregnant and postnatal women. Participants were invited to take part if they provided either maternity or mental health care to pregnant and postnatal women, and the participants had a range of experience in supporting women with FOC. There was no specific requirement for participants to have supported or treated women with FOC however most participants had some experience in this area. Overwhelmingly participants were from the Hull and East Yorkshire region.

Ethical approval

All participants gave written informed consent prior to interviews taking place. Ethical approval was obtained from the University of Hull Faculty of Health Sciences Research Ethics Committee.

Individual and group semi-structured interviews

Semi-structured interviews included 8 question items, see Table 2

(Table 2 here)

Participants were given a brief outline regarding the potential use of the outcome measures within a clinical setting, this information was brief, so at to not compromise the research findings.

Five group interviews and 4 individual interviews were conducted by 2 members of the research team, all interviews took place online using the MS Teams platform, and interview length ranged between 45 minutes and 1 hour for both group and individual interview.

Analysis

Anonymous transcripts were processed using NVIVO, QSR Software. Manual sentiment-coding analysis was implemented in NVIVO by initially using four a priori codes determined by NVIVO software. These codes are named/labelled as follows; positive, negative, mixed and neutral. Driving the analysis, and informed through the a priori codes, was an aim to identify positive, negative, mixed and neutral language embedded within the data and allocate to the individual codes accordingly. Statements made during the focus groups/interviews that could be assigned to one of the 4 a priori sentiment codes were labelled as such. Decisions regarding the allocation of text to individual sentiment codes were made on agreement by CAM and CJ.

Qualitative content analysis was then used to organise the data into additional categories based on a process of interpretation by the researcher's careful examination and constant comparison. This was guided by the Zhang and Wildemuth (2005) model. From reading and rereading the transcripts

a number of themes emerged in addition to the sentiment expressed towards the outcome measures and can be located below in the section "Factors that influence the assessment and measurement of childbirth".

Themes within individual interviews and group interviews were largely the same. This pragmatic hybrid approach of applying a sentiment and content analysis process to understanding the data, was considered fit for purpose, taking into account the constraints of available resources, that is funding and time. Sentiment coding was considered a suitable approach as it had potential to provide access to practitioner's views and opinions of the measures in a more manageable way. Table 3 the a priori codes.

(Table 3 here)

Final coding outcomes and themes were reviewed and agreed by authors CJ and CAM.

As researchers, academics and clinicians, we have been able to identify that we would not come to this study from a place of pure objectivity. Of the dispositions we brought to the study were, identifying as practitioners and as NMC registrants committed to the pillars of The Code Nursing and Midwifery Council (2018): prioritising people, practicing effectively, preserving safety and promote professionalism and trust. We have a collective rich history of supporting women that have experienced fear of childbirth, and supporting practitioners tasked with supporting women with fear of childbirth. We considered the underlying assumptions we held in relation to the use of screening tools, and we discussed these at length within the research team, being aware how these may influence others' views of the screening tools during the interviews. We discussed and

Results

The TSS received the most positive comments, followed by the SPECS scale and for each of the five FOC outcome measures, researcher interpretations of practitioners' narratives are summarised below in table 4.

[Table 4 here]

Outcome measure evaluations

The Fear of Birth Scale (FOBS)

Perceptions of the FOBS outcome measure tended to be more negative than positive. Practitioners felt that the outcome lacked detail with insufficient information for women with severe FOC. Some suggested that FOBS may be an opportunity for screening women for FOC, but that it would be of little clinical value for determining support or intervention needs for women with severe FOC. The shorter length of the measure, however, was highlighted as a benefit for use by midwives and other practitioners as a form of screening tool, for example, as *'a really quick screening tool rather than a thorough assessment':*

> *[...] quick visual tool, the Fear of Birth Scale would have a place somewhere, to lead onto further assessment or interventions, just to get that really clear overview.*

[FOBS] is the most basic simple one […] which I think maybe is a really good way to start off the conversation, but then you have not got any of that detail. It doesn't help somebody to maybe explain actually how they are feeling.

I felt like the Fear Of Childbirth Scale was too short […] I thought, "Oh, that does not give me any information at all"

The Oxford Worries about Labour Scale (OWLS)

Practitioners expressed mixed views regarding the OWLs. The measure was described as *"simple"* and *"to the point"*, and while some felt that the questions were clear and understandable, and that the outcome measure was brief enough to be used in the clinical setting, there were concerns that this measure was very clinical, and focused heavily on the physical aspects of labour and childbirth to the exclusion of emotional and relational issues that may impact on a woman's experience of FOC:

If you were with someone who didn't speak English and it was just an interpreter, I felt like that was quite easy. And I really like the bit where it gives the option […] I really like that the woman might have an option.

I thought [OWLS measure] was good because it's only 11 questions and I have got a lady at the moment who has a fear of going into labour early and I've got that information, but this is a bit broader and it could give me a lot more information about the fear of labour which I've never really thought about going into before

I didn't think it looked at mental health at all. It didn't look at any sort of anxiety or any mental health-based symptoms as such.

I don't think it grasps the idea of the whole of tokophobia, it's just about labour. I think it's a nice one to use maybe on top of this because sometimes it's not just the labour that everybody's worried about is it, it's about the whole shebang.

The Tokophobia Severity Scale (TSS)

The TSS was the outcome measure preferred by all practitioners, irrespective of professional background. The length of the tool was seen as positive and realistic for use within a clinical setting, and its content was deemed appropriate and relevant to the clinical need. Practitioners could see the benefit of including items which might help to identify other mental health problems such as post-traumatic stress disorder or obsessive-compulsive disorder. No negative views were expressed about the TSS:

I felt like this was a measure that I could see women filling out quite easily. I felt like it wasn't too long. It was detailed enough. You got what you needed from it, and I felt like you could score it quite quickly. It wasn't too lengthy. It felt like just the right balance. For like an initial assessment, if a woman was to fill out that in the waiting room, I felt like it would provide you with a lot of information.

I think this one had enough in it that felt like it would cover a lot, clinically.

I like that it spoke about having nightmares about childbirth. I felt like that was a good one, because I think it also could lead onto talking about questions about PTSD and

previous trauma they might have had. And yeah, I just like that they asked about

nightmares in particular.

The Slade-Pais Expectations of Childbirth Scale (SPECS)

Practitioners expressed mixed views regarding the SPECS. It was felt that this outcome measure is *"so detailed that it almost gave the goals that you could set for therapy"*. The level of detail it offered was suggested as a benefit for its use in the development of birth plans, or goals for therapy interventions. However, there were concerns that the level of detail in this outcome measure may be alarming or burdensome for clients, or perhaps be problematic in terms of inducing fear in women. The length of the outcome measure and level of detail was deemed unsuitable for use within midwifery but may be suitable for use by specialist perinatal mental health midwives.

> *My initial thought was that would be really helpful in the mental health birth planning*
>
> *process as well, because a lot of the things in that are ones that we openly discuss and talk*
>
> *about and add to it.*

> *Coming at this as a pregnant person, thinking about it could actually almost put fears and*
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> *thoughts into your mind that you maybe wouldn't have had previously. Yes, you might be*
>
> *afraid of giving birth, but you might not have thought of all of the detailed specifics that*
>
> *are in those questions. So, potentially that actually adds to those anxieties, I was thinking.*
>
> *It could certainly help with support if they have those, but it could provide those additional*
>
> *anxieties that they have maybe not even thought about yet.*

I'm not sure initial assessment is the right place for them. I think you would just feel really overloaded with questionnaires. If I was a patient, that's how I would feel.

Wijma Delivery Expectation Questionnaire (W-DEQ)

A number of concerns were raised by participants about the W-DEQ outcome measure. Many felt that it too long and would be time consuming for practitioners and burdensome for women to complete, and that it included unclear language throughout. There were no positive comments regarding this outcome measure:

If I was coming into the service and was presented with this questionnaire, I would just be like, "Oh gosh, no" [laughter]. There's lots of numbers. There's only two numbers that have like a meaning, and the rest, you just pick whichever one you think it is. And I think it's very easy for people to go for extremes or just go for the middle. I don't know if it's the way it's laid out, but it feels a bit overwhelming. I think, if I was already anxious, I would just think, "Oh gosh."

It was the terminology and the wording for me. I know, when I had a look through it, I was thinking, "Well, what does that mean? What does abandoned mean?"

Lengthy, so to score it up I think would take quite a bit of time.

Factors that influence the assessment and measurement of FOC

In addition to coding the outcome measures and associated sentiment, additional codes were identified, named and reviewed throughout. These factors that strongly influence the assessment and measurement of FOC are discussed below.

Burdening clinicians and patients

Practitioners highlighted reluctance to overwhelm or burden patients with too much information within the longer outcome measures, particularly where the patient may find the content distressing and/or difficult to talk about:

> *I guess it would be totally dependent on the person's presentation, wouldn't it? I think some you would probably maybe be able to do, and then others, you know if there was quite a high level of distress for example, I don't think it would be appropriate if they were to be presented with that and then you were trying to do a full assessment as well.*

> *If [patients] are just really incredibly anxious and really struggling to sort of take information in at that moment in time because of their anxieties and their fears. That is an awful lot of information to try and work your way through to be able to tell somebody that you are worried or that you are scared, I suppose.*

Midwives in particular were concerned about the practicality of completing the outcome measure within time-limited appointments, and raised the benefit of using a shorter outcome measure as a way of identifying women with FOC:

Because I think there was a couple that were quite lengthy, and I thought that would take up the majority of your session. And I know we're quite pressured with time, aren't we?

Maybe that's why the midwives could potentially use some of the shorter maybe less emotional ones to start with, so that they had a bit of priority maybe before further referral, or to offer then an extended appointment, you know to explore it in more detail next time.

Pathways of care

Ensuring that adequate pathways of care being are in place to meet patients' needs was reflected throughout the research interviews. In one geographical area in particular, there were no specialised guidance or pathway(s) in place for the management of FOC, which was highlighted as a source of doubt regarding the appropriateness of implementing outcome measures where no further system or structure exists for providing support and intervention to the woman:

The pathway needs to be in place for [practitioner] to do something with it, it's no good asking the questions if you're left hanging […] "I've got these answers, what do I do with this now?" Because actually the expectation for the woman then is, "Well you've asked me all these questions, I've told you all this so how are you going to help me?"

It's upsetting if you're sat with a woman doing some scoring and she's scoring highly and you're thinking "I know you're not going to get the help that you need here. I can see there's a problem but there's nothing that is going to be done about this."

For those practitioners who were already involved in an existing FOC pathway of care, feedback regarding the use of outcome measures in practice were positive, especially because they justified collective support from specialised teams, and between pathway teams and GPs, to better support to women beyond simple requests for caesarean sections, for example:

> *a specialist team to refer into or liaise with […] a great relief to know that there was somebody else that could help support these [patients].*

> *The difference that I'm seeing from [the beginning, prior to outcome measure use], I remember seeing somebody and we had to really fight for them to get the birth that they felt that they could cope with, to [present time] I spoke to a woman today who the consultant has written me a letter saying, "I agree with this but is there anything else that I need to … does she need your input to go through it; does she need extra?" Not to just book them for a Caesarean section without looking at their psychology needs. So, I think we've come a massive distance.*

Starting a conversation about FOC

Practitioners acknowledged the potential for feelings of embarrassment and shame surrounding FOC to inhibit patients' ability to openly discuss and confide in practitioners. The implementation of a dedicated outcome measure was perceived as an effective tool to open, or initiate, what can be difficult a conversation, offering *"something that's a bit more subtle"*, and a way of reducing some of the stigma surrounding the guild, shame, and embarrassment that can be associated with FOC:

> *If a woman really doesn't want to discuss her fears, she won't. But if you give her permission and opportunity, she might, that's the thing.*

Discussion

Current practices in UK perinatal mental health care pathways do not include assessment or pre-emptive identification of FOC. Instead, FOC is identified under extreme circumstances (see above), and women who experience FOC are at a greater risk of developing future mental health conditions and lower birth experience satisfaction (Dencker et al., 2019). Despite this growing awareness and understanding of FOC, outcome measures are seldom used within UK clinical settings, and the handful of validated measures available for use are yet to be verified in terms of suitability and perceived usefulness by specialised practitioners in perinatal mental health care pathways. Previous research has considered clarity and acceptability across FOC outcome measures within pregnant patient populations and established that there are difficulties in validity and understanding (Slade, Balling, Sheen & Houghton, 2020). Motivation for the present study was to establish practitioner perceptions of 5 FOC outcome measures for their efficacy in capturing FOC and evaluate their use as a practice tool used within dedicated perinatal mental health settings.

The TSS was the outcome measure preferred by all practitioners, regardless of professional background, as it was an ideal length, sufficiently realistic, and included relevant content for clinical need. It was commended for its usefulness in identifying other related mental health conditions, including PTSD and OCD. The FOBS scale received mixed feedback from practitioners. It was perceived as a simple tool to identify women at risk of FOC, but lack of detail was highlighted as an obstacle for capturing the level of need, or intervention, appropriate for patients' needs. The SPECS scale was perceived as detailed and focused enough to facilitate individualised mental health and/or birth plans but was potentially too long in many cases for assessing FOC.

However, an important caveat remains regarding the recommendation of using the TSS. Part of this issue concerns the conundrum between qualitative and quantitative methodologies which are often difficult to reconcile. Thus, the qualitative approach used in the current study highlights the participants preference for the TSS, however this evidence is garnered from a vacuum regarding the actual measurement and psychometric characteristics of the TSS, again, these are important considerations in the selection of a clinically utilised measure. A recent study by Martin and colleagues (2022) highlighted some fundamental measurement issues in the TSS development study. Reconstructing and reanalysing the original data based on details published by Wootton et al. (2020), it was observed by Martin et al. (2022) that the original study was both underpowered, thus, the sample size was insufficient for the analysis undertaken and the consequent conclusions drawn. It was also speculated that the measurement model of the TSS, proposed to be uni-dimensional, was also incorrect. Thus, an important concern is raised that may indeed generalise to other measures, that is, that practitioners may prefer a tool for practical reasons, but the tool may not measure adequately what it is designed to measure. Currently, until further work is undertaken, the psychometric properties of the TSS remain unclear.

It is also critical to acknowledge that whilst the outcome measures considered within this research study have been developed by clinical researchers and some of the measures have been widely used in research projects, very rarely are they used in clinical practice, and one must not assume that the utility within research can easily be translated to clinical care.

In line with the stepped care approach in management of perinatal mental health conditions it would seem appropriate to consider a stepped approach to the screening and identification of FOC, utilising perhaps the TSS (subject to the caveat above) or SPECS scales evaluated in the

present study. Different outcome measures may be preferred or utilised by the practitioner, according to where the practitioner is working within the perinatal mental health care pathway.

The application of a patient- centred and practitioner approved measure suitable for each stage of the patient pathway will aid in FOC identification, assessment and management, support women to be actively engaged in making decisions about their care and ensure that any interventions and services are correctly and efficiently implemented.

Strengths and limitations

It is considered a strength of this study that it has provided a lens through which the views of FoC outcome measures can be explored. This work has the potential to be highly influential in terms of illustrating how the existing suite of FoC outcome measures are perceived by practitioners involved in the care of women with FoC. It is the first of its kind to provide an evidence base around the use of FoC outcome measures in clinical settings. The involvement of patient representatives was key to the successful completion of this project. This work was truly inclusive, in that the project team included two members with lived experience of FOC who worked collaboratively on all aspects of the project design, delivery and dissemination, ensuring that the interpretation of the findings was pertinent for service development.

A limitation of this study is that the sample were self-selecting. There may have been self-selection bias in terms of the participants having strong views about specific measures. A further limitation is the lack of health visiting and midwifery representation within the sample. Many of the views were from mental health practitioners and other key stakeholder views are vital to develop our understanding of how these measures can be successfully operationalised across maternity care settings.

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Name of Tool	Number of Items	Scoring and cut of values
The Wijma Delivery Expectancy Questionnaire Version A (WDEQ-A) Wijma, Wijma & Zar, 1998	A self-administrated questionnaire with 33 items which evaluate fear of childbirth through the expectations of women in relation to the birth.	A six-point Likert scale that ranges 0 ~ 5, with a total score of 0 ~ 165.threshold scores for high (>=66) or severe (>=86) FOC have been suggested
Oxford Worries about Labour Scale - Antenatal version (OWLS) (Redshaw, Martin, Rowe & Hockley, 2009),	A (9-item) multi-dimensional measure of worry about labour and birth	Responses are scored on a 4-point scale ranging from 1 (very worried) to 4 (not worried at all), and total scores range between 1 to 40.
The Slade-Pais Expectations of Childbirth Scale (SPECS - Fear subscale) (Slade, Pais, Fairlie, Simpson & Sheen, 2016)	The SPECS is a multidimensional measure of birth expectancy - fear of childbirth represents a distinct sub-scale (10-items)	The scale consists of 50 items and six factors, on a 5 point scale ranging from 1 (strongly agree) to 5 (strongly disagree).
Tokophobia Severity Scale (TSS) Wooton, Davis, Moses, Moody & Maguire, 2020	A 13-item unidimensional measure for screening and case identification	The scale is 13 items with women rating the questions, not at all, sometimes, often, always. No cut of score is provided.
The Fear of Birth Scale (FOBS) (Haines, Pallant, Karlstro, & Hildingsson, 2011),	A simple 2 item clinical tool to identify elevated levels of FOC. Using 100 mm scale women indicate the extent to which they have felt (1) calm/worried or (2) no fear/ fear in relation to birth.	Using a 10cm visual analogue scale women indicate the extent to which they have felt (1) calm/worried or (2) no fear/fear in relation to birth. Cut of score of 54 indicates high level fear.
Table 1: Outcome measures considered in this research		

Table 2: Semi-structured interview question items

1. What are your views about the existing measures?

2. What did you like about them and what didn't you like?

3. What do you think are the most important considerations when thinking about a suitable measure?

4. What kind of conversations do you have with women before you use a measure?

5. In your views what are the 'fors' and 'againsts' of outcome measures in general?

6. Can you explain some of the barriers and facilitators of the use of these outcome measures?

7. What is the value of the existing measures?

8. What further work is required in relation to the use of outcome measures for fear of childbirth?

Table 3: Manual sentiment-coding analysis was implemented in NVIVO by initially using four a priori codes determined by NVIVO software. These are the four codes.

1. Positive Sentiment

2. Negative Sentiment

3. Neutral Sentiment

4. Mixed Sentiment

	Positive	Mixed	Negative	Neutral
The Fear of Birth Scale (FOBS) (Haines, Pallant, Karlstro, & Hildingsson, 2011),	9	10	14	1
Oxford Worries about Labour Scale - Antenatal version (OWLS) (Redshaw, Martin, Rowe & Hockley, 2009)	9	3	6	2
Tokophobia Severity Scale (TSS) (Wooton, Davis, Moses, Moody & Maguire, 2020)	21	2	0	1
The Slade-Pais Expectations of Childbirth Scale (SPECS) (Slade, Pais, Fairlie, Simpson & Sheen, 2016)	15	5	9	1
The Wijma Delivery Expectancy Questionnaire Version A (WDEQ-A) (Wijma, Wijma & Zar, 1998)	0	2	13	2
Table 4. Outcome measures by Sentiment, analysis performed using sentiment coding function in NVIVO. Values correspond to the frequency of codes in the source material.				