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Art Therapy Interventions for Fear of Childbirth: A Model for Implementing Expressive Arts

Interventions in Prenatal Populations

Capstone Thesis Option 2 Literature Review

Lesley University

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Expressive Arts Therapy

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Abstract

This capstone investigates fear of childbirth (FOC) and correlated prenatal anxiety and/or prenatal depression. This literature review examines the current research related to FOC in prenatal birthing populations and art therapy interventions. Careful considerations were taken in regard to language for this population. Gender neutral terminology is used to be inclusive of trans, non-binary, and queer pregnancies. FOC is common, affecting about 80% of birthing individuals (O’Connell et al., 2021). Symptoms and implications for FOC are vast, including anxiety, depression, preeclampsia, increased medical interventions, and possible long term mental health risks. The baby's wellbeing is also affected by FOC, including developmental delays and adverse health outcomes (Iordachescu et al., 2021; O’Connell et al., 2019; Webb et al., 2021). Clinically, there are a handful of evidence-based, non-pharmacological interventions being used to address FOC. This thesis focuses specifically on current art therapy interventions as a treatment method for FOC from the time of initial assessment onward. The literature reviewed shows specific intermodal techniques— including music, movement, meditation, and art—are already being utilized alongside more singular art therapy approaches. The art therapists in the reviewed studies implement intermodal practices under the title of ‘art therapy’ interventions and report their interventions as beneficial in reducing FOC symptoms. The intermodality of these studies suggests there may be benefits to utilizing and studying the specific impact of expressive arts therapy interventions for FOC. Further research is needed with hope of offering insight into using expressive arts therapy as a beneficial intervention for FOC.

Introduction

Fear of childbirth (FOC) impacts 2 out of every 5 first-time pregnancies and nearly one-third of subsequent pregnancies (O'Connell et al., 2021). At its most severe, FOC can result in denial of or termination of pregnancy (O'Connell et al., 2019). If FOC is left untreated, it can have far reaching implications for parent and child which go beyond birth, including developmental delays and adverse health outcomes for the child, as well as increased likelihood of mental health disorders for the parent long term (O'Connell et al., 2019; Webb et al., 2021; Aguilera-Martín et al., 2021; Veringa-Skiba et al, 2021; Nilsson et al., 2018; Klabbers et al., 2014; Karamoozian, Askarizadehm, 2015; Wahlbeck et al., 2020).

During the current COVID-19 pandemic, FOC takes on a particular timeliness. The stress and anxiety associated with pregnancy and childbirth during a global pandemic cannot be overstated. The pandemic has imposed new challenges that may increase anxiety, depression, and FOC. In 2021, licensed art therapist Nora Swan-Foster wrote about the impact of the COVID-19 pandemic on birthing populations:

Additionally, childbearing women have suddenly experienced heightened anxiety, fear, and grief... Undoubtedly, future research will show that the stories of maternal/infant relational trauma and grief associated with fear, anxiety, distance and separation, lack of touch, masked maternal and paternal faces, severe interruptions and losses will all cause un-worded wounds that will one day tell an important story through art therapy. (p. 4)

Expressive therapies are a well-suited intervention for fear, anxiety, and depression. The non-verbal aspects of these methods help to integrate traumatic or distressing information, much like that associated with FOC or the recent COVID-19 pandemic. Wahlbeck et al. 2018 explained, “women were able to acknowledge the type of emotion they felt, where it was

transposed in the body and to what extent it occurred. If something can be felt then it can also be expressed, [and] shared.” Using techniques that bring awareness to the body, mind, emotions, and senses can be helpful to process and release the complex emotions that accompany pregnancy in present times (Rogers, 1993).

This literature review examines the current research related to fear of childbirth (FOC) in prenatal birthing populations and art therapy interventions. Due to the immense physiological and psychological changes that surface during the prenatal period of pregnancy, birthing individuals are at serious risk of compromised mental health. FOC and tokophobia (the specific name for severe FOC) are prevalent problems within birthing populations. Psychological symptoms of FOC include anxiety, depression, and possible posttraumatic stress disorder (Wahlbeck et al., 2020; Veringa-Skiba et al., 2021). Physical side effects include insomnia, hypertension, and even preeclampsia (Klabbers et al., 2014). FOC also increases the use of medical interventions during birth—such as elective cesarean sections—that are more likely to cause birth trauma and can lower a baby’s Apgar score (Aguilera-Martín et al., 2021; Veringa-Skiba et al., 2021; Nilsson et al., 2018; Karamoozian, Askarizadehm, 2015). Due to the wide variety of health outcomes, interventions are needed to decrease symptoms associated with FOC.

Non-pharmacological interventions may be recommended due to the potential health risk of pharmacological medications during pregnancy. Non-pharmacological interventions for FOC include psychotherapy, haptotherapy, psychoeducation, increased midwifery care, and expressive art therapies. These non-invasive interventions have been shown repeatedly to be beneficial for FOC (Sezen & Ünsalver, 2019; O’Connell et al., 2021; Klabbers et al., 2014; Lönnberg et al., 2018; Wigert et al., 2020; Wahlbeck et al., 2018; Swan-Foster et al., 2003; Sezen and Ünsalver,

2019). “One benefit of these types of psychological interventions is the avoidance of antidepressant or anxiolytic prescriptions, which present certain risks during pregnancy” (Iordăchescu et al., 2021). Many people who already experience anxiety about the health of the baby and the health of their pregnancy might be fearful to take medication, especially medication that has any amount of risk associated with it. As a result, non-pharmacological interventions are especially important for this vulnerable population.

Overall, research around FOC and non-pharmacological interventions is limited. That being said, non-pharmacological, evidence-based interventions have been proven to be successful at lowering adverse health outcomes—as well as the many physiological and mental health symptoms—associated with FOC. In particular, recent research suggests that art therapy offers benefits to address the mental and physical effects of FOC, such as decreasing fear and lessening symptoms of anxiety and depression.

Art therapy is a documented form of expressive therapies being used with FOC. The expressive arts therapy intermodal approach includes art, drama, movement, and music therapy. Although expressive arts therapy has been documented to be generally beneficial for a wide variety of populations, its relevance to FOC has limited data. While this literature review focuses specifically on art therapy, two of the evidence-based art therapy studies reviewed utilized an intermodal approach. Music before artmaking and meditation before creative expression are examined as examples of techniques that employ the Creative Connection and intermodal transfer. As a result, expressive arts therapy utilizing multiple modalities may also be beneficial as an FOC intervention. Due to the gap in the literature, though, more research is needed in this topic.

This literature review took careful consideration of loaded language around pregnancy and birth. For one, ‘women’ and ‘mothers’ aren’t the only ones who give birth. The term ‘birthing individual’ is used throughout this capstone as a gender-neutral term inclusive of trans, non-binary, and queer pregnancies. Additionally, this literature review is inclusive of all forms of birth, including birth through cesarean delivery.

Methods

My research for this capstone thesis began at the Lesley Library. My initial focus was the use of expressive arts therapy with pregnant individuals. I was curious about using the expressive arts during the prenatal, birth, and postpartum time. Search terms included “expressive arts therapy and pregnancy,” “expressive arts therapy and birth,” and “expressive arts therapy during postpartum.” There were no peer reviewed articles specifically related to expressive arts therapy and these topics—Lesley research library confirmed these gaps in the literature.

Since the gap in research surrounding expressive arts therapy and pregnant individuals was evident, I broadened my search to any creative therapies. Art therapy interventions for FOC became apparent. Articles included art therapy for prenatal and postpartum depression as well as research regarding anxiety and, ultimately, fear of childbirth.

I switched my focus to art therapy and FOC. Search terms included “art therapy for fear of childbirth,” “art therapy for birth,” “art therapy for tokophobia.” After thorough investigation, I only found a handful of peer reviewed studies specifically related to art therapy and FOC. The lack of research on this prevalent problem was shocking. Even so, I was able to extend my research by considering symptomatology and comorbidity of FOC with anxiety and depression. New searches included, “art therapy for prenatal anxiety,” and “art therapy for prenatal depression.”

I then narrowed the time period around pregnancy and birth to the prenatal period for the purpose of this literature review due to the overwhelming amount of research that focused on the postpartum time. Studies on postpartum depression overshadowed my interests in pregnancy and birth. In addition, I was in my own prenatal period at the time, which guided my interest. I pursued FOC as my diagnostic focus, along with its constellation of prenatal symptoms (both anxiety and depression).

Once I found Wahlbeck's leading research on art therapy interventions for FOC in Sweden and O'Connell seminal work on tokophobia, I was able to use their well-regarded studies and citations as guides. With "fear of childbirth" as a guiding term and art therapy as a researched intervention, I went on to consider the birthing population that I would explore. Because research is still emerging regarding FOC and art therapy interventions, I decided not to further narrow the literature based on the birthing population. That meant that I included both nulliparous and multiparous individuals in my research. Nulliparous refers to people who have no previous birth experience and multiparous refers to people who have given birth one or more times (O'Connell et al., 2021). I also felt strongly about being inclusive around gender, which meant that I did not use any gendered language in my literature searches. As I anticipated my own upcoming birth, I found researching FOC and possible interventions therapeutic for me. The creation of this literature review helped me feel less alone in my personal fears regarding childbirth.

Literature Review

This literature review focuses on expressive arts therapy interventions for fear of childbirth (FOC) during the prenatal period, widely defined as the time during pregnancy before birth (Merriam-Webster). That being said, symptoms and outcomes of fear of childbirth occur

throughout the perinatal period— defined for the purpose of this capstone from about twenty weeks gestation to a few days or weeks after birth—and postpartum period—referred to as the fourth trimester and can extend up to six months after birth.

In addition to specific time markers before, during, and after birth, there are two categories that further identify populations experiencing fear of childbirth—nulliparous and multiparous. FOC affects about 40% of nulliparous birthing individuals, or those individuals who are giving birth for the very first time. FOC impacts 30% of multiparous birthing individuals, or those who have previously given birth one or more times (O’Connell et al., 2021). Previous traumatic birth was the predominant reason for FOC in multiparous birthing individuals, while nulliparous birthing individuals cited fear of the unknown as the driving force of their FOC (Wigert et al., 2020). Although some studies differentiate between these two categories, this literature review is inclusive of both nulliparous and multiparous birthing individuals based on the significant percentages of FOC in both and the use of non-pharmacological interventions across both categories.

Pregnancy—throughout all of its many stages—is a time of huge, complex transitions. Physical, physiological, and hormonal changes all come to bear on birthing individuals’ relationships to their own bodies, relationships to their baby or babies, and their relationships to the upcoming labor and delivery. The act of birth can be met with many unknowns, for both nulliparous and multiparous birthing individuals, as many aspects of labor and birth exist out of the birthing individual's control. In the lead-up to birth, these transitions and changes can cause birthing individuals to become anxious, depressed, and generally distressed to the point of clinical diagnosis. The technical term is fear of childbirth (FOC) or fear of birth (FOB). FOC is common, affecting about 80% of birthing individuals, with fear tending to increase later in

gestation (O'Connell et al., 2021). FOC is defined as, “fear of the pain of labor, anxieties about the health of the child, anxiety about the possibility of childbirth complications and about the loss of control” (Wahlbeck et al., 2020, p. 123). While Helén Wahlbeck— a midwife, art therapist specializing in maternal healthcare, and leading expert in prenatal healthcare in Sweden—uses this definition. Wahlbeck also states that “fear of giving birth was often disguised and difficult to grasp at the beginning of treatment and therefore difficult to understand and process” (2020, p. 46). Similarly, Klabbers et al. defines FOC as a birthing individual's “propensity to worry about her ability to deal with possible obstetric problems, her capacity to perform adequately and the health, or even survival, of herself and her child during and after the delivery” (2014). Fear itself is a difficult, abstract concept that shows up differently for different individuals. But ultimately, definitions of FOC all include a self-report of fear, often accompanied by a self-report of increased anxiety and/or depression, when thinking about or approaching the act of childbirth.

Fear of childbirth ranges on a spectrum, with one end representing little-to-no fear that does not affect one's life or the pregnancy. The other end of the spectrum represents severe fear of childbirth (labeled tokophobia) that causes considerable impact on day-to-day life (Striebich et al., 2017). Hofberg and Brockington (2000) defined tokophobia as “an unreasoning dread of childbirth,” due to which people have denied their pregnancy, terminated pregnancy, or avoided pregnancy altogether because of their fear (O'Connell et al., 2019). Tokophobia has been estimated to affect 14% of birthers worldwide (Striebich et al., 2017). Across the spectrum of severity, fear of childbirth has physiological symptoms that affect the birthing individual as well as the growing fetus.

Physiological Symptoms of FOC

At its most severe, FOC has significant physiological implications for birthing individuals. O'Connell's (2017) research suggests tokophobia has become more prevalent in recent years and shows "growing evidence linking tokophobia with increased maternal cortisol levels... which may lead to serious and long-term consequences." Fear can elevate cortisol levels in the body and have lasting health side effects. Iordachescu et al. (2021) discusses the implication of cortisol during pregnancy, stating that increased stress raises cortisol in the body, which can decrease the pregnant individual's blood flow. Decreased blood flow is unfavorable for the fetal development in the womb and can have long term effects for the baby. "Studies correlate maternal stress during pregnancy with atypical fetal development in a way that increases susceptibility to disease and maladaptation in children" (Iordachescu et al., 2021). Other symptoms for the birthing individual include "physical and psychological effects such as sleeplessness, nightmares, and stomach aches" (O'Connell et al., 2019). These symptoms can be extremely taxing on top of the already physical undertaking of pregnancy. Further, studies suggest that tokophobia can increase risk of preeclampsia, hypertension, and low birth weight for the baby (Klabbers et al., 2014). High levels of prenatal anxiety have also been shown to alter a baby's heart rate and can delay development of the child (Webb et al., 2021). The negative physiological impacts of FOC and tokophobia are well-documented and widely recognized.

Beyond prenatal physical symptoms, FOC has been found to increase the use and request for non-urgent medical interventions during childbirth, including, induction, epidural analgesia (EA), self-requested cesarean sections (sCS), and emergency cesareans (CS) (Aguilera-Martín et al., 2021; Veringa-Skiba et al, 2021; Nilsson et al., 2018; Klabbers et al., 2014). Unfortunately, these interventions come with health risks. For example, Veringa-Skiba et al. (2021) found that EA was associated with a lower Apgar score in newborns. An Apgar score is a test done on a

newborn at one minute and five minutes after birth to assess the need for care (Karamoozian & Askarizadehm, 2015). Low Apgar scores increase the risk of mortality, nervous system dysfunction, low body temperature, and can have lasting cognitive effects on the child (Karamoozian & Askarizadehm, 2015). Emergency cesareans as well as sCS involves major abdominal surgeries and “the risk of severe acute morbidity is five times higher with CS than with vaginal birth” (Veringa-Skiba et al., 2021). Due to the increased risk correlated with obstetric interventions (such as ‘unnecessary’ cesarean sections), the World Health Organization (2018) has recommended non-clinical interventions that specifically address FOC.

As is the case across many diagnoses, physiological symptoms of FOC can be difficult to separate from mental health symptoms. Untreated FOC has been shown to lead to both negative physical and emotional consequences (Veringa-Skiba et al., 2021). Multiple studies show that FOC may lead to increased medical interventions, which in turn are more likely to lead to birth trauma and subsequently increase the likelihood of posttraumatic stress disorder (PTSD) and postpartum depression (Wahlbeck et al., 2020; Veringa-Skiba et al., 2021). A negative birth experience and/or postpartum depression may also disturb attachment with the baby (Wahlbeck et al., 2020; Veringa-Skiba et al., 2021). Ultimately, physiological symptoms and mental/emotional symptoms of FOC are linked, with both negatively impacting the birthing experience for parent and child.

Mental Health Symptoms

Recent studies have identified predisposing mental health factors and personality traits that inform the development of FOC during the prenatal period. These factors include pre-existing affective disorders, general anxiety, depression, history of abuse, neuroticism, low self-esteem, vulnerability, or previous traumatic birth (Arfaie et al., 2017; Striebich et al., 2017).

New research suggests the Covid-19 pandemic could also increase FOC and have lasting mental health implications on this population (Swan-Foster 2021). That being said, pregnancy itself is the only criteria for developing FOC and many birthing individuals experience FOC absent these factors. “Pregnancy entails physiological, hormonal and psychological changes which could increase the probability of mental and emotional changes resulting in depression, anxiety or psychological distress” (Sheeba et al., 2019). These rapid changes in one’s own emotional and psychological landscape can be quite overwhelming and easily chalked up to typical pregnancy experiences, especially given the prevalence of depression and anxiety in birthing populations. Dowse et al. (2020) states that about 20% of people experience depression or anxiety during the perinatal period, which includes the prenatal period. A 2015 National Institute for Health and Care Excellence report stated that prenatal anxiety affects 1 in 4 birthing individuals (as cited in McDonald et al., 2021), which has lasting effects on the parent and child (Iordăchescu et al., 2021). Prenatal depression affects 1 in 5 birthing individuals (Van Heyningen et al., 2019). Navigating anxiety and depression during pregnancy remains a significant obstacle for any birthing individual, but it is especially hard for those also experiencing FOC.

According to a 2017 study by Arfaie et al., anxiety related to FOC stems from uncertainty and the many unknowns about the birth process. Their study found that the following factors informed birthing individuals’ anxiety around birth: fear of pain, fear of c-sections, lack of support, being left alone and incompetency (Arfaie et al., 2017). Other causes of anxiety related to FOC included, “fear of damage to mother and baby and lack of trust to the quality of maternity care and staff commitment” (Arfaie et al., 2017). Along with the fears about birth, prenatal anxiety can increase the health risks for the baby and have adverse effects on the physical and emotional development of the child (Karamoozian & Askarizadehm, 2015). Risks

for the baby include, “prematurity, low birth weight, and fetal growth restriction, which in turn are risk factors for cognitive and social development” (Iordăchescu et al., 2021). Pregnant individuals are vulnerable to developing mental health disorders and given the frequent comorbidity between anxiety and depression, individuals can develop more than one at the same time (Iordăchescu et al., 2021).

Prenatal depression is often characterized by mood changes, sadness, hopelessness, lack of energy, and guilt (Iordăchescu et al., 2021). In one 2019 study by Sheeba et al., 35.7% of participants screened positive for prenatal depression. “The risk of prenatal depression increases significantly as the pregnancy progresses and clinically significant depressive symptoms are common in the mid and late trimester” (Sheeba et al., 2019). Iordăchescu et al. similarly found that depression related to FOC tends to increase as the birth approaches. But the risk of depression does not necessarily decrease after birth has passed—in fact, prenatal depression increases the likelihood of postpartum depression (Sheeba et al., 2019). Beyond the experience of the birthing individual, prenatal mood disorders—such as depression—can have an effect on the baby after birth as well. For example, prenatal depression can affect the child’s attachment postpartum (Webb et al., 2021)

FOC, as a nuanced diagnosis, does not require that the birthing individual experience anxiety or depression, only that they self-report a high level of fear in a formal assessment. But birthing individuals “with both anxiety and depression had the highest prevalence of fear of childbirth” (Storksen et al., 2012) and most research studies assess and discuss prenatal anxiety and depression in close relationship with FOC. Lastly, the ongoing pandemic has imposed new mental health challenges that may increase anxiety, depression, and FOC.

Coronavirus, also known as Covid-19, was first identified in 2019 and quickly became a global pandemic. The virus can be deadly or have lasting negative health outcomes (Iordăchescu et al., 2021). For the purpose of this paper the mental health implications of Covid-19 will be addressed. Not only is there increased fear and stress associated with the potential of contracting the virus, but also lack of support and isolation around the changed prenatal experience. According to Iordăchescu et al. (2021) the, “pandemic has a powerful impact with potentially wide-ranging consequences for pregnancy and beyond... significantly increas[ing] the risk of anxiety and depression.” The added stress is a concern for the already vulnerable prenatal birthing population. We still do not know the long term side effects that this pandemic will have on our collective mental health, but isolation from family, friends, and community can only do a disservice to the birthing individual. Reducing prenatal visits, increased health anxieties, economic uncertainty, unknowns about hospital protocols, and ever-changing regulations have been other regrettable side effects of Covid-19 (Iordăchescu et al., 2021). The lasting implications of the novel coronavirus have yet to be fully researched. Emerging information is needed in regards to long term side effects of Covid-19 during pregnancy. The psychological implications of the pandemic should be considered when assessing pregnant individuals for FOC and when selecting appropriate interventions, with a particular focus on prenatal anxiety and depression.

Assessment Tools for FOC

Although there are a number of assessment tools for FOC, the most common assessment tool used by researchers is the Wijma Delivery Expectancy/Experience Questionnaire Version A (W-DEQ), often in combination with the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI) (Sezen et al., 2019; O’Connell et al., 2017; Nilsson et al., 2018). The

W-DEQ was developed and published in 1998 by Klaas Wijma and his colleagues in the *Journal of Psychosomatic Obstetrics & Gynecology*. Since that time, the W-DEQ has been translated into many languages and is used globally to diagnose FOC. The W-DEQ is a self-reported scale made up of 33 items assessed via a six-point Likert scale (0-5), ultimately resulting in total scores ranging from 0 to 165. The higher the score, the more severe the respondent's FOC, with a score higher than 85 widely considered as tokophobia. While the W-DEQ was originally intended to be unidimensional (interpreted based on a single total score), more recent validations have recommended a multidimensional reading of the scores may be more accurate (Pallant et al., 2016). Items on the W-DEQ ask pregnant individuals to imagine their upcoming labor and delivery and respond to each item based on how they expect to feel in those moments. Negative items on the W-DEQ include child will die, child will be injured, longing for child, lonely; positive items include happy, relaxed, composed, and confident.

While the W-DEQ is widely used, this assessment is not perfect. Criticisms of the W-DEQ have suggested that the questionnaire is too long and complex to use in clinical practice. There are also inconsistencies in how it is implemented and what cut-off scores are used, and it lacks recognition of systemic concerns for US populations in particular (Roosevelt and Low, 2016; Richens et al., 2018). For a well-informed assessment, it may be beneficial to use the W-DEQ in conjunction with BDI and BAI (Sezen et al., 2019; O'Connell et al., 2017; Nilsson et al., 2018).

The BDI and BAI are both self-reported, multiple-choice inventories with 21 items each. Both use a four-point Likert scale (0-3) for each item and, when all items are added together, produce total scores that range from 0 to 63. Higher scores indicate more severe anxiety/depression, with scores greater than 20 indicating clinically significant depression on the

BDI and scores greater than 16 indicating clinically significant anxiety on the BAI. BAI items cover common anxiety symptoms, including inability to relax, faintness/lightheadedness, fear of the worst happening, and heart racing or pounding. BDI items cover common depression symptoms, including sadness, dissatisfaction, guilt, disappointment, and suicidal ideation. The BDI and BAI were created by Aaron T. Beck, MD, and his colleagues in 1961 (with revisions in 1978 and 1996) and 1988 (with revisions in 1993) respectively. A current factor not taken into consideration by general assessments is the ongoing global Covid-19 pandemic. Due to the increase in stress caused by the pandemic, these assessments might benefit from emendation. Once assessed for FOC and/or anxiety or depression, non-pharmacological interventions can be offered as potential tools for decreasing negative symptoms.

Non-Pharmacological Interventions for FOC

The current theoretical landscape for treating FOC includes talk therapy like cognitive-behavioral therapy (CBT) and dialectical behavioral therapy (DBT), haptotherapy, psychoeducation, increased midwifery care, and expressive arts therapy. This literature review focuses on a non-pharmacological approach, meaning interventions without the use of medication. Many of these techniques have shown improvements for people suffering with FOC according to Iordăchescu et al. (2021), including decreasing the level of fear, increasing knowledge, and boosting confidence (Sezen & Ünsalver, 2019, O'Connell et al., 2021). The following interventions can be one-on-one, in group settings, on the telephone, or online.

Cognitive-behavioral therapy (CBT) and dialectical behavioral therapy (DBT) are evidence-based psychotherapies, proven to treat people suffering with anxiety by addressing thought patterns, noticing negative thoughts and reframing into positive thoughts to support behavioral change. Haptotherapy (HT) is another widely used psychotherapy for FOC that

utilizes touch in order to align the psyche and the body, focusing on changing the mindset of the individual, seeing birth in a more positive light, and gaining self-confidence. Klabbers et al. (2014) explain that “an objective of HT is to make the individual aware of his/her capacity to allow feelings and to experience them.” HT allows for an increase of self-awareness, and self-reliance which can be used as a tool to manage pain and reduce fear.

Mindfulness techniques have been successful treating FOC and helping individuals to navigate pregnancy by calming the body, connecting to the breath, and reducing stress within the body. The focus of mindfulness based childbirth and parenting (MBCP) is about finding acceptance and non-judgement. During MBCP sessions, the couples practiced mindful movement, body scans, awareness of baby, and breath. As Lönnberg et al. (2018) states, “The phenomenon of participating in the intervention, integrating the teachings and embodying mindfulness seems to develop inner resources that foster the development of wisdom.” Overall, participants found more compassion and empathy for themselves and their partners. They found tools to stay calm and connect to the baby, while developing patience, connecting to the here and now, and deepening their listening skills (Lönnberg et al., 2018). Many people felt MBCP was a resource that could be called upon during labor.

Increased midwifery care also helps to treat FOC by fostering a trusted support team that the birth person can rely on. “[Participant’s] fear also decreased when they felt they were listened to, confirmed, respected and could build up a good caring relationship with their midwives” (Wigert et al., 2020). Feeling heard and having emotions validated by trusted providers about the upcoming birth helped to lower FOC (Wahlbeck et al., 2020). Midwives can address FOC by offering comprehensive support including; birth preparations, coping skills, and educational resources (O’Connell et al., 2021). Regardless of the intervention chosen to address FOC,

continuity of care is important to build trust with all medical professionals, OBGYN and midwives alike.

Psycho-education has also been studied as a method to reduce FOC. The birther can be more prepared and gain self-confidence knowing what birth might look like. Wigert et al., (2020) found that education could, “increase tolerance for uncertainty... ‘therapeutic conversations’ in pregnancy may help to improve women’s self-efficacy.” Cognitive flexibility or being able to adapt behavior depending on the environment will facilitate a smoother birth process and believing in one’s capability to give birth will aid increased confidence. With many online classes, psycho-education is one of the more accessible options for FOC interventions. Knowledge can empower the birthing individual and help them combat uncertainty or catastrophizing. Finally, expressive arts therapy—as discussed in detail in the following sections—is a viable, non-pharmacological modality being used to address FOC in prenatal populations.

Expressive Arts Therapy

The International Expressive Arts Therapy Association (IEATA) defines expressive arts therapy as, “[t]he expressive arts combine the visual arts, movement, drama, music, and other creative processes to foster deep personal growth and community development. By integrating the arts processes and allowing one to flow into another, we gain access to our inner resources for healing, clarity, illumination and creativity.” Through expressive arts therapy, individuals can explore, process, connect, express, and release emotions. Person-centered expressive arts is one theory within the expressive therapies that focuses on the individual, the therapeutic relationship and transitioning between art forms. Within the person-centered therapeutic framework, Natalie Rogers coined the term Creative Connection. Rogers is the daughter of Carl Rogers, founder of

person-centered/humanistic psychology. The Creative Connection focuses on our connection to movement, art, writing, and sound to further access feelings, thoughts, and self-exploration, all while connecting authentically with the client (Rogers, 1993). There is little peer-reviewed literature on the specific use of expressive arts therapy interventions and FOC. That being said, within the therapeutic framework of person-centered expressive arts therapy, many FOC interventions focus on the specific modality of art therapy.

The American Art Therapy Association (AATA) was founded in 1969 and defines art therapy as “an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship.” Under the guidance and supervision of a licensed art therapist, art therapy utilizes visual arts interventions such as painting, drawing, coloring, collaging, photography, and sculpting. Art therapy interventions utilizing creativity have been noted as a valuable treatment modality for FOC.

Art Therapy Interventions

This literature review focuses on three art therapy interventions as effective treatment options for individuals suffering with FOC, including anxiety and depression symptoms. These art therapy interventions may be beneficial for this population due to the nonverbal aspects of the work. “Many traumatic perceptions and emotions remain as memories without narrative organization or verbal coding. Art therapy provides tools for communicating with the non-verbal mind and translates nonverbal material into verbal description” (Wahlbeck et al., 2018). Trauma or fear can be challenging to share or process verbally, thus giving voice and space to these emotions through artmaking might be beneficial. Rogers explains their theory of the Creative Connection, “by moving from art form to art form, we release layers of inhibitions, bringing us

to our center-our individual creative force. This center opens us to the universal energy source, bringing us vitality and a sense of oneness” (1993, p.44). Rogers feels that our emotional and physical wellbeing are linked, the act of transitioning from different art forms fosters the Creative Connection and can offer healing. The nonverbal aspects of expressive therapies fosters integration of information. (Rogers, 1993). In this way, accessing the Creative Connection via intermodal expressive arts therapy may serve as a positive intervention for birthing individuals diagnosed with FOC.

Although there is ample research using art therapy with the pregnant population, art therapy specifically targeted at FOC is limited. These studies found art therapy to be a helpful intervention for FOC, although more research is needed in this emerging field. Within the following art therapy interventions for FOC, art becomes a way to access, contain, explore and understand fear in a safe environment.

Swan-Foster et al. 's 2003 quantitative study entitled “The use of the human figure drawing with pregnant women” addressed the use of art therapy intervention as a tool to help identify emotional distress (including anxiety and depression) in prenatal individuals. The art therapist invited participants—categorized as high risk outpatient, high risk inpatient, or low risk outpatient—to create a human figure drawing (HFD). The drawings were then compared using the Formal Elements Art Therapy Scale (FEATS) and Content Tally Sheet, which allowed researchers to examine the similarities and differences between the artwork from the three groups. “The FEATS uses 14 global variables for independent scales that address structural qualities of a drawing... offering a ‘fresh approach to researching how art can be useful in clinical settings’ serving a population with psychiatric disorders” (Swan-Foster et al., 2003). Assessing the HFDs, Swan-Foster et al. looked at color, details, energy, transparency, clothing,

and space. Swan-Foster et al. notes signs of distressing symptoms in the artwork included a lack of visual indications of pregnancy, “suggesting a lack of integration regarding body image” (2003). Other concerning elements were significant empty space, lack of colors used or darker colors used, abnormal placement of images, and little investment in the drawing” (Swan-Foster et al., 2003).

While Swan-Foster et al.’s study aimed to explore HFD as a nonverbal screening protocol for prenatal emotional distress (2003), it simultaneously acted as an art therapy intervention. The human figure drawings created gave insight to the participants emotional world by making visible “the relationship between the internal state and the external expression of that state and is illustrated in the artist’s internal psychological state being reflected in the process of creating and the structural qualities of the final image” (Swan-Foster et al., 2003). Drawing is a nonverbal art form which allows for uncovering possible emotional concerns which might be difficult to verbalize (Swan-Foster et al., 2003). Although not the primary intent, final remarks from individuals described, “feeling ‘better’, ‘supported’, ‘proud’, ‘relieved’, and ‘emotionally calmer’” (Swan-Foster et al., 2003). While not formally quantified in Swan-Foster et al.’s study, the literature suggests that HFD interventions not only assess FOC, but may also be beneficial in treating it.

This research alone is not enough to make clear conclusions, as “[t]he reliability and validity of HFD in general needs to be taken into consideration when reviewing this data” (Swan-Foster et al., 2003) and the relatively small sample sizes in the study lacked diversity. Alongside other tests and more research, though, Swan-Foster et al.’s HFD research may offer insight into how art therapy can be used as both an assessment tool and an intervention for FOC. Within the scope of the literature itself, Swan-Foster et al. even suggest that HFD could be used

to open communication about fears and concerns with the birthing individual and their medical providers (2003).

In the 2020 quantitative article Wahlbeck et al. hypothesized that art therapy (AT) combined with midwife led counseling (MC) practices would decrease participants' FOC more than just MC alone. This study was done in Sweden with 128 participants. Participants were screened by self-reported rating of their fear of childbirth on an analog scale, with 0 being no fear at all and 10 being extreme fear of approaching birth. Participants that scored 7 or higher were referred to the study and were asked to complete the W-DEQ questionnaire. After selection, participants were broken up randomly into two groups—a control group in which participants only worked with MC and a study group, which included AT and MC.

The participants could decide if they wanted individual or group art therapy. Art therapy sessions were offered weekly in the third trimester—from 28 to 36 weeks gestation—for an hour and a half to two hours. The participants were given paper, watercolors, pastels, sponges and brushes to use for the session. Wahlbeck, one of the authors on this study, was the facilitating art therapist. Each session had a new theme and the artwork could be a tool for, “self-reflection to release feelings they were unable to express elsewhere, to strengthen the process of bonding with their baby, and to initiate the counseling component of AT” (Wahlbeck et al., 2020). Before they began painting, the participants were guided in a ten minute meditation that focused on breath and body awareness. While painting, they were encouraged to stand and use their whole body. To make the first session accessible, the participants were invited to paint a tree before being asked to paint their baby. The following session introduced mind/body mapping and participants were encouraged to “paint your own body,” including “worry and fear.” Later sessions included painting the “birth room” as well as painting their own goals. Some ideas included: “Where am I

going?”, “How can I get through this?”, and “What is hindering me?” Through this work, Wahlbeck et al., (2020) hoped to help “the women to find their own goal picture to bear with them on the journey toward birth.” In the final session, participants were asked to paint any final birth preparations.

The goal of Wahlbeck et al.’s intervention was to reduce fear, which encompassed parent-child bonding, releasing fear, and inviting open communication (2020). The art interventions were used as a treatment method to address, release, and diminish fear. “Art therapy provides tools for communicating with the non-verbal mind and translates nonverbal material into verbal description” (Wahlbeck et al., 2018). Art therapy can be used to uncover and express deep fears and non-verbal emotions. “When our feelings are joyful, the art form uplifts. When our feelings are violent or wrathful, we can transform them into powerful art rather than venting them on the world (Rogers, 1993, p. 5). Externalizing fear can be a healthy way to release and process feelings. According to the findings, the study found that most people who participated in either group did reduce their FOC. “After art therapy, fear decreased and they felt stronger, calmer and more self-confident. The unborn baby became real. The women described how the fear was ‘deposited’ in the images” (Wahlbeck et al., 2018). Using these techniques, the participants’ fear could be addressed, contained, and externalized. Visual art has been shown to elicit a positive change in regard to fear. Wahlbeck et al., (2018) stated, “by sharing and making the fear visible in the creation of images in paintings, the women were able to gain hope and self-confidence. The painting was an important tool to promote inner healing and they could then face their fear.” Through the act of creating artwork the fear became more transparent and the art could be used as a supportive resource. Sharing helped alleviate the burden and they could learn to recognize their strengths.

In the quantitative article “Group art therapy for the management of fear of childbirth,” Sezen and Ünsalver (2019) compared the benefits of group art therapy (AT) versus group psychoeducation for FOC in Turkey. Thirty pregnant participants were asked to complete a pre-test, mid-test, and posttest for this study, including questions regarding anxiety and depression. Outcomes were determined using the W-DEQ, BDI, and BAI assessments. Researchers hypothesized that AT would help decrease FOC more than psychoeducational groups and the study did ultimately find AT to be beneficial in lowering FOC and reducing anxiety and depression, demonstrated by the post test scores during the study period. Sezen and Ünsalver (2019) found the Beck Depression Inventory and Beck Anxiety Inventory and W-DEQ scores were statistically significantly lower ($p < 0.001$) for the participants in the AT group, suggesting that AT had a quantitatively measurable impact for decreasing FOC.

The participants met for six group art therapy sessions that lasted two hours each. Every session, the group began by listening to music and singing together prior to artmaking. Singing together in a group helped build a bond and trusting relationship between the members. Artmaking interventions varied from session to session in the following order: 1) mask making for authentic self-expression, 2) drawing to support self-reflection, 3) mandala making to promote peace of mind, 4) puppet making, which can facilitate embodiment and can be used as a projective object to help resolve conflicts, 5) photography as a way to build self-confidence, and 6) collages to reflect on their experience and foster autonomy (Sezen, Ünsalver, 2019). Changes were noted in participants’ ability to “face and express their fears through their artwork (drawing) and then gain control over their fears (mandala-making, puppet-making, taking photographs and collage-making) within a secure base and an on-going social support system provided by the group structure” (Sezen, Ünsalver, 2019). These art therapy interventions

reduced the symptoms of FOC, which led to more self-confidence and positive birth experiences. Group process developed authentically, and the art interventions aided group cohesion (Sezen, Ünsalver, 2019). Additionally, the group structure made this intervention more accessible to a larger population and the participants benefited from the group's support.

Within these last two studies, each art therapist used an intermodal approach—moving between multiple art forms in one session. While there is a gap in the research around expressive arts and FOC, the success of these intermodal art therapy approaches suggest that expressive arts therapy might also be a beneficial intervention for FOC, as reinforced by the theory of Creative Connection.

Discussion

While fear of childbirth was first recorded by a French psychiatrist in 1858 (as cited in Nilsson et al., 2018), research around non-pharmacological interventions for FOC and accompanying prenatal anxiety and/or depression remains limited. Recently, increased attention has been given to clinical art therapy interventions as treatment for FOC. While these studies did focus on primary art therapy interventions—such as human figure drawing, painting, mask making, collages, and mandala art—they frequently incorporated complimentary expressive arts therapy interventions, such as meditation, movement, music, singing, puppet making and storytelling. In this way, the available literature indirectly suggests that the intermodal approach of expressive arts therapy would be beneficial for birthing individuals suffering from FOC, prenatal anxiety, and/or prenatal depression.

Further research is needed in using expressive arts therapy as a singular modality which, within its intermodal framework, utilizes many modalities. Estrella (2018) explained how expressive arts therapy is different from the modality of art therapy.

“Expressive arts therapy, unlike its sibling professions of art therapy, dance/movement therapy, drama therapy, and music therapy, is not organized around the application of one specific art modality; instead, expressive arts therapy is an interdisciplinary/transdisciplinary multimodal practice that promotes radical inclusivity, one grounded in an approach that embraces a use of all arts” (Estrella, 2018).

In two of the interventions outlined in this literature review, the art therapists/researchers used multiple modalities within individual sessions. Although not formally documented or discussed in these specific terms, the art therapists/researchers facilitated Creative Connection and intermodal transfer by using more than one modality.

Sezen and Ünsalver (2019) offered multiple modalities within one group session. They began every group by listening to music and singing together. The participants noted that singing before artmaking, helped them feel a sense of community and connection. “Studies have shown that activities of listening to music and singing activities contribute to the development of trust and communication within a group. Music has positive effects on fear, anxiety, and depression in pregnant women” (Sezen, Ünsalver, 2019). Rogers explains the benefits of incorporating music into therapy, “[l]istening to a piece of music allows us to move into a deep sensory state of feeling. We can use recorded music to help us profoundly experience a feeling in order to transform that emotional energy” (Rogers, 1993). Listening to music and singing together helped the group engage in artmaking more easily (Sezen, Ünsalver, 2019). Music set the tone for self-expression and offered a more relaxed environment. In addition to music and art, they also offered puppets, which facilitated role play and storytelling, as well as mask making and photography.

Expressive arts therapists use the term ‘intermodal transfer’ defined as moving from one modality into a new one. “Intermodal transfer gives new perspectives on the image without moving into the literal reality... We communicate with the image using all of our senses, trying to make sense out of our experience with the help of our imagination” (Levine & Levine, 2017, p.151). I argue that Sezen and Ünsalver (2019) were using expressive arts therapy techniques and noticing the benefits of the intermodal transfer in their work. Rogers (1993) explained that “using various expressive arts in sequence heightens and intensifies our journey inward” (p.43). Sezen and Ünsalver (2019) noted, “our report seems to be the first study of group art therapy using different artistic techniques for managing FOC” (Sezen & Ünsalver, 2019). In the spring of 2022, this study remains the only one to utilize a wide variety of modalities as a treatment method for FOC. Due to the success of this study, more research using expressive arts therapy to treat FOC would be valuable to the pregnant population.

In another 2018 FOC study by Wahlbeck, Kvist, & Landgren, Helén Wahlbeck (a licensed art therapist and midwife) offered meditation at the beginning of each session. The guided relaxation exercises were noted as an important part of this intervention. The participants stated that mindfulness “[made] it possible to approach their emotions successively... giving a sense of safety and the ability to identify different types of problems, making the therapy more distinct” (Wahlbeck et al., 2018). The meditation helped set the mood and relaxed the participants prior to painting (Wahlbeck et al., 2018). One participant stated, “What was positive there, I must say, was that I never felt stressed – rather it felt like we had all the time in the world” (Wahlbeck et al., 2018). The opening mediation practice helped to alleviate stress and to connect birthing individuals to the here and now, which might have influenced their positive experience during artmaking. “Equally important, I believe, is to go inward in a quiet, receptive

mode. Tuning into ourselves and the universal energy source is a powerful method of opening up our creativity. Meditation helps evoke our inner strength and wisdom” (Rogers, 1993). By opening the session with a guided meditation, Wahlbeck helped to set the tone for the following creative process.

The participants in Wahlbeck et al. study expressed the power of their images and the process, “feelings of increased self-reliance, self-confidence and self-awareness that became useful tools for the impending birth. Art therapy gave room for reflection, maturity, and increased confidence in their own ability” (2018), noting that they had more belief in themselves after art therapy. The Creative Connection and moving between art forms helped to provide more insight for the individuals. “The client's self-knowledge expands as [their] movement, art, writing, and sound provide clues for further exploration. Using expressive arts becomes a healing process as well as a new language that speaks to both client and therapist” (Rogers, 1993). The insight, self-knowledge, and self-confidence facilitated by the opening meditation in Wahlbeck et al.'s study, then, can be clearly explained by the theory of Creative Connection.

Mindfulness and connection to the body while utilizing multiple art forms in a key theme is Creative Connection. Incorporating the body while creating offers deeper insight into the art (Rogers, 1993). Wahlbeck et al. (2018) encouraged their participants to utilize their whole body while painting. “The integration between mind and body starts and the healing process can begin, making her calm and stable, increasing self-reliance, self-confidence and self-awareness and helping her to get ready for birth” (Wahlbeck et al., 2018). Rogers (1993) explains movement aids in finding congruence and matching our inner and outer emotional landscape. The expressive arts helped feelings of fear to come through in the images as well as allowing participants to find physical release through movement. “By creating, seeing, and feeling the

image, the fear became distinct and therefore possible to deposit outside of self. The art therapy sessions in this study gave rise to both internal and external processes for the participants” (Wahlbeck et al., 2018). Although deemed an ‘art therapy’ intervention, Wahlbeck et al.’s study utilized both intermodal transfer and Creative Connection in order to decrease FOC.

Sezen and Ünsalver study and the Wahlbeck et al. study also noted that group work played a role in the beneficial outcomes of their art interventions. The benefits of group art therapy include being a cost-effective model as well as a model that is more accessible for a wider population. Sezen and Ünsalver (2019) stated that they, “chose the group therapy approach as a cost-effective method suitable for middle and low-income countries.” They also noted the added benefit of social emotional support that the group offered. Finally, the participants also gained a community outside of their family where they could share their fears and concerns with people who could relate (Sezen, Ünsalver, 2019). Sezen and Ünsalver’s 2019 study found that:

Moreover, formation of group cohesion is based on sharing among group members, trust, and honest expression. Mask-making was chosen for the members to express themselves honestly without making them feel naked, so that the group is allowed to progress and develop.

Similarly, in Wahlbeck et al.’s 2018 study, group members felt that sharing within the group also made it easier to share and communicate fears with spouses, and medical providers. One participant stated, “Before it felt like a lump in my throat because I wasn’t able to communicate the difficult feelings” (Wahlbeck et al., 2018). Finding community during pregnancy, especially one that reminds birthing individuals that they aren’t alone with their fears, clearly offers necessary support. Future research around expressive arts therapy as an intervention for FOC

should consider the important role of the group and investigate how the group therapy model could support these interventions.

Prior to the implementation of intermodal expressive arts interventions, though, birthing individuals must be assessed for FOC, prenatal anxiety, and prenatal depression. FOC increases as the pregnancy moves later into gestation (O'Connell et al., 2021). Since FOC has negative health implications for the parent and child, (O'Connell et al., 2019; Webb et al., 2021; Aguilera-Martín et al., 2021; Veringa-Skiba et al., 2021; Nilsson et al., 2018; Klabbers et al., 2014; Karamoozian, Askarizadehm, 2015; Wahlbeck et al., 2020) earlier detection can increase healthy outcomes for birthing individuals struggling with FOC. More diverse and practical assessment tools to identify FOC in pregnancy would be advantageous for this population.

Early assessment may benefit from being paired with an intervention. For example, in the Swan-Foster et al. study, human figure drawing was used as an assessment tool to help identify prenatal distress (2003). The study showed that arts assessments may be useful when diagnosing FOC and also in better understanding the emotional world of the birthing individuals. Referring to the 2003 HFD study with Foster and Dorsey, Nora Swan-Foster states, "I have viewed prenatal art therapy as an early intervention modality that invites a woman to reflect upon her pregnant self" (Swan-Foster, 2021). Although the original goal of this study was to use HFD as an assessment tool, participants stated the therapeutic benefits of the assessment, suggesting it could also be used as an intervention. "The images that women create in art therapy, and their connection with other women, allows them to see parts of themselves not yet seen by the world" (Swan-Foster, 2021). Participants in the 2003 Swan-Foster et al. HFD study self-reported this to be true, even though their drawings were generated during an assessment.

Fear of childbirth, along with prenatal anxiety and depression, can have lasting effects on the parent and child into the postpartum period and beyond. Left untreated, FOC and its many symptoms have been shown to increase a birthing individual's risk for postpartum depression and may impact initial child attachment as well as increase complications in future pregnancies (Veringa-Skiba et al., 2021; Sheeba et al., 2019; Webb et al., 2021). It is important that FOC is effectively addressed during pregnancy so as to lessen the fear, support a healthy pregnancy, and achieve better birth outcomes for both birthing individual and child(ren). In order to treat the population of birthing individuals currently experiencing FOC in an informed and appropriate manner, there must be more research around expressive arts therapy as an intervention for FOC.

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THESIS APPROVAL FORM

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Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Expressive Arts Therapy, MA**

Student's Name: Cheyne West

Type of Project: Thesis

Title: Art Therapy Interventions for Fear of Childbirth: A Model for Implementing Expressive Arts Interventions in Prenatal Populations

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Carla M. Velázquez-García