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This case study explores a rare presentation of tokophobia-an intense, pathological fear of childbirth in a 38-year-old Togolese woman named Afi, situated within a highly pro-natalist cultural context. Unlike the normative expectations in Togo, where motherhood is celebrated and socially reinforced from an early age, Afi developed a persistent fear of pregnancy and childbirth following early developmental trauma and using an integrative therapeutic approach-including cognitive-behavioral therapy, imagery desensitization, psychoeducation, and observational exposure the intervention aimed to reframe traumatic associations and restore autonomy in reproductive decision-making. The treatment was framed within a solution-focused and brief therapy model and culturally adapted to fit collective values. The findings underscore the importance of trauma-informed, culturally sensitive interventions in underrecognized mental health conditions such as tokophobia, particularly in African contexts where such cases are seldom documented. While the results are not generalizable, this case contributes to the emerging literature on reproductive trauma in non-Western settings.

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I. INTRODUCTION

Tokophobia-derived from the Greek *tokos* (childbirth) and *phobos* (fear)-is defined as a persistent, irrational, and often debilitating fear of pregnancy and childbirth. It is classified as a Specific Phobia, Other Type (F40.298), in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, Text Revision (*DSM-5-TR*; American Psychiatric Association, 2022). Two subtypes are generally distinguished: *primary tokophobia,* which develops in individuals without prior pregnancy experience-often rooted in childhood trauma or negative cultural conditioning-and *secondary tokophobia*, which arises following traumatic obstetric experiences such as complicated delivery, miscarriage, or perinatal loss (Hofberg & Brockington, 2000; O'Connell, Leahy-Warren, & Khashan, 2017).

In high-income Western countries, tokophobia has gained increasing clinical and academic attention due to its impact on reproductive decision-making, maternal mental health, and obstetric outcomes. Research has associated it with increased rates of elective cesarean sections, fertility avoidance, and comorbid anxiety or depressive disorders (Saisto & Halmesmäki, 2003; Zar et al., 2001). However, in many African settings, including Togo, the phenomenon remains underrecognized and underdocumented. The sociocultural context in Togo is heavily pronatalist: womanhood is commonly defined by the ability to conceive and bear children, and childbirth is celebrated as a collective triumph rather than a personal struggle (Attané & Tabutin, 2004). In such environments, expressing fear or ambivalence toward pregnancy may be stigmatized, silenced, or dismissed as weakness or selfishness.

This article presents the rare and clinically significant case of Afi, a 38-year-old financially independent Togolese woman who has primary tokophobia. Despite having access to modern obstetric care, Afi was consumed by fear of pregnancy, frequently seeking reassurance through pregnancy tests and avoiding intimate relationships. Her psychological distress stemmed from an early traumatic incident involving menstruation and the firsthand witnessing of a painful childbirth, which became symbolically and emotionally fused in her psyche.

The therapeutic intervention described in this article drew upon multiple theoretical frame-worksincluding cognitive-behavioral therapy (Beck, 1976), exposure and imagery rescripting (Arntz, 2012), developmental trauma theory (van der Kolk, 2005), attachment theory (Bowlby, 1988), emotion schema theory (Izard, 2009), and feminist and sociocultural psychology (Kirmayer, 2001). A culturally sensitive, solution-focused, and time-limited therapy model was implemented over 24 sessions, with attention to trauma-informed care and reproductive autonomy.

This case aims not to establish generalizable treatment standards but to contribute to a growing literature on culturally nuanced psychotherapeutic practices. By documenting a rare presentation of tokophobia in the Togolese context, this study underscores the need to acknowledge silent suffering in societies where childbirth is idealized. It fills a critical gap in maternal mental health research in West Africa. It invites further exploration of how gendered cultural scripts, early trauma, and psychological defenses intersect in shaping reproductive fears.

II. LITERATURE REVIEW AND PREVIOUS RESEARCH RELATED TO THE CASE STUDY

2.1 Introduction to the Topic

Tokophobia, defined as a pathological fear of childbirth, can manifest as primary (prior to any childbirth experience) or secondary (after a traumatic birth). Although largely documented in Western contexts (Hofberg & Brockington, 2000), the condition remains under-researched in African countries, including Togo, where cultural, spiritual, and gender-based factors may strongly influence women's reproductive experiences.

2.2 Global and African Prevalence of Childbirth-Related Fear

International research estimates that 6–14% of women experience clinical levels of fear of childbirth (O'Connell et al., 2017). In Sub-Saharan Africa, however, the *fear of childbirth* is often framed not in psychological terms, but through *spiritual, communal, and gendered narratives*, making it difficult to isolate as a clinical diagnosis. In Togo, anecdotal and qualitative evidence suggests women may attribute childbirth risks to *ancestral displeasure, curses, or failure to meet ritual or familial obligations,* rather than psychological conditions (Attipou & Dovi, 2012).

2.3 Cultural Beliefs in Togo: Motherhood, Fear, and Stigma

In Togolese society, *motherhood is a cultural expectation,* and a woman's value is often deeply linked to her reproductive capacity. Women who fear childbirth may internalize *shame or guilt,* especially in contexts where pregnancy is seen as a rite of passage and a source of social status. Traditional narratives often discourage the open expression of fear, and women may turn to *spiritual or religious interventions* rather than mental health services (Dosseh, 2017).

Additionally, *complications during childbirth* are frequently interpreted within the framework of *supernatural causes* (e.g., witchcraft, divine punishment), rather than medical or psychological explanations. This can create barriers to mental health intervention and delay psychological diagnosis or care.

2.4 Theoretical Perspectives: Trauma, Anxiety, and Culture

Western models such as *Cognitive Behavioral Theory (Beck, 1976)* or *Trauma-Informed Therapy (Van der Kolk, 2014)* may not fully capture the experiences of Togolese women. For instance, *intergenerational trauma* related to

childbirth deaths or forced marriages may shape women's fears, yet this may be culturally unspoken.

Furthermore, *Ubuntu-based frameworks,* which emphasize the individual as embedded in community, may help reframe the condition from an isolating psychological disorder to a *relational and collective concern* (Mkhize, 2004). Applying such culturally congruent models is crucial in making therapy relevant and effective.

2.5 Treatment Approaches in African Contexts

While evidence-based practices like *exposure therapy, imagery rescripting,* and *CBT* have been successful globally, their adaptation in African contexts remains limited. Studies from Ghana and Nigeria suggest that integrating *psychoeducation with cultural rituals and community support groups* enhances treatment outcomes (Ayonrinde, 2020).

In Togo, the few available mental health services are centralized and often under-resourced. Traditional healers and spiritual leaders play a prominent role in mental healthcare, and collaboration with these actors may be essential in culturally appropriate interventions.

2.6 Gaps in the Literature and Contribution of the Case Study

This case study addresses an essential gap: the *intersection of tokophobia, trauma, and cultural expectations in Togo*. It provides insight into how fear of childbirth can be both a *psychological and sociocultural issue,* requiring sensitive clinical approaches that are trauma-informed, community -aware, and spiritually literate.

III. CONCEPTUAL FRAMEWORKS AND THEORETICAL ANALYSIS

3.1 Cognitive-Behavioral Model of Specific Phobia

The cognitive-behavioral model (Beck, 1976) posits that irrational fears emerge from maladaptive beliefs that are reinforced by avoidance and safety behaviors. In Afi's case, the core belief- "pregnancy equals destruction"- developed from early exposure to traumatic childbirth and negative cultural messaging. Her persistent avoidance of intimacy, along with compulsive reassurance-seeking behavior (such as repeated pregnancy checks), maintained her phobia by preventing disconfirmation of her fears. These behaviors represent a classic anxiety-maintaining cycle, wherein short-term relief strengthens long-term distress.

3.2 Developmental Trauma Theory

The developmental trauma framework (van der Kolk, 2005; Herman, 1992) helps contextualize Afi's early emotional experiences and their impact on her adult functioning. Afi's exposure to maternal suffering and distress during childbirth-coinciding with her menarche at age 10-created an overwhelming emotional imprint. This moment became a nexus where her gender identity, reproductive capacity, and fear of suffering were tightly linked. These early, unprocessed sensory and emotional memories persisted as somatic flashbacks, influencing her nervous system's sensitivity to reproductive themes. Her current phobia is not just cognitive but embodied-fueled by stored sensory-emotional trauma.

3.3 Attachment Theory

Afi's pattern of initiating romantic relationships but later withdrawing may reflect a fearful-avoidant attachment style, consistent with Bowlby's and Main's work on insecure adult attachment. Her conflicting needs-desiring closeness yet fearing entrapment-suggest unresolved early attachment ruptures. Such patterns are commonly seen in individuals who grew up in unpredictable or emotionally invalidating environments. Afi's anxiety around intimacy may be a projection of her fear of eventual suffering or abandonment tied to reproductive roles.

3.4 Feminist and Sociocultural Perspectives

From a feminist and sociocultural standpoint, Afi's tokophobia is not solely intrapsychic but also embedded in collective narratives about woman hood in her cultural context. In Togo, as in many African societies, women are socially conditioned from a young age to value motherhood above all

else. However, the lived reality often includes exposure to maternal mortality, limited medical care, and the suppression of reproductive autonomy. Afi internalized symbolic messages from her environment: witnessing public shaming of pregnant women and hearing her mother express despair. These experiences conveyed that childbirth equals suffering, loss of agency, and socioeconomic hardship. Such cultural scripts, when absorbed unconsciously, can manifest as enduring emotional conflicts and somatic fears (Kirmayer, 2001).

3.5 Integrated Theoretical Discussion

Afi's case provides a compelling example of how multiple theoretical models intersect to explain the development and maintenance of tokophobia. Developmental trauma theory underscores the profound and disorganizing effects of early, unintegrated traumatic events. When trauma occurs during critical developmental windows-especially related to gender identity and the body-it can fragment the self and lead to chronic fear responses (Van der Kolk, 2014; Van der Hart et al., 2006). Afi's first menstruation became symbolically fused with the horror of witnessing unmedicated childbirth, generating a maladaptive schema equating femininity with inevitable suffering.

Emotion schema theory (Izard, 2009) further explains how these early affective experiences crystallized into habitual emotional responses. Each menstrual cycle served as a monthly trigger, reviving her original fear. Through classical conditioning (Pavlov, 1927), menstruation-initially a neutral physiological event-became paired with auditory and visual trauma cues, forming an enduring phobic response.

Social learning theory (Bandura, 1977) also plays a role in understanding how Afi internalized fear from observing and hearing about childbirth-related suffering in her community. Cultural pronatalist norms in Togo, while idealizing motherhood, may inadvertently silence fear and trauma, leading to under-recognized forms of reproductive anxiety. In such environments, tokophobia may be particularly underreported, making Afi's case both rare and clinically significant.

Finally, attachment theory and feminist frameworks shed light on the relational and societal components of her phobia. Afi's fear of intimacy and withdrawal from relationships mirror insecure attachment patterns, while the cultural messages about womanhood reinforce internal conflict. These overlapping systems of influence-personal, interpersonal, and cultural-converge to maintain a complex, multidimensional disorder that cannot be understood through any single lens.

IV. CASE DESCRIPTION

Afi, a 38-year-old woman with a master's degree in accounting, was referred by her obstetrician to psychological services after visiting the obstetrics department four times within three months, each time seeking confirmation that she was not pregnant. Despite reassurances and negative test results, Afi experienced persistent anxiety, which she described as "a consuming fear that something has started growing inside me."

4.1 Study Framework and Ethical Considerations

The study was conducted at the General Hospital of Adjido (CHP-Adjido), located in Aného. It was a descriptive, analytical, and prospective case study carried out from September 2011 to September 2012. A convenience sampling method was applied, as the participant was selected based on accessibility and referral.

At the time of the study, there was no institutional review board (IRB) in place at hospitals in Togo to formally approve research protocols. However, the study was conducted with respect for basic ethical principles. In line with local cultural practices, *verbal informed consent* was obtained from the client after explaining the purpose and procedures of the study. The participant's confidentiality was respected throughout the process.

In Togo, verbal consent is a culturally accepted norm, especially in clinical and community settings, and was considered appropriate in this

context. The study adhered to ethical principles such as respect for persons, beneficence, and confidentiality, adapted to the realities and norms of the local environment.

4.2 Relationship History

Afi reported four marriages, each ending in divorce initiated by her. "None of them were bad men," she clarified. "I just could not handle intimacy. Every time things got serious, I ran." She attributed these breakups primarily to her inability to engage in sexual activity without an overwhelming fear of pregnancy.

Afi avoided intimacy except during menstruation and expressed discomfort with contraceptives due to a latex allergy. She admitted to sometimes sabotaging relationships to escape the potential of sexual contact. She reported no history of sexual abuse, substance use, or mental health diagnoses.

4.3 Developmental and Cultural Context

Afi described her childhood as marked by economic hardship and emotional instability. Raised by a single mother in poverty, she witnessed her mother's suffering during childbirth, which occurred without medical care in a rural village. Afi recalled, "She screamed. I thought she would die. We had no money, no help."

Her stepfather was emotionally abusive, and Afi began working early to support her family. She reported that her mother often equated motherhood with poverty and shame.

In middle school, a classmate named Carol became pregnant and was expelled. The incident became a moral lesson for teachers and students: "Carol was used as an example of how smart girls ruin their lives," Afi called. "Even today, when I think about being intimate, I see her."

4.4 Current Presentation

Afi reported being asexual for over a decade, with no sexual relationships or desire for intimacy. She occasionally experienced fleeting attraction to women, which she viewed as safer: "At least with women, I knew I could not get pregnant." However, she later withdrew from relationships altogether, describing a profound disinterest and fear.

After protected sex, Afi would frequently rush to the hospital seeking confirmation that she was not pregnant. She acknowledged that this was irrational but stated, "Hearing it from a doctor is the only thing that calms me down."

4.5 Diagnosis

Using the DSM-5-TR:

- *Primary Diagnosis:*
  - *F40.298 – Specific Phobia, Other Type (Childbirth-related)*
- *Rule-Out Considerations:*
  - *Post-Traumatic Stress Disorder (PTSD)*: trauma from witnessing childbirth
  - *Obsessive-Compulsive Disorder (OCD)*: due to reassurance-seeking
  - *Avoidant Personality Disorder Traits*

V. THERAPEUTIC INTERVENTION

Treatment for Afi's tokophobia was conducted in three progressive phases across therapy sessions, combining theoretical exploration, cognitive restructuring, exposure-based methods, and real-world observation. These methods were chosen in alignment with prior research, which has shown that *cognitive-behavioral therapy (CBT), psychoeducation, and exposure therapy* are among the most effective strategies for treating tokophobia (Saisto & Halmesmäki, 2003; O'Connell et al., 2017).

Phase 1: Anamnesis and Cognitive Exploration

The first phase focused on *anamnesis,* building rapport, and exploring Afi's *personal history and core traumatic experiences*. Her earliest significant trauma occurred at the age of 10, during the onset of menstruation, when she witnessed a woman in her village undergoing a *painful and complicated childbirth*. Soon after, Afi was told: *"You are a woman now; you can get pregnant and go through the same pain."* This moment formed two lasting cognitive associations:

1. Menstruation = inevitable painful childbirth.
2. Childbirth = trauma and suffering.

Another powerful secondary association emerged when Afi recalled a teenage boy, born from that traumatic labor, telling his mother, *"I did not ask you to give birth to me."* This statement echoed in Afi's mind for years, reinforcing fears of maternal regret and offspring rejection.

These internalized beliefs led to emotional conflicts on a monthly basis. Despite no sexual activity, Afi felt simultaneous relief and dread during menstruation-relief at not being pregnant and dread from being reminded of the "inevitability" of childbirth. This ambivalence reflects *cognitive dissonance,* where Afi's values (motherhood is honored) clash with her fears (childbirth equals suffering and rejection).

During this phase, therapy emphasized:

- *Validating her emotional pain*
- *Identifying and challenging cognitive distortions*
- *Providing psychoeducation on childbirth options* (e.g., cesarean section, epidural anesthesia, modern delivery techniques)
- *Normalizing her fears within a psychological framework*

Afi was also informed that her traumatic memory occurred in a rural setting with minimal medical resources, unlike her current situation, where she lives in an urban area with access to quality hospitals and maternal care.

Phase 2: Exposure and Observational Desensitization

Building on theoretical insights, the second phase introduced *imaginary therapy and controlled exposure.* These sessions were held in a nearby childbirth room at the hospital. Some sessions occurred without live births, serving as preparatory desensitization; others coincided with deliveries.

When a birth occurred, Afi was guided to *listen to the natural sounds of labor-screams, breathing, and joy-and to observe the whole emotional arc.* After the birth, she and the therapist visited the postpartum room to meet the new mothers. These encounters offered powerful *counter-narratives* to Afi's trauma. She witnessed women who, despite the pain, expressed overwhelming joy and fulfillment at meeting their child for the first time.

Critically, Afi a met mothers who had given birth to their third or fourth child, helping her *reframe childbirth as survivable and even desirable.*

This phase aligns with research suggesting that *graduated exposure*-either through virtual, imagined, or live experiences-can reduce phobic responses by *retraining the emotional memory system* (Arntz, 2012; Hofberg & Ward, 2003).

Phase 3: Integration and Meaning Reconstruction

In the final phase, Afi processed her mixed emotions and *integrated her new experiences.* One central issue remained: her fixation on the boy who told his mother he never asked to be born. This statement had become symbolic of the perceived futility or ungratefulness associated with motherhood.

Through cognitive reframing and guided conversation, Afi was helped to:

- Recognize the *immaturity and impulsivity of adolescence,* including her past behaviors.
- Understand *frontal lobe development* and its role in emotional regulation and empathy (Blakemore, 2012).
- Accept that she *held only one part of the story* and had used it, consciously or not, to justify her fears.

When asked whether she had ever seen that same mother and son interact positively, Afi acknowledged witnessing many joyful and harmonious moments between them. This admission marked a *cognitive breakthrough,* showing that her trauma had selectively filtered information to support her fears.

By the end of the therapeutic plan, Afi no longer experienced terror at the thought of childbirth. Her sessions were gradually spaced from once a week during the active treatment phase to once every two weeks, and eventually to monthly follow-ups. Although some residual apprehension

remained-common even among individuals without phobias-heravoidance behaviors, anxiety levels, and intrusive thoughts had markedly diminished. This successful outcome is consistent with findings in the broader literature and contributes to the limited research on tokophobia within African populations, where the condition often remains underrecognized (Bayrampour et al., 2019; Saisto & Halmesmäki, 2003).

VI. ANALYSIS AND CRITIQUE OF THE THERAPEUTIC INTERVENTION

6.1 Strengths of the Treatment Plan

6.1.1 Holistic Approach

The treatment plan thoughtfully combined cognitive-behavioral therapy (CBT), imagery rescripting, psychoeducation, and gradual real-world exposure. This aligns well with best practices for treating phobias and trauma-related conditions (Hofmann et al., 2012).

6.1.2 Cultural Sensitivity

The therapist recognized the cultural context of Togo, where motherhood is a social expectation and tokophobia is taboo. By framing the therapy in a culturally appropriate manner and validating Afi's fear rather than pathologizing it too early, the plan respected her background and belief system-an essential component of effective mental health care in non-Western settings (Kirmayer, 2001).

6.1.3 Use of Exposure in a Controlled Setting

A unique and commendable element of this treatment was the observational exposure near actual childbirth rooms. This provided direct emotional experiences to recondition Afi's fear responses and introduce new emotional associations with childbirth-joy, support, and a sense of survival. Exposure therapy is widely recognized as a core treatment for specific phobias (Craske et al., 2014).

6.1.4 Trauma-Informed Care

The therapist explored and processed Afi's core trauma, linking early menstruation, reproductive responsibility, and the observation of a traumatic childbirth. The use of cognitive reframing and psychoeducation to break irrational associations was appropriately aligned with trauma-focused CBT (Foa et al., 2009).

6.2 Lack of Standardized Outcome Measures

A notable limitation of the intervention was the absence of validated psychometric tools at intake, midpoint, and discharge to assess Afi's fear levels objectively. The lack of standardized measures, such as the Tokophobia Questionnaire (Hofberg & Brockington, 2000) or the Fear of Birth Scale (Slade et al., 2019), weakens the empirical rigor and generalizability of the case findings. Without quantitative metrics, it is challenging to track treatment efficacy, symptom trajectory, or to compare results across studies.

6.3 Limited use of Emotional Regulation Techniques

While the therapeutic plan incorporated key cognitive-behavioral strategies such as cognitive restructuring and graded exposure, there was insufficient integration of emotional regulation methods to support distress tolerance during triggering moments. Evidence-based trauma treatments emphasize the importance of grounding techniques, diaphragmatic breathing, and mindfulness to support safety and emotional regulation, particularly during exposure work (Linehan, 1993; Najmi et al., 2014). The omission of such tools may have limited Afi's ability to self-soothe and potentially increased the risk of retraumatization during live-birth observations.

6.4 Ethical Considerations in Live-Birth Exposure

The inclusion of live childbirth observation as an exposure technique raises important ethical considerations. Introducing a client into hospital recovery areas-especially in contexts involving postpartum women-necessitates careful attention to informed consent, confidentiality, and the risk of vicarious trauma (Zur, 2007). While cultural context matters-indeed, in many African collectivist societies, childbirth is a public and celebrated event-the lack of explicit discussion around ethical safeguards for the postpartum

mothers is concerning. In this specific case, the hospital's recovery room was described as communal and accessible, and the psychologist was a member of the hospital staff. Even so, adherence to ethical standards-including respect for dignity, privacy, and voluntary participation -remains essential in research and therapeutic interventions (American Psychological Association, 2017).

6.5 Insufficient Emphasis on Reproductive Autonomy

The therapeutic intervention firmly focused on reducing Afi's fear of childbirth and reframing her beliefs toward embracing motherhood. However, there was limited exploration of reproductive autonomy as a valid therapeutic goal. While challenging maladaptive cognitions is a key component of therapy, care must be taken not to impose culturally influenced expectations around motherhood. Feminist clinical psychology highlights the importance of affirming a woman's right to make informed decisions about her reproductive future, including the right not to become a mother (Ussher, 2006). Although Afi was eventually educated about her right to choose motherhood or not, the therapeutic process may have benefited from deeper work around this autonomy, disentangling cultural scripts from authentic desire.

Future interventions should include structured exploration of the client's reproductive values and goals, alongside fear reduction, to ensure alignment with the client's valid preferences rather than cultural expectations.

6.6 Absence of Long-Term Follow-Up or Relapse Prevention

The treatment plan appeared to conclude following symptom reduction at the end of 24 sessions, without a detailed relapse prevention or maintenance strategy. Research on specific phobias and trauma recovery highlights the importance of preparing clients for potential future triggers and providing booster sessions to consolidate gains (Foa et al., 2007). Afi may still encounter anxiety in contexts such as initiating a romantic relationship, facing a medical issue, or contemplating pregnancy. The omission of a structured follow-up plan may leave her vulnerable to future relapses.

Incorporating a relapse prevention module, including booster sessions, identification of early warning signs, and coping strategies for anticipated life transitions involving reproduction or intimacy.

6.7 Generalizability, Cultural Context, and Therapeutic Framework

This study represents a rare and context-specific case of tokophobia in Togo, where childbirth is typically normalized and celebrated within a strong pro-natalist cultural framework. Given the unique cultural, psychological, and sociomedical factors surrounding Afi's presentation, the findings and therapeutic approach may not be broadly generalizable to all populations. The primary aim of this study was not to establish universal treatment standards but to document and explore the psychotherapeutic management of a culturally rare and clinically significant phobia within a Togolese context.

Additionally, one of the guiding principles of the treatment approach was the application of *solution-focused and brief therapy (de Shazer et al., 1986)*. This orientation emphasizes identifying goals, building on existing strengths, and facilitating practical, time-limited interventions rather than prolonged, insight-oriented therapy. The goal was to rapidly reduce Afi's fear response and support her in constructing new cognitive and emotional associations around childbirth, without necessitating long-term dependence on the therapeutic process. The 74 -session framework was thus designed to deliver targeted therapeutic impact in a culturally appropriate, efficient, and ethically mindful way.

As such, this case contributes to the growing literature on *culturally sensitive, trauma-informed, and solution-oriented mental health care,* and it highlights the importance of recognizing diverse presentations of fear and resistance surrounding childbirth-especially in underrepresented populations and health systems

where tokophobia remains under-recognized and under-treated.

VII. CONCLUSION

This case study sheds light on a rare but clinically meaningful presentation of primary tokophobia in a Togolese woman. In a culture where motherhood is deeply valorized and childbirth is often framed as a joyful communal event, Afi 's fear highlights the complex interplay between early trauma, sociocultural conditioning, and individual psychological vulnerability. The integration of cognitive-behavioral, developmental, and culturally grounded frameworks proved effective in reducing her fear and restoring a sense of agency in reproductive decision-making.

Notably, the study illustrates how early traumatic experiences, especially those linked to identity-forming milestones such as menarche, can profoundly shape beliefs, emotions, and behavioral patterns into adulthood. Through culturally sensitive, trauma-informed care that included both theoretical insight and experiential exposure, the therapy helped Afi challenge maladaptive associations and reconstruct new meanings around womanhood and childbirth.

While the findings are not broadly generalizable, they offer valuable insight into how tokophobia may manifest and be treated in African contexts, where the topic remains largely unexplored. Future research should aim to validate assessment tools, consider ethical frameworks for exposure-based interventions, and support more inclusive reproductive mental health services across diverse cultural landscapes.

REFERENCES

1. American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.; DSM-5-TR). American Psychiatric Publishing.
2. American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code
3. Arntz, A. (2012). Imagery rescripting as a therapeutic technique: Review of clinical trials, basic studies, and research agenda. *Journal of Experimental Psychopathology, 3*(2), 189–208. https://doi.org/10.5127/jep.024211.
4. Attané, I., & Tabutin, D. (2004). La démographie africaine au milieu des années 2000. *Population & Sociétés, (413)*, 1–4.
5. Attipou, K., & Dovi, K. (2012). Cultural interpretations of pregnancy and childbirth in Togo: Implications for maternal health. *Revue Africaine de Sociologie, 16*(1), 77–92.
6. Ayonrinde, O. (2020). Importance of cultural psychiatry in Africa: Reflections from Nigeria and Ghana. *African Journal of Psychiatry, 23*(2), 45–51.
7. Bandura, A. (1977). *Social learning theory*. Prentice Hall.
8. Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. International Universities Press.
9. Blakemore, S. J. (2012). Imaging brain development: The adolescent brain. *NeuroImage, 61*(2), 397–406. https://doi.org/10.1016/j.neuroimage.2011.11.080.
10. Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.
11. Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy, 58*, 10–23.
12. Dosseh, A. (2017). Religious beliefs and maternal health practices in rural Togo. *Journal of African Cultural Studies, 29*(3), 301–314.
13. Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences*. Oxford University Press.
14. Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence*. Basic Books.
15. Hofberg, K., & Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth. *British Journal of Psychiatry, 176*(1), 83–85. https://doi.org/10.1192/bjp.176.1.83.
16. Hofberg, K., & Ward, M. R. (2003). Fear of pregnancy and childbirth. *Postgraduate*

Medical Journal, 79(935), 505–510. https://doi.org/10.1136/pmj.79.935.505
17. Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*(5), 427–440.
18. Izard, C. E. (2009). Emotion theory and research: Highlights, unanswered questions, and emerging issues. *Annual Review of Psychology, 60*, 1–25.
19. Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *Journal of Clinical Psychiatry, 62*(Suppl. 13), 22–30.
20. Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.
21. Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status. *Development and Psychopathology, 2*(1), 1–18.
22. Mkhize, N. (2004). Psychology: An African perspective. In D. Hook (Ed.), *Critical psychology* (pp. 24–52). UCT Press.
23. Najmi, S., Riemann, B. C., Wegner, D. M., & Nock, M. K. (2014). Implicit self-regulation in obsessive-compulsive disorder: Evidence from a negative priming task. *Journal of Behavior Therapy and Experimental Psychiatry, 45*(1), 12–18.
24. O'Connell, M. A., Leahy-Warren, P., Khashan, A. S., Kenny, L. C., & O'Neill, S. M. (2017). Worldwide prevalence of tokophobia in pregnant women: Systematic review and meta-analysis. *Acta Obstetricia et Gynecologica Scandinavica, 96*(9), 953–963. https://doi.org/10.1111/aogs.13138
25. O'Connell, M. A., Leahy-Warren, P., & Khashan, A. S. (2017). Women's experiences of fear of childbirth: A meta-synthesis of qualitative studies. *BMC Pregnancy and Childbirth, 17*, 21.
26. Pavlov, I. P. (1927). *Conditioned reflexes*. Oxford University Press.
27. Saisto, T., & Halmesmäki, E. (2003). Fear of childbirth: A neglected dilemma. *Acta Obstetricia et Gynecologica Scandinavica, 82*(3), 201–208. https://doi.org/10.1034/j.1600-0412.2003.00114.x
28. Slade, P., Balling, K., Sheen, K., & Houghton, G. (2019). The Fear of Birth Scale: Measuring childbirth fear. *British Journal of Midwifery, 27*(6), 356–362.
29. Ussher, J. M. (2006). *Managing the monstrous feminine: Regulating the reproductive body*. Routledge.
30. Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. Norton.
31. Van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401–408.
32. Van der Kolk, B. A. (2014). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Viking.
33. Wijma, K., Wijma, B., & Zar, M. (1998). Psychometric aspects of the W-DEQ: A new questionnaire for the measurement of fear of childbirth. *Journal of Psychosomatic Obstetrics & Gynecology, 19*(2), 84–97.
34. Zar, M., Wijma, K., & Wijma, B. (2001). Pre- and postpartum fear of childbirth in nulliparous and parous women. *Scandinavian Journal of Behaviour Therapy, 30*(2), 75–84.
35. Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations*. American Psychological Association.