Be Quiet and Man Up: A Qualitative Study into Men Who Experienced Birth Trauma

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Abstract

Background: Research focusing on paternal mental health is limited, especially regarding the impact of the experience of poor mental health in the perinatal period. For example, little is known about the experiences of men who witness their partner's traumatic birth and the subsequent impact on the father's mental health. Therefore, the aim of this study was to explore fathers' experiences of witnessing a traumatic birth, how these experiences impacted their wellbeing, and what support they received during and following the traumatic birth. **Methods:** Sixty-one participants were recruited via targeted social media to complete an anonymous online qualitative questionnaire regarding their birth trauma experience. Eligible participants were aged eighteen or over, resided in the UK and had witnessed their partner's traumatic birth (that did not result in loss of life). Thematic analysis was used to analyse the questionnaire data. **Results:** Three main themes were identified: 'fathers' understanding of the experience' (subthemes: nothing can prepare you for it; merely a passenger; mixed experiences with staff; not about me); 'life after birth trauma' (subthemes: manhood after birth; inability to be happy; impact on relationships); and 'the support fathers received vs what they wanted' (subthemes: prenatal support; birth support; and postnatal support). **Conclusions:** Fathers reported that witnessing their partner's traumatic birth had a significant impact on them. They felt this affected their mental health and relationships long into the postnatal period. However, there is no nationally recognised support in place for fathers to use as a result of their experiences. The participants attributed this to being perceived as less important than women in the postnatal period, and maternity services' perceptions of the father more generally. **Implications** include ensuring support is available for mother and father following a traumatic birth, with additional staff training geared towards the father's role.

Introduction

Concern for maternal mental health has risen in recent years, as shown by the expansion in research and public interest that has focused on the causes and impact of poor maternal mental health on the mother and her family. Evidence suggests the prevalence of anxiety disorders in women during pregnancy is 15.8% and in the postnatal period 17.1% (Fairbrother, Janssen, Anthony, Tucker & Young, 2016). The mother's mental health during pregnancy and up to a year postnatally is crucial to not just her wellbeing, but also the development and wellbeing of her child (Goodman, 2019) and the mental health of her partner. Additionally, post-traumatic stress disorder (PTSD) following birth trauma in women is an emerging new area of research, with evidence suggesting that 3.17% of women report post-traumatic stress symptoms following childbirth (Ayers, Bond, Berullies & Wijma, 2016). Evidence presented here will show what we know about the impact of birth trauma on mothers. However, little is known about the impact on fathers. The current study sought to address that by exploring fathers' perceptions of witnessing their partner's traumatic birth. For this paper, 'birth trauma' is defined as physical and emotional suffering during birth that resulted from either complications, physical injury or negative reactions during the birthing experience (Shaban et al., 2013). Examples include, but are not limited to, sudden changes to the birth plan, emergency caesarean, post-birth complications and inadequate care

received from staff. A lack of control may also increase the likelihood of a birth being perceived as traumatic (Ford & Ayers, 2009). This definition was also used when advertising the study for potential participants.

Although the experience of a traumatic birth is likely to be distressing, not all mothers subsequently develop PTSD. In a study of over 1500 mothers, while 18% reported elevated levels of posttraumatic stress symptoms, only 9% met the diagnostic criteria for PTSD after childbirth (Beck, Gable, Sakala, & Declercq, 2011). Reports of more severe PTSD were related to poorer support from the partner, greater prevalence of co-existing depressive symptoms, increased (birth-related) physical difficulties, and less engagement in positive health behaviour.

A range of risk factors have been identified for PTSD following birth trauma, including a history of mental health problems, lack of information, obstetric procedures and low social support postnatally (Modarres, Afrasiabli, Rahn timer & Montazeri, 2012; Ford, Ayers & Bradley, 2010; Elmir, Schmied, Wilkes & Jackson, 2010). In a meta-ethnographic study into women's experiences of birth trauma, Elmir et al. (2010) identified that women feel invisible and out of control. They highlighted the need for women to be fully informed and included in decision-making in order to increase their sense of control, which could in turn reduce perceived trauma.

Shaban et al.'s (2013) definition of birth trauma is often used to describe women's experiences. However, a study of post-traumatic stress and depression in 212 couples following the birth of their child found that men appeared to mirror their partners responses, especially regarding symptoms of post-traumatic stress (Iles, Slade & Spilby, 2011). Posttraumatic stress symptoms can have significant consequences on parents' wellbeing and functioning postnatally (Iles et al., 2011). Crucially, in recent years, fathers are more likely to be present at their child's birth than has traditionally been the case. If that birth becomes traumatic, fathers are potentially witnessing (often helplessly) the potential risk of physical harm and/or death of their partner and/or child. Current evidence tells us very little about fathers' experiences of witnessing that trauma, the impact that this may have on them, and the support they receive to help them deal with such trauma.

Limited research has addressed the impact of traumatic birth on fathers. Etheridge and Slade (2017), in an interview study on the impact of birth trauma in 11 fathers, found that they experienced it as a rollercoaster of emotions, characterised by 'isolation and abandonment'. Their findings that fathers can experience trauma as a result of childbirth are likely intensified by the current maternity model, where the mother tends to be the sole focus as the patient. Participants reported feeling unjustified in their feelings and coped by avoiding the events of the birth trauma and their emotions surrounding that. Harvey and Pattison (2012), in an interview study with 20 fathers who had witnessed the resuscitation of their newborn child, found that fathers recalled the event as clear and negative, characterised by fears over their partner and child, and lack of support postnatally, which led to them displaying PTSD-like symptoms. These studies emphasise the importance of considering men's experiences in a female-dominated environment.

In a cross-sectional study of fathers who witnessed 'normal' births on maternity wards in Belgium, Eggermont, Beeckman, Van Hecke, Delbaere and Verhaeghe (2017) found that fathers' need for information during the birth was greater than their need for involvement. Fathers required information around the process of birth, medical equipment used and their involvement in labour. This varied by educational level and parity such that fathers with a higher education level reported a lower need for information, as did fathers who had experienced birth previously. However different levels of need (or support) may be required for traumatic births.

There is limited research around the experiences of men regarding pregnancy and childbirth, likely due to men's historical nonattendance in the delivery room. King (2012) noted that prior to the 1970s, birth tended to be a female-only concern. Early theories of attachment downplayed the role of the paternal caregiver in childrearing (Bowlby, 1940; Ainsworth & Bell, 1970), emphasising the importance of the mother as the 'primary caregiver'. This is reflected in UK Government legislation, whereby mothers are automatically issued with full parental responsibility, whereas fathers are given parental responsibility only when they are married to the mother, listed on the birth certificate or receive a parental responsibility order from the mother or court (UK Government, 2018). However, the presence of fathers at the birth has increased within the last few decades, with nearly 95% of fathers in England and 98% of fathers in Scandinavian countries now reported as attending childbirth (Draper, 1997). Further, becoming a father is one of the most life-changing events a man can experience (Jomeen, 2016) suggesting it is imperative to understand the father's perinatal experiences and their possible consequences.

However, despite fathers attending the birth becoming more common, evidence suggests that men still do not feel welcomed by perinatal health professionals. In an analysis of 62 studies of perceptions about Swedish healthcare professionals from 2000 to 2015, Wells (2016) found that fathers felt excluded at prenatal clinics and consequently unprepared for the experience of birth and fatherhood. Across the perinatal stages, fathers feel that midwives are often disrespectful towards them (Poh, Koh, & He, 2014; Wells, 2016). Fathers who reported being treated respectfully by healthcare professionals were four times more likely to describe the birth as a positive experience, as they felt that they had greater control, lower anxiety and believed their partner was safe (Wells, 2016). Such findings in Sweden, considered a gender-equal society, suggests that experience of feeling excluded is likely to be experienced by fathers worldwide.

Wells (2016) emphasises that fathers felt societal pressures to be an equal parent, in contrast to the treatment they received from healthcare professionals. Being treated as a secondary parent made fathers feel they were not entitled to the support and information they felt they needed. This had an impact on the division of parental duties and reflected the message from healthcare professionals that mothers are more important in caring for their children. Wells (2016) also suggested that men may need more support than women in the transition to parenthood, as they are less likely to access support networks, and may develop unhelpful coping strategies to deal with the transition to parenthood (Vogel et al., 2014). These issues of gender inequality need to be addressed in order to help empower fathers for the benefit of all

the family. Overall, evidence suggests that men's poor mental health tends to be overlooked by healthcare professionals.

The present study aimed to explore the following questions: what are the experiences of men who witnessed their partner's traumatic birth; how do these experiences impact their wellbeing; and what support did these men receive during and following these experiences? It was open to all men who perceived the experience as traumatic, rather than setting specific criteria regarding trauma.

Methods

Participants:

A purposive sample of 61 participants was recruited. Inclusion criteria included being a UK-based father aged 18 or over and having witnessed their partner's traumatic birth (involving at least one child). Exclusion criteria included if the birth trauma experience was over ten years previously (as the issues mentioned may no longer be relevant under the current National Health Service, and because fathers whose partners had given birth more than 10 years previously were considered less likely to be able to recall the event in detail); or if the participant's partner and/or child had died as a result of the experience (as this was considered unethical in an online study as the participants might need additional specialist support that could not be offered).

Potential participants were invited via social media (Twitter, Facebook and LinkedIn) targeting mental health support groups and national perinatal mental health charities. This recruitment method also meant participants were able to access the necessary support they may have required during (and following) their completion of the study from those organisations. As a result, a wider audience could be reached. Participation was voluntary and anonymous.

Nine participants were excluded because their experiences took place more than 10 years ago or because they were from outside of the UK. Flow of participants during the study is described in Figure 1. Despite the specific inclusion criteria, the variety within the sample allowed for the reporting of a wide range of experiences. This contributed to the understanding of the similarities and differences of each individual participant's trauma that may have been lost if the study had focused on a specific traumatic birth, for example, new-born resuscitation (Harvey & Pattison, 2012).

Study design

The study was a qualitative questionnaire study. This is a well-established method for gathering information about sensitive topics, as it maintains participant anonymity.

Procedure:

An online (anonymous) qualitative questionnaire was created using Qualtrics™ to explore participants' experiences and feelings of their partner's traumatic birth. Given the nature of this subject, the questions posed were assessed for relevance and sensitivity by experts at Make Birth Better, a highly respected UK birth trauma network comprising perinatal health (and mental health) professionals. These experts were also a source for signposting participants for support if they needed that. The questionnaire consisted of 20 open-ended questions and took up to an hour to complete. It focused on pregnancy (how the man felt when he became aware of his partner's pregnancy, his involvement during the pregnancy), the birth experience (how he felt when his partner went into labour, what happened during the birth to him and his partner, whether he had received antenatal preparation for the birth, whether he understood what was happening, how in control he felt) and postnatal experiences (how he felt after the birth, what changes he expected after the birth, the extent to which what he witnessed at the birth had come back to his mind, whether the birth had affected his day-to-day life, whether he had had the opportunity to talk to someone about the birth, how the birth trauma had affected his mood, how it had affected his relationship with his partner), as well as the levels of support the participants received at each stage. The questionnaire is provided as supplementary online material.

A link to the study was distributed online on social media through an anonymous link (as described earlier). Traumatic birth was defined as "physical and emotional suffering during birth that resulted from either complications, physical injury or negative reactions during the birthing experience". Once potential participants accessed the study online, they were presented with a participant information sheet, which explained the purpose of the study and provided the opportunity for them to ask for further information. They were then asked to indicate whether they consented to participate. Participants were shown the questions only if they consented. Each page of the questionnaire provided a link to Make Birth Better to request support if they felt they needed that. They were also reminded that they could discontinue participation if they found the questionnaire distressing. After completing the questionnaire, participants were presented with debriefing information, further highlighting sources of support and providing more detail about the study.

Data Analysis:

Thematic analysis was used in order to allow for the complexity of the data as individual and collective accounts. The six stages of thematic analysis were followed (Braun & Clarke, 2006). The first author familiarised herself with the data collected by reading and rereading the transcripts. She then generated initial codes and combined them into broad themes. These were then refined and reviewed with the help of the second author, defined and validated and reported in a theme table. The first author was a young, childless female. This might have made it harder for her to understand the perspective of the participants (men experiencing childbirth). However, discussion with the third author, a man who had experienced normal childbirth, and is an expert in perinatal mental health, confirmed that the themes were relatable from a father's perspective.

A reflexive diary was completed through all stages of analysis to identify possible misconstructions of themes and create transparency in analysis (Ortlipp, 2008).

Ethical Considerations:

The study was approved by Bournemouth University (BU), Faculty of Science and Technology, Ethics Committee (BU Ethics ID 12939). The study focused on sensitive topics that included birth trauma and mental health, which many of the participants may not have spoken about before. Therefore, participants’ right to withdraw from the study was highlighted. Participants were told to write only what they were comfortable with sharing to reduce potential distress. Participants were also encouraged to access support they already receive or to seek further support for their experiences. The responses were kept anonymous to protect confidentiality and to give participants the chance to speak freely about their experiences.

Results

Participants came from all regions of England, as well as Scotland, Wales and Northern Ireland. Participant characteristics are reported in Table 1. One participant reported having twins, and three reported currently expecting another child. It was the first pregnancy for 81.9% of participants, and all participants were married.

Table 1: Participant data

Participant data	Mean $\pm$ SD	Range
Current age	36.6 $\pm$ 6.3	24-51
Age at time of trauma	33.8 $\pm$ 5.3	23-36
Time since birth trauma (years)	2.8 $\pm$ 2.0	
No. of children in family	1.6 $\pm$ 0.7	1-4

The data analysed emphasised the situations that contributed to or protected from the birth trauma experience. Three main themes were identified: ‘fathers’ understanding of the experience’; ‘life after birth trauma’; and ‘the support fathers received vs what they wanted’. The flow of themes is demonstrated in Figure 2.

Fathers’ Understanding of the Experience

This first theme identifies the participants’ experiences during the birth of their child. This includes what participants believed contributed to their trauma experience as well as potential protective factors. This theme had several sub-themes: nothing can really prepare you for it; merely a passenger; not about me; and support from staff.

Nothing Can Really Prepare You for It

Participants felt that they were not adequately prepared for the experience. They perceived preparation as being in the form of information gained from antenatal classes and from healthcare professionals during the experience. Information was either not given or not provided to a standard of satisfaction. For example, one participant said "At no point was there any explanation to either my partner or myself to calm the situation." (P16)

Information given at antenatal classes also failed to prepare fathers for traumatic birth. Participants felt they focused more on standard deliveries and lacked detailed coverage of potential negative situations. For example, "They briefed us on the basic pain relief options for labour and the basics of a birth plan. These seem almost laughable in hindsight." (P2), and "The antenatal classes are too positive and preparation for all eventualities was poor." (P20).

Participants explained that they were unable to understand what was going on around them due to lack of information or time to explain during the emergency. As a result, some reflected that the experience of traumatic birth may not be something you can prepare for: "To be honest, I don't think anything could have prepared me for what happened." (P3).

The participants knew when something was wrong during the birth experience, but they were not involved in decision making or in relaying information. Often, they were also left alone which contributed to the trauma, as one participant described "When our son was taken away there was no one to ask what had happened to him for quite a while." (P1)

Overall, participants believed that they had not been properly made aware or given the opportunity to make themselves aware and prepared for the likelihood of a complicated birth, from antenatal classes and from staff during the experience. However, they recognised that it is not always possible to be prepared.

Merely a Passenger

A lack of control during the complicated birth experience was described as a major contributor to the trauma. Participants either felt they never had control, or control was taken away from them by the situation and/or staff. For example, one participant explained "I wasn't involved. Merely a passenger." (P60), and another said the lack of control made him feel as if: "I had lost all control of the situation, which scared me to death." (P10)

If any control was reported during the experience, it was from trying to help their partner, as one participant mentioned: "I did not feel in control at all, but I did feel very involved in looking after my partner's welfare." (P40)

Fathers who reflected more positively believed they had some level of control (even if small), which could be considered a protective factor against later developing mental health problems. While they spoke about having little control and finding it traumatic, it was also noted how they probably did not want any control in that situation: "I knew I had no control and I did not feel involved. I didn't think it appropriate

that I was involved to be honest.” (P4); “Felt I had no control at all as there was nothing I could do to fix the situation just had to wait for the doctors to sort things out.” (P52).

In conclusion, this theme details how control featured in fathers’ experiences, how they attempted to create control by looking after the interests of their partner, while also exploring how having little control in this situation appeared to be most appropriate for fathers.

Not About Me

This theme explores the roles fathers believed they had during the birth experience and their treatment as a result of being male. During the pregnancy and birth experience, participants suggested that being male may have impacted their treatment by professionals, family and friends, based on societal expectations around birth and the role men play in general. Participants mentioned not being listened to and their questions not being answered.

Participant 7 described how he felt regarding his role during the birth: “I felt mostly like a spare wheel to be kept out of the way.” (P7) Participants often felt that their presence in the experience was not acknowledged: “No. I’m the male. My presence was often not acknowledged let alone my feelings.” “The midwives weren’t very helpful after the birth as my wife developed depression. They ignored my concerns.” (P9) and; “However, not being made to feel like the enemy, a useless caveman that has thoughtlessly impregnated this innocent girl, would be a start.” (P13).

When fathers felt acknowledged, it was only as they were there to support their partners: “I remember feeling very emotional and almost breaking down when they wheeled her off, but quickly pulled myself together as I knew she still needed me to be strong and upbeat.” (P51).

This treatment controlled the fathers’ views of themselves and sometimes prevented them from accessing and seeking help when needed, in some cases leading to further problems long after the birth. Participant 47 explained: “I never would of brought it up to anyone even my wife how could I possibly tell her how traumatised I was when she’s the person that had the ordeal of having a baby.” (P47)

Overall, participants’ experiences of being male in this female dominated experience meant that they felt unimportant (like a spare wheel), with their role in supporting their partner. As a result, they felt they could not explore or discuss their thoughts and feelings during and after the experience.

Support from staff

When participants reported that staff were calm and communicated with the couple, this appeared to ease the father and act as a protective factor in their overall view of the experience and how they felt after the birth, as described by participant 26: “as the midwives and consultants were extremely calm, clear and communicated every stage with us.”. This was also reflected by participant 51: “While, what seemed like muted panic or urgency was erupting around my wife, he [surgeon] calmly explained what was going on and what would happen. Not much of what he said went in, but his calmness was infectious.”. This

behaviour from staff helped fathers to feel calmer about the situation and therefore, could feel more relaxed.

Unfortunately, this level of support was not always possible, in some cases due to system issues:

“Unfortunately, the shift changes right before things escalated, so we didn’t have much opportunity to build a rapport with the new midwife.” (P2)

Life After the Birth Trauma

This theme explores the participants’ postnatal experiences, including expectations of and from fathers, their mental health and the way in which their birth experiences impacted their relationships. Sub-themes include perceptions of manhood after birth; inability to be happy; and impact on relationships.

Perceptions of Manhood After Birth

This sub-theme explores changes in the participants’ roles going into fatherhood and how this impacted their health. Some fathers found that as a result of the traumatic birth, they became the primary caregiver for their child and sometimes their partner, as this quote shows: “We didn’t expect the difficulties we would face with my wife’s recovery. She ended up with a few issues and I spent a bit of time off work looking after her.” (P12) Participant 13 also reflected on his experience of becoming the primary caregiver for his child and partner that eventually impacted his work role and friendships: “The trauma of my son’s birth put me immediately into what felt like sole-responsibility for my entire family 24/7, ultimately excluded me from colleagues and friends and I struggled to cope.” (P13)

The trauma also impacted the participants’ expectations of fatherhood, where they felt that they did not meet the standards or expectations that society had given them. For example, they did not experience an instant bond with their child and in turn felt guilt and shame about themselves as fathers:

“I expected to feel an instant bond with the baby and I didn’t. I came to have a very strong bond with my daughter and I think not getting it initially was a combination of an unrealistic expectation of a romanticised version of what it is to have a child and the situation I was in. Had my wife been fine I wouldn’t have felt so conflicted and it may have come easier at the start.” (P57)

Participants also explored their role of being a ‘man’ and what their experiences meant in a female dominated experience. This also impacted how they coped with their experiences postnatally. They saw being a ‘man’ as being quiet and avoiding discussion of their experiences: “A man’s role in the birth is nothing to talk about really. Be quiet and man up, etc,” (P11). This was partly because they were aware of their partner’s trauma and believed it was greater than their own: “I chose not to think about it for some time; as a man, it does feel churlish to go on about your trauma when the female involved has this harrowing experience happening within her own body.” (P13)

However, participants also acknowledged the stigma around discussing emotions with other men, and not wanting to burden their friends, preventing them from speaking up and seeking support. For example: "As a lad it's not easy to talk to male mates. I'm sure they'd listen but I don't want to be a burden or a downer." (P31)

In conclusion, this theme identifies how preconceived expectations of birth and the postnatal experience for men as men and fathers can contribute to feelings of unimportance around their own experiences. This in turn, leads to less support seeking and reinforces these expectations.

Inability to be Happy

Participants described how the postnatal period affected their daily lives and how the trauma still affected them in the present day. Traumatic births negatively affected their mental health during the postnatal period, leading to difficulties coping with everyday functioning: "Upset, distressed and unable to cope very well. It was a feeling about the fragility of life during the birth and the overwhelming nature of the birth and the subsequent days." (P14) Some participants experienced the development of mental illness in some cases: "...develop[ed] OCD within weeks of the birth. That might have been about the life changes that becoming a father involved but it might be rooted in that birth experience too." (P1)

Most participants reported feelings and experiences during and after the birth trauma that can be linked to symptoms of PTSD. Participant 47 was diagnosed with PTSD and described flashbacks, triggers and avoidance: "I had flashbacks that seemed so real it was like I was there again, I deal with it better now but going back to the maternity wing of that hospital caused great anxiety, walking past the theatre doors etc the sound of a heart rate monitor sets me off even when it's on the TV, I can't watch things like Call the Midwife or One Born Every Minute or anything involving childbirth on the TV either." (P47). Participant 60 also discussed flashbacks that were directly linked to the birth experience: "I regularly have flashbacks and see the number 61 on the heart rate monitor in my mind." (P60).

Overall, participants described a range of mental health problems in the days and weeks following the birth, with some incidences leading to mental health disorders, which continued to impact their lives up to the present day.

Impact on relationships

This theme explores the impact the traumatic birth had on the important relationships in their lives with their partner, children and friends. Most participants reported that the experiences brought them closer to their partner. Going through such a traumatic experience, including the fear that they could have lost their partners, created a stronger bond for participants: "Maybe there's an extra layer to us as we survived such a difficult experience and we know that whatever happens in life we're unlikely to encounter anything as testing." (P3); "It's made us closer because I know I could have lost her." (P8).

However, many discussed struggling to form a bond with their child (and feeling guilty): "I wanted to be with my wife but I felt guilty that I didn't want to be with the baby. When I was with the baby I didn't feel

the level of love that everyone says you do and I felt guilty about that. I was just really confused and frightened.” (P57) Participants also expressed having fears around more children. “Only in the way that I’m reluctant to have sex in case she accidentally gets pregnant.” (P51) These feelings also manifested as difficulty celebrating their children’s birthdays, and fears about emotional intimacy with their partners, which impacted their relationships long term: “We don’t talk about what went on that day, each birthday is very difficult and not a celebration.” (P16).

In some cases, participants also felt this negatively impacted their relationships with friends, due to others lacking comprehension of the situation. As one participant explains: “I tried to talk to my friends, but most of them have no idea of children, or what it involves, so it’s hard for them to relate.” (P10)

Overall, negative birth experiences made the relationship with partners stronger in some cases. However, it also had a negative impact on partner relationships through affecting bonds with their children and leading to avoidance of physical and emotional intimacy. Relationships with those outside of the family were also negatively impacted in some cases, as friends did not share the same experiences and could not understand.

Support Fathers Received vs What They Wanted

This theme consists of the levels of support fathers felt they received either personally, as a couple or for their partner, in relation to what support they believed would have been beneficial. It is split into three sub-themes that explore different time periods of the experience: prenatal support; birth support; postnatal support.

Prenatal Support

During the pregnancy, participants reported receiving a good level of support, where all concerns raised were answered: “As much support as was needed. The pregnancy was pretty good to be honest so we didn’t require any additional support but whenever we had questions then we got the answers.” (P11) However, they did note that antenatal classes were very much tailored towards mothers. For example, when participant 51 was asked about the support he received prenatally, he said “Personally, none. But my wife was well looked after and supported. However, I never felt left out or unwelcome.” (P51)

However, in retrospect, participants felt antenatal classes only discussed normal births, which they felt created an idealised experience. Participants reported wanting antenatal classes to expand on the breadth and depth of the childbirth experience, to cover departures from the norm: “... in retrospect, I see these as “idealised” birth training classes. Breathing exercises, birth pool options, stages of normal labour etc,” (P29) and “More information on what a birth plan could involve, and learning about how variable each pregnancy is, as any change from the norm made us quite nervous.” (P10)

Furthermore, participants felt that ideally antenatal classes would include more information around being included as a father. For example, one participant felt that: “I should have been more included from the beginning. A mother and father should both complete questionnaires regarding depression and a father

should be asked how he is feeling or if there is anything that he wants to ask or doesn't understand. These questions are solely aimed at the expectant mother whilst a father has to butt in and speak during a conversation he is only there to witness." (P21) Participants also explained the importance of peer support for partners during the prenatal period: "Peer to peer support from other fathers, an antenatal session for partners on supporting birth & the early days and information tailored to males (language, imagery & context)." (P55)

Overall, fathers felt they could have been provided with more information and involved more in sessions such as antenatal classes during the prenatal period.

Birth Support

Participants described the levels of support varying throughout the birth as generally less positive than prenatal support. For example: *"In the 70ish hours before the actual birth support levels went up and down."* (P1)

However, the fathers often reported that this was understandable due to the emergency situation. They were aware that the lack of support for them meant that their partners were being saved:

"Emotionally/mentally, I remember receiving very little support. Can't fault them too much though - they were busy saving my partner and baby!" (P30)

Nevertheless, participants would have liked to be informed and involved throughout the birth. They felt that being involved would have made them feel more useful: "I would have liked to have had someone to stay with me or at least pop in regularly to see if I was okay and to tell me what was happening with my wife." (P8) and "To be made to feel like a useful part, to be involved and kept updated on what was going on and why" (P58).

In some cases, they felt that the lack of support received contributed to them labelling the experience as traumatic: "More support in making decisions regarding this [implications of delivery] – this was a major contributor to the trauma of our delivery." (P2)

This theme explored how a lack of support was perceived by participants as a contributor to their traumatic experience. Participants wanted to be involved in making decisions and wanted someone to support them but were aware of the need to focus on the mother.

Postnatal Support

Participants discussed support received in the months after the birth, plus what they felt would have been beneficial. Many fathers felt there was minimal support for themselves or their partners: "We had some follow up care for our daughter and 2 discussions with doctors regarding the delivery and what went wrong. These were minimally informative." (P2). Some participants sought professional help as a result: "I paid for private therapy. My wife had no follow up from her mental health team except a 20 min meeting alone with them..." (P4)

Participants felt a chance to discuss their experiences and have them explained after the event would have helped them make sense of the situation. As participant 2 explains: "More information from doctors about what happened to us – and an interview, possibly with administration or some other body to help us understand what happened and to give feedback – this we would not get unless we took the initiative to pursue such an opportunity. I think this kind of debriefing should be standard when things go outside the parameters of a normal delivery." (P2) Many participants reported wanting a support group for dads, and even mental health support/therapy themselves. This included support from other dads: "Maybe I could have joined a group of dads to discuss." (P42); "Advice from other dads." (P56).

However, participants acknowledged that men do not always seek help: When asked how much support he received, one father responded "Very little, but I could have sought more help, so I put no blame there." (P30) Participants suggested that help could be explicitly signposted and made easier to find in an attempt to break down barriers that prevent men from seeking help, as the following quote reflects: "Perhaps it would of been nice to be told about the support rather than having to seek it." (P43).

This final theme described the lack of or minimal amount of support for fathers in the postnatal period. Fathers felt that support could be given in the form of debriefs, 'dad groups' and support being made explicit to encourage fathers to seek support when they needed it.

Discussion

The current study explored narratives of 61 fathers who had witnessed their partner's traumatic birth. The themes that emerged reflected fathers' experiences of traumatic birth, how these experiences impacted their mental health, and fathers' feelings regarding support they received.

Findings and interpretation

Participants felt that nothing could really prepare them for a traumatic birth, echoing the findings of Harvey and Pattison (2014), who explored the experiences of fathers who witnessed their child's resuscitation. Although fathers had been aware that a traumatic birth was possible and had tried to prepare themselves for all eventualities, they had not considered the possibility of resuscitation so did not access information on that. In the current study, many fathers reported attempting to prepare for the birth by attending antenatal classes, and appointments with doctors and other perinatal health professionals. However, fathers still felt unprepared as they believed information they received focused on 'normal' births, leading lack of awareness of the possibility of a traumatic birth.

Eggermont et al., (2017) also found that a father's need for information outweighed his need for involvement during the experience, and he required less information if he had experienced a birth before. Many fathers in the current study reported similar experiences of their first childbirth to Eggermont et al. (2017). However, these researchers focussed on 'normal births' meaning only limited comparisons can be made. Further, in a study into women's traumatic birth experiences, Modarres et al., (2012) found that a lack of information contributed to the trauma, which was supported in the current study.

The fathers in the current study saw lack of control as a major contributor to their perceived trauma. Ford, Ayers and Bradley (2010) suggested that loss of control in the birth experience is a contributing factor for experiencing birth trauma in women. Fathers' reported lack of control in our study was linked to being left out of decision-making and having limited access to information during the birth, which are contributing factors to women's perceptions of traumatic birth (Meyer, 2012). The fathers in the current study who reflected more positively on their experiences noted that they had some control during this experience.

The concept of loss of control during birth has been identified in numerous studies. For example, Elmir et al., (2010) identified the theme 'feeling invisible and out of control' in their meta-ethnographic study of women's perceptions of birth trauma. In that study, women believed their lack of control was a direct result of limited information received from staff. Similar findings are witnessed in Harvey and Pattison's (2014) theme of "knowing what happened", in their exploration of experiences of fathers who witnessed their new-born child's resuscitation. Control is also a common male identity in western societies (Vogel et al., 2014). This control was denied during childbirth in the current study.

Fathers' experiences with staff greatly influenced their perceived trauma. For example, more positive experiences with staff appeared to act as a protective factor against low mood postnatally. On the other hand, participants associated negative experiences with staff (changes in plans, staff issues, not being listened to, treatment of partner and self) as contributing to the trauma. Similarly, Po, Koh and He (2014) found that fathers believed that they were not respected by healthcare professionals during the prenatal period, leading to a lack of control of the situation and ultimately, a less positive experience.

The fathers felt that being a man in the birth experience affected how healthcare professionals treated them, reinforcing that they should not be involved as this was a woman's domain. This underpins the concept that fathers are 'secondary parents' (Wells, 2016), placing further stereotypical roles and responsibilities on the mother. This may also explain the lack of research into men and birth trauma. These narratives were also mirrored by Harvey and Pattison (2012), where participants felt unimportant as a result of their treatment by professionals.

However, the reasons for men not being given the support they need during childbirth may go beyond labour being a female-dominated experience. Within Western societies, gender roles demand that men should be strong and in control, not needing help with their problems (Vogel, Wester, Hammer & Downing-Matibag, 2014). Women tend to speak more freely about how they feel regarding mental health, whereas men's behaviour may be more of an indication that they are experiencing poor mental health, rather than what they say (Wilhelm, 2014). For example, higher rates of substance use (nicotine, alcohol and drugs) have been documented in men than women during the post-natal period. Wilhelm (2014) suggests this could be due to men having poorer emotional health literacy than women, meaning they are less likely to report their feelings and seek help. Also, men tend to regard frequently utilising healthcare resources as a female trait, believing that they are less likely to be ill in comparison (Noone & Stephens, 2008). Regardless of the reason, men's poor mental health tends to be overlooked by healthcare professionals.

Our study found that perceptions of masculinity limited men from talking about their experiences and may have prevented them from seeking help. The fathers in the current study stated it felt inappropriate to talk about their experiences because 1) they were not the patient and 2) men do not talk about their experiences and emotions. Similarly, Etheridge and Slade (2017) found that fathers' coping strategies were controlled by their beliefs about masculinity. This included keeping their emotions to themselves, avoidance and remaining strong for their partners.

Perceptions of masculinity also appeared to impact expectations of fatherhood in the early postnatal period. For example, participants reported struggling with their new role as a father, often having to take on more responsibility than they previously expected, causing doubts in their own abilities. This caused participants to keep quiet about their struggles and evade the topic of birth, even avoiding intimacy with their partner to prevent another birth. Men experience psychological distress when they fail to live up to internalised beliefs of masculinity, which can prevent them from fully reacting to the birth experience (Zerach & Magal, 2017). This means fathers struggle with overcoming the trauma and seeking help. We suggest that these male coping styles fall in line with gender roles that are primarily emotionally restricted and lead to men failing to seek support (as found by Vogel et al. (2014). These negative coping styles can contribute to the development and maintenance of PTSD (Bisson, 2009).

However, it we note that our findings do not suggest healthcare professionals are actively acting against the father during the traumatic births. It is more likely that the nature of the situation and other factors (such as gender stereotypes) contributed to the outcomes. For example, Harvey and Pattison (2012) suggest that fathers may not register that healthcare professionals may be supporting them, due to the traumatic experience. Etheridge and Slade (2017) also report that only a small number of fathers were angry with perinatal staff for their treatment, and many were positive about the healthcare professionals' role in helping their partners. Nevertheless, evidence suggests that fathers' needs are not always being addressed.

The impact of traumatic birth had serious implications for some the participants in the current study, with mental health issues such as depression, anxiety, postnatal stress, obsessive-compulsive disorder (OCD) and PTSD symptoms being described. Participants also spoke of guilt about their feelings regarding their child and some fathers reported struggling to connect with their partner due to fears of intimacy and pregnancy. Similar mental health difficulties and relationship problems for fathers as a result of their traumatic experiences have been reported elsewhere (Elmir et al.2010; Etheridge and Slade, 2017; Iles et al., 2011; Harvey and Pattison, 2016). Fathers also talked about how the relationship with their infant had been affected. Previous research by Ramchandi, et al. (2008) indicated why the bond is so important for that child's long-term mental health and behaviour.

Despite the difficulties participants and their partners faced before during and after the experience, fathers in the current study were often not offered, nor sought, support. Fathers who did not seek help reported not being aware of what support was available or being unable to access support. This may

have been due to men taking longer than expected to realise they had a problem, and consequently experiencing delays in detection of health issues (Wilhelm, 2014).

During the birth experience and postnatally, fathers reported receiving only minimal support despite needing more. Many reported receiving a short debrief by practitioners after the event, but were left feeling they had not been given the time and space to effectively process the event. Participants often explained concerns over their partner's mental health, which in turn affected their own wellbeing, with perinatal services failing to effectively address this. Overall, participants wanted to be offered an opportunity to talk to someone (either professionally or to a peer); information to explain what had happened; and therapy or counselling for themselves and for their family. However, it is important to note that debriefs are not effective in themselves at addressing the effects of a traumatic birth. Sheen and Slade (2015) found that postnatal debriefs were ineffective in reducing post-traumatic stress or depressive symptoms and should not replace targeted interventions. They also suggested alternative terminology: debriefing should be referred to as 'childbirth review', as it more fully encompasses the discussion of the labour, feeling and subsequent responses to their experience without sounding like a 'fix' to the traumatic experience. Despite this, the participants in the current study suggested a debrief would assist with their own understanding of what happened.

Implications for Clinical Practice and Policy

Healthcare professionals need to be aware of factors that may prevent men from seeking help and professionals providing support; and be aware of where the fathers can be signposted to receive help and support. The fathers in the study stated that they felt ill-prepared for the possibility of birth trauma, and poorly informed about potential impact (for their partner and themselves) following that experience. This implies that adequate information during the experience and aftercare from birth trauma is key, as birth trauma is a unique and difficult phenomenon to prevent and prepare for. Possible improvements to clinical practice could involve offering parents a full debrief of the birth experience in the postnatal period. This could occur even if the birth is considered 'normal' by professionals, as parents can still perceive births as traumatic if they deviate from expectations (Ford, Ayers & Bradley, 2010). Parents could be offered the opportunity to understand what happened and be signposted to opportunities for support. Such support could be provided by the voluntary and charity sector, focusing on interventions such as peer specialist help, online support groups, or targeted interventions such as postnatal PTSD therapy.

Fathers in this study indicated that they felt excluded by postnatal health professionals (such as midwives and health visitors), claiming that those services were focused mostly on the mothers. This suggests that it is essential that healthcare professionals recognise fathers as primary parents, in line with mothers, so that they can receive the necessary support.

Many fathers discussed how the traumatic birth impacted the bond with their child. Services need to be provided to help fathers develop that relationship. If further or more complicated issues are identified during the debrief, parents could be referred to specialist NHS interventions. Follow-up screening and

referral needs to be ongoing, as trauma symptoms can sometimes be delayed for several months (American Psychiatric Association, 2013).

Strengths and Limitations

The current study generated rich and broad data based on the narratives of 61 fathers reflecting on their experience of witnessing their partner's traumatic birth. By preserving participant anonymity through online questionnaires, this study elicited detail that might otherwise have been withheld. This is especially important as the data showed how difficult men find it to discuss birth trauma. However, questionnaires may limit the extent to which additional information can be generated. It could be useful for future studies to consider interview techniques that maintain anonymity. Such interviews might permit further probing of important perceptions.

By advertising this study online, it was possible to raise awareness about birth trauma and men's mental health. However, the fact that participants were recruited via social media linked to mental health support and national perinatal mental health charities suggests our participants had engaged with mental health support at least to some degree, and men who had not engaged with mental health support services were likely underrepresented. This issue might be overcome by engaging men who are part of other fatherhood groups, perhaps not necessarily related to mental health support.

Also, all participants were married, suggesting a lack of engagement of unmarried fathers. Future studies could explore whether there are any differences for outcomes when considering marital status. Further, 140 participants started the questionnaire but did not complete it. It is possible that the length of the questionnaire may have been a barrier to participation. Equally, some participants may have found the questions too distressing to answer. Future studies could include pilot stages that gather feedback about these factors.

A further limitation is that the questionnaire was subject to recall bias. Participants, particularly if the traumatic birth occurred a long time ago, may not remember it accurately, or their memories may have become distorted over time. The current study excluded participants if the birth trauma occurred more than 10 years previously. Future studies may consider whether that period is still too long.

Implications for future research

Future studies could explore the experience of more specific types of birth trauma within the same study (to allow comparison). This could include fathers whose partners gave birth in different environments (e.g., home birth, hospital), and fathers who have experienced a traumatic birth subsequent to a birth that was not experienced as traumatic. Such an examination could potentially highlight how different types of traumatic experience might trigger poor mental health outcomes. Future research could also aim to directly compare normal and traumatic births in a single study. Future research may also benefit from comparing the birth trauma experiences of men and women together, in order to identify similarities and differences in traumatic experiences. Following on from Iles et al., (2011), who explored

similarities between mothers' and fathers' post-traumatic stress post-birth, it would be beneficial to explore potential differences between mothers and fathers as active participants and active/passive bystanders to the experience. Further research is also needed to explore fathers' concepts of masculinity in the context of birthing, as current evidence may be based on outdated perceptions.

Research into effective interventions or preventative measures for men and their families may be crucial to fully address this area of research. This includes developing a deeper understanding of the barriers that prevent men from seeking help, as well as why practitioners may not offer support to men. By encompassing all perspectives from a traumatic birth, a better understanding can be achieved, resulting in preventative action, or, where this is not possible, effective aftercare.

Conclusion

Our findings suggest that traumatic births can have a profound impact on some fathers, which can ultimately negatively impact their relationship with their family and their own mental health. Many fathers in this study reported feeling unable to access support during and following a traumatic birth, which were related to perceptions of the birth and treatment by perinatal staff. Many fathers in this study spoke about the impact that the traumatic birth had on how well they bonded with their new child. Several recommendations for clinical practice merit consideration: more education is needed for perinatal health professionals about the role of the father in the perinatal period; strategies are needed to encourage fathers to seek help; screening needs to be put in place to identify fathers who are most at risk of poor mental health; and services need to be developed to ensure fathers receive appropriate support for their own mental health and help nurture the father-infant relationship.

Abbreviations

PTSD—Post-traumatic Stress Disorder

OCD—Obsessive-compulsive Disorder

Declarations

Ethical approval and consent to participate

Ethical approval was granted by Bournemouth University Faculty of Science and Technology Ethics Committee and all participants consented to take part in the study

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

Authors declare no competing interests

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Authors' contributions

The study was designed by AM and ED. Analysis was completed by ED and verified by EAC. ED completed the write up of the study, which was critically reviewed and edited by AM and EAC. All authors read and approved the final manuscript for publication.

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Figures

Figure 1

Flowchart of participant engagement

Figure 2

Flow chart of themes explored

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