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Paternal mental health following perceived traumatic childbirth

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ABSTRACT

Objective: the objective behind the current study was to explore the experiences and perceptions of fathers after childbirth trauma, an area of minimal research. This is part two of a two-part series conducted in 2014 researching the mental health of fathers after experiencing a perceived traumatic childbirth.
Design: qualitative methodology using semi-structured interviews and reporting of qualitative questions administered in part one's online survey (Inglis, 2014).
Setting: interviews conducted face-to-face at an Australian University or on Skype.
Participants: sixty-nine responded to the online qualitative questions and of these seven were interviewed.
Measurements: thematic analysis of verbal and written qualitative responses.
Findings: thematic analysis of qualitative survey data and interviews found a global theme 'standing on the sideline' which encompassed two major themes of witnessing trauma: unknown territory, and the aftermath: dealing with it, and respective subthemes.
Key Conclusions: according to the perceptions and experiences of the fathers, there was a significant lack of communication between birthing teams and fathers, and fathers experienced a sense of marginalisation before, during, and after the traumatic childbirth. The findings of this study suggest that these factors contributed to the perception of trauma in the current sample. Whilst many fathers reported the negative impact of the traumatic birth on themselves and their relationships, some reported post-traumatic growth from the experience and others identified friends and family as a valuable source of support.
Implications for practice: improved communication between midwifery staff and fathers before, during and after childbirth may reduce the rates of paternal postpartum mental health difficulties and experiences of trauma.

A large number of research articles have studied the prevalence, causes, and effects of childbirth trauma on mothers. Birth trauma refers to the actual or threat of harm to the mother or infant, including injury or death (Elmir et al., 2010). Moreover, a study by Soet et al. (2003) found that 34% of participants perceived their childbirth experience as traumatic. It is estimated that 1 to 6% of females develop Post-traumatic Stress Disorder (PTSD) symptoms following childbirth (Elmir et al., 2010). However, to the best of the authors knowledge only eight research articles have been published examining the influence that childbirth trauma has on fathers in the postpartum (Nicholls and Ayers, 2007; White, 2007; Parfitt and Ayers, 2009; Johnson, 2011; Harvey and Pattison, 2012; Snowdon et al., 2012; Stramrood et al., 2013; Hinton et al., 2014), and four published which investigated traumatic childbirth as a primary aim (Skari et al., 2002; Ayers et al., 2007; Bradley et al., 2008; Iles et al., 2011). Many of these studies have requested that future research be done using a qualitative element to more fully understand the fathers' experiences subsequent to childbirth trauma.

For the last 30 years, it has become socially acceptable and even encouraged in western societies for fathers to be in the birthing room (Draper, 2003), and studies have started to explore the possible psychological effects on fathers of attending a partner's childbirth (Bradley and Slade, 2011). Many fathers' describe the

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experience of witnessing childbirth as mostly positive, and accompanied by feelings of pride, happiness and excitement (Bradley and Slade, 2011; Premberg et al., 2011). An important factor in these positive experiences was the fathers' perception of feeling supported by the midwives during childbirth (Johansson, et al., 2015). The presence of a father can help lower a woman's anxiety (Szeverényi et al., 1989) and influence birth outcomes including reductions in medication needed, length of labour, and urgent medical care for the infant (Pestvenidze and Bohrer, 2007). Alternatively, some research suggests that male partners can become too emotionally involved and are unable to exert a calming influence, a result possibly due to their inexperience with childbirth (Dellmann, 2004). Studies examining the negative effects of fathers attending a partner's childbirth have indicated that fathers report a number of deleterious psychological outcomes. Bradley and Slade (2011) found that the prevalance of depression in fathers shortly after childbirth was around 1–8%. Bradley et al. (2008) found that 6.6% of fathers experienced signifcant anxiety, and 3% of fathers reported a signficant number of symptoms of PTSD.

White (2007) examined the experiences of 21 New Zealand fathers who witnessed traumatic childbirths, using descriptive phenomenology and a qualitiative content analysis. *Four key themes were identified by* White's (2007) study. Fathers felt frustrated with being forced into spectating the birth of their babies, leading them to feelings of alienation. They held disparaging feelings when healthcare staff fell short in acknowledging their integrity, partnership with the mother, and role of protector of his family. Some fathers went as far to say that sexual activity was very difficult, as their partners bodies were cues that reminded them of the traumatic event, a finding validated by Nicholls and Ayers (2007). The fathers had an overall sense of shame, and helplessness when concealing their emotional distress.

The aim behind the current study was to examine the experiences and perceptions fathers held regarding their perceived traumatic childbirth, within a qualitative framework. While a large number of research articles have examined the experience of birth trauma in mothers, the purpose of this study was to expand the research on fathers' experience of child birth trauma. The qualitative component addresses the recommendations of prior research, to use qualitative methods to more fully understand this issue. Through the mixed-methods analysis – a novel research method to the childbirth trauma literature – the thoughts and experiences of fathers' following a traumatic childbirth were investigated.

Method

Overview

This is part two of a two-part series researching the mental health of fathers after experiencing a perceived traumatic childbirth. The first phase was the completion of online surveys (quantitative methodology), the findings of which are described in part one (Inglis, 2014). The survey included questions on demographics, descriptive birth assessments, parent-infant attachment, partner relationship quality, current mental health, and coping strategies used after the trauma. The research team sought to predict the presence of PTSD/-like and depressive symptoms in fathers. The findings of the second phase are described in this paper, which included semi-structured interviews (qualitative

Table 1
Father's demographics ($N=69$).

Variable	*M* (SD)	n	(%)
Marital status		69	
Married		58	(84.1%)
De Facto		4	(5.8%)
Single		3	(4.3%)
Divorced		2	(2.9%)
Separated		1	(1.4%)
Other			
Engaged		1	(1.4%)
Number of children	2.23 (1.78)	69	
1		30	(43.5%)
2		19	(27.5%)
3		10	(14.5%)
4		5	(7.2%)
5		2	(2.9%)
> 5		3	(4.4%)
Age range of children	5.14 (3.97)	69	
0–2 years		37	(53.6%)
3–5 years		16	(23.2%)
6–8 years		7	(10.1%)
9–11 years		6	(8.7%)
> 12 years		3	(4.3%)
Age of youngest child	2.59 (3.60)	66	
Age of oldest child	6.00 (5.42)	66	
Fathers Region of Origin		69	
Australasia		32	(46.5%)
North America		22	(31.9%)
Europe		11	(15.9%)
South America		2	(2.9%)
Africa		2	(2.9%)
Language spoken			
English		65	(94.2%)
Other		4	(5.8%)
Education			
Did not finish high school		1	(1.4%)
Finished high school		14	(20.3%)
Trade of technical qualification		17	(24.6%)
Undergraduate degree		25	(36.2%)
Postgraduate degree		12	(17.4%)
Mental health previous to childbirth			
None		54	(78.3%)
Yes, unspecified		3	(4.3%)
Depression		6	(8.7%)
Anxiety		4	(5.8%)
Bipolar		1	(1.4%)
Depression and anxiety		1	(1.4%)
Type of birth			
Unassisted vaginal birth		18	(26.1%)
Assisted vaginal birth (ventouse or forceps)		10	(14.5%)
Planned caesarean		10	(14.5%)
Unplanned caesarean		31	(44.9%)
Place of birth			
Public hospital		50	(72.5%)
Private hospital		11	(15.9%)
Birth centre		1	(1.4%)
Planned birth centre transfer to hospital		1	(1.4%)
Homebirth		2	(2.9%)
Planned homebirth transfer to hospital		3	(4.3%)
Unplanned out of hospital birth		1	(1.4%)
Special nursery care			
Yes		42	(60.9%)
No		27	(39.1%)
Days in special nursery care			
Mean (SD) days in special nursery care	20.74 (39.79)		
0–10		50	(72.5%)
11–20		3	(4.3%)
21–30		4	(5.8%)
> 30		12	(17.4%)
Fathers present at birth			
Yes		57	(82.7%)
No		12	(17.4%)