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Paternal Mental Health Following Perceived
Traumatic Childbirth

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Running Title: FATHERS AND TRAUMATIC CHILDBIRTH

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 (Author, 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.

Keywords: posttraumatic stress disorder, childbirth, father, qualitative, midwife

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 baby, including injury or death (Elmir et al., 2010). Moreover, a study by Soet, Brack, and DiIorio (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 (Harvey & Pattison, 2012; Hinton et al. 2014; Johnson, 2011; Nicholls & Ayers, 2007; Parfitt & Ayers, 2009; Snowdon et al. 2012; Stramrood et al. 2013; White, 2007), and four published which investigated traumatic

childbirth as a primary aim (Ayers et al. 2007; Bradley et al. 2008; Iles et al. 2011; Skari et al., 2002). 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 & Slade, 2011). Many fathers describe the experience of witnessing childbirth as mostly positive, and accompanied by feelings of pride, happiness and excitement (Bradley & 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 baby (Pestvenidze & 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 prevalence of depression in fathers shortly after childbirth was around 1-8%. Bradley et al. (2008) found that 6.6% of fathers experienced significant anxiety, and 3% of fathers reported a significant number of symptoms of PTSD.

White (2007) examined the experiences of 21 New Zealand fathers who witnessed traumatic childbirths, using descriptive phenomenology and a qualitative 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 (Author, 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 methodology) and analysis of the

qualitative component of the survey. The research team sought to gain a greater understanding of a father's experience of the childbirth trauma.

Participants

Of the eighty-seven fathers who responded to the online survey described in part one, sixty-nine fathers responded to the qualitative component of the online survey. Fathers ($N = 7$) that responded to the invitation at the end of the online survey to participate in the interviews had a mean age of 36.71 years. The fathers were recruited from online social media forums, including a midwife blog, and had experienced self-reported traumatic childbirth. Traumatic childbirth was self-defined as an individual can perceive childbirth to be traumatic despite not witnessing actual or threatened death, serious injury or sexual violation (American Psychiatric Association, 2013). The only inclusion criteria used was that fathers must be fluent in English, and the trauma must have occurred at any phase during childbearing. No exclusion criteria for the time since the birth was imposed, as a father's telling of the childbirth many years later is as detailed as new fathers (White, 2007). Father demographic data of the 69 responding to the qualitative component of this study is presented in Table 1.

INSERT TABLE 1 HERE

Measures

Ethical approval for this research project was obtained through the Research Ethics Review Board at the University of the Sunshine Coast (Approval number S/14/590). An online survey was used through the program Survey Monkey to collect online qualitative datum. A qualitative question asking fathers to describe what they found traumatising was included in the online survey from part one of this study. Consent was obtained from participants by their completion of the online survey, and again prior to interviews. The semi-structured interviews consisted of open questions that were developed from the father-specific childbirth trauma literature (Harvey & Pattison, 2012; Hinton et al. 2014; Nicholls & Ayers,

2007). The questions were validated by a current midwife academic and encompassed four themes: the father's expectations of childbirth, experience of traumatic childbirth, traumatic response, and current well-being. To ensure positive outcomes could be discussed, the question 'have you experienced personal growth in your life since the trauma' was included. Full details of the interview questions can be found in appendix A.

Procedure for Interviews

An information sheet and consent form was presented to participants through email exchange if the participant resided outside Australia, or in person. These documents contained information on the voluntary and confidential nature of the research, and the background, purpose and description of the research. The consent forms also contained information on services available to the participant should the interviews evoke intense feelings. The interviewer was a young adult male with no children of his own who was completing the research component requirements of an undergraduate psychology degree, with no prior interviewing experience or midwifery knowledge, who held no relationship with participants interviewed, and is the primary author of the study. As the interviewer had no children of his own, any potential issues of counter-transference of interviewer trauma surrounding childbirth was eliminated. Participants were informed of the interviewers characteristics and position regarding authorship of the study. Five interviews were conducted in April of 2014 in a private room at an Australian University, while two interviews with participants who resided outside of Australia were conducted via Skype. Participants were notified that interviews were audio recorded would go for approximately 30 minutes, but could change according to the participant's responses, and were reminded of their ability to withdraw from the interview at any time. Interviews ranged from 17 to 48 minutes ($M = 29.71$ minutes), and were transcribed verbatim for further analysis.

Analysis

Braun and Clarke's (2006) method of thematic analysis was used to analyse qualitative data, which included a combination of written survey data and a written transcribed version of the interview. Braun and Clarke's (2006) phases of thematic analysis was followed wherein researchers familiarised themselves with the data, and initial codes were generated and collated into potential themes. Themes were then reviewed by an academic and current practicing midwife in Australia – who is an author of the study – to ensure the validity of themes; a thematic map was subsequently generated. The themes were identified at a semantic level, where each datum was described, patterned, summarised, and interpreted. An inductive 'bottom up' approach of thematic analysis was used so that the thematic description obtained distinctly reflected the data. Data analysis concluded in August of 2015.

Findings

One global theme represented the qualitative findings; "*Standing on the Sideline*", which was underpinned by major themes and subthemes as displayed in figure 1. Fathers that only responded to the online survey were referenced with a number, and the seven fathers that were interviewed were given pseudonyms to maintain anonymity.

INSERT FIGURE 1 HERE

Global Theme: "Standing on the Sideline"

A global theme "*Standing on the Sideline*" underpinned the qualitative findings. The findings suggest that the fathers experienced a sense of marginalisation before, during, and after the traumatic childbirth from medical staff. One father said:

You just had no idea what was going on you just sort of standing on the sidelines watching... 'cause, 'cause being a guy you sort of, um, see yourself as you know the rock of

the family, or the provider or whatever... knowing that it's outta your hands and you're relying on doctors to make things okay (Cooper).

Major theme one: witnessing trauma: unknown territory. Fathers reported being traumatised by witnessing the procedures used during birth such as ventouse, forceps or emergency caesarean surgery, and seeing their infant and partner in distress. In the online survey, fathers often responded with single word answers such as “terrifying” (61), “suction” (15), and “died” (49). Others provided more detailed descriptions:

... it was like she was getting attacked by a shark she was (demonstrates) thrashing around and that was them pulling the baby out through the caesarean scar section so it was pretty intense (Steven).

(Laughs nervously) I still remember it this day... she (nurse) had both hands on it (instrument)... leaning on this thing with both hands and straining, to pull this baby out... And you know that sticks to my mind... nobody ever has to see that happening again that was really awful (Ryan).

Inter-related subthemes emerged – being unprepared; out of control; and not knowing.

Being unprepared. Most fathers held positive expectations about the birth of their child, and were sure of the type and place of birth. In retrospect, eleven fathers described their feelings of frustration and uncertainty about not being prepared for possible complications. One father felt so underprepared that the birth of his child was “all done by the seat of the pants” (Reece). Other fathers also expressed a sense of being unprepared:

...my perceptions leading up to the birth were actually around the whole, you go in, it's painful, you go through for a few hours, and after that it's kind of okay and you come home, so I didn't have any visions of anything going wrong...I don't think anybody probably does (Dan).

Out of control. Fathers expressed a sense of being out of control over the events during childbirth, and feeling ultimately powerless at the hands of medical professionals:

Sometimes there are things in life that are way out of our control. They rip our entire lives apart and change it more than we could ever imagine, while all we can do is stand by and watch. ... It's like you have your legs and arms tied up behind your back and you have been thrown overboard and slowly sinking to the bottom of the ocean but all you can do is wiggle around. It won't help the situation because there is ultimately nothing you can do... I just broke down for a few minutes (1).

Not knowing. The fathers often did not know what was happening or what the outcome would be, which added to their feelings of marginalisation:

... I felt absolutely helpless (long pause)... I'm starting to cry I've called Mindy's parents and told them "look I don't know what's happening" um you know, I just had no idea... I just feel like I got left behind... never told me what was going on and I was just waiting in this room like is my wife about to die... (Steven)?

The trauma resulting from 'not knowing' was influenced by the communication of care providers. Despite four fathers mentioning good communication before and after the trauma with midwives, doctors and nurses, one of the major concerns that fathers had was the lack of communication during the traumatic birth experience. Most fathers felt marginalised throughout the entire experience as vital pieces of information were conveyed to them:

The lack of communication to myself they kept just trying to ask my partner questions and not tell me what was happening (12).

Nobody's told us anything yet, um, and it wasn't until I said "what's going on", that they said, "she hasn't breathed"... There was probably a good forty-five minutes until I actually found someone and said "can I at least pick me daughter up?" And they went "oh yeah of course!" It's like... (laughs; Ryan).

In some cases fathers were physically separated from their partners/babies without any communication about what was happening:

Men are not allowed in the birthing room in the Philippines so I was shut out. I was told to get a room in the hospital and wait. 36 hrs and absolutely no communication about the birth. I finally had enough and stormed into the office and demanded to know what was happening, a quick phone call was made, then the nurse said congratulations your daughter was born 45 min ago (60).

Major theme two: the aftermath: dealing with it. Experiencing a traumatic childbirth had quite an impact on the fathers' lives, such as experiencing negative emotions

and relationship difficulties with their partners. The methods employed by fathers to overcome the difficulties they faced varied. A common finding was that fathers again felt marginalised, but this time during the postpartum period, and this resulted in them being reluctant to speak out and receive help.

The impact. Fathers described the debilitating consequences that the childbirth trauma had upon their life:

I must have put on two stone in weight... And I think that was all due to stress mainly.... I didn't really focus any energy anymore on doing the things I used to do like playing football, tennis, going to the gym and that all kind of just stopped pretty quickly, because I guess mentally I wasn't in a place to even be thinking about those sorts of things... So it was unbelievably stressful and all the weight of that really took me to a fairly dark place where I kind of withdrew from the rest of the world really (Dan).

Mentally, I was shaking for a little while, you know um, it's not like me to cry for no reason, but I shed a lot of tears in the first couple months, ah just thinking about it and our situation. (Geoffrey).

This impacted on their relationships, for example Dan described how the trauma had affected his relationship with his partner: "Pretty detrimentally..., when I look back on it now... probably from birth to three years old we probably barely spoke". Some fathers stated that they would avoid subsequent pregnancies:

... no more kids ever again (65).

I have been thinking about vasectomy every day after the birth as I do not want to have the chance of going through it again (21).

In stark contrast to those who responded to the online survey, fathers who were interviewed face-to-face described posttraumatic growth, although they did acknowledge the significant and negative impact the trauma had upon their entire life. In particular, some felt that in the long term the experience had made their relationship with their partner stronger:

... in terms of personal growth... It just gives you that kind of mental strength... but when I look back on it now I actually, don't get me wrong I wouldn't say I wouldn't change it but having gone through that has made us both as individuals and as a family a lot stronger and a lot closer I think (Dan).

...we grew a tonne, you know it's the closest we've been, and we've been married for eight years already (Geoffrey).

Getting past it. In terms of being offered support, fathers shared a sense that they were once again marginalised:

My partner got offered counseling and pnd drugs after she left hospital... the nurse on staff at the time just said to me...well you'll need a beer after this night...no serious are u ok..do u need anything..do u have any question type remarks...that was it (12).

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Found very little support for me as a father/male. Everyone asked about my wife but very rarely did anyone ask about me (28).

Putting on that brave, its all going to be okay front [w]as very difficult (8).

A number of fathers identified religion, or trusting in God as a coping mechanism and source of strength to endure the trauma:

But one thing is certain I wouldn't have got through it without the blessings God has given (1)!

Accepting the reality of the situation was another coping mechanism fathers commonly identified with:

...alright we've been through it once, we got, we got through it, let's just knuckle down and get through it again (Cooper).

(long pause, breaths heavily) I think, it's hard to say, I don't think that I'd really grieved, um, we were put in a tough situation and I think we, tried to just understand that it was reality, you know there's, (sighs) it happened, we had to get past it and, do what was best for her... (Geoffrey).

Some fathers detached emotionally from the trauma to cope:

Um, yer it was going to that clinical sort of very business-like situation trying to deal with what I've just seen... Just going to that sort of mode (Ryan).

...because I didn't really want to confront the whole situation I just threw myself more and more into work so I was probably doing about 70 hours a week of work (Dan).

Many fathers felt encouraged after receiving emotional and social support from friends and family:

I don't think I personally could have made it through this experience without the support of my family and friends!! They gave me something else to look forward to (1)!

Um. (Long pause). Hm. I guess, like just speaking about it, even like now, two and a bit years later, you sort of feel emotional when you talk about it, but, I didn't feel um, I didn't feel like depressed but um, you know just, just talking about the situation with mates you probably have a few tears or something (Cooper).

um, my wife and I are extremely close we have a very solid foundation... you know I think having somebody that I can turn to and tell her how terrible I felt about the situation and her, to be able to be calm and say you know, I understand but she's okay she's you know she's getting better, or she's, she has the, you know the medical care that she needs right now and, we just go and be with her, and let her know that we're there for her (Geoffrey).

Venting about their experience was seen as cathartic, and was seen as a positive experience by some fathers:

...that was a chance for me to really express everything that was wrong everything that happened...and submit that to the hospital to say this is what I'm not happy with you know this is how you potentially f****d up our lives. It was very therapeutic (Barry).

We got approached by I think it was News of the World paper in the UK... it was almost like a bit of a healing process for us, and allows to kind of shut the door on the whole experience as well, it was fairly cathartic actually (Dan).

Lack of Communication. This was a significant factor in the subthemes 'being unprepared', 'not knowing', and 'getting past it', and was fundamental to fathers' experiences. It was clear that a failure of communication between caregivers and fathers exacerbated their feelings of distress.

Discussion

Fathers in this study experienced a sense of marginalisation before, during, and after the traumatic childbirth. Communication between medical teams and fathers was perceived to be lacking at all stages of childbirth. Fathers were traumatised from witnessing birth procedures and felt they had not been adequately prepared for possible complications. Furthermore, they felt they had no control and received little communication during the birth. The impact of experiencing traumatic childbirth resulted in negative emotions, relationship difficulties, and fear of future pregnancies. In contrast, some fathers experienced posttraumatic growth from the traumatic childbirth. Coping strategies included finding comfort in religion, emotional detachment, and support from friends and family. The findings

of this study suggest that these factors contributed to the perception of trauma in the current sample.

The findings of major theme one, that witnessing childbirth trauma was an unknown territory, reflects findings from previous research (Harvey & Pattison, 2012; Hinton et al., 2014; Johnson, 2011; Nicholls & Ayers, 2007; Snowdon et al., 2012; White, 2007). Several subthemes emerged from this major theme, including 'being unprepared'. Because the events of childbirth are considered natural, fathers can go into the experience expecting a complication-free birth. The realism that medical interventions are routine and/or may be required isn't being conveyed during antenatal information sessions; some have suggested that most medical interventions are unnecessary and occur to meet the needs and/or timeframes of hospital systems rather than evidence based (safe) practice (Dannaway & Dietz, 2013). Childbirth, irrespective of medical interventions, is being perceived as a traumatic event to some fathers.

Further subthemes that emerged from the major theme 'witnessing trauma: Unknown territory', were 'out of control' and 'not knowing'. The findings of this study suggest that maternal caregivers marginalised fathers through creating a spectator role and gatekeeping information at all stages of childbirth. Nicholls and Ayers (2007) identified issues with external control (i.e., lack of involvement in decision-making, perceived control over staff duties), which was mirrored in the current study. Despite a primary absence of communication and support, fathers highly value it, causing fathers to feel undermined in their involvement at birth (Hinton et al., 2014). The information-deprivation and involuntary disconnect at birth gave the fathers a sense of disempowerment (Snowdon et al., 2012).

Johnson (2011) suggested that when fathers take on a passive, witnessing role during childbirth, they struggle to adjust. The second major theme, 'the aftermath: dealing with it' strongly supports this idea. A significant subtheme which emerged was 'the impact' wherein

fathers described the debilitating consequences that childbirth trauma had upon their life. To evade subsequent trauma, some fathers are going to the extremes by seeking medical procedures such as a vasectomy. Similar to women, experiencing childbirth trauma can extinguish a man's desire for more children (Allen, 1998). Some fathers who were interviewed face-to-face described posttraumatic growth as a result of their experiences. They described feeling emotionally stronger, and a strengthening in their relationship with their partner. Although a minority of online responders spoke of post-traumatic growth on their own volition, this was in contrast to some who only responded to the survey with very emotive answers. A possible explanation is that compared to the survey questions, the nature of the interview questions addressed personal growth (e.g. have you experienced personal growth in your life since the trauma?).

This subtheme 'the impact' also included relationship quality. In support of previous research, some fathers elaborated on how difficult it was to maintain a healthy relationship (Johnson, 2011; Nicholls & Ayers, 2007; White, 2007). The results of part one of this study found that fathers had slightly worse relationship quality with their partners compared to previous research of fathers in Australia (Author, 2014; Seymour et al. 2013). This suggests a convergence of results between the quantitative findings in part one and the current qualitative findings. Part one of this study further found that a number of mental health issues emerged in the postpartum, including clinically significant levels of depression (Author, 2014). Whether difficulties in the relationship contribute to a father's depression, or the depression is the cause of relationship difficulties remains to be investigated.

In further investigation of the impact of childbirth trauma on relationship quality, White (2007) identified that childbirth trauma can be sexually scarring. However, this was not reported by fathers in the current study. Given the high level of PTSD symptomatology reported in part one, a degree of emotional suppression may have been occurring that was not

evident in the qualitative responses. While emotional suppression is only one component of PTSD, the possibility that couples do experience intimate relationship difficulties should not be discounted, but should drive future research investigations. It may have been that fathers did not feel comfortable in addressing their intimate relationships.

Although numerous caregivers are present throughout pregnancy, only the professional conduct of midwives will be explored further, given their involvement was most frequently referenced by participants. According to the perceptions and experiences of the fathers in the current study, it is suggested that two conduct statements in the Code of Professional Conduct for Midwives in Australia (Nursing and Midwifery Board of Australia, 2008), may have been breached.

Conduct statement 4 states that “midwives respect the dignity, culture, values and beliefs of each woman and her infant(s) in their care, and the woman’s partner and family, and of colleagues”. Explanatory note 1 identifies respect as a key element, which was somewhat lacking according to the father’s responses. As suggested by Explanatory note 4, a competent midwife should plan effectively to respect and value each woman, “including partners”. It was the perception of many fathers that midwives did not include them throughout their planning of midwifery care.

Conduct statement 7 states, “midwives focus on a woman’s health needs, her expectations and aspirations, supporting the informed decision making of each woman”. Explanation notes 3 and 4 clearly state that this involves communicating with her family and partner about the “nature and purpose” of care. However, a common finding was that fathers were not involved in the decision-making process during birth. Midwives are to “give the necessary support, care and advice during pregnancy, labour and the postpartum period” in a woman-centred framework (International Confederation of Midwives, 2011). To be woman-

centred means providing information and support to those individuals – such as fathers – who are fundamental to the woman’s wellbeing.

Practical Screening and Support Mechanisms

The overall thrust emerging from the findings of the current study is that communication from healthcare teams to fathers before, during, and after childbirth is crucial. The following recommendations are created within the midwifery woman-centred framework, as all recommendations will ultimately empower the woman by strengthening her birthing partner’s ability to offer support:

1. During antenatal classes, midwives and educators prepare fathers for a realistic childbirth, introducing them to possible complications and discussing routine interventions. This is based on the theme which emerged in the current study “witnessing trauma: unknown territory”, with fathers experiencing frustration and uncertainty in the face of complications they felt unprepared for. The role of fathers during various birth scenarios and procedures is clearly demarcated;
2. It is strongly recommended that all fathers attend the 36-week midwifery appointment during pregnancy, as this is typically the birth planning session. The issues that fathers struggle with the most should be covered such as their expectations, involvement with decision-making, and coping throughout all events. This involvement is important, given the findings of the current study, in which fathers felt they had no control and were powerless during the birthing process;
3. Midwifery clinical guidelines need to make explicit the requirement of the midwife to support the woman’s chosen birth partner. In the current study, fathers felt that there was a serious lack of communication, particularly upon being separated from their partner/infant. During an emergency/ unexpected situation during childbirth, a staff member should be

allocated to be primarily responsible for caring for the chosen birth partner in the birth room.

Strengths

To the authors knowledge this is the ninth study investigating paternal mental health after a traumatic childbirth, and includes a qualitative aspect recommended by previous research. Another unique feature was the author's choice in neglecting to include a definition of trauma. Traumatic childbirth was self-defined because an individual can perceive childbirth to be traumatic despite not witnessing actual or threatened death, serious injury or sexual violation (American Psychiatric Association, 2013). This definition allowed the researchers to more fully investigate the dimensions of trauma.

Limitations

It is not known whether these were first time fathers, nor if there had been any subsequent births. The retrospective interviews and surveys is a limitation, in that fathers' responses could have been influenced by current moods, subsequent experiences to the childbirth, or treatment for mental health problems. Fathers that were interviewed were from the same ethnicity, and relatively socioeconomically homogenous; thus care should be taken when generalising the findings. It should also be noted that though insightful, qualitative data cannot necessarily be generalised.

Recommendations for Future Study

There are a number of recommendations for future research investigating paternal mental health subsequent to birth trauma. Inclusion criteria of a birth time-frame of fathers having the birth no later than one year previously would give greater understanding into initial problems during the transition to home. To examine this issue cross-culturally, non-English speakers of varied ethnographies should be researched. Studies comparing first-time fathers with fathers of more than one child on their perception of, and coping with childbirth trauma

would provide interesting avenues of research. Finally, randomised controlled trials of promising interventions to reduce paternal mental health issues in a pre-post study design are needed.

Conclusion

Given the dearth of research investigating paternal experiences of childbirth trauma, this study has offered a novel research contribution. 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. The sidelining of fathers before, during, and after childbirth requires action from healthcare workers and future researchers to allay this phenomenon.

Conflict of interest

The authors have no conflict of interest to declare.

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I would like to thank my two supervisors on this project. Thank you for your constant guidance and expertise.

To the fathers who were brave enough to share their traumatic childbirth experience: I feel privileged to have researched your families' personal lives, thank you. Your stories are incredibly important to share and will never be forgotten.

Appendix A

Possible Interview Questions with Fathers

Assessing Father's Expectations of Childbirth

1. Can you tell me about how you felt going into the childbirth experience?

2. Can you tell me how you were prepared for the childbirth, and possible complications?

Assessing Father's Experience of Traumatic Childbirth

1. Can you tell me of your experience during the birthing period?
2. Can you elaborate on why this birth was traumatic for you?

Assessing Father's Traumatic Response

1. Following the traumatic experience, how did you cope?
2. Can you tell me how the trauma impacted upon you?
3. *Following on* – Your family? Your relationship with your partner?

Assessing Father's Current Well-Being

1. How is your health status now? Was it influenced by the trauma?
2. Have you experienced personal growth in your life since the trauma?

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Figure 1. Thematic Map depicting the relationships between the Global Theme, Major Themes, and Subthemes.

Table 1 *Father's demographics* (N = 69)

Variable	<i>M</i> (SD)	<i>n</i> (%)
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%)

Highlights

- Fathers perceived themselves to be sidelined before, during, and after childbirth
- Lack of communication was central to perceiving childbirth as traumatic
- Greater antenatal information about childbirth is required for fathers

