

**PATERNAL POSTTRAUMATIC STRESS FOLLOWING CHILDBIRTH:  
TOWARDS A THEORETICAL MODEL**

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## Abstract

Previous research has established that fathers can develop posttraumatic stress disorder (PTSD) following witnessing their partner's labour and birth. This study aimed to develop a model of fathers' experiences of trauma following childbirth to identify factors contributing to the experience being perceived as traumatic and understand how fathers experience trauma symptoms in the postnatal period. A qualitative approach was adopted, using grounded theory methodology to explore first-time fathers' experiences of witnessing a subjectively identified traumatic labour and/or childbirth. Ten UK-based fathers were interviewed individually. Fathers either reported full symptoms of PTSD (n = 1), partial or clinically significant symptoms (n = 4), or met criteria for the experience being traumatic but had no symptoms of PTSD (n = 5). The emergent model consisted of six interacting theoretical codes highlighting antenatal, peri-traumatic (during labour and birth) and postnatal processes involved in the development and maintenance of paternal trauma following childbirth. Despite some similarities between the emergent theory and existing theories of PTSD and maternal PTSD following childbirth, comparisons between these models indicate factors that may be unique to the paternal experience. These include fathers' perceived responsibility to protect and support their partner and baby, the influence of partner emotions, shock when attempting to reconcile expectations and reality, the desire for information, preparation and support throughout the experience, and systemic factors and maladaptive coping strategies which act as barriers to fathers being able to process their experience in the postnatal period. The emergent model highlights important areas for development in clinical practice at

various stages of the maternity process and could inform formulation and treatment of fathers experiencing trauma following childbirth.

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## **Chapter 1: Introduction**

The aim of this research study was to explore the experiences of fathers who were present at, and perceived their partner's labour and childbirth to be traumatic. Whilst the literature exploring maternal trauma symptoms and experiences following childbirth is becoming well established, much less is known about the way that labour and childbirth is perceived and experienced as traumatic by fathers. Models of posttraumatic stress have been developed in the general posttraumatic stress disorder (PTSD) literature, and in the maternal literature specific to birth trauma. However, it is unknown whether existing models are applicable to the understanding of paternal posttraumatic stress disorder following childbirth (PTSD-FC). Based on research highlighting gender differences in processing and responding to traumatic events, it is possible that there may be differences in maternal and paternal experiences. This study aims to develop a theoretical model of paternal PTSD-FC which can then be compared to existing trauma theories.

This chapter will begin with a brief overview of the context of childbirth and postnatal mental health in the United Kingdom (UK), followed by an outline of the general and postnatal posttraumatic stress literature, and relevant conceptual issues. Given that the current study is explorative, qualitative research aimed at increasing understanding of experiences and symptoms of PTSD-FC will then be critically reviewed. Existing theoretical models of PTSD and their application to paternal symptoms following childbirth will be considered. Finally, the aims and rationale for the current study will be

presented, demonstrating how the study will expand knowledge and understanding of fathers' experiences of a traumatic labour and birth.

### **Contextualising childbirth in the UK**

Approximately 695,000 babies are delivered every year in England and Wales (Office for National Statistics (ONS), 2015) with 97% of these born in an NHS hospital (ONS, 2013). 60% of deliveries in NHS hospitals are spontaneous in onset and 14% are medically induced. For deliveries involving medical intervention, 13% require emergency caesarean section and a similar number require instrumental assistance (forceps or ventouse; Health & Social Care Information Centre (HSCIC), 2015). The majority of delivery episodes (69%) have a total duration of 2 days or less (HSCIC, 2015). The highest number of deliveries are recorded for mothers aged 30-34 (31%; HSCIC, 2015) with the average age of mothers being 30.2 years and fathers 33.1 years (ONS, 2015). The NHS approach to maternity care begins in the antenatal period where it is recommended that women have at least ten contacts with maternity professionals to monitor the health and wellbeing of the mother and baby and make plans for antenatal education, the birth, and postnatal care appropriate to their needs (National Institute for Clinical Excellence (NICE), 2006; NICE, 2008; NHS, 2015). Guidelines also exist outlining best practice for involving fathers in maternity care (Royal College of Midwives (RCM), 2011).

## **Postnatal Mental Health**

The transition to parenthood is often an emotional and challenging time that involves both men and women making significant psychological changes and adapting to new roles (RCM, 2012). For many parents, this is coupled with the positive experience of welcoming a new baby into the world. However, for others it is a more difficult time; parents who are in relationships often experience decline in relationship satisfaction following the birth of their first baby (Doss, Rhoades, Stanley, & Markman, 2009) and the transition to parenthood can have adverse effects on parental mental health, such as depression and anxiety (e.g. Brockington, 2004).

Postnatal depression (PND) and anxiety disorders can affect both women and men. However, whilst maternal postnatal mental health difficulties are becoming increasingly understood and recognised within services and society, paternal postnatal mental health difficulties are less well researched and understood. A recent study examining the transition to parenthood and mental health difficulties in first-time parents reported anxiety in 21% of women and 8% of men five months postpartum (Parfitt & Ayers, 2014). The same study reported postnatal depression in 11% of women and 8% men, and PTSD-FC in 5% of parents. The postnatal depression literature has established that there is high concordance of depressive symptoms within couples, with prevalence in fathers rising by 50% if their partner is also experiencing symptoms (Ramchandani, Stein, Evans, O'Connor, & ALSPAC Study Team, 2005).

The perinatal period is a particularly important time for a baby's development and forming parent-infant relationships. Mental health difficulties at this time can therefore have a particularly negative impact on child outcomes (Stein et al., 2014). For example, paternal postnatal depression is associated with an increased risk of emotional (i.e. sadness and worry) and conduct (i.e. hyperactivity) difficulties in children aged three, even when controlling for maternal depression (Ramchandani et al., 2005). The annual cost of perinatal mental health disorders per annual cohort to society and public services in the UK is estimated to exceed £8 billion (Bauer, Parsonage, Knapp, Lemmi, & Adelaja, 2014) therefore it is important that perinatal mental health experiences are better understood to inform appropriate interventions.

### **Posttraumatic Stress Disorder**

Up to 30% of individuals who identify an event as traumatic will develop PTSD (NICE, 2005). There has been much debate over the definition of PTSD as a diagnosis, particularly because it is alleged that it pathologises normal events, that the criteria are inadequate, that symptoms overlap with other disorders and that the diagnosis is etiologically heterogeneous compared to other disorders (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; Rosen, Lilienfeld, Frueh, McHugh, & Spitzer, 2010). However, the diagnosis filled an important gap in psychiatric theory and practice by positioning the etiology of symptoms outside of the individual and it is a diagnosis with a strong psychological and biological evidence base (Friedman, 2016). The definition of symptoms has allowed research to advance our understanding of

psychological responses to trauma and enhance clinical practice (Brewin et al., 2009).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association (APA), 2013), PTSD occurs following exposure to actual or threatened death, serious injury, or sexual violation. The exposure must result from direct experience, witnessing in person, indirectly learning that a close friend or relative was exposed to trauma, or having repeated or extreme indirect exposure to aversive details of the event usually through the course of professional duties. The disorder is characterised by specific symptoms occurring at least 1 month following the event, including re-experiencing, avoidance, negative cognitions and mood, and arousal (full diagnostic criteria are outlined in Appendix 1). These symptoms cause considerable distress and can negatively impact on individual functioning (NICE, 2005).

### **Changes to diagnostic criteria & implications for the current study**

There have been a number of revisions to the DSM criteria over the past three decades which have implications for conceptualising, detecting, and diagnosing PTSD. For example, earlier versions such as DSM-III (APA, 1980) listed the stressors that might produce PTSD and did not include childbirth as an event which could be considered 'traumatic'. However, more recent versions acknowledge the role of individual appraisals and focus on the event involving the *perception* of threat to life (DSM-IV; APA, 1994) which broadens

the range of experiences that could lead to the development of PTSD symptoms.

DSM-5 has modified the event criteria and symptoms required for a diagnosis compared to DSM-IV (APA, 1994). For example, Criterion A2 (APA, 1994) which specified that an individual must have responded to the traumatic event with intense fear, helplessness, or horror has been removed in DSM-5 due to being criticised as being overly specific (Brewin et al., 2009). The revised criteria also include an additional cluster of symptoms (Criterion D) relating to 'negative alterations in cognitions and mood associated with the traumatic event(s)' due to individuals with PTSD persistently experiencing negative mood states (Friedman, 2013).

These changes to the classification and symptoms of PTSD have implications for the literature reviewed for this study which has used measures and definitions based on DSM-IV criteria. Initial analyses comparing DSM-IV and DSM-5 criteria following exposure to traumatic events in a national US sample indicate that prevalence rates are similar (Kilpatrick et al., 2013). However, two large studies in the UK and Australia suggest that prevalence rates of PTSD-FC will increase due to the removal of A2 because many women perceive a threat of injury or death during birth and do not have an intense negative emotional response (Ayers, Harris, Sawyer, Parfitt, & Ford, 2009; Boorman, Grant, Gamble, Creedy, & Fenwick, 2014). These findings indicate that the prevalence of PTSD-FC may have been underestimated using DSM-IV and increasing numbers of individuals may now be able access appropriate

treatment because clinicians can focus on symptomology as opposed to whether the individual felt the 'right diagnostic emotions' at the time of the traumatic event (Brewin et al., 2009).

Changes to DSM criteria also necessitate changes to measures of PTSD. At the time of the current study, no measures of PTSD consistent with DSM-5 criteria had been validated for use following childbirth and this makes it difficult to accurately describe the sample in the current study and compare findings with previous studies.

### **Posttraumatic stress disorder following childbirth**

As previously mentioned, there is growing evidence that both men and women can develop PTSD-FC<sup>1</sup>. Research into PTSD-FC was initially based on clinical case reports indicating trauma symptoms following childbirth (e.g. Ballard, Stanley, & Brockington, 1995). Studies then began to identify possible risk factors, such as obstetric events (e.g. emergency caesarean section, instrumental assistance) elevating levels of posttraumatic stress as these could 'objectively' be seen as events which may be considered as traumatic (Ryding, Wijma, & Wijma, 1998). Although obstetric events are a risk factor for the development of PTSD-FC (Ayers, Bond, Bertullies, & Wijma, 2016), symptoms can also emerge following what would be perceived by maternity

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<sup>1</sup> A wide range of terms have been used to conceptualise symptoms consistent with trauma responses following childbirth (i.e. birth trauma, postnatal stress disorder, postnatal PTSD). On the recommendation of an international group of researchers in the field (Ayers et al., 2008), the term 'PTSD following childbirth' has been suggested as most appropriate and will therefore be used henceforth.



staff as a 'normal' birth (Beck, 2004a; Lemola, Werner, & Grob, 2007). Therefore, it is the subjective appraisal of threat to life that is important, not simply the presence of complicated obstetric events as was first thought (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008).

Prospective, longitudinal studies with large sample sizes have reported that over 30% of women perceive childbirth as traumatic (N = 499: Creedy, Shochet, & Horsfall, 2000; N = 103: Soet, Brack, & Dilorio, 2003). A recent meta-analysis suggested that PTSD affects approximately 3.1% of women after birth in community samples (N = 15,637) and around 15% of women in high-risk groups (N = 3,345; including those with a previous psychiatric history, preterm baby or those who have experienced a stillbirth; Grekin & O'Hara, 2014). Prevalence rates for PTSD-FC in fathers who were present during the labour and childbirth are less well established and limited by small sample sizes. Some studies report that between 5% (N = 32: Ayers, Wright, & Wells, 2007; N = 40) and 12% (N = 26; Parfitt & Ayers, 2009) of fathers develop symptoms consistent with a diagnosis of PTSD. Other studies report that fathers develop symptoms that are below diagnostic threshold level but are nonetheless distressing (Bradley, Slade, & Leviston, 2008; Skari et al., 2002). Conceptualising sub-threshold symptoms is addressed later in this chapter. Consistent with the literature for other mental health difficulties, studies have also indicated that trauma symptoms following childbirth are associated within couples, meaning that if one member of a couple is experiencing trauma symptoms, the other member is at a higher risk of

experiencing symptoms themselves (Ayers et al., 2007; Iles, Slade, & Spiby, 2011).

Symptoms of PTSD and depression show high lifetime co-morbidity in the general PTSD literature (Breslau, Davis, Andreski, Peterson, & Schultz, 1997; Shalev et al., 1998) and in the postnatal period for mothers (Stramrood et al., 2001; T. White, Matthey, Boyd, & Barnett, 2006) and fathers (Bradley et al., 2008). Given the addition of criteria describing negative alterations in mood in DSM-5, reported co-morbidity between symptoms of PTSD and depression in the postnatal period may in fact be a direct response to the traumatic event. There is a focus on postnatal depression in services and the literature which raises the possibility that individuals' symptoms are misdiagnosed as postnatal depression opposed to a trauma response. However, symptoms of PTSD and depression can occur independently of each other following traumatic events (Shalev et al., 1998). Given symptoms of both disorders are sequelae of traumatic events, separate exploration of the two is warranted but co-morbidity may make recruiting a 'pure' sample problematic and therefore it is an important consideration.

A recent review and meta-analysis of PTSD following other events (including accidental injury, interpersonal violence, and physical disease) suggests an average spontaneous recovery rate of 44% in the first 10 or more months after the event (Morina, Wicherts, Lobbrecht, & Priebe, 2014). However the few studies examining the course of PTSD-FC are focused on maternal symptoms and report inconsistent findings. Some studies find that symptoms

diminish over the first six months (Ayers & Pickering, 2001), whereas others report that symptoms remain stable over the first 12 months (T. White et al., 2006). The course and onset of comorbid postnatal PTSD and depressive symptoms for both men and women is also unclear. In the general PTSD literature, comorbidity is thought to reflect overlapping diagnostic criteria with depressive symptoms as an emotional response to loss encountered during trauma (Brewin, Hunter, Carroll & Tata, 1996). Similarly, the postnatal literature suggests that depression is usually secondary to PTSD-FC (McKenzie-McHarg et al., 2015). However, postnatal depression has also been found to predict PTSD-FC (van Son, Verkerk, van der Hart, Komproe, & Pop, 2005).

## **Conceptualising PTSD following childbirth**

### **Trauma responses on a continuum**

Studies into PTSD-FC have predominantly measured *symptoms* of PTSD as opposed to the full DSM criteria and few have examined trauma history, leaving questions about the incidence of PTSD-FC unanswered (Ayers & Ford, 2014). Whilst it remains to be established as to whether the phenomenology of PTSD-FC is the same as PTSD following other events, key researchers in the field have suggested broadening the focus of PTSD-FC to include clinically significant distress, therefore viewing trauma responses on a continuum (Ayers et al., 2008). Though universal diagnostic criteria are useful for research, more participants are likely to experience significant symptoms of PTSD but do not meet the full criteria. Despite concerns in the general

PTSD literature about over-pathologising and over-diagnosing trauma responses (McNally, 2003), sub-threshold symptoms can be distressing for individuals, impact negatively on individual functioning (McKenzie-McHarg et al., 2015) and often require intervention (Carlier & Gersons, 1995; Naylor et al., 2013). Studies examining symptom prevalence of PTSD-FC with large samples indicate that up to 30% of women (Czarnocka & Slade, 2000; Davies, Slade, Wright, & Stewart, 2008; Soet et al., 2003) and 12% of men (Bradley et al., 2008) develop clinically significant symptoms. Therefore, there are a significant proportion of men and women who may suffer significant distress but do not reach the symptom threshold required for a diagnosis and treatment.

Sub-threshold symptomology has been described as 'partial PTSD' in the general PTSD literature (Friedman, Resick, Bryant, & Brewin, 2011; Stein, Walker, Hazen, & Forde, 1997). Friedman and colleagues argue that partial PTSD should be included as a diagnosis in the DSM to facilitate treatment for individuals with clinically significant symptoms that impact on levels of distress or functioning. However, studies exploring the impact of sub-threshold symptoms on individuals are inconsistent as there has been no standardised definition of what constitutes 'partial' symptoms. Recently, McLaughlin and colleagues (2015) conducted the first large-scale study on prevalence and correlates of sub-threshold PTSD and found that partial PTSD is most usefully defined as meeting two or three of DSM-5 criteria B-E. Indicative of the impact of these symptoms, participants with partial PTSD had significantly elevated distress impairment, suicidality and comorbid mental health difficulties.

## **Distinguishing PTSD following childbirth with PTSD following other events**

Given that it is the subjective perception of threat that can lead to the development of PTSD opposed to a list of events that are objectively traumatic, any situation could have the potential to be perceived as traumatic (McNally, 2003). Furthermore, PTSD symptoms vary dependent on the type of index trauma (Graham et al., 2016; Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009) and cognitive and emotional valences of the traumatic event (Brewin & Holmes, 2003). This explains Brewin and colleagues' warning against attempting to "build a general vulnerability model for all cases of PTSD" (Brewin, Andrews, & Valentine, 2000, p. 756) as with other psychiatric disorders. Therefore, it is important to consider how PTSD-FC might differ from PTSD following other events.

Childbirth as a potential traumatic stressor differs in a number of ways from other traumatic events. For example, childbirth is usually a voluntary experience, is predictable, is experienced by the majority of women in society, and involves large physiological changes. Yet childbirth can involve physical violations that not all other traumatic events involve (Ayers et al., 2008). There is societal pressure for the birth of a baby to be a positive experience, therefore distress following childbirth is often associated with the loss of the experience and positive emotions expected which may make it different to other traumatic events (Ayers et al., 2008). Childbirth always involves at least

one other person – the baby. Therefore, not only can the experience lead to perceived or actual threat to the mother, there is also the potential for threat to the wellbeing of the baby.

Studies have begun to consider how symptoms of PTSD-FC might differ from symptoms following other traumatic events. For example, studies have identified higher levels of hyperarousal symptoms in women with PTSD-FC (Ayers, Harris, Sawyer, Parfitt, & Ford, 2009; Cigoli, Gilli, & Saita, 2006; Czarnocka & Slade 2000; Maggioni, Margola, & Filippi, 2006). However, this may be due to increased fatigue and physiological changes associated with childbirth (Ayers, Wright & Ford, 2015) and increased vigilance and parental preoccupation with the newborn (Leckman et al., 2004) opposed to an indicator of PTSD-FC. Studies have not explored symptoms in fathers in this way.

Childbirth tends to be excluded from studies exploring variability in symptoms across populations and events unless 'complicated or extraordinary' (e.g. Santiago et al., 2013). Manual comparison of the maternal PTSD-FC literature (Grekin & O'Hara, 2014) with prevalence rates for developing PTSD following other events (Breslau et al., 1998) indicate that the risk of developing PTSD-FC (3.1%) is lower than the risk of developing trauma following assaultive violence (20.9%), for example, or the general probability of developing PTSD following exposure to a traumatic event (9.2%) based on DSM-IV criteria. However, the risk of developing PTSD following witnessing someone be killed or seriously injured is higher (7.3%). Therefore, it is important to explore the

experiences of traumatic birth for fathers who may witness injury to their partner or child.

### **Gender differences in PTSD**

It is perhaps not surprising that paternal prevalence estimates of PTSD-FC will be lower than maternal rates as the general PTSD literature has highlighted that women are more likely to develop trauma symptoms than men (Breslau et al., 1998; Tedstone & Tarrier, 2003). One explanation for this gender difference is that women more often experience traumatic events that have a higher probability of developing PTSD (e.g. interpersonal assaults; Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Other explanations for gender differences in PTSD include differences between men and women in cognitive appraisal and coping processes. Meta-analyses of PTSD risk factors indicate that subjective appraisals of events better predict PTSD than objective facts (Brewin et al., 2000; Ozer, Best, Lipsey, & Weiss, 2003). Therefore, sex differences in the subjective experience and evaluation of the trauma, both during and following the event are particularly important (Spindler, Elklit, & Christiansen, 2010). Findings from numerous studies indicate that males report lower feelings of fear than women in similar traumatic events (e.g. Ehlers, Mayou, & Bryant, 1998; Rind, Tromovitch, & Bauserman, 1998). Furthermore, it has been suggested that gender differences in threat appraisal might contribute to differences between men and women's neurobiological responses to trauma (Rasmusson &

Friedman, 2002). Also related are differences in appraisals of control which is associated with PTSD (Baum, Cohen, & Hall, 1993; Dunmore, Clark, & Ehlers, 1999); men tend to report higher levels of perceived control (Mak, Blewitt, & Heaven, 2004) which is associated with a lower risk of developing PTSD. Women report lower levels of control and more self-blame for traumatic events (Tolin & Foa, 2002). Therefore, it is possible that fathers subjectively perceive and cope with a traumatic birth in a different way to mothers.

Studies have also explored differences in symptom patterns between men and women. For example, men have been found to be more likely to report externalizing symptoms such as conduct difficulties or substance use disorders (Kessler, Chiu, Demler, & Walters, 2005), and higher levels of irritability, impulsiveness, anger, or violent behaviour following traumatic events compared to women (Green et al., 1994; Kessler et al., 1995; Palm, Strong, & MacPherson, 2009). Although these findings are potentially confounded by differences in base rates of psychopathology, if sex differences in symptom patterns do exist, one possible explanation is that gender role expectations might be more supportive of certain symptoms in male participants and of others in females (Tolin & Foa, 2006). This has implications therefore for men's reporting of symptoms and the sensitivity of measures of PTSD.



### **Witnessing versus directly experiencing a traumatic event**

The DSM-5 makes no distinction between direct exposure to threatened death or serious injury and exposure to such an event through witnessing it in person (Criterion A; APA, 2013). A study of the 9/11 terror attacks found that both witnessing horror and sustaining injury were predictive of PTSD in a large sample (N = 3,271, 58.5% male; DiGrande, Neria, Brackbill, Pulliam, & Galea, 2011), with images encoded into memory similarly for both forms of exposure. Therefore, it is likely that fathers could develop PTSD symptoms from witnessing childbirth if they witness actual or threatened injury to their partner or baby and perceive the birth to be traumatic.

The requirement that for witnesses of a traumatic event, the victim had to be among family or friends was removed in DSM-IV (APA, 1994) which led to an increase in studies exploring PTSD symptoms in health professionals witnessing traumatic experiences, including midwives (Sheen, Slade, & Spiby, 2014). For example, a study of labour and delivery nurses in America (N = 464) reported that 26% had symptoms suggestive of a clinical diagnosis of PTSD according to DSM-IV (Beck & Gable, 2012). Qualitative studies have suggested a link between empathy with distress and traumatic stress in professionals (Goldblatt, 2009; Jonsson & Segesten, 2004) which is consistent with the notion that PTSD symptoms result from the interpretation of the meaning of the stressor (McNally, 2003). In terms of fathers witnessing threat to the integrity of a family member or partner one could assume that the increased empathy and personal connection could be a more potent predictor of trauma symptoms.

PTSD-FC is made more complex by the addition of potential threat of injury to the baby. Studies have demonstrated that parents can develop PTSD after witnessing injury to their child (e.g. following paediatric traffic injury; de Vries et al., 1999). However, comparing prevalence rates in these populations with PTSD-FC is problematic given the older age of the children and the influence of the child's own PTSD symptoms. Literature exploring PTSD in parents following admission of the baby to the neonatal intensive care unit (NICU) may be a more helpful comparison. For example, Shaw and colleagues (2009) measured PTSD symptoms in twelve mothers and six fathers after their babies had spent between 14-96 days in NICU. Four months post-discharge, 33% of fathers were 'likely' to have PTSD based on a non-diagnostic screening measure, with 67% 'at risk' for future development. Fathers' symptoms were higher than mothers' and although the sample was small, the authors hypothesised that fathers might delay their emotional response to protect mothers – another possible factor influencing the development of paternal PTSD-FC.

Similarly, the parental PTSD literature includes many studies on the development of PTSD following the death of a baby. For example, Turton et al. (2006) reported PTSD in 20% of fathers following stillbirth. Another study reported PTSD symptoms up to 5 years following pregnancy loss in 12% of fathers (Murphy, Shevlin, & Elklit, 2014). However, comparison of PTSD-FC with these studies is complicated by the actual loss of the child and associated grief response.

PTSD-FC is unique as a potential traumatic event given that there is the risk of harm to both the mother and baby, but that in the main, both survive. Therefore, it is important to explore fathers' experiences of witnessing childbirth and how they construct this experience as being traumatic.

### **Paternal PTSD following childbirth**

In England, 90% of fathers are present during labour (National Maternity Survey; Redshaw & Henderson, 2013) and there are a number of policies that advocate and support the involvement of fathers during pregnancy and childbirth (Department of Health (DH), 2007; NICE, 2006). However, few studies have explored the extent to which fathers may develop PTSD following being present at their partner's labour and/or witnessing the birth of their child.

Studies exploring transition to fatherhood have documented fathers' experiences during labour and childbirth. Studies find that fathers frequently feel helpless, useless and anxious during labour (Chandler & Field, 1997; Chapman, 1992; Greenhalgh, Slade, & Spiby, 2000; Hallgreen, Kihlgren, Forslin, & Norberg, 1999). A Finnish study (N = 107) demonstrated that whilst many fathers view the birth of their child positively, there is the potential for fathers to fear for loss of their partner or baby during childbirth (Vehvilainen-Julkunen & Liukkonen, 1998) which is consistent with Criterion A in the DSM-5 criteria for PTSD (APA, 2013). Therefore, fathers witnessing their partner's

labour and childbirth and perceiving threat to the wellbeing of the mother and/or baby could develop PTSD.

There are a limited number of studies reporting prevalence rates of PTSD-FC in fathers. Parfitt and Ayers (2009) explored PTSD-FC symptoms in fathers as part of a wider study and reported that 12% of men (N = 26) fulfilled DSM-IV criteria for a diagnosis of PTSD using the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) 1-24 months after the birth (mean = 10 months). This is in contrast to studies reporting no evidence of paternal PTSD-FC at six weeks (Stramrood et al., 2013) and six months postpartum (Skari et al., 2002). However, these studies are confounded by small sample sizes and the use of different measures of symptoms across studies limits comparisons within paternal studies and with maternal studies. Furthermore, Parfitt and Ayers' (2009) sample may be biased as more participants reported obstetric interventions than is representative of the UK birthing population.

Other studies have reported the prevalence of sub-threshold or clinically significant symptoms. For example, a longitudinal study which examined men's 'stress' levels (N = 53) using the Impact of Events Scale (IES; Horowitz, Wilmet, & Alvarez, 1979) during their partner's pregnancy, at birth, and six weeks postpartum reported higher scores at all time points compared to normative data for the IES, even when controlling for higher stress levels during pregnancy (Johnson, 2002). The study identified that stress levels were particularly high amongst men who felt they did not fulfil their role expectation or perceived pressure to be present at the birth. Consistent with

these findings and using the same measure, Ayers, Wright and Wells (2007) as part of a study exploring PTSD-FC in couples, found that 5% of men (N = 32) had 'severe symptoms' of PTSD at nine weeks postpartum. Multiple regression analysis indicated that intrusions and avoidance in both men and women were predicted by reports of delivery problems and emotions during birth. Although these studies used the IES which does not measure the full DSM criteria, the findings suggest mechanisms through which men may develop trauma symptoms.

Bradley and colleagues (2008) partially addressed the methodological flaws of previous studies by investigating the prevalence of paternal PTSD symptoms in a larger sample of men using a measure based on the full DSM-IV criteria and comparable with maternal studies, the Posttraumatic Stress Disorder Questionnaire (PTSD-Q; Czarnocka & Slade, 2000). At six weeks postpartum, no men (N = 199) reported symptoms consistent with a diagnosis of PTSD across all 3 DSM-IV dimensions. However, 12% reported clinically significant symptoms on at least one dimension – the highest frequency dimension being hyperarousal. Given there was a high drop out rate, this figure may be an underestimation of symptoms; men who dropped out were more likely to have not planned the pregnancy and be more distressed by the labour and birth, which in regression analyses were predictors of total scores on the PTSD-Q.

There is evidence for symptoms of PTSD-FC in fathers both at the full diagnostic and sub-threshold level at least six weeks postpartum which is indicative of a more chronic, opposed to acute, presentation (NICE, 2005).

However, it is difficult to establish prevalence rates because all of the studies use different questionnaires which are based on self-report and are not validated measures specifically for childbirth. Diagnostic criteria are also not always measured which limits comparisons with the maternal and general PTSD literature. As mentioned previously, where studies do use diagnostic criteria, measures are based on DSM-IV which may underestimate prevalence rates by excluding fathers who perceived threat or injury to their partner or infant but experienced a wider range of emotions to those in Criterion A2. Further research is needed that utilises clinical interviews (Ayers et al., 2008) and the most recent diagnostic criteria in order to better specify the prevalence of PTSD in fathers.

### **Understanding PTSD following childbirth**

Maternal PTSD-FC is becoming better understood with a number of qualitative studies which are more exploratory and have helped to describe and explain women's experiences, symptoms and individual appraisals (Ayers, Eagle, & Waring, 2006; Ayers, 2007; Beck, 2004b; Iles & Pote, 2015). However, few studies have explored fathers' experiences in this way. Given earlier discussions of childbirth differing from other traumatic events and gender differences in the processing of traumatic events, there may be differences in fathers' experiences of PTSD-FC compared to mothers' experiences. Greater understanding of fathers' experiences could allow for better recognition of the phenomenon by families and health professionals as

the postnatal depression literature has done (Tuszynska-Bogucka & Nawra, 2014).

In order to review the existing literature on fathers' experiences of PTSD-FC, a detailed literature search was conducted (for search terms and databases used see Appendix 2). The literature predominantly explores fathers' general experiences of childbirth. However, more relevant studies explore fathers' experiences of what the authors perceive to be potentially traumatic or complicated births, focus on subjectively identified traumatic birth, and explore symptoms of PTSD-FC in couples.

### **Paternal experiences of a potentially traumatic birth**

A literature review of paternal fears of childbirth (Hanson, Hunter, Bormann, & Sobo, 2009), including prospective and retrospective studies, indicated that the main fear for fathers across countries was the fear of harm to their partner or their partner dying during childbirth. An equally large proportion of fathers reported fear for their unborn child as their greatest fear. This is consistent with Criterion A of the DSM-5 (APA, 2013). Other frequently expressed concerns are fear from observing their partner in pain, feelings of helplessness, lack of knowledge about the process, and risk of interventions (e.g. operative delivery). The review indicated that fathers identify health-care providers as their primary source of information yet express the need for more support and reassurance that they are doing the right thing to support their partner during childbirth. They also express a desire for more information

about the feelings they will experience after birth. These antenatal fears of childbirth have the potential to influence the development of PTSD-FC given the possible influence of prior beliefs on cognitive processing during a traumatic event (Ehlers & Clark, 2000). However, most of the research related to paternal childbirth fears has focused on first-time fathers from White, middle-class backgrounds which limits the representativeness and generalisability of findings.

Similar findings are reported in a meta-ethnographic analysis of 23 qualitative studies exploring fathers' encounters with pregnancy, birth and maternity care (N = 719; Steen, Downe, Bamford, & Edozien, 2012). Six themes were generated from the data including 'risk and uncertainty', 'exclusion, fear and frustration', 'the ideal and the reality', 'issues of support', and 'experiencing transition'. The authors reported that most fathers saw themselves as being a partner and parent, wanting to support their partners and be fully engaged with the process of becoming a father. However, their experience of maternity care was often as 'not-patient and not-visitor'. This situated fathers in an undefined space both emotionally and physically, leaving fathers to feel uncertain, excluded, and fearful. These findings are relevant to the study of paternal PTSD-FC because they suggest that fathers want to be actively engaged in the labour/birth experience but this expectation can lead to a sense of trauma when events do not go well, were unexpected, or where men experienced dehumanising behaviour towards their partner (Steen et al., 2012). Whilst these two review papers offer some insight into how a birth



could become traumatic for fathers, they are not limited to the experiences of fathers who perceived their partner's labour as traumatic.

Elmir and Schmied (2016) conducted a meta-ethnographic synthesis focusing on fathers' experiences of complicated births that are potentially traumatic (N = 100). The authors report four key themes; 'the unfolding crisis', 'stripped of my role: powerless and helpless', 'craving information', and 'scarring the relationship'. Participants described fear and anxiety, feeling worthless and inadequate, and having insufficient information about the unfolding events. The birth experience subsequently impacted on relationships with partners and fathers had 'unresolved feelings' which referred to the ongoing impact of witnessing the trauma and being prevented from 'moving on' due to having little opportunity to talk about the experience. Some men described experiencing nightmares, flashbacks, and vivid recollections of the birth. These are symptoms consistent with the diagnostic criteria for PTSD (DSM-5; APA, 2013). However, none of the studies included in the analysis used a measure of PTSD symptoms. The authors also focused on obstetrically complicated births that they thought could be 'potentially traumatic', including 'near-miss' obstetric emergencies such as postpartum haemorrhage, caesarean section, and resuscitation of the baby at delivery. Given that the subjective perception of threat is important and not necessarily obstetric events (Ayers et al., 2008), the synthesis is limited and further exploration of the experiences of subjectively identified traumatic births is necessary.

G. White (2007) explored fathers' experiences of subjectively identified traumatic birth experiences (N = 21) using descriptive phenomenology. While not all fathers described symptoms of PTSD, all reported feeling distressed about their experience. White described how fathers 'cope by breaking down in private' and identified four themes: (1) 'it's not a spectator sport', (2) 'it's about being included', (3) 'it's sexual scarring', and (4) 'it's toughing it out'. Themes referred to fathers being constructed as a spectator rather than a participant which led them to feel alienated during childbirth. Fathers also felt excluded by maternity staff from decision making. Sexual activity was distressing and came to remind many fathers of the traumatic event. Finally, fathers tended to suppress emotional distress which led them to feel anger, shame, humiliation, and helplessness. White reports that at least three, but possibly five, of the participants appeared to demonstrate a 'probable' diagnosis of PTSD according to DSM-IV. However, no standardised measure of symptoms was used which makes applying these findings to the paternal PTSD-FC population problematic. There was also a large variation in time since birth; some participants were only 2 weeks postpartum and therefore possibly presenting with acute distress. Others were over 30 years postpartum which makes it difficult to separate factors specific to the birth and the influence of subsequent life events which could have affected participants' memory and appraisals of the event. Participants also varied in the number of previous children they had (0-4). Given that the literature on paternal PTSD-FC is in its infancy, it would be helpful to restrict the sampling criteria in order to better situate the sample, and understand for whom emerging findings may generalise to.

### **Paternal experiences of PTSD following childbirth**

Only one study qualitatively exploring the experiences of fathers who perceive their partner's labour and childbirth as traumatic has objectively assessed trauma symptoms. Nicholls and Ayers (2007) explored the experiences and perceived impact of a traumatic birth and PTSD-FC in six couples using semi-structured interviews. Three of the six men fulfilled DSM-IV criteria in the first year after birth and two couples reported PTSD in both partners using the PDS (Foa, 1995). Thematic analysis identified 4 themes; birth factors (pain, negative emotions, lack of control), quality of care (lack of information, poor communication), negative effects on relationship with partner (intimacy, level of support, communication, emotions), and negative impact on relationship with child (mother-child and/or father-child). Men reported more feelings of helplessness and shock than women who reported more fear. Participants reported loss of intimacy, with men feeling rejected and helpless.

The study highlights factors specific to our understanding of PTSD-FC and alludes to potential similarities and differences between mothers and fathers' experiences. However, the findings are again limited with the wide variation in time since birth (<2 years-10 years). Furthermore, due to the way the data are presented, it is not possible to separate themes completely between men and women or between symptoms occurring due to witnessing the birth, being secondary to living with a partner with PTSD, or general difficulties with the transition to parenthood. Whilst thematic analysis allows for broad analysis of

the data in this study, the methodology does not allow for the themes to be developed further (Braun & Clarke, 2006).

It is important that fathers' experiences of PTSD-FC are explored further given the potential impact PTSD symptoms may have in terms of distress and negative effects on daily functioning (NICE, 2005). From the literature reviewed, there is evidence to suggest that the psychological responses of men and women following childbirth are strongly interlinked, with men's symptoms affecting the mental health of their partner (Iles et al., 2011). Currently services tend to only target the mother but greater understanding of fathers' experiences could lead to better prevention and early identification of symptoms for both parents. There is also emerging evidence to suggest the negative impact of parental trauma symptoms on the parent-baby relationship (Nicholls & Ayers, 2007) and infant development (Ramchandani & Psychogiou, 2009) but better knowledge of fathers' symptoms is required before drawing firm conclusions.

### **Theoretical models of PTSD**

Relevant theories of PTSD have the potential to contribute to broadening our understanding of PTSD-FC. General theoretical models describing the development and maintenance of PTSD symptoms after traumatic events in other populations include cognitive (Ehlers & Clark, 2000) and neurobiological models (Brewin, 2001), social theories (Charuvastra & Cloitre, 2008), and stress theories (Lazarus & Folkman, 1984). Though limited to the maternal

population, the literature is now beginning to apply some of these frameworks to PTSD-FC. This section will outline key general and maternal theories of PTSD and discuss their relevance to the paternal population.

The diathesis-stress framework (Lazarus & Folkman, 1984) proposes that the characteristics of the traumatic event interact with individual vulnerability or strength to determine whether or not a person develops PTSD. Sex and gender have been implicated as biological factors in the development of PTSD, including who might be at greater risk for developing the disorder (McKeever & Huff, 2003). Diathesis-stress theories have been proposed to explain the aetiology of maternal PTSD-FC (Ayers et al., 2016; Ayers, 2004; Ayers & Ford, 2014; Slade, 2006). Ayers and colleagues (2016) recently conducted a meta-analysis (N = 21,429) of risk and vulnerability factors for PTSD-FC. The authors updated the diathesis-stress model to include factors most strongly associated in the interaction between individual vulnerability prior to birth (e.g. history of PTSD and/or PND, poor health and depression in pregnancy, fear of childbirth, counselling in pregnancy), risk factors during birth, (e.g. subjective birth experience, operative birth, lack of support, dissociation), and factors influencing the resolution or maintenance of symptoms over time (e.g. poor coping and stress). Diathesis-stress frameworks are helpful as they emphasise both the importance of appraisal in stress responses (Ayers, 2004) and obstetric factors (Ayers et al., 2016). However, such frameworks have not been tested in their entirety with mothers (Ayers & Ford, 2014) nor applied to paternal PTSD-FC. The qualitative literature reviewed suggests that men feel helpless and excluded during

childbirth which are factors that could precipitate the development of PTSD-FC through a similar interaction with existing vulnerability and appraisal of the labour and birth experience as traumatic.

Similar to vulnerability and risk models, in the general PTSD literature a gender-differentiated traumatic-stress-coping model has been proposed to explain gender effects in PTSD (Olf, Langeland, Draijer & Gersons, 2007). The model highlights the role of personal, social, and cultural vulnerability factors (e.g. genetics, gender role orientation, trauma history), their impact on coping (e.g. social support, coping styles) and the bidirectional influences between coping with, exposure to, appraisal of, and psychological and biological responses to traumatic events (e.g. anxiety, distress) and subsequent outcomes (e.g. health, behaviour). The authors make suggestions for clinical practice, such as gender-specific interventions, which lends support for the need to better understand paternal PTSD-FC as it is likely there may be factors specific to the male experience.

Cognitive models of PTSD, such as Ehlers and Clark's (2000) model are widely used for understanding and treating PTSD and have been more rigorously tested and applied to PTSD-FC. Ehlers and Clark propose that PTSD occurs when an individual processes the trauma in a way that leads to a sense of current threat arising from: negative appraisals during and subsequent to the trauma, inadequate integration and elaboration of memories for the event, strong associative memory, and strong perceptual priming. Change in cognitive processes and memory are prevented by a

series of dysfunctional cognitive and behavioural strategies. Not only is the model consistent with the main clinical features of PTSD but it provides the most detailed account of the maintenance and treatment of PTSD and has been strongly and consistently supported by empirical research (Brewin & Holmes, 2003). For example, the model has been found to account for 71% of the variance in trauma symptoms six months later in individuals developing symptoms following personal assault (Halligan, Michael, Clark & Ehlers, 2003).

A small number of studies have begun to explore the applicability of the cognitive model to PTSD-FC. Using structural equation modelling, Ford, Ayers, and Bradley (2010) found that the model accounted for 23% of the variance in maternal acute stress symptoms at three weeks postpartum but dropped to just 9% at three months. When social support (partially mediated by posttrauma cognitions) was added to the model, an extra 7% of the variance was explained. So whilst the cognitive model goes some way to explaining maternal PTSD-FC symptoms, other factors are clearly important. A more recent study developed a new postnatal model of PTSD using factors identified in previous maternal research (e.g. pregnancy wellbeing, age, pain, peritraumatic emotions, social support) alongside the cognitive factors in Ehler's and Clark's model (Vossbeck-Elsebuch, Freisfeld & Ehling, 2014). When exploring the predictive power of this model in a maternal sample (N = 224) between one and six months postpartum, wellbeing during pregnancy and age emerged as significant prenatal variables, and when combined with birth-related variables (peritraumatic emotions and general wellbeing during

birth), accounted for 33% of trauma symptoms. In contrast to Ford and colleagues, social support did not add to the predictive power of the model. However, cognitive variables significantly accounted for a proportion of variance in symptoms, increasing the predictive value to 68%. This suggests that a combination of factors identified in the maternal PTSD-FC literature and factors in the cognitive model of PTSD can explain, to some degree, PTSD-FC symptoms. However, a proportion of the variance remains unexplained and findings vary between studies.

Iles and Pote (2015) sought to identify whether other factors unique to the maternal experience and context of childbirth emerged whilst developing a theoretical model of maternal PTSD-FC. Using a qualitative grounded theory design, 11 first-time mothers who subjectively identified their labour and childbirth as traumatic were interviewed to explore their experience of pregnancy, labour, birth, and the postpartum. All mothers reported symptoms that were either fully or partially consistent with DSM-IV criteria for PTSD on the PTSD-Q. Five overall themes emerged from the data which were arranged into a theoretical model explaining symptoms in terms of predisposing (antenatal), precipitating (peri-traumatic) and maintaining (postnatal) factors. Whilst some of the factors are consistent with those included in Ehlers and Clark's model (e.g. prior experiences and beliefs, processing during the event, post-event appraisals), the model highlights factors very specific to the perinatal period. For example, antenatal expectations and anxieties, constructions of the experience, perceptions of other people's views, social support, and adaptive and maladaptive coping



strategies. The study demonstrates that there are specific adaptations to the existing cognitive model which could be helpful when understanding and treating maternal posttraumatic stress. Whilst the qualitative design only allowed for a small number of women to be included, participants reported symptoms across a continuum of PTSD responses. Therefore, the model is applicable to all clinically significant symptoms, not just diagnosis which increases generalisability. However, a limitation is that the study did not collect information regarding previous psychological difficulties or prior traumatic experiences which may influence emotions and beliefs regarding pregnancy and birth (Grekin & O'Hara, 2014). The model has also not been tested with a larger sample of mothers.

The discussion of theoretical models suggests that there are factors specific to the perinatal context of PTSD-FC. Whilst these models aid understanding, formulation and treatment of mothers, it is unknown as to whether general and maternal models of PTSD adequately explain the development and maintenance of symptoms for fathers who witness and perceive their partner's labour and birth as traumatic. Factors identified in the maternal models could have some relevance for fathers. However, fathers are exposed to childbirth as a witness and there is evidence of gender differences in the development of PTSD. Therefore it is possible that there may be unique factors involved in the paternal experience, or factors in existing models that are less relevant for fathers.

## **The Present Study**

A number of studies have sought to explore paternal experiences of witnessing potentially traumatic labour and childbirth. However, to the author's knowledge, only one study has explored paternal PTSD-FC and measured symptoms using a validated measure of PTSD. Measuring symptoms of PTSD-FC is important given that prevalence rates in the paternal population remain inconsistent. Furthermore, an individual may describe an experience as being traumatic, but not go on to develop PTSD. Without an objective measure of symptoms based on DSM criteria it is difficult to know to whom the findings of a study can be generalised.

The current study built on the existing literature and addressed gaps and methodological inconsistencies in the conceptualisation of paternal PTSD-FC through the qualitative development of a theoretical model derived from fathers' experiences of witnessing a labour and birth they perceive as traumatic. Theoretical understanding of the experiences and symptoms of paternal PTSD-FC is highly relevant to aid identification, formulation and treatment. Paternal symptoms may manifest differently and alternative models may be needed to guide specific interventions for fathers, therefore it is important to further develop understanding in this area.

As this was a first step in further exploring paternal PTSD-FC, the current study narrowed the characteristics of the sample in order to better situate and focus the findings. First-time fathers with chronic, opposed to acute, symptoms of PTSD-FC according to DSM criteria were recruited between 3-

36 months following the birth. Fathers who subjectively identified witnessing their partner's labour and childbirth as traumatic and who met some or all of the criteria for a diagnosis of PTSD were interviewed to explore their experience of pregnancy, labour, birth, and the postpartum. The findings were then be used to develop a theoretical model of paternal trauma following childbirth.

### **Aims of the Present Study**

The study specifically aimed to:

1. Explore fathers' experiences of traumatic labour and birth through;
  - a. Understanding factors contributing to the experience being perceived as traumatic
  - b. Identifying how fathers experience trauma symptoms in the postnatal period
  - c. Identifying risk and protective factors for the development and maintenance of symptoms
2. Develop a theoretical model of paternal PTSD-FC and compare the emergent theory with existing trauma theories in order to;
  - a. Identify whether new factors emerge specific to the paternal population and unique to the context of childbirth
  - b. Identify whether factors in existing theories (general and maternal) are relevant for fathers

## **Chapter 2: Method**

### **Design**

Consistent with the aims of the research, an exploratory, qualitative design was utilised. Interviews were conducted with ten first-time fathers who reported witnessing their partner's labour and childbirth as traumatic. Charmaz's (2014) social constructivist version of grounded theory was the chosen qualitative methodological approach adhered to through design, recruitment, and analysis.

### **Choice of methodology**

#### **Qualitative analysis: Grounded Theory**

A qualitative approach was chosen as the most appropriate methodology to construct a theoretical understanding of paternal PTSD-FC based on individual meanings, appraisals and constructions (Charmaz, 2014).

Qualitative methods are also suited to generating knowledge about areas that have received limited research attention (Smith, 2007) and so it seemed appropriate for the current study given the paucity of literature exploring PTSD-FC in fathers.

Grounded theory is an approach to qualitative research developed by Glaser and Strauss (1967) emphasising individual experiences and perceptions. The approach analyses data systematically in order to generate a theory grounded in the data.

### **Rationale for selecting grounded theory**

Grounded theory was chosen as the most compatible qualitative methodology to meet the research aims of this study for several reasons. Grounded theory enables the researcher to develop a theory to explain experiences, concepts and categories arising directly from the data. The theory can then be compared to existing literature and models (Glaser & Strauss, 1967; Glaser, 1998) which will enable comparison of the emergent theory with existing trauma theories.

Although grounded theory was considered most appropriate, other qualitative methods were considered when designing the current study and are briefly outlined below.

### ***Interpretative Phenomenological Analysis (IPA)***

IPA is an approach that seeks to understand experiences through interpreting data to hypothesise the meaning a participant ascribes to it (Larkin & Thompson, 2011; Smith, Flower, & Larkin, 2012). IPA therefore goes beyond the data opposed to developing an understanding and constructing a theory which is grounded in the data. Given the lack of research into paternal experiences, it seemed more appropriate to remain close to the data to ensure fathers' experiences are reflected as accurately as possible (Glaser & Strauss, 1967).

### ***Discourse Analysis (DA)***

DA examines the way language is used to construct the reality of an individual's world (Giles, 2002). The approach assumes that multiple realities of the world exist, shaped by existing knowledge or discourses. Whilst underpinned by social constructionism, which is consistent with the current study, the emphasis placed on broader societal narratives could detract from the aim of exploring individual experience and meaning.

### **Divergent methods in Grounded Theory**

Grounded theory methods have evolved and been taken in divergent directions since the initial inception of the approach in the 1960s. Earlier versions were based on a positivist epistemology (focusing on uncovering objective truths and realities) whereas more recent approaches are defined by post-positivist, interpretivist epistemology (allowing for multiple constructions of experiences based on individual perceptions and meanings opposed to a universal reality; A. Bryant & Charmaz, 2007). Charmaz (2000) has taken a social constructivist<sup>2</sup> approach to grounded theory which challenges the classic notion that grounded theory can be used to discover objective truths in data and argues instead that neither data or theories are discovered, but are constructed by the researcher and the participant. Factors such as age, gender, culture, and individual experience affect both the way a participant

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<sup>2</sup> N.B. Constructivism and constructionism are defined differentially in the UK, but not in the US. Grounded theory approaches described as constructivist in the US are consistent with the contemporary social constructionist approaches in the UK (Tweed & Charmaz, 2012). For consistency, constructivist grounded theory will be referred to as social constructionism hereafter.

chooses to tell their story and the way a researcher makes sense of the data (Charmaz, 2014).

### **Rationale for selecting Charmaz's social constructivist approach**

The constructivist approach was selected for the current study because it considers the role and involvement of the researcher, allows for more methodological flexibility and is sensitive to changing contexts (Tweed & Charmaz, 2012). Not only is this appropriate given the area of research is so under-defined, but it fits with the constraints of a Clinical Psychology Doctoral study as discussed in further detail below.

### **Research sensitivity & reflexivity**

Charmaz emphasises the role and influence of the researcher on the topic studied, the data collected, and analysis produced (Charmaz, 2014).

Therefore, the researcher maintained a reflexive stance by considering how their interactions, positions, values, and experiences influenced the research process.

The researcher adopted a critical realist social constructionist position, promoting the existence of multiple constructions of individual experiences which fits with Charmaz's approach. The researcher thought that this position was particularly important given the lack of understanding of paternal postnatal trauma experiences and recognised that the emergent theory would

not be a universal truth but a first-step towards increasing our understanding of paternal PTSD-FC.

As the current study was completed as part of a Doctorate in Clinical Psychology it was an essential requirement to conduct a literature review prior to commencing data collection. Therefore it was not possible to enter into the research process without pre-existing knowledge, as recommended by earlier versions of grounded theory (Glaser & Strauss, 1967). At the time of carrying out the research, the researcher was also working clinically with mothers and fathers in a perinatal setting and had been exposed to some reports of difficult and traumatic birth experiences. The researcher was interested in antenatal and postnatal experiences generally and had previously considered a career in midwifery. She had several friends who had recently experienced childbirth and had engaged in open conversations about this with them but had not witnessed a birth; traumatic or otherwise. Based on experience and the literature reviewed, the researcher entered the study with some knowledge of fathers' general experiences of childbirth but very limited knowledge of fathers' experiences of traumatic childbirth given that most of the literature and services are focused on mothers' experiences.

The researcher was a White, female Trainee Clinical Psychologist and therefore differed from participants in several ways, particularly in terms of gender. Unlike the participants, the researcher was not a parent but intended to start a family in the future. This may have influenced the researcher's assumptions and interpretations of participants' experiences. The researcher



was aware of the need to 'own their perspective' (Elliott, Fischer, & Rennie, 1999) and acknowledged that their experiences would influence the way in which the data was 'co-constructed' between them and the participants (Charmaz, 2014). In order to remain reflexive and sensitive to these issues, the researcher kept a research diary from the inception of the research and actively reflected on her position to consider its impact in the research process. Thoughts and reflections were discussed in both research and peer supervision on multiple occasions throughout the study (see Appendix 3 for extracts).

### **Credibility checks**

A peer supervision group was established with several other Trainee Clinical Psychologists who were also using grounded theory methodology. Peers commented on codes, categories and models which was extremely useful. Supervisors also commented on analysed transcripts, emergent concepts and categories, and a draft model. Following data analysis, the emergent theory was validated with a sample of participants to further enhance credibility.

### **Ensuring quality in qualitative research**

Qualitative research methods in psychology have been criticised for lacking scientific rigour, relying on anecdotal evidence, and lacking reproducibility and generalisability (Mays & Pope, 1995). However, it has been argued that due to the different epistemological positions of qualitative and quantitative methodologies, the approaches should not be judged in the same way

(Chamberlian, Stephens, & Lyons, 1997; Henwood & Pidgeon, 1992). As a response to the various criticisms of the methodology, researchers working within the qualitative field have attempted to develop evaluative guidelines for use with qualitative approaches (e.g. Elliott et al., 1999; Henwood & Pidgeon, 1992). The current study used the guidelines developed by Elliott and colleagues (1999) and Charmaz's (2014) criteria for evaluating grounded theory studies to ensure methodological rigour.

## **Procedure**

### **Ethical approval**

Ethical approval was granted by the Royal Holloway University of London Psychology Department Ethics Committee (see Appendix 4). The main ethical considerations and issues that arose were as follows:

- **Informed consent & right to withdraw:** Participants were provided with detailed information about the study to make an informed decision about participation (see Appendix 5). All participants were given the opportunity to ask questions about the research before participating. Participants were made aware throughout the study that their participation was voluntary and that they had the right to withdraw from the study at any time without having to provide a reason or explanation. Consent was obtained in two stages; electronically prior to completion of the online questionnaires and subsequently written consent to participate in a semi-structured interview (see Appendix 6).

- **Confidentiality:** Anonymity of participants' identities was maintained at all times. Participants were informed about confidentiality and its limits (e.g. should a participant identify a risk to themselves or others). Participants were informed that their data would be kept confidential from their partner who may have also taken part in the first part of the study by completing initial questionnaires.
- **Emotional distress & debriefing:** Participants were able to take breaks as necessary during the interviews. All participants were provided with a debrief sheet at the end of the interview outlining sources of support and emergency contacts (see Appendix 7).
- **Risk & safeguarding:** All participants were required to provide their GP details in case of immediate risk to a participant's safety or that of someone else. The researcher also followed a lone working and risk protocol should urgent risk issues arise whilst with a participant (e.g. disclosure of risk, potential risk to the researcher; see Appendix 8). The researcher contacted the GP for two participants (one father and one partner of a participant) following discussion with the individuals concerned due to elevated scores and risk information disclosed on the initial questionnaires. Three other participants with elevated scores were encouraged to speak to their GP.
- **Professional boundaries:** Participants were informed that the interviews were being conducted for research purposes, not to provide treatment. If participants asked for further therapeutic support they were signposted to other services using the contacts on the debrief sheet.

## **Recruitment procedure**

### **Initial inclusion criteria**

The following inclusion criteria and rationale were applied when recruiting participants into the study:

#### **1) *First-time fathers:***

The researcher decided to focus on the experiences of first-time fathers to focus the sample. The maternal literature suggests that multiparous mothers may have a different experience of birth to primiparous mothers (Czarnocka & Slade, 2000) and men with previous children report reduced trauma symptoms than first-time fathers following childbirth (Bradley et al., 2008). Therefore, the researcher considered it likely that first-time fathers experience the birth of their first child differently to subsequent births. However, imposing this criterion means that the emergent theory may only be applicable to first-time fathers.

#### **2) *Healthy children:***

The researcher chose to only include fathers whose baby had been well at the time of birth and had not been admitted to special care for more than 24 hours. This criterion was adopted as the literature suggests that having a baby admitted to special care may be perceived as traumatic itself (Holditch-Davis, Bartlett, Blickman, & Miles, 2003; Shaw et al., 2009). The researcher wanted to ensure that the traumatic experience explored was not potentially

complicated by the experience of having a child in special care and any associated ongoing difficulties.

### **3) *Child born 3-36 months ago:***

The maternal literature varies a great deal in terms of the length of time since the birth experience. Whilst a shorter time frame may increase the richness of memories and increase the depth of data collected, longer time frames may provide some insight into the longitudinal course of symptoms. The NICE guidelines (2005) recommend 'watchful waiting' for individuals presenting with trauma symptoms for 1 month following the traumatic event and there are some data to suggest that trauma symptoms decrease initially but that spontaneous remission is unlikely beyond 3 months post-trauma (J. Davidson & Fairbank, 1993). Therefore, it was decided that the birth should have occurred at least 3 months ago. The upper limit of 36 months was chosen as a middle ground between the time frames used in the maternal literature. It was hoped that this more focused time span would allow for better recall and reduced likelihood of other traumatic events or subsequent children.

### **4) *Diagnostic threshold:***

The study aimed to recruit participants experiencing symptoms on a continuum of trauma responses in line with recommendations made for research in this field (Ayers et al., 2008); therefore including participants with full or partial symptoms of PTSD which were assessed using the initial screening questionnaires. Participants were required to fulfil both parts of

'Criterion A' of the DSM-IV (1994) criteria for a diagnosis of posttraumatic stress disorder:

- Participants witnessed some or all of their partner's labour and childbirth and perceived a threat to their partner or their infant's life or physical wellbeing (A1);
- And they responded with intense fear, helplessness, or horror (A2).

### **Changes to inclusion criteria**

Due to recruitment difficulties, the inclusion criteria were changed slightly as the study progressed to be more inclusive of a wider range of participants. For example, whilst the original criteria excluded participants whose baby had been admitted to special care, one father expressed an interest in the study whose baby had spent eight days in special care with a well-managed infection. As he felt able to focus predominantly on the labour and birth rather than the subsequent special care admission in the interview, he was included in the study.

The inclusion criteria were also broadened to include participants who fulfilled Criterion A but were not experiencing any ongoing symptoms of PTSD. It was thought that this would facilitate exploration of what made the experience traumatic and identify potential protective factors which prevented participants from developing PTSD symptoms.

Increasing the inclusivity of participants was in keeping with grounded theory methodology which proposes that participants should be chosen based on theoretical interest to allow for more information to be discovered (Charmaz, 2014). Modifications to the inclusion criteria allowed for greater exploration of fathers' experiences of a labour and childbirth which they perceived as traumatic, despite not fulfilling the full diagnostic criteria, without losing sight of the initial aims of the study.

### **Recruitment**

A UK-based community sample of first-time fathers was recruited through websites, online networks supporting new parents, and disseminating flyers (see Appendix 9). As sources aimed specifically at fathers are scarce, some of the forums and websites were aimed primarily at mothers and the researcher anticipated that some participants may have been recruited through their female partner.

The recruitment information advertised included a brief description of the study, the researcher's contact details and a link to the study website (see Appendix 10). Interested participants could either contact the researcher for more information or take part in the first part of the study by completing the initial questionnaires via the website. Participants were also given the option to have paper versions of the information sheet, consent form and questionnaires sent to them if they provided their postal address though no participants chose to do this.

Whilst there was a steady flow of interest to the website, with 1321 visitors recorded during the recruitment period July 2015 – March 2016, only 86 visitors clicked through to participate in the initial questionnaires and of these, 18 participants completed the questionnaires. Difficulties with recruitment and potential barriers to participation are discussed in Chapter 4.

### **Sampling and theoretical saturation**

In grounded theory, recruitment of participants should be purposeful and theoretically driven with participants selected for interview in order to answer questions arising from insights gained from previous interviews (Charmaz, 2014). However, due to the sporadic nature of recruitment this was not always possible. Grounded theory also aims to collect data until ‘theoretical saturation’ is achieved; the point at which data collection reveals no new information about the emerging theory (Charmaz, 2014). However, due to time constraints and recruitment challenges, the study aimed to reach ‘theoretical sufficiency’ (Dey, 1999).

### **Data collection**

#### **Screening questionnaires**

Screening questionnaires collected basic demographic information about participants and details about the labour and birth (see Appendix 11).

Questionnaires were also used to assess symptoms of posttraumatic stress (Posttraumatic Stress Disorder Questionnaire, PTSD-Q; Czarnocka & Slade,



2000) and postnatal depression (Edinburgh Postnatal Depression Scale, EPDS; J. Cox, Holden & Sagovsky, 1987). Psychometric properties of these scales and rationale for their use are outlined below.

Whilst qualitative methodology and epistemology does not routinely advocate the use of questionnaires, collecting this information allowed the researcher to check participants were eligible and met the inclusion criteria before selecting participants for interview. Having this information also allowed for the sample to be situated; increasing homogeneity and identifying for whom the results might apply to.

#### ***Posttraumatic Stress Disorder Questionnaire (PTSD-Q)***

The PTSD-Q (Czarnocka & Slade, 2000) is a self-report questionnaire adapted from the PTSD-I (Watson, Juba, Manifold, Kucala, & Anderson, 1991) to assess symptoms of PTSD-FC. The measure uses 17 items to assess the frequency of intrusions, avoidance, and hyperarousal (based on diagnostic criteria for PTSD according to the DSM-IV). Symptoms are considered clinically significant if they occur at least 'commonly'. A minimum of 1 intrusion item, 3 avoidance items and 2 hyperarousal items occurring at least 'commonly' are indicative of a diagnosis of PTSD. Czarnocka and Slade (2000, cited in Iles & Pote, 2015) reported high internal consistency (alpha = .92), test re-test reliability ( $r = .95$ ), and diagnostic agreement (87%) of this scale (n=264).

The scale also includes questions to assess whether participants met Criterion A of the DSM-IV diagnostic criteria which was an important inclusion criteria in the current study. Although there have been recent changes to DSM criteria, at the inception of this study no measures reflecting these changes had been validated for use in the postnatal period. Given that DSM-IV criteria can be used to approximate a diagnosis according to DSM-V (Rosellini et al., 2015) and the PTSD-Q has been previously used in research into postnatal posttraumatic stress for both maternal (Iles & Pote, 2015) and paternal populations (Bradley et al., 2008), it was selected as appropriate for use in the current study.

'Partial' PTSD was classified using McLaughlin and colleagues' (2015) definition: a participant must meet 2-3 of the DSM-5 criteria B-E (e.g. two or more of the following; 1 intrusion item, 1 avoidance item, 2 negative alterations in mood; 2 arousal items).

### ***Edinburgh Postnatal Depression Scale (EPDS)***

The EPDS (J. Cox et al., 1987) is a well validated 10-item self-report screening tool for symptoms of postnatal depression. It has been widely used in research and clinical settings with women and has also been validated for use with men (Matthey, Barnett, Kavanagh, & Howie, 2001). The EPDS has 10 statements with respondents asked to choose one of four possible options to reflect how they have been feeling within the last week. Scores range from 0-30, with higher scores representing higher symptom frequency. In women,

scores of 13 and above are generally used to indicate 'at risk' cases for postnatal depression, with satisfactory sensitivity and specificity (J. Cox et al., 1987). In men, the optimal cut off point for screening for depression is 10, with good sensitivity (89.5%) and specificity (78.2%) reported using a UK sample against a structured clinical interview (Edmonson, Psychogiou, Vlachos, Netsi, & Ramchandani, 2010).

The EPDS was chosen to further situate the sample given evidence to suggest that symptoms of PTSD and depression are often co-morbid. Furthermore, changes to diagnostic criteria for PTSD in DSM-V include the additional category of symptoms focused on negative alterations in cognitions & mood associated with the traumatic event (APA, 2013) and it was thought that this measure could provide some indication of these symptoms.

### **Partner Questionnaires**

Participants who were selected for interview were asked to consent for their partner (the mother who delivered their child) to be invited to complete the two screening questionnaires (PTSD-Q and EPDS). This was to further describe the characteristics of, and situate the sample. Participants were not excluded from the study if their partner did not wish to participate or did not complete the questionnaires.

Six partners were reported by participants to be interested in taking part and were sent an electronic link via email to complete the screening questionnaires. Four partners completed the questionnaires.

### **Interviews**

Semi-structured interviews were selected as the method of data collection. A semi-structured interview schedule was developed prior to data collection with a mixture of open-ended and direct questions to enable new concepts to emerge as well as addressing specific gaps and questions (see Appendix 12). Questions aimed to elicit participants' expectations, thoughts, feelings, beliefs, and behaviours during the antenatal, labour and childbirth, and postnatal period. Questions exploring the specific processes and symptoms known to be implicated in posttraumatic stress such as intrusions, avoidance, and hyperarousal were included to allow for later comparison of the data with existing trauma theories.

The screening questionnaires and interview schedule were reviewed by two first-time fathers known to the researcher to assess the acceptability of questions. Two professionals (a midwife and a doula) also reviewed the interview schedule to ensure that all aspects of the antenatal and postnatal periods had been adequately covered.

The researcher conducted all the interviews at a place and time convenient to the participant. Participants were given the option of completing the interview

in person (if geographical constraints allowed) or via telephone. These methods of participation were chosen partly to aid recruitment by increasing flexibility and opening up a broader geographical area from which to recruit but also to allow fathers who would feel uncomfortable meeting the researcher in person to participate. Five participants completed the interview at their home or a location chosen by them, two completed the interview at the University of London, and three completed the interview over the phone. The interviews lasted between 60 and 119 minutes (Mean = 78.8 minutes) and were recorded on a digital voice recorder. In total, the interviews collected 788 minutes (13 hours, 8 minutes) of data.

### **Modifications to the interview schedule**

As the interviews were conducted the researcher noticed that participants spent most of the interview telling the birth story and there was limited time to explore symptoms of posttraumatic stress as hoped towards the end. The researcher hypothesised that this may have been due to difficulty discussing emotions and cognitions relating to the experience, as well as the chronological order of the interview schedule (starting with antenatal experiences, through to the labour and birth, then postnatal experiences). For the final two interviews the researcher reversed the order of the questions, starting with postnatal experiences and symptoms which naturally led into discussion of the labour and birth, and finishing with antenatal experiences (such as expectations and preparation for the birth, if this had not already been mentioned). This led to much richer descriptions of postnatal

experiences but may have been at the detriment to collecting detailed information about antenatal experiences.

### **Participants**

18 participants took part in the first stage of the study by reading the information sheet and completing the online questionnaires. 12 participants (66.6%) met the inclusion criteria and formed the sample of men used to select participants to take part in the interviews. Of these, 10 men responded to participate in the interview. One participant did not respond to this invite, and one participant did not have time to take part in an interview at the time.

### **Situating the sample**

Basic demographic characteristics, questionnaire scores, and details pertaining to the labour and birth for the 10 participants who were interviewed (Table 1), and the four partners who completed the initial screening measures (Table 2) are outlined below.

Table 1. Participant demographic information.

PP	Time since birth (months)	Age of PP	Ethnicity	PTSD-Q						Symptom frequency	Symptom classification	EPDS Score	Birth details <sup>^</sup>
				A1: threat to partner/baby	A2: fear/horror/helplessness	Intrusions	Avoidance	Hyper-vigilance	(No. of clinically significant symptoms)				
P1	13	36	White British	Both	Yes	3	5	4	Current: 2-3 times per month	Full	19*	14 hrs, HLW; induction; AVB; baby resuscitated	
P2	7	37	White British	Infant	Yes	0	0	2	Current: once a week	Partial	15*	11 hrs, HLW; induction; AVB	
P3	28	37	White British	Infant	Yes	0	1	1	Past: at least once since birth	Criterion A	3	78 hrs, HLW; AVB	
P4	25	34	White British	Partner	Yes	0	0	0	Past: at least once since birth	Criterion A	2	10 hrs, HLW; AVB	
P5	3	28	White British	Both	Yes	1	1	4	Current: daily	Partial	12*	120 hrs, HLW; induction; ECS; pre-eclampsia	
P6	19	38	White British	Both	Yes	0	0	0	Past: at least once since birth	Criterion A	5	2.5 hrs, MLU; NVB; baby admitted to NICU (6 days)	
P7	17	45	White British	Infant	Yes	0	0	0	Past: at least once since birth	Criterion A	7	10 hrs, MLU; NVB	
P8	25	33	White British	Both	Yes	0	0	2	Past: at least once since birth	Clinically significant	5	22 hrs, HLW; ECS	
P9	13	28	White British	Infant	Yes	0	1	0	Past: at least once since birth	Criterion A	16*	6 hrs, HLW; AVB	
P10	5	46	Black British	No	Yes	0	3	1	Past: at least once since birth	Partial	14*	48 hrs, HLW; induction; ECS	

\*Scores ≥10 indicate significant symptoms of postnatal depression for men (Edmonson et al., 2010)

<sup>^</sup>Hospital Labour Ward (HLW), Midwife Led Unit (MLU), Assisted Vaginal Birth (AVB; forceps and/or ventouse), Non-assisted Vaginal Birth (NVB) Emergency Caesarean Section (ECS).

Table 2. Partner demographic information.

Partner of PP	Partner age	Partner ethnicity	PTSD-Q					Symptom frequency	Symptom classification	EPDS Score
			A1: perception of threat to self/infant	A2: fear/horror/helplessness	Intrusions	Avoidance	Hypervigilance			
			<i>(No. of clinically significant symptoms)</i>							
P1	37	White British	Both	Yes	2	3	3	Past: 2-3 times per week	Full (Past)	7
P2	36	White British	No	No	0	0	0	Past: once	None	2
P5	29	White British	Both	Yes	2	3	4	Current: 2-3 times per week	Full	13*
P6	34	Asian British	Both	Yes	0	0	0	Never	Criterion A	2

\*Scores  $\geq 13$  indicate significant symptoms of postnatal depression for women (J. Cox et al., 1987).



### ***Father demographics***

All participants were first-time fathers based in the UK and were present for the duration of their partner's labour and birth. All participants reported being married. Participants were generally educated to a high level; four participants had qualifications equivalent to degree level and five participants had a postgraduate qualification. One participant had qualifications equivalent to GCSE level. All participants reported being employed at the time of the interview. Eight participants had an annual household income of over £40,000, one participant had an income of £15,000-39,999 and another participant less than £14,999.

One participant met the criteria for a diagnosis of PTSD according to DSM-IV on the PTSD-Q (P1). Using EPDS scores as an approximation of negative alterations in mood (Criterion D), it is likely that this participant would also meet criteria for a diagnosis of PTSD according to DSM-5. Three participants met the criteria suggested by McLaughlin and colleagues (2015) for partial PTSD (P2, P5, P10). One participant indicated clinically significant symptoms on one dimension (P8) and five participants had no clinically significant symptoms but subjectively reported the experience as traumatic and fulfilled both items for DSM-IV 'Criterion A' (which would also be consistent with DSM-5 Criterion A). Five participants met the threshold indicative of significant postnatal depression symptoms.

Three participants (P1, P7 & P9) reported experiencing mild-moderate difficulties with anxiety and/or depression prior to the birth. Two participants reported difficulties with anxiety and depression following the birth (P1 & P8). Three participants (P3, P5 & P6) reported other potentially traumatic events following the birth including a missed miscarriage, bereavements and witnessing the death of a family member. Two participants reported that their partners had experienced pre- (P8) and post-natal (P1, P8) depression.

### ***Partner demographics***

Female partners of participants were reported to be aged between 29 and 37 years old (mean = 33). Fathers identified their partner's ethnic origin as White British (70%), Asian British (10%), White American (10%), and Brazilian (10%). All partners were reported to be in employment or on maternity leave at the time of the interview. Of the four partners who consented to complete the initial screening questionnaires, two met the criteria for a diagnosis of PTSD according to DSM-IV criteria on the PTSD-Q (P1, P5), with symptoms occurring in the past for one partner (P1). One partner reported both 'Criterion A' criteria (P6) and one partner reported no 'Criterion A' criteria or symptoms (P2). One partner met the threshold indicative of significant symptoms of postnatal depression (P5).

## **Data analysis**

### **Transcription of Interview Data**

The researcher transcribed the interviews in order to become immersed in the data and gain an in-depth understanding of it (Charmaz, 2014). Interviews were transcribed as close as possible to the interview to assist with theoretical sampling, although the unpredictable and time-limited nature of recruitment did not permit this in all instances.

A denaturalised approach to transcription was used and thought to be well suited to grounded theory methodology as it focuses on meanings and perceptions created and shared between the researcher and participant (C. Davidson, 2009). Interviews are transcribed verbatim but there is less focus on depicting accents and vocalisations (Oliver, Serovich, & Mason, 2005). A criticism of the approach is that it results in “white-washed data” (Oliver et al., 2005, p. 8), therefore in order to remain sensitive to the data and unspoken data, the researcher included short involuntary utterances (such as ‘erm’ and ‘uh’), hesitations, and pauses.

### **Coding**

Coding is a core element of data analysis in grounded theory. Coding begins by initially breaking down transcripts into smaller segments which are then analysed and focused as coding begins to move the data to an analytical level (Charmaz, 2014).

### ***Phase 1: Initial coding***

Data analysis commenced with the line-by-line coding of each transcript. Each initial code was a label or short summary of the content. The use of gerunds (nouns made from verbs, i.e. verbs ending with '-ing') and 'in-vivo' coding (where exact terms used by participants to describe their experiences are preserved) ensured codes were grounded in the data (Charmaz, 2014).

### ***Phase 2: Focused coding***

Focused coding involved developing the initial codes so that they described larger segments of data (Charmaz, 2014). Focused codes were therefore more abstract, conceptual, and involved using the most frequent or significant codes identified during the initial coding stage (Charmaz, 2014). It was important to maintain a reflexive stance during focused coding to avoid over interpretation or forcing data into preconceived categories.

An extract from an interview transcript is included in Appendix 13 to demonstrate the interview process and development of codes.

### **Memo-writing and constant comparison**

Memos were written throughout the coding process to capture and summarise thoughts, ideas and concepts arising from the data (see Appendix 14). These provided a bridge between data collection and the final theory, kept the researcher actively involved in the analysis, guided comparisons, and directed theoretical sampling (Charmaz, 2014). Memos took the form of spontaneous

notes made by the researcher during the analytical process which were then discussed with the research supervisors to allow theoretical concepts to be expanded and developed.

Memos significantly aided the constant comparative method where initially data were compared within the same interview to explore how the same participant talked about experiences and then compared between interviews, exploring differences and similarities between participants' experiences and interpretations (Charmaz, 2014).

### **Theoretical coding**

Theoretical coding demonstrates relationships between focused codes by conceptualising them into categories and demonstrating relationships between them (Charmaz, 2014). The emergent theory was therefore based on a smaller number of theoretical codes, and within these, initial and focused codes were used to explain the properties. A diagram was developed to demonstrate the emergent theory and relationships between themes (see Figure 1, Chapter 3).

## Chapter 3: Results

This chapter summarises the main findings from the grounded theory analysis of fathers' experiences of traumatic labour and childbirth. The specific aims of the study were to:

1. Explore fathers' experiences of traumatic labour and birth through;
  - a. Understanding factors contributing to the experience being perceived as traumatic
  - b. Identifying how fathers experience trauma symptoms in the postnatal period
  - c. Identifying risk and protective factors for the development and maintenance of symptoms
2. Develop a theoretical model of paternal PTSD-FC and compare the emergent theory with existing trauma theories in order to;
  - a. Identify whether new factors emerge specific to the paternal population and unique to the context of childbirth
  - b. Identify whether factors in existing theories (general and maternal PTSD) are relevant for fathers

The analysis is presented below alongside quotations to illustrate each theme.

All identifying details, such as names of people and places have been removed from quotations to maintain participants' anonymity<sup>3</sup>

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<sup>3</sup> In order to situate the results, participant numbers correspond to those in Table 1 in Chapter 2. These numbers will be removed from quotes to protect confidentiality in the final thesis submission.

Six theoretical codes were identified and are presented in Table 3 below. These theoretical codes comprise 18 focused codes, each made up of the initial codes that were developed during the first stage of coding.

A summary table presented in Appendix 15 illustrates the presence of focused codes across participants. A diagrammatic model is presented at the end of this chapter showing the relationship between codes and highlighting the factors contributing to paternal experiences of traumatic birth which facilitates comparison with existing theories.

Table 3. Theoretical codes, focused codes and properties.

Theoretical code	Focused codes	Properties (initial codes)
<b>1</b> <b>Anxious cognitions leading to sense of threat &amp; disrupted memories</b>	1.1 Antenatal anxiety about the unknown	Antenatal apprehension Fear of interventions Experience of others fuelling uncertainty Uncertainty about own feelings
	1.2 Perceived threat & anxiety during labour & birth	Fear for partner or baby's wellbeing Moments of heightened anxiety Unpredictability and uncertainty of events Impact of partner's emotions on my own
	1.3 Ongoing sense of threat postnatally	Vivid intrusive images & emotional reminders Physical sensations Triggers Hypervigilance
	1.4 Disrupted memories	Surreal experience Having gaps in memory Blurred memory of experience
<b>2</b> <b>Shock of comparing expectations &amp; reality</b>	2.1 Desire for information	Feeling unprepared antenatally Feeling uninformed (during labour) Feeling unprepared emotionally
	2.2 Enormity of shattered expectations	Overwhelming experience Reality of having a baby Realising false expectations Surprise at the unexpected Sadness at losing the ideal Cognitive rigidity & flexibility
	2.3 Unexpected feelings	Unexpected feelings Associating emotion with it being personal



Theoretical code	Focused codes	Properties (initial codes)
<b>3</b> <b>The battle for control to protect &amp; support</b>	3.1 Perceived responsibility	Needing to support my partner Holding everyone in mind Feeling guilty
	3.2 Powerless to influence fate	Lack of control Handing over trust for partner/baby Feeling disempowered Desire for a role to maintain control Feeling useless
	3.3 Being a witness unable to help	Watching from the sidelines Having an alternative perspective to partner
<b>4</b> <b>Coping with &amp; processing an unexpected reality</b>	4.1 Desire to process the experience	Needing to process the experience Needing to validate experience
	4.2 Adaptive coping strategies	Being able to tell my story Using reassurance & support from others Choosing to focus on positives Using humour to lift distress
	4.3 Maladaptive coping strategies	Avoiding discussing experience with others Suppressing thoughts & emotions Avoiding reminders of the birth Shifting focus away from emotions Ruminative blame

	Theoretical code	Focused codes	Properties (initial codes)
5	<b>Barriers to processing &amp; coping</b>	5.1 Being unable to tell my story	Withholding feelings to protect others Lack of discussion among men about birth Feeling ashamed
		5.2 Feeling excluded	Maternity experience being focused on mother Feeling physically excluded Unacknowledged feelings Lack of support
6	<b>Ongoing impact of the experience</b>	6.1 Negative perceptions of own coping	Self criticism and blame Ongoing impact of birth on self
		6.2 Negative impact on family	Impact on parenting & preparation for parenthood Impact on plans for future children Impact on couple relationship
		6.3 Family growth	Strengthened couple relationship Positivity in becoming a family Feeling more prepared for future birth experiences

## **1. Anxious cognitions leading to sense of threat and disrupted memories**

Participants described their anxious and fearful cognitions about the labour and childbirth throughout the interviews, from antenatal apprehension through to moments of perceived threat during the labour, childbirth, and into the postnatal period.

### **1.1 Antenatal anxiety about the unknown**

There was a general theme of uncertainty about the labour and childbirth as an unknown experience for first-time fathers which created anxiety and fear. In the antenatal period, fathers described feeling excited but apprehensive with anxious cognitions predominantly focusing on the wellbeing of their partner and/or baby during pregnancy, labour and childbirth. Fathers' anxiety was influenced by fears and expectations around interventions. Hearing the mixed, but often negative experiences of others fuelled uncertainty about expectations for many fathers.

*“So I think that [discussions with other parents]<sup>4</sup> started me thinking about it as well...and different stories as well, kind of fuelling that [worry], everyone’s different and there are some commonalities...but there is absolutely no predictability...uh you know, do you have to have a rush in for a caesarean, does the cord go round the neck, all these*

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<sup>4</sup> Words placed within square brackets (i.e. [worry]) have been added by the researcher to give context based on the preceding interview content so that the extract can be more easily understood. A string of dots (...) denotes that a section of the extract has been removed to promote the clarity of the quote. Words placed within an arrow bracket (i.e. <partner>) are used to ensure anonymity.

*kind of worries...uh, the build-up in my mind of what it could be and the build-up to labour too. You know, the reality, as dramatic as it sounds is that I could come out of this as a single parent”*

The experiences of others and general stereotypes about childbirth also led fathers to feel uncertain during the antenatal period about how they would feel during the labour and birth. Fathers expressed having some expectations based on these stereotypes and oscillated between thinking the experience could be the most amazing and/or the most horrific experience of their lives. Fathers often had not been able to think beyond these stereotypes and picture what the reality would be like for them, particularly in terms of how they would feel.

*“I don't know really, I guess it's kind of...you know the whole hollywood moment of...people say this is the most amazing moment of your life...this is probably how I'm going to feel... I'm gonna feel like that but is it going to be like that....and perhaps just thinking about other people's experiences and what they had said... things like, yea it's horrific...”*

## **1.2 Perceived threat and anxiety during labour and birth**

Whilst many participants described the arrival of their child as being a positive experience, the preceding labour and birth was often appraised as being threatening which generated anxiety and fear. Almost all participants described feeling anxious and fearful when recalling their partner's labour and

childbirth. Most participants spoke about fearing for the wellbeing of their partner or baby, with some participants fearing for them both, either separately or at the same time. Participants often reported feeling scared due to their partner's or baby's state.

*“Well the picture I was building up was that something was going wrong, that something wasn't right here, there's a complication developing and that one and/or both of my wife and baby were in trouble, and that risk...(becoming emotional) well I thought...I might lose my baby...or my wife, or both actually...I found it really tough, really really tough, I found it very scary”*

Whilst these fears were often a moment of heightened anxiety for fathers, peaks in anxiety were also triggered by other events. For some participants this was related to their worst fears in the antenatal period becoming a reality. Other participants sensed heightened anxiety in the room from professionals which impacted on their own anxiety. Some fathers also spoke about the impact that their partner's emotions had on their own, particularly by increasing fears.

*“<partner> was in the distress that [we had] been worrying about...panicking and really really struggling...she was using the gas and air so much that her face had started to wobble and she couldn't speak properly...I've never seen somebody who is clearly an experienced professional [the anaesthetist]...scared by her face...she*

*was like, oh my god. And I thought <partner> was gonna make the anesthetist cry just by screaming out”*

The uncertainty and unpredictability of events during labour and childbirth appeared to underpin the sense of threat fathers perceived, in terms of not knowing what was coming next. Many fathers described the labour and birth as a ‘rollercoaster’ experience with the changing situation, variation in their partner’s state, and their own fluctuating emotions.

### **1.3 Ongoing sense of threat postnatally**

The perceived threat and heightened anxiety fathers experienced during the labour and birth was ongoing for many participants into the postnatal period. There was variation between participants in the nature and strength of the emotions reported. Some participants described strong emotional responses resulting from negative appraisals of the labour and birth which caused them to feel anxious and threatened.

Many fathers’ accounts featured the recall of vivid, visceral images and key emotional hotspots which came back to them voluntarily and involuntarily, sometimes requiring attention before going away again. For some participants these intrusions were in the form of specific moments, and for others, images or emotions reminded them of the sheer weight of the whole experience. Images were often associated with hotspots of intense emotion, both at the time of the birth and whilst recalling them during the interview. Some

participants were able to reflect on these reminders being of an event that happened in the past. However, for others, there was indication of the lasting nature of images and emotional hotspots, along with the emotional distress associated with recalling them, and remaining current sense of threat.

*“...it's one of those experiences that I think will just stay with me...sometimes if I sit and think about it then of course it comes in, but other times it could be just like...something random...or just quiet moments...it's a fuller awareness of just what we went through...that's what comes back to me, the sheer weight of it...an emotional rush that I just need to take a moment or two to sit with it and tune into it before it will go away”*

Other participants spoke about the physical sensations that they experienced during the labour and continue to feel when reliving key moments. One participant (P1) described how reliving memories now triggers more physical sensations than emotions, indicating that his intrusions have changed over time. Two participants specifically mentioned feeling easily and frequently reminded of the experience, with one participant feeling easily startled. Other participants described specific things that continue to trigger memories and reminders of the experience.

*“...if <baby> coughs, I remember her coughing huge amounts...whenever <partner> mentions her scar, I go back to how she got the scar...you wanna get out of it as fast as you can, think of*

*something else...whenever we we're at somewhere noisy...I mean to be honest even just the same er, set-up...the non-slip floor...sometimes you can be in a restaurant and the bathroom has it, and that reminds me of it..."*

#### **1.4 Disrupted memories**

All participants reported disruptions to their memories for the event which appeared to influence fathers' anxiety and perceived threat. Several participants spoke about their memories of the experience being very surreal, as if the experience was unreal, or happening to somebody else. Many fathers had gaps in their memories of the experience. This was either stated whilst recalling the experience, or became apparent with participants struggling to recall specific details of the experience, finding it difficult to sequence the order of events, or realising during the interview that there were periods of time or events which they could not recall. Other fathers described their memories of the experience as being blurred and they had difficulty recalling or separating events, thoughts, and emotions.

*"...it's like I can't remember that bit between the image of her being in the bathroom, I can't remember her getting into the pool...its almost like there's a series of photographs...it's quite weird...but it is like I've kind of got a handful of photographs...it's hard to put everything into order, so you've got the polaroids, and some of them are very clear and in order, others are just like well this happened..."*



## **2. Shock of comparing expectations and reality**

All participants mentioned the expectations they had about the labour and birth, even if they had been uncertain about what to expect antenatally.

Fathers talked about the roles they anticipated they would play; expecting that they would be able to support and encourage their partners. For many participants there was a disparity between their expectations and the reality of the labour and birth they witnessed. This led them to make comparisons which created surprise, shock, and left fathers feeling like they were not adequately informed about possible eventualities and the emotional impact of this.

### **2.1 Desire for information**

All participants talked about attending antenatal classes with their partner to help them to prepare for the labour and birth. However, whilst making comparisons between their expectations and the reality of their experience, participants identified that they felt unprepared. Participants appeared to associate feeling unprepared with the shock of finding their experience so different.

*“I knew it wouldn’t be like on TV and I knew it wouldn’t be like in the sitcoms but, I wasn’t, I didn’t have anything real to go on”*

Participants also reported feeling uninformed during the labour and birth, particularly when things were not going to plan, or were unexpected. These 'unknowns' often led to an increase in distress for both the father and his partner. Participants had a desire for more information in the postnatal period, in terms of the facts about what happened in order to process their experience.

Some participants indicated that they felt prepared for the labour and birth in a practical sense but they were much less prepared for the emotional impact of being witness to their partner's labour and birth, which contributed to perceiving the experience as traumatic.

*"...it was still, there's a shocking element to it I think, that's the best way I can put it...I had no idea about that at all...in the run up to it it's all about the practicalities, and I haven't come across many avenues which talk about the emotional impact...I was totally surprised by the sheer weight of the wall of emotion that hit, so I had no idea"*

## **2.2 Enormity of shattered expectations**

The majority of participants talked about the experience of witnessing their partner's labour and birth as being more overwhelming than they had ever expected. Many fathers reflected on their expectations and spoke of a realisation that their expectations and birth plans had been unrealistic. Other fathers realised that they had not known what to expect. With the

reconciliation of expectations and reality came expressions of shock, surprise, and disbelief. The reality of the experience for many participants was compounded by suddenly being confronted with a baby, which was described positively but nonetheless appeared to be surprising. Several participants described sadness at the loss of the expected or ideal birth experience.

*“...the whole thing was quite urgent and that's the thing that was most difficult about it I think, you know it was great in many ways but it was just the speed of it was really quite surprising for my wife and I...[It was] difficult, fast, intense, kind of in that sense of more than I ever expected it to be, not how any of us expected it to go”*

Many fathers demonstrated rigidity in their thoughts and expectations about the birth plan and role they would play which appeared to increase the distress they felt both during the labour and birth, and in the postnatal period. However, others spoke about being more flexible with their plans and were able to accept that their preferred expectations might not be the actual reality. These participants reflected on how this helped them to manage unexpected events and feel less distressed at the time and into the postnatal period.

*“...we had these birth preferences...I think people get really hung up on having this plan so knowing that people did and how it never ever goes as planned, I think the thing that helped was you know, whatever you plan it's just not going to happen...you've got to be a bit flexible and if you're not I think that's when people really struggle....[being*

*flexible] made it a better experience for us, I think we got through it in the best way we could”*

### **2.3 Unexpected feelings**

Fathers described feeling a range of emotions during their partner’s labour and the delivery of their baby. Many accounts described the joy, excitement and overwhelmingly positive experience of welcoming their baby into the world. However, with comparing expectations and reality came identifying negative emotions that were both experienced at the time and continued to be experienced. Participants were surprised by the negative emotions they had and by the weight of the unexpected emotion they felt. Participants described feeling anxious, fearful, sad, guilty, angry, and ashamed. Some participants spoke about only realising how anxious or fearful they were after the event. For one participant, it was the lack of expected feelings that was most distressing.

*“I surprised myself because I’d always thought that the moment I saw my child I would just think, wow...um and just have this infinite bond that this is it forever...it’s upsetting...that I didn’t have the emotions I expected...”*

Fathers associated the unexpected distress with it being very personal to witness their own partner and baby go through the experience, opposed to other potentially traumatic events they had been through.

*“...it's one of the most difficult things I had to witness I think...you [hear of] all kinds of traumatic events but this is more personal...it's my own...and as well as being a wonderful experience...it was still, there's a shocking element to it I think, that's the best way I can put it...I had no idea about that at all...”*

### **3. The battle for control to protect and support**

The theme of control featured strongly in almost all participants' accounts of their experience. Fathers' collective accounts were representative of an emotional and often physical battle to have some control in order to be able to protect and support their partner. Fathers spoke of the perceived responsibility they had to protect their partner and baby. They were often torn between feeling powerless and helpless and desperately wanting a role to maintain their responsibility. Fathers spoke about wanting to be able to help but often feeling like a witness to the whole experience.

#### **3.1 Perceived responsibility**

Many fathers described an overwhelming sense of responsibility to protect their partners. This was mainly in a practical sense related to making decisions, advocating for her, ensuring she got to the hospital or birthing centre, and that she had everything she might need.

*“...it was that kind of not knowing what was the right thing to do, feeling completely completely vacant in terms of knowing how to deal with this and what was going on...I felt totally responsible for doing making the right decisions”*

Fathers also spoke about the responsibility they felt to hold everyone in mind; their partner, baby, and also themselves. Fathers described feeling torn between their partner and baby after delivery, and torn between supporting their partner and looking after themselves in order to continue being supportive. For some fathers, the feeling of responsibility towards their partner was so overwhelming that they felt less able to focus on the baby. Several fathers reported feeling guilty that their partner had to go through the experience, or about the decisions or actions they took which they perceived as having a negative impact on the experience and/or their partner.

*“...so then there's like 2 things happening...that <baby> is going over to the far side of the room...and ten midwives and a senior registrar um...stitching back up [my partner] and then...making her deliver the placenta...”*

### **3.2 Powerless to influence fate**

Feeling powerless and out of control featured strongly in fathers' accounts. They spoke about the heightened anxiety that arose from feeling out of control, not knowing what to do, and feeling unable to influence the unfolding

events. Associated with feeling out of control and having no role was the need for fathers to hand over trust and responsibility for their partner and baby to medical professionals. One father also compared the sense of control and role he has supporting his wife in general daily life and feeling powerless to do this in the labour room.

*“...it was just uh...the lack of control, there's nothing really as the guy that you can do...I'm quite traditional in...the kind of male role models is to... supporting your wife and taking the pain away, and making things better, that kind of uh, a part of being a husband, boyfriend, partner etc...there's a certain powerlessness, um, I think associated with the birth”*

Many fathers questioned how useful them being there was. Feeling useless featured in almost all of their accounts, whether throughout the experience or at specific moments during the labour, such as when the situation felt more out of control or was more distressing. Some fathers described how their roles diminished as the labour progressed and the contrast between their levels of involvement at different time-points. For example, feeling powerless and then suddenly being handed the baby and having a major role. Feeling unable to help added to the lack of control fathers perceived and the distress associated with being unable to protect and support their partners.

*“...scary, because you just feel completely useless, you know you can't do anything...trying to convince her that, you know, she was doing*

*really well, which she was, and probably actually feeling like a bit of an idiot for...for...the past god knows how long saying you're doing really well, and whatever it is, I don't know you say the same thing over and over again, you're like really, what? Just feel like I'm pointless, what is my role here? Am I really...does she even notice me? Basically I have no way of actually helping here, I can't help medically and...I don't feel like I can actually do anything more than just sit here and say the same thing over and over again and hold her hand. Um...am I actually really helping?"*

Throughout participants' accounts of feeling powerless there was a sense that fathers wanted a role or task to feel more in control. Some fathers spoke about their attempts to maintain control which included being more assertive with healthcare professionals or taking it upon themselves to monitor contractions. A few fathers said that they found it helpful when they were acknowledged by the midwife and given specific tasks.

### **3.3 Being a witness unable to help**

For many fathers, the battle for control was compounded by feeling like they were a witness to the whole experience, watching from the sidelines and unable to help. Being a witness further heightened the disempowerment and helplessness fathers felt. Fathers also spoke about being a witness in terms of the perspective they had of the birth. Some fathers found it difficult to judge the situation and have some control because they were not physically



experiencing labour themselves. For others, being on the sidelines meant that they observed conversations and non-verbal communication between professionals which gave them a fuller awareness of the situation and heightened their distress. One father described how he felt more distressed because he perceived himself to be the only person fully present in 'feeling' the experience because the delivery had become so medicalised.

*“[it was] was worse in a way because um...she wasn't really aware of what was going on but I was fully aware of what was going on, and all the complications that had arose. And it's the stuff that people don't say, it's the looks between practitioners and the quiet word in the corner, and someone going out and a different doctor coming in, it's all that stuff and that happened a lot..”*

#### **4. Coping with and processing an unexpected reality**

It was the unexpected nature of events that made the labour and birth experience particularly shocking and distressing for fathers. Fathers described a need to process the experience and their accounts featured a range of more or less adaptive coping strategies employed to manage the experience and related emotions.

##### **4.1 Desire to process the experience**

Many of the fathers' accounts described a desire or need to process the experience they had been through. For some participants this was related to

having factual information to fill in the gaps where they felt uninformed or where there were disruptions to memory. For other participants there was an acknowledgment of the emotional impact of the experience and a desire to process it. Fathers also spoke about needing to validate their experience by speaking with others or comparing their experience to that of other couples as a way of processing their experience.

*“...thinking about it...can be useful...I know it can be helpful but...I probably haven't quite processed the full emotional impact...I'm the sort of person who needs to process it and to be with it in order for it to pass on”*

*“...we don't really know, relative to the rest of the population, where that sits on the scale of horrific...how unusual this was, to help rationalise how we should feel...to help us understand how we are feeling and give us a scale of how we feel about things...just to quantify it...”*

#### **4.2 Adaptive coping strategies**

Fathers described a range of cognitive and behavioural coping strategies that had helped them to manage the impact of a traumatic birth experience. For many fathers strategies included finding ways to tell their story as a way of processing the experience. Some fathers talked about becoming part of the ‘parents club’ which allowed them to talk about their experience with other

fathers. For others, talking about the experience with their partner had been helpful.

*“It was quite nice in a way...to talk about it, and tell <partner>...she was just on the gas and air, she says she has no recollection of anything, so filling in the gaps talking about it just kinda helped me get it straight in my head, so this happened and then this, and she had bits she could remember, so it did help in a way”*

Several fathers reported finding the interview itself a helpful way of processing their experience, particularly when they had not had the opportunity to tell their story before. It seemed as though the interview helped fathers to think about the experience in a different way and highlighted to them that they were not the alone in their experience. Many fathers realised and reflected on things that they had not considered before through the questions that were asked. At the end of the interviews, fathers spoke about being able to think more rationally about how they felt at the time, and how they feel now.

Throughout fathers' accounts there was evidence of reassurance and support from others being helpful coping mechanisms, both during the birth and postnatal period. During the birth fathers reassured themselves that they could cope with the experience and drew on support from health professionals. Fathers described how midwives helped them to feel calmer and more in control. One participant reported that the hospital had a doula who was able to support both him and his partner and gave them the

reassurance that they needed. Following the birth, fathers focused on reassurance from their partners which included hearing that their presence had been comforting and helpful. This appeared to help reduce the distress fathers experienced in the postnatal period.

Fathers also reported focusing on the positive aspects of their birth experience as a way of coping during and following the birth. Fathers described how focusing on the baby helped to manage the distress of the birth being traumatic at the time. Focusing on the baby as a positive end result also helped fathers to balance the lasting negative emotions they were left with in the postnatal period. One father said he had made the decision to forget about the experience in order to move on from it, which appeared to be an adaptive coping strategy opposed to avoidance strategies reported by other participants and described later.

*“...[thinking the baby could] pick up on how anxious I am, if I get really worried...I think there was a window next to where I was standing, so I think I literally arched both of us towards the window. And just kind of, cooed and did all that kind of stuff...which yea, I think really did kind of bring it down...”*

Humour also featured in many fathers' accounts of their experience. For some fathers humour seemed to be a way of coping with the interview and being able to tell their story. For other fathers, humour helped to cope with and lift distress at the time of the birth.

### 4.3 Maladaptive coping strategies

Alongside adaptive coping strategies, all but one participant described a range of coping strategies which appeared to be more maladaptive in terms of preventing processing of the experience. Avoidance featured in more than half of fathers' accounts, taking the form of either consciously avoiding discussing the experience with others, suppressing thoughts and emotions, or avoiding reminders. Where fathers did discuss their experience with others, there was a tendency to skim over emotive content and focus on factual information.

*“[when I spoke about it...] probably from a third party perspective, probably a sort of a bird’s eye view...just a sort of a narrative of how it was and what happened... quite open and honest, without going into emotions”*

Two fathers spoke about using distraction as a way of managing distressing thoughts and emotions postnatally. Avoidance for one participant extended to avoiding specific people in order to prevent difficult conversations about the experience and avoiding driving in the direction of the hospital, therefore indicating some of the long-term impact on him and his family. Several fathers spoke about consciously avoiding reminders and objects that they now associate with the experience, or things that could trigger unwanted intrusive thoughts and images.

*“I was looking through some old photos from that time and I tend not to look at those ones, to skip over those quite quickly...in the ward and so on, where I'm holding the baby and my wife is there, I've just not looked at those very often...I think it's some sort of avoidance of the impact of this...the pain of it, the powerlessness, the fear, the anger that it's got to that point...the sadness of it all...”*

There was also evidence of subconscious avoidance of thoughts and emotions as a protective strategy following the birth where fathers only became aware of what they had been through later in the postnatal period. More subtle avoidance strategies came in the form of participants avoiding difficult emotions by shifting the focus away from the question and focusing on facts during the interviews. Fathers would sometimes need to be prompted to focus on their experience and emotions rather than describing the birth story.

Participants' accounts often featured negative appraisals of health professionals. It seemed as though blaming staff for various factors perceived as contributing to the birth being traumatic for fathers was a way of coping in the postnatal period. Fathers reported feeling angry towards staff and wanting to take them to account for things that happened to make the experience traumatic. There was blame towards staff for not adequately acknowledging and supporting both the father and the couple during the birth. These negative perceptions of staff often featured in accounts which also reported finding staff helpful and supportive. Some fathers appeared to engage in a ruminative

focus on these negative perceptions of and blame towards staff which subsequently became more entrenched. This seemed to prevent fathers from moving on and being able to process the experience.

*“There’s been some bad care here...it made me feel like...I am going to take you to account for what’s happened here...and this is one of the silly things they do, they bring you a cup of tea and a slice of toast...and you're like really, that's guna fix it is it?”*

## **5. Barriers to processing and coping**

As reported previously, many fathers felt the need to process their experience. Whilst adaptive and maladaptive coping strategies facilitated or prevented this, fathers also identified more general barriers to being able to process and cope with the experience. Many fathers described feeling unable to tell their story which prevented them from processing their experience. Fathers also described feeling excluded and unacknowledged throughout the entire perinatal period, perceiving a lack of acknowledgement for the paternal experience and lack of support for fathers.

### **5.1 Being unable to tell my story**

Fathers identified a number of factors which prevented them from being able to tell their story. The majority of participants described withholding their feelings, both during the labour and afterwards in order to protect others; including their partner, baby, or other family members. This therefore

prevented their feelings from being recognised and supported by those close to them.

*“...I was just sort of in a bit of a panic mode, and at the same time trying to keep my wife calm which was (sighs)...difficult in itself really, you're just trying to be strong but at the same time you feel like crumbling...(sighs) trying to restrain myself and thinking no I've gotta be strong, gotta be supportive...”*

Several fathers highlighted stereotypes about men discussing feelings and reported a lack of discussion amongst men about birth. This left fathers feeling frustrated about being unable to tell their story or share experiences and be supported in processing the experience. Some fathers also reported feeling unable to express their true feelings about the birth as they felt ashamed.

*“It is a bit frustrating actually...we [men] aren't very talkative. I can't remember a time, sober anyway, having a conversation about how anyone feels to any of my male friends...[there is] a fear of people that you know knowing how you feel”*

## **5.2 Feeling excluded**

For many fathers, there was an acknowledgement that the maternity experience is focused on the mother and her experience. Fathers reported a



tendency to tell the mothers' story, opposed to their own, if they discussed the experience with others. During the interviews, fathers often told the birth story from their partner's perspective and had to be prompted to focus on their own experience.

*“[discussing the birth with others] it was all about their birth stories, about what the situation was with them...not the mum and dad, just the mums side of the story and what they experienced”*

Fathers respected that it was the mother physically giving birth but often felt like they were both physically and emotionally excluded from the process, both by services and society in general. There was a sense that fathers were not allowed, or entitled to have negative feelings about the experience, despite it being a familial experience and fathers being present at the birth. Some fathers felt as though they experienced an equal amount of emotional pain as mothers but were expected to deal with it alone. Coupled with this was a perceived lack of support which fathers identified as a barrier to helping them to cope better during labour and process the experience subsequently. One participant described feeling as though he could not use sources of support because they were all focused on mothers. Another participant said that he thought he would be able to better support his partner if he had some support too. Fathers stressed the need for more awareness of the emotional impact of witnessing a traumatic birth on fathers and targeted support for men.

*“...you know maybe its culturally, a stereotype...we've been having babies for hundreds of thousands of years and yet...we've forgotten that there might be an impact on men, and I think we've played into a bit of a stereotype there, you know it's a familial experience...”*

## **6. Ongoing impact of the experience**

Accounts varied in terms of the impact fathers perceived the experience to have had on themselves, their couple relationship, and their family. Many fathers described the long-term negative effects of the birth whilst others described more positive influences.

### **6.1 Negative perceptions of own coping**

Fathers described negative perceptions about their ability to cope with the experience and were often self-critical; blaming themselves for the way that they felt (or did not feel) or believing that they were not good enough father, partner, or person. For some fathers, these critical appraisals about coping had a knock-on impact in other domains of their life, leaving them feeling less able to cope with life in general. Some fathers were also worried about the birth continuing to affect them which sometimes led them to feel angry with themselves, frustrated, and impacted on their mood.

*“[I feel like I'm] not being a good enough father...not being, so life just not being perfect and being the perfect support. You know my job is to do X, Y and Z and I've not done those things...[the birth] does feel like*

*it's taken a big chunk out of me and made me less capable of dealing with life...it really does affect your ability to function properly”*

## **6.2 Negative impact on family**

Most participants described the impact that witnessing a traumatic birth had had on them as a family and as a parent. Several fathers described the experience as hindering their start to parenthood due to feeling physically and emotionally drained. Other fathers identified specific examples to highlight how they believe the experience being traumatic has altered their parenting. For example, being more overprotective of the baby than anticipated and being desperate for the baby to be happy (to avoid crying as a reminder of the birth). One participant highlighted the negative impact the birth experience had on his partner and her parenting, which had affected their parenting as a couple.

*“...I'm a little bit more overprotective of <baby> at times...because of the birth, I think the relief of <baby> being ok after the forceps and that panic of everyone rushing in and not wanting anything to happen to <baby>...I didn't intend to be like that”*

Two participants spoke about specific ways in which the birth experience had negatively impacted on their couple relationship, particularly feeling connected and being intimate. For many fathers, the birth being traumatic had affected their plans for future children. For some, this was a decision shared with their

partner. However, others reported that their partner would like more children but they either did not feel that they could go through the experience again, or felt they needed to process the experience first before contemplating having another child. Fathers described feeling like they had lost the innocence of first-time parents, predicting that they would be more anxious, apprehensive, and worried that the same experience, or something more extreme, could happen next time. This appeared to be a possible mechanism maintaining the sense of threat and fear fathers experienced opposed to being able to situate the experience in the past.

*“We struggle a bit...we're okay and we still love each other, but we don't have any sexual relations...a lot of the time I really don't feel like it at all, and especially just after the birth she wasn't on any contraceptives and I just, I don't want to go back there, so abstinence was the only way of really making sure it didn't happen again um....and that's affected us”*

### **6.3 Family growth**

Whilst the birth experience was traumatic and distressing for fathers, many accounts highlighted ways in which the experience had had a positive impact. There was a sense of growth for many fathers in terms of their own confidence as a parent, in their couple relationship, and with the experience signifying becoming a family.

Throughout their accounts fathers often spoke from the perspective of the couple, with the birth representing a shared experience that strengthened their relationship. Fathers described becoming closer to their partner over the experience, recognising that they needed to pull together in order to cope with it. Fathers were also able to positively reframe some of the traumatic elements of their experiences which helped to balance more negative emotions. For example, one father expressed feeling thankful to his partner for going through the experience in order to produce a child. Another father saw the threat he perceived towards his partner and baby during labour as a recalibration and realisation of what was important to him. One father said that he was the first person to hold his daughter because of the impact of the birth on his partner's wellbeing which he felt heightened the bond he had with her.

*“...there's a kind of bonding over [the experience]... that was the start of when we had to kind of really be a unit to get through [the trauma]”*

Despite some fathers having concerns about more children and witnessing future births, others felt more prepared for the uncertainty and unexpected events that could occur and thought they would be more flexible in their expectations.

### **Theoretical model**

One aim of this study was to develop a theoretical model of paternal PTSD-FC to highlight the factors contributing to witnessing childbirth being perceived

as traumatic by fathers. This would also facilitate comparison of the emergent theory with existing (maternal and general) trauma theories to identify whether there are factors relevant to the paternal population or whether factors emerge that are unique to fathers and the context of childbirth. Figure 1 below demonstrates how the theoretical and focused codes outlined in this chapter interact and have the potential to contribute to the development and maintenance of trauma symptoms following childbirth in fathers. It should be noted that not all participants presented with trauma symptoms and therefore the model is representative of paternal trauma, opposed to PTSD, following childbirth.

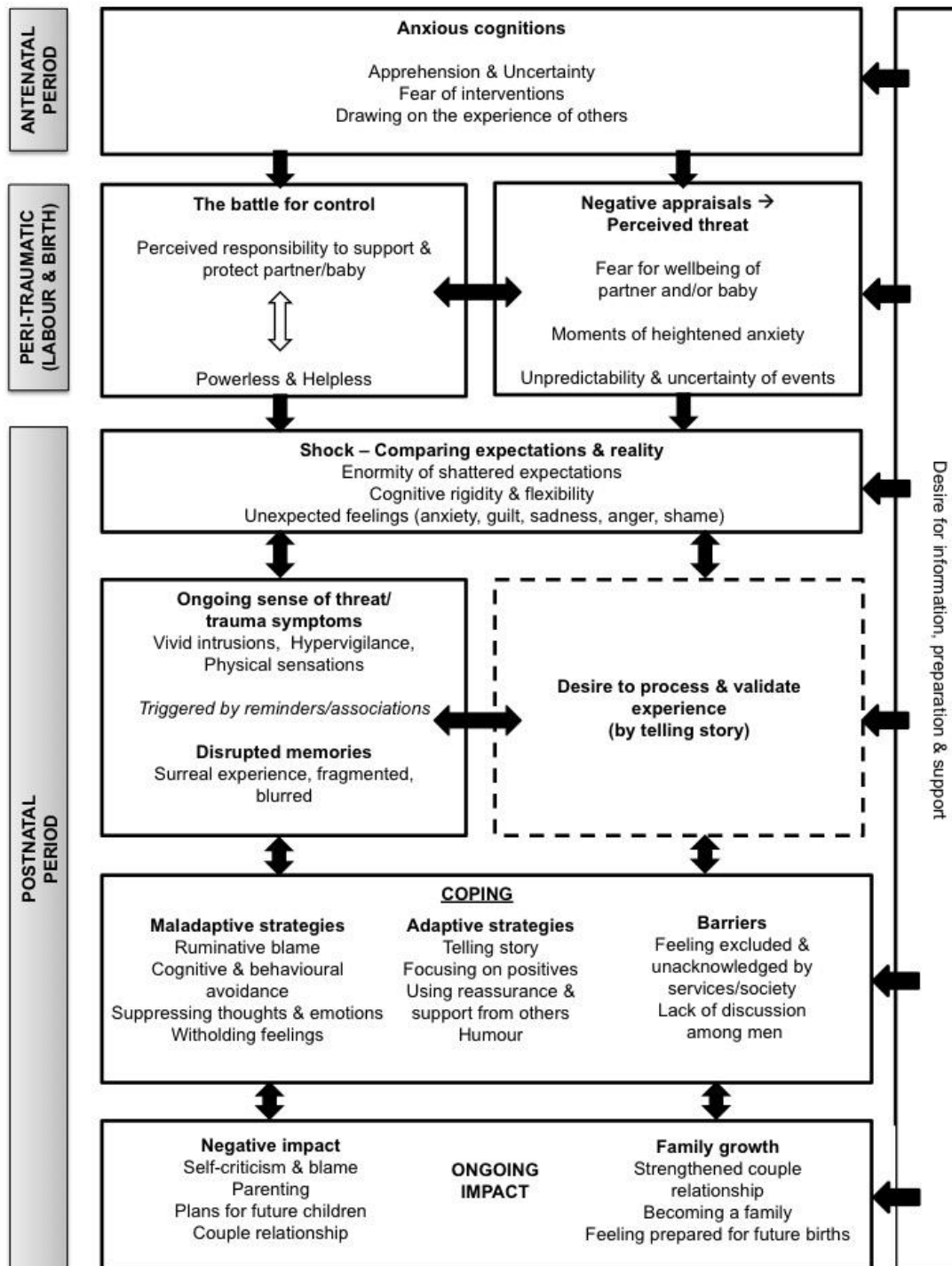


Figure 1. A theoretical model of paternal trauma following childbirth.

The model follows the chronological order of experience, describing processes and factors specific to the development and maintenance of trauma symptoms occurring during the antenatal, peri-traumatic (labour and birth), and postnatal periods for this sample.

The model begins with identifying anxious cognitions in the antenatal period; including apprehension about and uncertainty of feelings and expectations during the labour and birth and fear of interventions, fuelled by experiences of others. This antenatal anxiety appeared to be a potential risk factor for difficulties in the peri-traumatic period including the need for control, perceptions of increased responsibility (and subsequently feeling powerless and helpless), and appraising the labour and birth as threatening (by fearing for the wellbeing of their partner and/or baby and perceiving the unpredictability and uncertainty of events to heighten anxiety).

Fathers were left to reconcile differences between their expectations and experienced reality of the labour and birth in the early postnatal period. With the enormity of their shattered expectations came shock and unexpected feelings, such as anxiety, guilt, sadness, anger, and shame. Fathers who were anxious in the antenatal period but more flexible in their expectations and cognitive processing appeared to be less distressed in the peri-traumatic and postnatal periods and were more able to access more adaptive coping strategies.



Fathers who struggled to reconcile their expectations and the reality of their experience continued to experience an ongoing sense of threat in the form of trauma symptoms triggered by reminders and associations of the birth. Many fathers reported disrupted memories and there was a desire for fathers to process their experience by telling their story. Being unable to do so appeared to maintain the ongoing sense of threat and associated symptoms.

The desire to process and validate the experience was facilitated for some fathers through being able to tell their story and subsequently engaging in more adaptive coping strategies. However, fathers who were more distressed, unable to tell their story, and experiencing an ongoing sense of threat often engaged in more maladaptive coping strategies which may have maintained threat and anxiety in the postnatal period and left fathers still trying to reconcile differences in their expectations and experience. There were a number of barriers to processing the experience and using more adaptive coping strategies. This subsequently had the bidirectional effect of maintaining threat, unexpected emotions, and disrupted memories. Fathers' perceptions of the ongoing impact of the experience appeared to be dependent on the coping strategies employed and the extent to which they were able to process and validate their experience. Fathers who were more distressed and less able to process the experience reported increased negative impacts. Those engaged in more adaptive coping appeared to report increased family growth.

At each of the three stages fathers had a desire for information, preparation, and support. Fathers identified that they could have been better prepared and informed in the antenatal period, supported during the labour and birth, and in processing and validating the experience in the postnatal period. Information, preparation and support is linked with barriers to coping and processing as services and society were identified as having the potential to recognise and be more aware of the potential emotional impact of witnessing birth on fathers, and facilitating better support.

## Chapter 4: Discussion

A qualitative design was used to explore the experiences of first-time fathers who witnessed and perceived their partner's labour and birth as traumatic by addressing the following research aims:

1. Explore fathers' experiences of traumatic labour and birth through;
  - a. Understanding factors contributing to the experience being perceived as traumatic
  - b. Identifying how fathers experience trauma symptoms in the postnatal period
  - c. Identifying risk and protective factors for the development and maintenance of symptoms
2. Develop a theoretical model of paternal PTSD-FC and compare the emergent theory with existing trauma theories in order to;
  - a. Identify whether new factors emerge specific to the paternal population and unique to the context of childbirth
  - b. Identify whether factors in existing theories (general and maternal PTSD) are relevant for fathers

### Overview of findings

Based on interviews with 10 first-time fathers (1 reporting full symptoms of PTSD, 4 reporting partial or clinically significant symptoms, and 5 reporting no symptoms but meeting Criterion A), the findings suggest a number of factors contributing to fathers' experiences of their partner's labour and birth being

perceived as traumatic. Given that fathers' experiences of traumatic birth have seldom been explored and particularly without reference to symptoms of PTSD-FC, the findings make an important contribution to the literature. Six theoretical codes emerged to explain how fathers experience PTSD-FC, including potential risk and protective factors. The six themes relate to:

1. Anxious cognitions leading to sense of threat and disrupted memories
2. The shock of comparing expectations and reality
3. The battle for control to protect and support them
4. Coping with and processing an unexpected reality
5. Barriers to processing and coping
6. Ongoing impact of the experience

These themes will now be examined in the context of the research aims outlined above, relevant literature, and psychological theory. The strengths and limitations of this study will then be discussed, followed by proposed clinical implications of the study and suggestions for future research. Finally, the researcher's personal reflections will be presented in order to consider their influence on the research process.

## **Aim 1: Exploring fathers' experiences of traumatic labour and birth**

### **1. Anxious cognitions leading to sense of threat and disrupted memories**

Anxious cognitions and sense of threat emerged as being fundamental in fathers' experiences of traumatic birth. This is consistent with antenatal fears identified in the existing paternal postnatal literature (e.g. Elmir & Schmied, 2015; Hanson et al., 2009), including fathers fearing for their partner or baby's wellbeing, which was a perceived threat during labour and birth for the participants in this study. However, rather than exploring fathers' general fears of childbirth, the current study explored the experiences of fathers who identified the labour and birth as traumatic and highlighted that anxious cognitions are not limited to the antenatal period but appear to be pervasive throughout the perinatal period. Fathers experiencing trauma following childbirth appear to have had anxious cognitions in the antenatal period, perceived threat and anxiety during labour and childbirth, and experience an ongoing sense of threat in the postnatal period.

Fathers' antenatal anxiety was influenced by hearing the negative experiences of others and general stereotypes of labour and birth which left them feeling uncertain about how they would feel. This is in contrast to previous literature which has found that fathers do not rely on the experiences of others to inform their own expectations (Steen et al., 2012). However, this literature is based on fathers' general experiences of pregnancy and birth opposed to traumatic experiences. In the general trauma literature, cognitive

processing during a traumatic event is influenced by prior beliefs (Brewin, Dalgleish, & Joseph, 1996; Ehlers & Clark, 2000). Therefore, prior fears or hearing the negative experiences of others may influence cognitive processing for fathers when witnessing a labour and birth they perceive to be traumatic. Furthermore, perceiving the birth as traumatic may act to confirm prior negative or fearful beliefs and expectations (Ehlers & Clark, 2000).

All fathers in the current study met Criterion A of the DSM-5 (APA, 2013) by reporting perceived threat to their partner and/or baby at the initial screening stage. Fathers' appraisals of the labour and birth were often based on this threat of serious injury to their partner and/or child, or moments of heightened anxiety which were associated with heightened emotional distress during the interviews. This is consistent with literature exploring 'hotspots', defined as moments of peak emotional distress in the memory of traumatic events in the general PTSD literature (Ehlers & Clark, 2000; Holmes, Grey, & Young, 2005). Also consistent with the general literature was correspondence between participants' moments of heightened distress in the interview and voluntary and involuntary intrusive images experienced postnatally (Holmes et al., 2005). What appears to be unique for fathers during traumatic birth are the uncertainty and unpredictability of the event and the influence of their partner's emotions. Fathers described the labour and birth as a rollercoaster experience in terms of the changing situation and variation in their partner's state which impacted on their own fluctuating emotions. Although there is the potential for other traumatic events to be uncertain and unpredictable, other events may not involve directly witnessing the emotions of a loved one in the

same way as childbirth and have such dramatic alternations between positive and negative emotions and events.

Fathers' ongoing sense of threat following the traumatic birth highlighted a number of symptoms that are consistent with the DSM-5 criteria for PTSD (APA, 2013); including vivid intrusive images and emotional reminders, physical sensations, hypervigilance, and disrupted memories. It is interesting to note that these symptoms were mainly described by participants who also reported at least clinically significant symptoms on the initial screening measure, except for disrupted memories which were described by all participants. The emergence of these symptoms is unique to our understanding of paternal trauma following childbirth as prior studies have not qualitatively explored these symptoms in fathers. Some researchers have suggested that fathers develop these symptoms secondary to living with a partner with PTSD-FC (Beck, 2016; Nicholls & Ayers, 2007). However, although the current study only collected screening data for four partners and measuring maternal prevalence was not a specific aim, partners' scores suggest that not all had trauma symptoms and therefore fathers appear to develop these symptoms as a direct result of witnessing the birth and perceiving it as traumatic.

The emergence of disrupted memories is a unique addition to the understanding of paternal PTSD-FC. Fathers in this study described having fragmented and blurred memories of the experience which made recalling details of the labour and birth difficult. This is in keeping with the literature on

memories for traumatic events following other events where intentional recall of the traumatic event is fragmented with missing details and poor organisation in terms of the temporal order of events (Foa, Riggs, Dancu, & Rothbaum, 1993; Halligan et al., 2003; Zoellner & Bittinger, 2004). The presence of disrupted memories is also interesting from a gender perspective given that men are less likely to talk about traumatic events (McClellan & Anderson, 2009) and have poorer access to emotional memory compared to women (Segal & Cahill, 2009) which may maintain disrupted memories by preventing adequate processing following trauma (Brewin et al., 1996; Ehlers & Clark, 2000; Felmingham & Bryant, 2012).

Fathers also reported their memories for the experience feeling surreal, as though the experience was unreal or happening to somebody else. Though not conclusive, this description of memories could be consistent with dissociation, involving derealisation, depersonalisation and emotional numbing, which may also impede elaboration and integration of the trauma memory (Ehlers & Clark, 2000). Peritraumatic dissociation has been found to be a strong predictor of PTSD in the general PTSD literature yet not all individuals experience dissociative phenomenon (Ozer et al., 2003) and very little is known about mechanisms underpinning trauma-related dissociation (R. Bryant, 2007). One explanation is that dissociation is in fact a memory process occurring following the event to dampen emotional reliving at the time of recall (Berntsen, Johansen, & Rubin, 2008) which could fit with the avoidance observed in the current study.



## **2. The shock of comparing expectations and reality**

Fathers in this study engaged in making comparisons between their expectations and the reality of the birth witnessed which left them feeling surprised and shocked. Differences between the 'ideal and the reality' (Steen et al., 2012) have been identified as themes in the general paternal experiences of childbirth literature. However, this study identified that what appeared to make the experience traumatic for fathers were perceived lack of information and preparation to develop realistic expectations, the surprise of the unexpected, and the enormity and overwhelming sense of disparity between expectations and the traumatic experience. Nicholls and Ayers (2007) also reported that shock and expectations not being met were factors involved in the birth being perceived as traumatic for fathers, therefore it is likely that making comparisons between expectations and reality is important in paternal trauma following childbirth.

Whilst making comparisons between expectations and reality, fathers identified a desire for information. This supports previous qualitative findings that indicate fathers feel uninformed (Nicholls & Ayers, 2007) and crave further information (Elmir & Schmied, 2016). The maternal literature has also highlighted the importance of information in reassuring mothers and helping them to understand their experience postnatally (Iles & Pote, 2015). Specific to the paternal trauma experience appears to be fathers' desire to be more informed about the emotional impact of birth. It would appear that both mothers and fathers seek certainty in the antenatal and postnatal periods which warrants further exploration as a potential risk factor for PTSD-FC.

Cognitive rigidity and flexibility featured within the theoretical code of comparing expectations and reality. Fathers who described more shock and surprise when making these comparisons appeared to be more rigid in their expectations and cognitive processing and less able to reconcile differences. Fathers who identified themselves as being more flexible with their expectations explicitly commented on it helping them to cope and feel less distressed. Previous research in the general PTSD literature has shown that low cognitive flexibility is associated with PTSD symptoms (Joseph & Gray, 2011), while greater cognitive flexibility is associated with better long-term adjustment (Bonanno, Papa, Lalande, Westphal, & Coifman, 2004), growth (Hijazi, Keith, & O'Brien, 2015), and wellbeing (Fu & Chow, 2016) following traumatic events. Cognitive rigidity in beliefs and expectations about the labour in the antenatal period and the battle to remain in control peri-traumatically were also identified in the maternal PTSD-FC literature (Iles & Pote, 2015). Therefore the emergent themes in the present study provide some indication that risk and protective factors in the general PTSD literature are relevant for both mothers and fathers following traumatic birth.

Unexpected feelings resulting from the reality of the experience being different to expected added to the shock and surprise fathers reported. Fathers identified a broad spectrum of emotions during and after the birth including fear, anxiety, guilt, sadness, anger, and shame. This supports recent changes to DSM criteria which have expanded the diagnostic emotions from fear, helplessness or horror (DSM-IV, criterion A2) to include 'negative trauma-

related emotions' such as fear, horror, anger, guilt, or shame (DSM-5, criterion D). Therapy for PTSD has predominantly focused on addressing fear (Holmes et al., 2005). However, treatment of paternal trauma following childbirth may need to address a broader range of emotions. Fathers also identified that their unexpected feelings were due to the perceived threat being personal – to their partner and/or baby, opposed to someone they did not have a personal connection with. Many fathers had been unable to picture themselves in the birth environment in the antenatal period, therefore the perception of threat to their partner and/or baby's wellbeing added to their shock. This theme highlights factors specific to the paternal experience of witnessing childbirth. Although further exploration is warranted, it appears that witnessing childbirth for a father may be different to a health professional who does not have the same personal connection, or an individual witnessing threat to the wellbeing of a stranger.

### **3. The battle for control to protect and support**

As in the general childbirth literature, fathers in this study were committed to being involved and supportive during their partner's labour and birth but felt unable to do this (Johansson, Fenwick, & Premberg, 2015). Fathers felt responsible for, and torn between holding everyone in mind; their partner, the baby, and themselves. This is consistent with the findings from a qualitative study of fathers' experiences of the resuscitation of their baby at delivery which indicated that fathers felt conflicted between being with their baby or partner and had symptoms synonymous with PTSD (Harvey & Pattison,

2012). Furthermore, findings from the current study indicated that fathers felt guilty that they had been unable to support their partner and baby as anticipated, and for the decisions and actions they took during the labour and birth. In the general PTSD literature, researchers have highlighted the importance of guilt which has been found to impede emotional processing of the traumatic event (Brewin et al., 1996). Guilt-based PTSD has also been formulated as a specific model of PTSD (Lee, Scragg, & Turner, 2001) where guilt is suggested to arise “when the meaning of the traumatic event conveys a violation or departure from standards of behaviour and/or a feeling of responsibility for causing harm to others” (p. 462). Individuals who feel guilty following a traumatic event are often left to replay the situation over and over again, looking for indications of how they could have done things differently and can also be motivated to conceal and hide their feelings (Lee et al., 2001). This fits with the experiences of fathers in the current study and highlights the role of guilt in paternal trauma following childbirth which has implications for identification and treatment.

An important theme in the battle for control was fathers’ ‘powerlessness to influence fate’. This supports findings from previous studies which reported fathers being ‘stripped of their role; powerless and helpless’ (Elmir & Schmied, 2016) and as being passive observers with no control over what was happening (Nicholls & Ayers, 2007). Perceived lack of control is also an important predictor of PTSD symptoms in the maternal population (Czarnocka & Slade, 2000; Soet et al., 2003). The postnatal literature has made the distinction between external control during birth (e.g. control over what is done

to you) and internal control (e.g. control of your own body and behaviour; Green & Baston, 2003). Nicholls and Ayers (2007) in their study of couples' experiences of traumatic birth found that men placed importance only on external control, whereas women placed importance on both external and internal control. What is interesting in the current findings is that men appeared to describe feeling out of control externally (e.g. handing over trust to staff) but also internally (e.g. being unable to do anything themselves to help). It is likely that there are specific elements of control and feeling powerless that are therefore unique to the experience being traumatic for fathers compared to the maternal literature. Having control therefore seems important to the postnatal experience yet the need to feel in control may be detrimental if it is necessary for healthcare professionals to hold control in order to adequately care for the mother and baby.

Being a witness also emerged as important in fathers' battle for control; adding to fathers' sense of disempowerment and giving fathers an alternative perspective to their partner which meant they observed things that their partner did not (i.e. conversations and non-verbal exchanges between professionals). This is a new finding in the paternal trauma literature that warrants further exploration as it suggests that fathers may be less protected than mothers from potentially distressing information.

#### **4. Coping with and processing an unexpected reality**

A desire to process the experience emerged as an important factor for fathers in coping with the reality of the experience. Being able to tell their story was adaptive and helped fathers to process the experience. This is interesting given that this is an aim of debriefing for which there is no evidence supporting its effectiveness for women following childbirth (Rowan, Bick, & da Silva Bastos, 2007) and it is not recommended for treatment of PTSD (NICE, 2005). Talking with others however is thought to facilitate opportunities for feedback from others that might help correct excessively negative views about the meaning of the event (Ehlers & Clark, 2000). For women, clinical guidelines recommend a less standardised 'postnatal discussion' which gives the opportunity for evaluation of the course of labour and delivery, to ask questions, and to voice opinions to a trained professional (NICE, 2014). However, it is not known whether this service is accessible in all geographical areas or whether fathers are included in this discussion and able to tell their story. Therefore it is likely that fathers will be seeking alternative ways to process the experience.

Fathers in the current study identified that becoming a father and being part of the 'parenthood club' helped to facilitate talking about, and processing their experience. However, lack of discussion among men about birth and the tendency to tell the mothers' story were also barriers to talking. It may be that men have restricted opportunities to talk about and process their experience of the birth compared to women. Given the prevalence of partial symptoms in fathers, many may not reach service criteria for treatment which can also

facilitate telling and processing the story, for example through reliving. From the perspective of the cognitive model, processing the experience through reliving is thought to promote the elaboration and contextualisation of the trauma memory (Foa et al., 1993) which makes it more difficult to retrieve the original sensory impressions (e.g. intrusions, flashbacks; Ehlers & Clark, 2000).

Fathers reported a range of other adaptive coping strategies which facilitated processing and reduced distress (e.g. using reassurance and support from others, focusing on positives, and using humour). These are consistent with emotion and approach-focused coping strategies described in the general PTSD literature which are regarded as adaptive (Folkman & Moskowitz, 2004; Snyder & Pulvers, 2001). Choosing to focus on the positives may be unique to coping in paternal trauma following childbirth compared to other traumatic events given that childbirth is an event where the outcome is generally the much anticipated birth of a healthy baby which gives something positive and concrete for fathers, or the couple to focus on. However, there is then the potential for increased distress in the case of neonatal complications.

Emotional and behavioural avoidance emerged as maladaptive coping strategies for fathers. These strategies are seen to be maladaptive as they maintain PTSD symptoms through directly producing symptoms, preventing change in negative appraisals of the trauma, and preventing change in the nature of the trauma memory (Ehlers & Clark, 2000). For example, fathers in the current study described suppressing thoughts and emotions which have

been found to increase the frequency of unwanted intrusive recollections (Laposa & Aiden, 2003). Similarly, avoidance could maintain PTSD symptoms by preventing change in problematic appraisals (e.g. 'If I go to the hospital the trauma will happen again') and in the nature of the trauma memory as reminders of the trauma often provide retrieval cues for inaccessible details (Ehlers & Clark, 2000).

Fathers' negative appraisals of the experience included blame towards staff for unexpected events. Though it is possible that participants may have experienced negligent care, fathers seemed to become preoccupied with staff actions which could have hindered processing of the experience. The cognitive model of PTSD (Ehlers & Clark, 2000) suggests that recall of the traumatic event is biased by individual appraisals and that individuals selectively retrieve information consistent with these appraisals which subsequently prevents change in the appraisals. Therefore, fathers may be biased towards recalling negative examples of care and prevented from remembering aspects of the birth that contradict and change these appraisals (e.g. examples of positive care). Nicholls and Ayers (2007) reported perceived staff incompetence in their study of couples' experiences of PTSD-FC. However, the current study extends this to blame. The maternal literature has also reported blame towards staff for difficulties experienced during labour and birth (Czarnocka and Slade, 2000) but only in partially and fully symptomatic mothers whereas blame emerged across all classifications of symptoms in the current study. Blaming staff appeared to be a way of avoiding the emotional distress of witnessing the experience and giving a



sense of control. However, blaming others has been found to lead to poorer prognosis in the general PTSD literature (Joseph, Williams, & Yule, 1995) and it could further exclude fathers from a potential source of support if blame is generalised to all health professionals.

### **5. Barriers to processing and coping**

There were a number of factors that emerged as barriers to fathers' processing and coping with the traumatic labour and birth. As previously discussed, fathers telling their story appeared to be key to processing the experience. However, many fathers identified being unable to tell their story due to withholding their feelings to protect others. Similar findings have emerged in studies exploring parental coping following the death of a child (Stroebe, Schut, & Finkenauer, 2013) however, this is a new contribution to the paternal trauma following childbirth literature. Withholding emotions is problematic as it could lead fathers to suppress their emotional responses which has been found to be associated with increased trauma symptoms in the general PTSD literature (Shepherd & Wild, 2014).

Fathers also felt unable to tell their story due to feeling ashamed about their emotional reaction. In the general PTSD literature shame has been found to affect help seeking (Gilbert, 1997) and similarly to guilt, impede emotional processing of the event (Brewin et al., 1996). In PTSD, symptoms carry idiosyncratic meanings and shame can be seen as a sign of weakness or of not being able to cope (Ehlers & Steil, 1995). Shame is also associated with

underlying core beliefs influenced by early experiences which are activated following a traumatic event and interfere with an individual's ability to process the traumatic memory (Lee et al., 2001). Therefore, shame may be an important barrier to processing and coping for fathers experiencing trauma symptoms.

Fathers also identified systemic or cultural factors affecting processing and coping. Alongside reporting lack of discussion among men about birth, fathers felt generally excluded from the pregnancy, labour, birth and postnatal process. Fathers' feelings may be unacknowledged because fathers appear to be cast as supporters in the maternity process rather than parents witnessing the birth of their child. This leads fathers to feel like they are not entitled to experience distress which also prevents discussions about the experience found to be so important in this sample.

Fathers' perceived exclusion was heightened by a lack of support. This is particularly important as lack of social support during, and after trauma has been found to be predictive of PTSD symptoms (Brewin et al., 2000; Ozer et al., 2003). As previously discussed, support facilitates talking about the experience with others which helps with accessing memories, emotionally processing the event, and can mitigate symptoms (Brewin et al., 1996; Ehlers & Clark, 2000). Due to fathers feeling physically excluded in the birth room they may receive little support from health professionals during the labour and birth and in the postnatal period. Indeed, the Royal College of Midwives (2011) reported that many mothers feel their partners receive little or no

support during maternity care. Social support may therefore be an important factor influencing the development of trauma symptoms following birth for both men and women (Ford et al., 2010; Iles & Pote, 2015).

## **6. Ongoing impact of the experience**

Fathers identified both positive and negative ways in which the labour and birth experience had impacted on themselves and their families. Negative effects seemed to facilitate maladaptive coping strategies whilst more positive influences appeared to facilitate more adaptive coping strategies. However there was overlap between the two within participants' accounts. Fathers across the classifications of symptoms, experience the negative impact of traumatic birth supporting the notion that an individual does not need to meet the full diagnostic criteria of symptoms to experience impact on functioning (McLaughlin et al., 2015).

On an individual level, fathers had negative perceptions of their own coping abilities, including self-criticism, which is associated with higher rates of PTSD in men the general PTSD literature (B. Cox, MacPherson, Enns, & McWilliams, 2004). Fathers identified a number of factors impacting negatively on their couple relationship as a result of trauma symptoms and being unable to process the experience. Consistent with other studies exploring paternal PTSD-FC, fathers reported negative effects of the birth on intimacy (G. White, 2007; Nicholls & Ayers, 2007). However, opposed to feeling rejected because their partner avoided sex (Nicholls & Ayers, 2007),

the present study identified that men actively avoided sex and did not want future children themselves, even if their partners did. Interestingly, fathers did not report effects of their own trauma symptoms on their partner's coping.

At a family level, fathers described ways in which their parenting had been negatively impacted as a result of their traumatic birth experience. For example, with fathers being more protective of their child and being motivated to avoid potential triggers for intrusions, such as the baby crying. This contradicts the findings of Nicholls and Ayers (2007) which suggested that male partners played a role in compensating for mothers' emotional detachment from their infant. The impact of trauma symptoms following childbirth on parenting and the parent-infant relationship therefore warrants further exploration, particularly if both parents have symptoms.

Elements of growth and positive change emerged as important factors in fathers' experiences, particularly at a family level. This is novel given that research on psychological adjustment following childbirth has predominantly focused on negative outcomes (McKenzie-McHarg et al., 2015). Growth following trauma is seen as a potential consequence of redefining beliefs and assumptions (Tedeschi & Calhoun, 2006). In the present study, fathers identified their couple relationship becoming strengthened, positivity in becoming a family, and feeling more prepared for future birth experiences as positive changes following traumatic birth. Some of these elements are consistent with qualitative research on women's experiences where participants report a sense of strength or purpose (Elmir, Schmied, Wilkes, &

Jackson, 2010; Thomson & Downe, 2010). However, given there is significant overlap between elements of posttraumatic growth and positive experiences associated with becoming a father, further exploration is necessary to understand the relationship between growth and distress following childbirth in the paternal population.

### **Aim 2: Comparing the emergent theory with existing trauma theories**

The second aim of the study was to compare the emergent paternal theory with existing trauma theories reviewed in Chapter 1 to identify whether new factors emerge specific to the paternal population and unique to the context of childbirth, and whether factors in existing theories are relevant to the paternal experience. Discussion of the emergent themes has highlighted some consistencies with previous literature in the general PTSD and maternal PTSD-FC fields yet some factors appear to be unique to our understanding of the development and maintenance of paternal trauma following childbirth. Comparisons will focus on the cognitive model of PTSD (Ehlers & Clark, 2000) which has been applied and found to account for a significant proportion of the variance in maternal PTSD-FC symptoms (Ford et al., 2010; Vossbeck-Elsebuch et al., 2014) and diathesis-stress models which have drawn on key vulnerability factors found to be important in maternal PTSD-FC (Ayers et al., 2016; Ayers, 2004; Slade, 2006). Comparisons will also be made with the theoretical cognitive model of maternal PTSD-FC developed by Iles and Pote (2015) which has not yet been tested but explored mothers' experiences qualitatively, also using grounded theory.

### **Similarities between the emergent theory and existing theories**

Comparison of the emergent theory with the general and maternal cognitive models of PTSD highlights a number of factors which appear to be consistent across traumatic experiences and are relevant for both mothers and fathers following traumatic birth. For example, cognitive theories of PTSD identify the importance of pre-existing beliefs (Brewin et al., 1996) which also appear to be influential in terms of anticipatory birth-related anxieties and fears for maternal and paternal experiences of PTSD-FC. Shared across the models is also the role of cognitive rigidity in these beliefs and expectations, and the battle to remain in control in the peri-traumatic period.

The cognitive model of PTSD emphasises the importance of appraisals of the traumatic event which produce a sense of current threat and also emerged as important factors in the maternal and paternal experience following childbirth. Negative appraisals of the sequelae of the traumatic event can contribute to the maintenance of PTSD and threaten an individual's assumptions (Ehlers & Clark, 2000). For both mothers and fathers, the birth appeared to alter assumptions in terms of their perceived coping abilities and future plans. Across the cognitive models and emergent theory are both fragmented and poorly elaborated memories for the trauma and detailed, vivid moments for specific moments of fear which maintain sense of threat. Mothers and fathers described a similar range of postnatal emotions related to the experience and ongoing impact as those established in the general PTSD model.

The need to develop a narrative and tell the story in order to understand and process the experience was consistent across the maternal and paternal experience of trauma following childbirth and has been established as a method through which individuals are able to process trauma memories in the general cognitive model. There were other similarities in terms of coping strategies between mothers and fathers; both appeared to focus on the baby as a positive outcome of the experience and used cognitive (emotional) and behavioural (physical) avoidance, also consistent with the general cognitive model of PTSD. Poor postnatal coping and stress have also been associated with trauma symptoms in the diathesis-stress model of maternal PTSD-FC (Ayers et al., 2016).

Support features across models; mothers identified the importance of antenatal support, and support continuing throughout the labour, birth and into the postpartum from a range of sources (partner, family, friends, and healthcare professionals; Iles & Pote, 2015). However, although some fathers were able to use reassurance and support from others, the more overarching theme was that of fathers highlighting a desire for support throughout the experience. Lack of support has been identified as a risk factor for the development and maintenance of PTSD-FC symptoms in the diathesis-stress model (Ayers et al., 2016).

## **Differences between theories and factors unique to the paternal PTSD-FC experience**

Despite a number of similarities between models, comparisons indicate factors that may be specific to the paternal PTSD-FC experience.

In the peri-traumatic period, the battle for control emerged for both the maternal and paternal experience. For mothers this was related to making choices, having a role in decision making and staying in control. However, for fathers, the battle for control was related to their perceived responsibility to support and protect their partner and/or baby, feeling powerless and helpless to do so, and feeling guilty for their own actions. Given there are distinctive differences in mothers and father's roles during labour and childbirth, differences in the battle for control are perhaps not surprising. Also emerging as unique factors in the peri-traumatic period for fathers is the alternative perspective they have as witnesses and the impact of partner emotions which have the potential to increase fathers' appraisals of threat and fear during the labour and birth.

Although the maternal model points to mothers engaging in a process of reconciling their expectations with the reality of the experience, for fathers in the current study, it appeared that this was a definite process that influenced the extent of the ongoing sense of threat and distress experienced. It is possible that this is unique for fathers in its link with the perceived lack of preparation, information, and support to be flexible in expectations and help reconcile differences. Trauma symptoms may also be different between



mothers and fathers. For example, surreal memories, physical sensations and arousal featured for fathers but are not in the maternal model (though this does not mean that they do not exist for mothers). This may be reflective of sex differences in PTSD or due to mothers and fathers unique positions in the delivery room. This warrants further exploration with better scrutiny of differences in symptoms reported on measures of PTSD.

Though there are similarities in adaptive and maladaptive coping strategies between models, other strategies employed may be unique to the paternal experience. For example, the use of humour was important for fathers; both helping to lift distress during the birth and a way of coping when telling the birth story. In terms of maladaptive coping strategies, fathers appear to withhold their feelings to protect others which acts as a barrier to accessing support and processing the experience. This may be unique to the paternal experience given fathers' perceived responsibility to protect their partner and baby. Blaming staff also emerged in the paternal model as a coping strategy. In the maternal model, difficult interactions with staff appeared to have a significant lasting emotional impact on mothers however, fathers seemed to get stuck in the process of blaming staff and wanting to know if someone is accountable for their experience which also acts as a barrier to managing distress and processing the experience. The ongoing impact of the experience on family and parenting may also hold factors unique to paternal trauma following childbirth. For example, whilst the maternal model highlighted mothers' difficulties bonding with their infants, fathers reported their parenting being impacted by being more overprotective of their baby

than anticipated. Fathers also identified the impact of the birth on their partners' parenting, therefore the impact of trauma on parenting should be explored further within couples.

Factors specific to the paternal experience and running throughout the antenatal, peri-traumatic and postnatal periods are the desire for information, preparation and support, and the influence of systemic factors on this. Whilst the maternal model highlights an absence of professional postnatal support, the paternal experience highlights a lack of information, preparation, professional support and general acknowledgement of fathers' roles and feelings throughout. This was an overarching barrier to fathers being able to process their experience and a unique contribution to the existing literature.

It is interesting to note factors in the cognitive model of maternal PTSD-FC which may be specific to the maternal experience as they did not emerge for fathers in the current study. For example, mothers' narratives of the labour and birth were intertwined with pain, difficulty healing and breastfeeding pressures which impacted on postnatal mood and the emotional lens through which the experience was viewed (Iles & Pote, 2015). It is interesting that nothing emerged in the present study about the impact of these difficulties on fathers' symptoms and experiences. However, information on partner symptoms was only available for four partners in the current study therefore the extent to which symptoms were shared between couples is unknown. Further exploration of partner symptoms and experiences is warranted in future paternal PTSD-FC research. However, this study offers a unique

contribution to the existing literature in terms of potential differences between maternal and paternal experiences of trauma following childbirth.

## **Critical Review**

### **Strengths**

Given the lack of research explicitly exploring fathers' experiences of trauma following childbirth with a validated measure of symptoms, this study is an interesting contribution to the literature. Qualitative research is often criticised for its limited generalisability (Mays & Pope, 1995). Yet consistent with the constructivist critical realist perspective, the study did not aim to represent the views of all fathers experiencing trauma following childbirth. Rather, it sought to offer a contextualised exploration of this from the perspective of a UK-based sample who subjectively identified themselves as experiencing their partner's labour and childbirth as traumatic and met some or all of the criteria for a diagnosis of PTSD according to DSM-5 (APA, 2013). Charmaz argues that rather than seeking to construct generalisable theories, the aim of grounded theory is to construct tentative theoretical understandings viewed as "partial, conditional, and situated in time, space, positions, action and interactions" (Charmaz, 2009, p. 141).

Key strengths of the study were the inclusion of a standardised measure of PTSD symptoms, reporting of Criterion A (Ayers et al., 2008), and narrowing of time since the birth for fathers interviewed which addressed limitations identified in previous studies (Nicholls & Ayers, 2007; G. White, 2007). Rather

than solely recruiting participants who met the diagnostic criteria for PTSD, symptoms of PTSD-FC in the fathers interviewed represented a continuum of trauma responses which is thought to be a more helpful way of conceptualising symptoms opposed to distinct diagnostic categories (Ayers et al., 2008). Over-emphasis on diagnostic criteria may mean that men and women with clinically significant distress and impairment in functioning may be ignored and may not receive appropriate treatment. Interviewing participants who met Criterion A but reported fewer or no symptoms also enabled exploration of potential risk and protective factors.

Another strength is the use of a range of external bodies to maintain the quality of the research (Madill, Jordan, & Shirley, 2000). Three first-time fathers and three health professionals working in maternity services reviewed the demographic screening questionnaires and interview schedule which ensured that the questions were accurate, clear, relevant, and acceptable to fathers.

### ***Methodological rigour***

Charmaz (2014) recommends using eight factors to assess the quality of a grounded theory approach which are similar to the evaluative guidelines utilised in the current study to ensure methodological rigour (Elliot et al., 1999). These were used to guide the critical review of the study as follows:

1. **Fit:** This factor relates to how closely the concepts and theory describe the data they represent (Glaser, 1978). The emergent theory of paternal experiences of trauma following childbirth fits together to form an integrated and coherent summary of the analysis (Elliot et al., 1999) in the form of a theoretical model. Examples of the data are provided to illustrate the process of analysis and to allow for appraisal of fit between the data and the presented understanding.
2. **Workability:** A theory 'works' if it is able to provide insight and explanation in the context to which it seeks to refer (Glaser, 1978). The emergent theory provides insight into and an explanation of some of the factors contributing to the development and maintenance of paternal PTSD-FC.
3. **Relevance:** This refers to whether the theory focuses on a core concern or process and is not purely of academic interest (Glaser, 1978). The current study was relevant given the paucity of research specifically exploring paternal trauma symptoms following childbirth and the implications of the findings for fathers witnessing their partner's labour/birth. There is increasing interest in fathers involvement in the maternity experience (RCM, 2011) therefore the findings are relevant not just in the academic domain.
4. **Modifiability:** The theory's ability to be open to further development to accommodate new insights refers to its 'modifiability' (Glaser, 1978). Suggestions for further research and development are discussed later in this chapter.

5. **Originality:** This factor is assessed based on whether the findings offer new insight and how these contribute to existing social and theoretical understanding. The study was novel and original in its focus on specifically exploring paternal experiences of trauma following childbirth. Whilst previous studies have explored general paternal experiences of childbirth, experiences which were potentially traumatic without measuring trauma symptoms, and have presented results for couples, this study exclusively focused on paternal experience and identified factors specific to it which permit comparisons with existing trauma theories. These novel contributions contribute to the originality of the research.
6. **Credibility:** The researcher achieving familiarity with a topic and making strong links between the data and analysis which an independent would agree with is indicative of 'credibility'. The constant comparative method allowed for rigorous comparison both between and within participants' accounts to highlight similarities and differences in experiences (Charmaz, 2014). Memos captured the researchers' observations which helped to develop codes and categories. Verification of codes, emergent concepts, and the theoretical model was provided by the research supervisors and a peer supervision group to check that they fit the breadth of the data they covered.
7. **Resonance:** This factor refers to whether the categories accurately portray the studied experience and make sense to participants. Participants were given the opportunity to review the codes and categories which were presented with brief explanations in order to

assess their accuracy. Seven of the ten participants interviewed provided feedback indicating that the findings were comprehensive and resonated with their experience. The use of extracts from the data to illustrate the analysis is intended to increase resonance with the reader.

8. **Usefulness:** The extent to which the theory can be of use to people in their everyday lives, how it contributes to knowledge, and whether it can offer any improvement to people's lives is indicative of its usefulness. The 'usefulness' of the study in terms of clinical implications will be addressed later in this chapter.

### **Limitations**

Ensuring appropriate sampling was achieved was a challenge for the current study. Despite significant interest in the study website during the recruitment period (1321 visitors), only 18 participants completed the initial questionnaires. The researcher hypothesised that this may have been due to a lack of online sources aimed directly at fathers through which to advertise the study. Therefore, interest in the website may have been mainly from mothers, services, and researchers. Given fathers reported withholding their feelings from their partners, mothers may not have passed on information about the study to fathers as originally anticipated due to not knowing about their experience. Furthermore, due to barriers to fathers discussing their experiences identified in the study, fathers may not have felt able to participate.

Given that a significant factor in the emergent theory was the desire for support and to process the experience, the sample recruited may have been specifically seeking an avenue to do this and may have been more likely to express interest in the study. It has also been suggested that self-selected samples yield higher prevalence rates of symptoms (Ayers et al., 2009). Furthermore, using the internet to recruit participants may have affected the diversity of the sample. Although research suggests that internet samples are shown to be relatively diverse with respect to socioeconomic status, geographic region, and age (Gosling, Vazire, Srivastava & John, 2004), the participants in the sample were mainly White British, well educated, and with high household incomes. Therefore the findings may not be applicable to a more diverse population. Though the study focused specifically on the experiences of first-time fathers to build on the limitations of previous studies and focus the sample, the findings may only be applicable to this population. The sample was also influenced by the experience of other traumatic events subsequent to the birth, high scores on the EPDS, and reported prenatal and postnatal difficulties with, and treatment for mild-moderate anxiety and depression. However, this may be representative of the paternal PTSD-FC population given high levels of co-morbidity (Bradley et al., 2008). Prospective studies could extend the current findings and control for the impact of these variables.

At the inception of the study, DSM-5 had recently been published and a limited number of measures of PTSD symptoms had been validated to



account for changes to the diagnostic criteria. No measures consistent with DSM-5 had been validated for use in the postnatal population. In order to permit comparability with the existing literature, the PTSD-Q was chosen as a measure of PTSD which had been validated in the postnatal population but was based on DSM-IV criteria. The EPDS was used to measure symptoms consistent with depression in order to situate the sample. This also permitted some approximation of negative alterations in mood (DSM-5 Criterion D) though should be interpreted with caution.

Although the study sought to recruit participants who presented with full or partial symptoms of PTSD-FC, only five participants presented with at least clinically significant symptoms. The other five participants reported identifying the experience as traumatic (Criterion A) and subjectively reported distress and impact on functioning in the interviews. This enabled exploration of potential risk and protective factors but the overall findings may be more representative of experiences of paternal trauma following childbirth opposed to PTSD-FC. Alternatively, this may be representative of the prevalence of paternal PTSD-FC given the number of studies that have identified sub-threshold symptomology. Future research should assess the applicability of the emergent theory with a larger sample of fathers experiencing more clinically significant distress.

Given the critical realist social constructionist position adopted by the researcher, the use of screening questionnaires may be problematic as they fit participants' experiences into preconceived categories and promote a

universal truth. However, Charmaz (2014) permits the flexible use of a range of methods as research tools. Screening questionnaires were used in the present study to situate and describe the sample, increase homogeneity, and to identify for whom the results might apply to. The researcher reflected on ways in which they may have been biased in the interviews by participants' questionnaire scores and how participants may have potentially been primed to talk about trauma symptoms following completing the screening questionnaires. In future studies, brief pre-screening items could be used to assess eligibility and questionnaire data collected at the end of the interview to reduce any priming effects. The sample may have been further limited as the trauma questionnaire used has not been validated with a paternal postnatal population and therefore participants whose experience did not fit the questionnaire items may have been inadvertently excluded.

In line with recommendations for grounded theory studies, theoretical sampling was an aim of the study (Charmaz, 2014). However, due to difficulties with recruitment and time limits imposed by the doctoral course requirements, it was not always possible and theoretical saturation was not achieved for all categories. Given that the study demonstrates a sufficient understanding of paternal experiences of trauma following childbirth for an exploratory study, it can be concluded that the study met theoretical sufficiency (Dey, 1999). It is likely that there are outstanding factors warranting further exploration which has implications for how well the research works and how closely the findings resonate with the experiences of other fathers following traumatic birth.

The study sought to collect data from participants' partners in order to situate the sample in terms of PTSD-FC symptoms in the couple. The literature suggests that fathers could develop secondary traumatic stress resulting from hearing their partner talk about the birth being traumatic and that trauma responses in fathers could be a combination of direct witnessing and vicarious trauma (Beck, 2015; Figley & Kleber, 1995). Unfortunately only four partners returned screening measures, therefore knowledge of partner symptoms is limited.

Finally, participants expressed some difficulty during the interviews distinguishing between the impact of traumatic birth in the postnatal period and general difficulties in the transition to parenthood. Indeed, there are similarities in themes between the present study and the transition to parenthood literature (e.g. becoming a family, difficulties with intimacy, and feeling surprised and overwhelmed; Chin, Hall, & Daiches, 2011). Further research is therefore needed comparing the impact of birth in fathers with and without PTSD-FC. Quantitative methods which permit causality would also be helpful.

### **Implications for clinical practice**

This qualitative model of paternal trauma following childbirth facilitates an understanding of fathers' experiences. Fathers highlighted the need for more accessible information, preparation and support throughout the antenatal to

postnatal period. Although fathers' attendance at birth has been debated (Odent, 1999), guidelines have highlighted the importance of including fathers in maternity services (e.g. RCM, 2011). Whilst the findings are not generalisable, they offer some implications for guidelines, services and clinicians as follows:

### **Antenatal period**

- Fathers felt prepared practically for childbirth but unprepared for the emotional impact of being present during their partner's labour and birth. The literature recommends antenatal education as a potential avenue for the emotional preparation of expectant fathers (May & Fletcher, 2013). As antenatal anxieties and beliefs about birth may influence later trauma symptoms (though prospective studies are required), increased exploration of emotional aspects of birth with fathers could moderate negative appraisals of threat during the labour and birth.
- It might be helpful for professionals to be aware of anxieties for the father as well as the mother, and discuss their beliefs and expectations in antenatal classes and at appointments to reduce anxieties. Increasing flexibility in the way expectant fathers think about the labour and birth may also prevent later difficulties reconciling expectations and the experienced reality. This could include more flexibility using the birth plan (NHS, 2015).

- Fathers with significant distress antenatally could be referred to primary care services for psychological therapy.

### **Intrapartum period**

- Maternal studies have highlighted the importance of partner presence and support during labour and childbirth (Iles & Pote, 2015). However, fathers may be limited in providing this due to feeling unsupported themselves, their own fear response, and symptoms.
- Fathers identified that feeling unsupported contributed to the experience being traumatic. Though exploration with a larger sample of fathers is warranted, participants reported finding the presence of additional maternity staff (i.e. a doula) helpful and felt more supported when they were given an active role, which has been recommended for involving fathers in intrapartum care (RCM, 2011).

### **Postnatal period**

- Whilst support groups and online forums do exist specifically for men, fathers in the current study identified a lack of support in the postnatal period.
- The Royal College of Midwives suggests ways in which services and clinicians might be able to better support fathers postnatally (RCM, 2011) including providing information and support, supporting fathers to support their partners, and providing opportunities to explore and discuss the father's birth experience. Some services offer 'postnatal

discussions' (NICE, 2014) but it is not known whether these are equally accessible to fathers and mothers, given that fathers might develop PTSD-FC independently of their partner.

- Fathers reported barriers to discussing their experience with other men but some were better able to talk about and process their experience once they became part of the 'parents club' and could talk to other parents. It may be that more opportunities for first-time fathers to engage with each other could normalise difficulties and reduce stigma, breaking down some of these barriers and facilitating better support in the postnatal period.
- Given this study confirms the presence of symptoms of PTSD-FC in fathers it adds weight to the need for the assessment of paternal perinatal mental health (RCM, 2011), which could include a measure of PTSD-FC. It is also clear that fathers experience symptoms of PTSD-FC on a continuum. Therefore, services may wish to keep in mind making treatment available to fathers based on levels of distress and impact on functioning opposed to whether an individual meets diagnostic criteria.
- Given the potential impact paternal trauma symptoms may have on the family (e.g. the couple relationship, parenting), maternity services may need to adopt a whole-family approach opposed to just focusing on the mother and baby.
- The emergent model in the current study could be used to guide clinical formulation and treatment for new fathers presenting to services. There are currently no evidence-based treatments for PTSD-

FC (Peeler, Chung, Stedmon, & Skirton, 2013). The current recommended treatment in the UK for PTSD is cognitive-behavioural therapy (CBT: NICE, 2005). Because this model is grounded directly in fathers' experiences, it aids understanding of factors specific to the paternal experience and may be an important first step towards suggesting specific areas for CBT and other treatments to target. For example, by focusing on reconciling differences in expectations and reality, helping fathers to tell their story, considering future birth experiences without a sense of threat, and strengthening areas of growth.

### **Implications for future research**

Given the explorative nature of the study and limited generalisability of the findings, a number of areas for future research are suggested as follows:

- It would be useful to quantitatively test the applicability of the model with a larger number of participants who are more representative of the general paternal population. A structured questionnaire incorporating the key dimensions of the emergent model could be generated and circulated with a larger sample of fathers presenting with symptoms of PTSD-FC to test the central tenets of the theory.
- An extension of this qualitative study would be to recruit a more diverse sample (e.g. demographics, trauma symptom severity, not limited to first-time fathers), perhaps through NHS services, following fathers from the first antenatal contact. A prospective study would also help to

control for the impact of mood and experiences subsequent to the birth. Fathers could be interviewed at multiple time points with quantitative data captured alongside this measuring factors such as pre-existing anxiety, co-morbid perinatal mental health difficulties, and measuring the presence of other traumatic events.

- The use of measures consistent with the current DSM criteria or clinical interviews may also help to better establish prevalence.
- It would also be interesting to explore differences between men reporting clinically significant trauma symptoms and no symptoms to further elaborate on potential risk and protective factors, and explore the experiences of fathers whose partners did and did not have trauma symptoms.

### **Personal reflections**

In line with the constructivist grounded theory approach (Charmaz, 2014), I used a research diary to note my thoughts and reflections throughout the research process. This helped me to reflect on my own views, assumptions, and experiences in order to own my perspective and consider how this may have influenced analysis of the data.

I was particularly aware of differences between myself as a woman, not having experienced labour and birth, and not being a parent, compared to the participants. Several participants asked me if I had children and I wondered whether my position influenced their accounts of their experience. On the one



hand they may have withheld information in order to protect me, similar to the emergent theme of withholding feelings to protect others who don't yet have children. On the other hand, fathers often recalled vivid, visceral images of their experience so perhaps they did not see me as someone who might go through the experience in future. I sometimes found it difficult to hear these vivid and visceral descriptions which made me inwardly squirm. I also found it difficult to hear fathers' descriptions of their partners having 'low pain thresholds' or 'poor coping' and found myself wanting to side with the partner. This made me curious about how my own anxieties about childbirth may have shaped the interviews. I also found telephone interviews more challenging in terms of being able to empathise with the participant, manage emotional distress, and ask follow up questions. After each interview, I reflected on the questions I had asked, my feelings coming away from it, and questions I could have explored further.

I was also aware of my position as a Trainee Clinical Psychologist working in a perinatal mental health service. I think this could have informed participants' expectations of participating in the study and several fathers commented on the interview giving them chance to process, reflect on, and understand their experiences, therefore acting as an informal intervention. I found myself wondering whether the interview facilitated fathers having conversations with their partners, particularly if they had been able to better process the experience. Above all, I was struck by reactions from friends, family members, and colleagues when I told them the topic of my thesis which ranged from complete surprise that fathers could be affected by their partner's birth to

triggering discussions about their own, or their partner's difficult birth experience. I was privileged to be in a position to hear fathers' experiences in the interviews and am aware that I was often the first person they had told their birth story to.

## **Conclusions**

This study makes a valuable contribution to the knowledge and understanding of paternal experiences of trauma following childbirth. The development of a theoretical model permits comparisons with existing trauma models. Whilst some factors in the emergent model appear to be similar across the general and maternal PTSD models, other factors emerged which appear specific to the paternal experience. These include fathers' perceived responsibility to protect and support their partner and baby in the peri-traumatic period, the influence of partner emotions, shock when attempting to reconcile expectations and reality, the desire for information, preparation and support throughout the experience, and cultural factors and maladaptive coping strategies which act as barriers to fathers being able to process their experience. This study was an important first-step in generating a model to understand paternal experiences. Future studies should explore the findings further as these factors highlight important areas for development in clinical practice at various stages of the maternity experience and could inform formulation and treatment of fathers experiencing PTSD-FC.

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## **Appendices**

Appendix 1: DSM-5 criteria

Appendix 2: Literature search terms

Appendix 3: Extracts from research diary

Appendix 4: RHUL Ethical Approval

Appendix 5: Participant Information Sheet

Appendix 6: Consent Forms

Appendix 7: Debrief Sheet

Appendix 8: Risk protocol

Appendix 9: List of recruitment sources

Appendix 10: Study Advert

Appendix 11: Screening Questionnaires

Appendix 12: Interview Schedule

Appendix 13: Example transcript with coding

Appendix 14: Example memos

Appendix 15: Table of focused code frequency

## Appendix 1: DSM-5 criteria

According to DSM-5 (American Psychiatric Association, 2013), individuals must fulfil eight criteria for a diagnosis of Posttraumatic Stress Disorder (PTSD) as follows;

*Criterion A:* The person must be exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence through direct exposure, witnessing in person, indirectly learning that a close friend or relative was exposed to trauma, or having repeated or extreme indirect exposure to aversive details of the event usually through the course of professional duties.

*Criterion B:* The person must be experiencing at least one symptom of intrusions including; recurrent, involuntary and intrusive recollections, traumatic nightmares, dissociative reactions (e.g. flashbacks), intense or prolonged distress after exposure to traumatic reminders, or marked physiological reactivity after exposure to trauma-related stimuli.

*Criterion C:* The person must persistently and deliberately avoid distressing trauma-related stimuli after the event including either avoiding trauma related thoughts or feelings, avoiding trauma related external reminders (e.g. people, places, activities, objects, situations), or both.

*Criterion D:* The person must be experiencing at least two symptoms of

negative alterations in mood that began or worsened after the traumatic event including; inability to recall key features of the event, persistent negative beliefs and expectations about oneself or the world, persistent distorted blame of self or others for causing the event, persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame), markedly diminished interest in activities, feeling alienated from others, and restricted positive affect.

*Criterion E:* The person must be experiencing at least two symptoms of alterations in arousal and reactivity that began or worsened after the traumatic event including; irritable or aggressive behaviour, self-destructive or reckless behaviour, hypervigilance, exaggerated startle response, problems in concentration, and sleep disturbance.

*Criterion F:* The symptoms (in Criteria B, C, D, & E) must have persisted for more than one month.

*Criterion G:* There must be significant symptom-related distress or functional impairment.

*Criterion H:* Symptoms must not be due to medication, substance, or illness.

## **Appendix 2: Literature search terms**

### *Search terms/keywords:*

'fathers' OR 'dads' OR 'paternal' OR 'men' OR 'partners'

AND

'childbirth' OR 'birth' OR 'labour' OR 'labor'

AND

'posttraumatic stress' OR 'PTSD' OR 'traumatic birth' OR 'traumatic stress'

OR 'postnatal trauma' OR 'birth trauma' OR 'complicated birth'

### *Methods & Databases:*

Databases were searched between January-April 2016 and included PubMed, PsycINFO, JSTOR, Scopus and ScienceDirect. Papers were also included from hand searches and contact with authors. Papers were reviewed if they were published in English, were available as full text, and in peer-reviewed journals.

### **Appendix 3: Extracts from Research Diary**

The researcher kept a research diary to promote reflexivity throughout the course of the research to capture thoughts, process ideas and reflect on assumptions and values.

#### ***Extract 1: Following Interview 1***

Moved by experience, clearly experiencing trauma, strong desire to tell his story, had never told it before in this capacity. Difficult to manage distress in the room. Interview was long – almost 2 hours – mainly due to desire to tell every detail in the birth story. Almost like reliving.

Taken aback by participant asking me if I had children and telling me not to! Made me curious about my position in the interviews – different to participants – I'm a woman, haven't witnessed or been through childbirth myself. This participant really didn't hold back. Would other participants hold back if they thought about me potentially having children in the future?

In therapy sessions with clients I've often found men to fit the stereotype of being socialised not to talk about their feelings – managing his distress was more challenging. Signposted him to GP. It was also interesting conducting the interview at RHUL, overlapping boundaries.



***Extract 2: Research supervision – discussion about barriers to recruitment***

Update to supervisors: 4 months into recruitment only recruited 2 participants, one with significant PTSD symptoms and one without. Exhaustively advertising the study on online forums, cafes, play-areas etc in SW London.

Discussed whether NHS services would have been a better route? Still think that fathers would not be accessing these services postnatally. Health visitors could be an option but then would involve recruiting through the mother. From interviews so far seems like fathers don't talk to their partners about their experience.

Outcomes from meeting: Discussed needing to pursue avenues already advertising in and keep posting to make advert visible. Discussed contacting London Live to do a TV advert as another London research group have done recently. Also considering advertising where there is a small fee (i.e. NCT branches, fatherhood institute, local forums for parents).

***Extract 3: Following Interview 8 and 9***

In research supervision following interview 8 discussed changing order of interview schedule – fathers seem to be 'processing' their experience by telling their birth story in chronological order and this is lengthening the time of the interviews and causing them to go into minute-by-minute detail (where

they have memory for it) about aspects of the experience. Whilst this is interesting, not always able to address research questions. Are they telling story as method of avoidance?

Plan to amend interview schedule for subsequent interviews to begin with the labour/birth experience (key memories, images) and work through this experience and how it has left them feeling since (postnatal section) before returning to antenatal/anything missed out.

Following interview 9: trialled using the amended order of the interview schedule, was also a telephone interview so was feeling apprehensive. Worked really well, did not feel like we were jumping around. Actually meant that lots of antenatal expectations etc were covered by the participant. Became clear that comparing expectations and reality was important – recurring theme. Participant still commented at the end of the interview that it had helped him to put the experience into context and realise some things he hadn't before.

## Appendix 4: Royal Holloway University of London Ethical Approval

From: psychology.it.support@rhul.ac.uk  
Subject: Ref: 2015/035R1 Ethics Form Approved  
Date: 27 May 2015 12:09  
To: pava064@rhul.ac.uk, h.pote@rhul.ac.uk  
Cc: PSY-EthicsAdmin@rhul.ac.uk, Hanna Zagelka@rhul.ac.uk, Annette.Lock@rhul.ac.uk, uqjt005@rhul.ac.uk

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Application Details: View the form click [here](#) Revise the form click [here](#)

Applicant Name: Florence Bristow

Application title: Developing a theoretical model of paternal postnatal posttraumatic stress

Comments: Approved.

## **Appendix 5: Participant Information Sheet**

### **Information Sheet (V3 26.09.15)**

#### **Fathers' experiences of labour and childbirth**

##### **What is the research about & why are we interested in this?**

The study is exploring the experiences of first-time fathers' who found the birth of their child upsetting, distressing or traumatising. We are interested in how fathers think and feel about this experience and the impact this has had on their wellbeing since the birth.

We know that similarly to mothers, fathers respond to the labour and birth of their child in different ways. A small number of fathers experience unpleasant thoughts and images about the birth into the first few months or years of parenthood. We would like to understand these experiences further to enable healthcare providers to understand the needs of fathers during labour and into the postnatal period.

##### **Can I take part?**

- ✓ I am a father who witnessed some or all of my partners' labour and childbirth and found it to be difficult, upsetting or traumatising
- ✓ I am aged 18 or over
- ✓ My baby is 3-36 months old and is the first child for both me and my partner

##### **Do I have to take part?**

No – taking part is entirely voluntary and completely up to you. You can decide not to take part without having to provide a reason. If you do decide to take part, you can choose not to answer all of the questions and you are free to withdraw from the study at any time without having to provide a reason.

##### **What will I have to do?**

If you are interested in taking part, I will ask you to complete some questionnaires which ask for some brief background information about you and your partner, information about the labour and birth, and questions about your own experiences following the birth. The questionnaires should take no longer than 30 minutes to complete.

I will contact a small number of fathers to ask if they are happy to take part in the next stage of the study; an interview with me. You will be under no obligation to take part in the interview. If you did take part, the interview would be at a time and place convenient for you, or could take place via phone or Skype. It would last approximately 1 hour. The interview will be recorded on a digital recorder. The interview will be an informal discussion, led by you, about your experience of your partner's labour and childbirth and how you have been feeling since.

With your permission, if you are invited to take part in the interview, we would also like to contact your partner and ask her to complete the same questionnaires to give us more information about the factors that might impact on fathers' experiences. However, you do not have to give permission for us to do this, and your partner does not have to take part. We would still like to speak to you if this is the case.

##### **What are the possible risks and benefits of taking part?**

This study does not involve any direct risks. Some fathers may find it hard to talk about their experiences, especially if they have upsetting memories of the labour and birth. However, some fathers might find talking about their experiences helpful and interesting. Your involvement in the study may give you satisfaction that you have contributed to important research, which may influence the care new parents receive in the future.

The interviews are being conducted for research purposes, not to provide treatment. However, if after taking part in the study you think you would like to access support or treatment, the researcher can provide you with some useful contacts.

**Will my taking part in this study be kept confidential?**

All your details will remain confidential and your responses anonymised. If your partner also takes part in the study, their data will be confidential and you will not have access to each other's information. Your data will be stored securely.

The results may be published in academic journals and presented at conferences. Participants will not be identifiable in any reports. Once the study is complete all data will be destroyed.

As in any piece of research, if information is disclosed which clearly indicates that you, another adult or child is at risk of harm, I would be obliged to discuss this with your GP or other appropriate service though I would always try to discuss this with you first.

**Who has reviewed the study?**

The study has been reviewed and approved by the Department of Psychology Ethics Committee at Royal Holloway University of London.

**Who should I contact if I would like more information or would like to take part?**

*Florence Bristow, Trainee Clinical Psychologist*

*florence.bristow.2013@live.rhul.ac.uk*

*Or visit: <https://fathersandbirth.wordpress.com>*

If you would like to discuss any aspects of the project with the supervisors, please feel free to contact:

**Thank you for taking the time to read this information**

## Appendix 6: Consent Forms

### Consent Form (1) Fathers' experiences of labour and childbirth

You have been invited to participate in a study about first-time fathers' experiences of witnessing labour and childbirth, which is being carried out by Florence Bristow.

This part of the study will involve completing two questionnaires. One questionnaire is about your own experiences following your child's birth and how you have been feeling. The other questionnaire asks for basic information about you and your partner.

**Please tick YES or NO for each of the following:**

	YES	NO
1. I confirm that I have read and understand the information sheet about the study	<input type="checkbox"/>	<input type="checkbox"/>
2. I have had the opportunity to ask questions about the study	<input type="checkbox"/>	<input type="checkbox"/>
3. I have received satisfactory answers to my questions	<input type="checkbox"/>	<input type="checkbox"/>
4. I understand that my participation is voluntary, and that I am free to withdraw from the study at any time, without giving a reason	<input type="checkbox"/>	<input type="checkbox"/>
5. I agree to take part in this part of the study	<input type="checkbox"/>	<input type="checkbox"/>

Name (BLOCK LETTERS) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Supervisors:**

***NB: This consent form will be stored separately from the anonymous questionnaire responses you provide.  
The questionnaires will be anonymous and destroyed at the end of the study.***

**Consent Form (2)**  
**Fathers' experiences of labour and childbirth**

This part of the study will involve taking part in an interview lasting approximately 1 hour. The interview will ask more about your experience of your partner's labour and childbirth, how you have been feeling since, and how this has impacted your life and relationships with others.

**Please tick YES or NO for each of the following:**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. I confirm that I have read and understand the information sheet about the study  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have had the opportunity to ask questions about the study  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have received satisfactory answers to my questions   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I understand that my participation is voluntary, and that I am free to withdraw from the study at any time, without giving a reason  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I understand that my interview will be recorded and transcribed for the research study   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I understand that anonymised quotes from my interview responses may be used in the final research report   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I agree to provide my partner's contact details in order for the researcher to contact her and ask her to complete some questionnaires about how she has been feeling since the birth. I understand that this information will remain confidential and will not be shared with me. | <input type="checkbox"/> | <input type="checkbox"/> |

Partner's name \_\_\_\_\_  
 Telephone number \_\_\_\_\_  
 Email \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 8. I agree to take part in this part of the study | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Name (BLOCK LETTERS) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Supervisors:**

***NB: This consent form will be stored separately from the information you provide.  
 Electronic recordings will be destroyed once interviews have been transcribed.  
 The interview transcripts will be destroyed at the end of the study.***

**Consent Form (Partner)**  
**Fathers' experiences of labour and childbirth**

Your partner is participating in a study exploring first-time fathers' experiences of witnessing labour and childbirth, which is being carried out by Florence Bristow. As part of this study, we are also interested in finding out how mothers have been feeling about the labour and birth to give us more information about the factors that might impact fathers' experiences. Therefore, we are inviting you to take part in this part of the study.

This part of the study will involve completing two questionnaires which ask about your own experiences following your child's birth and how you have been feeling. We have also asked your partner to complete a Birth information questionnaire and would encourage you to complete this together.

**Please tick YES or NO for each of the following:**  
**YES NO**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. I confirm that I have read understand the information sheet about the study  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have had the opportunity to ask questions about the study  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have received satisfactory answers to my questions   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I understand that my participation is voluntary, and that I am free to withdraw from the study at any time, without giving a reason  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I understand that my responses will be kept confidential and not shared with my partner. Any information my partner provides will also be kept confidential and will not be shared with me, including interview responses. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I agree to take part in this part of the study   | <input type="checkbox"/> | <input type="checkbox"/> |

Name (BLOCK LETTERS) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Supervisors:**

***NB: This consent form will be stored separately from the anonymous questionnaire responses you provide.  
The questionnaires will be anonymous and destroyed at the end of the study.***



## Appendix 7: Debrief Sheet

### **Father's experiences of labour and childbirth**

Thank you for taking part in this study exploring father's experiences of labour and childbirth. We really appreciate your participation and hope that by understanding more about father's experiences we may be able to influence the care that new parents receive in the future.

We realise that for some fathers, it may be difficult to talk about your experience and that this might raise difficult feelings for you.

#### **For more information and sources of support:**

- In the first instance, speak to your GP who can advise you on local psychological services and support groups.
- Many NHS psychological therapy services accept self-referrals - search for your local service here: <http://www.nhs.uk/service-search>
- The Birth Trauma Association has more information on fathers' experiences following a traumatic birth: <http://www.birthtraumaassociation.org.uk>

*If you require urgent support for yourself, or are concerned about the mental health of someone else, go to your nearest Accident & Emergency department. Or call the Samaritans on 116 123.*

## Appendix 8: Risk protocol

### Father's experiences of labour and childbirth Home Visits, Lone Working & Risk Protocol

#### Home visits:

- The researcher and research supervisors will be equally responsible for ensuring the study is conducted as safely as possible.
- The research supervisors will know where the researcher plans to be – a list of planned home visits will be available electronically (password protected) with the client's name, contact details and visit location.
- One research supervisor will always be available to contact during a planned visit and research supervisors will inform the researcher if they will be unavailable so that the visit can be rearranged.
- Clients will be numbered and the researcher will text the research supervisor (on the morning of the visit) with the number of the client she is visiting, the time she will arrive and her estimated time of departure.
- Upon departure from the participant's home, the researcher will send another text message to the research supervisor to indicate that the visit has ended and no safety issues arose.
- The researcher will conduct a risk assessment when arriving at a property an exit route
- If, on arrival to the participant's home or other location, the researcher is met with an unexpected situation which gives cause for concern, the researcher will make an excuse to leave the property and leave immediately. Once safely out of the property the research supervisor(s) will be contacted and informed of the researcher's actions.
- The researcher will always carry a charged mobile phone programmed with contact numbers for the research supervisors.
- If a visit takes significantly longer than planned, the researcher will make contact with the research supervisor(s) to update them on the revised timings.
- If the research supervisor does not receive confirmation that the visit has ended and the researcher is safe, the research supervisor will:
  - In the first instance, call & make contact with the researcher
  - If the researcher requires the alarm to be raised, an agreed code phrase will be used ("Can you check something on the database")
  - The research supervisors will have the contact number of the researcher's next of kin to ensure the researcher has not returned home but forgotten to send a message
  - If the research supervisor is unable to make contact with the researcher, they will contact the participant
  - If necessary, the alarm will be raised

**Managing risk issues:**

- If the researcher is concerned about a participant's responses on the online questionnaires, the research supervisors will be contacted prior to a response being sent.
- If the researcher is concerned about a participant's wellbeing following an interview, the research supervisor will be informed in the text message that is sent upon leaving the interview. The researcher and supervisor can then decide if the issue needs to be followed up immediately or discussed in the next supervision meeting.
- If a participant is thought to be at immediate risk of harm, the researcher will escort them to their GP or to A&E. In the case of telephone or Skype interviews, the GP will be contacted.

## Appendix 9: List of recruitment sources

- Birth Trauma Association (National; [www.birthtraumaassociation.org](http://www.birthtraumaassociation.org) & [facebook support group](#))
- Netmums (Local & National; [www.netmums.co.uk](http://www.netmums.co.uk))
- Mumsnet (Local & National; [www.mumsnet.com](http://www.mumsnet.com))
- The Fatherhood Institute (National website & advertisement in monthly newsletter; [www.fatherhoodinstitute.org](http://www.fatherhoodinstitute.org))
- Dad Info (National; [www.dad.info](http://www.dad.info))
- London based parenting forums (e.g. [www.nappyvalleynet.com](http://www.nappyvalleynet.com), [www.forsanityssake.com](http://www.forsanityssake.com)).
- Social media networks such as Facebook and Twitter
- Dissemination of flyers through:
  - London & Home Counties branches of the National Childbirth Trust
  - London Children's Centres
  - London soft play venues and family friendly cafes

## Appendix 10: Study Advert



### **First-time Dad? We need you!**

***Are you a first-time father with a baby aged 3-36 months?***

***Were you present for some or all of your partner's labour and childbirth?***

***Did you find this experience difficult, upsetting, or traumatising?***

***Have you had any unpleasant thoughts or images about the birth subsequently?***

If you answered *YES* to these questions, we would like to invite you to take part in a research study exploring fathers' experiences of their partners' labour and childbirth. The study involves completing some questionnaires and possibly being interviewed about your experiences.

If you would be interested in taking part or would like some more information, please contact me:

**Florence.Bristow.2013@live.rhul.ac.uk**

**07501 842827**

**Or visit: <https://fathersandbirth.wordpress.com>**

This research has been granted ethical approval by the Department of Psychology Ethics Committee at Royal Holloway, University of London.

## Appendix 11: Screening Questionnaires (reproduced with authors permission)



### Fathers' experiences of labour and childbirth

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#### Consent to participate in the study

You have been invited to participate in a study about first-time fathers' experiences of witnessing labour and childbirth, which is being carried out by Florence Bristow, Trainee Clinical Psychologist (Royal Holloway, University of London).

This part of the study will involve completing some questionnaires about you and your partner, your experiences following your child's birth and how you have been feeling. This will take approximately 30 minutes.

Your responses will remain confidential. Your personal details will be stored separately to your responses so that your responses remain anonymous. Your data will be stored in password-protected electronic files so that they are only accessible by the research team.

Please tick YES or NO for each of the following:

1. I confirm that I have read and understand the information sheet about the study\*  
 Yes  No
2. I have had the opportunity to ask questions about the study\*  
If you have any unanswered questions, please contact the researcher.  
 Yes  No
3. I have received satisfactory answers to my questions\*  
 Yes  No
4. I understand that my participation is voluntary, and that I am free to withdraw from the study at any time, without giving a reason\*  
 Yes  No
5. I agree to take part in this part of the study\*  
 Yes  No
6. Name\*
7. Today's Date\*  
 dd/mm/yyyy
8. Your email address\*  
So that the researcher can contact you to discuss your responses and/or the next stage of the study (if applicable)
9. Your telephone number\*  
So that the researcher can contact you to discuss your responses and/or the next stage of the study (if applicable)
10. Your GP & GP's Address\*  
So that the researcher can contact your GP in the event that your responses indicate that you or another person are significantly distressed or at risk or harm (The researcher would always discuss contacting your GP with you)
11. Your Date of Birth\*  
 dd/mm/yyyy

Next

Cancel



## Fathers' experiences of labour and childbirth

Page 2 of 7

Thank you for taking part in this study.

The following questions ask for some background information about you and your partner, the birth of your child, and how you have been feeling since. They will take around 30 minutes to complete.

If possible, please complete this questionnaire where you are free from distractions and can think about the answers.

Please be as honest and accurate as possible - your responses will remain anonymous. However, try not to spend too long on each question, it is your first responses that are important.

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Cancel



## Fathers' experiences of labour and childbirth

### SECTION A: About you and your partner

You

1. Your age\*

2. Your occupation\*

3. Your marital status\*

- Single  Married  Co-habiting  Separated  Divorced  
 Other, please specify

4. Your Ethnicity\*

5. Please indicate your highest level of education attained (or equivalent)\*

- GCSE/key skills level 1 or 2/ NVQ level 1 or 2  
 A-level/key skills level 3/ NVQ level 3 or 4  
 Bachelors degree  
 Postgraduate qualification

6. Please circle the item below that accurately describes your family income.\*

- Less than £14,999  
 £15,000 to £39,999  
 Over £40,000

7. Have you experienced any mental health difficulties?\*

- |     | Prior to the birth       | Since the birth          |
|-----|--------------------------|--------------------------|
| Yes | <input type="checkbox"/> | <input type="checkbox"/> |
| No  | <input type="checkbox"/> | <input type="checkbox"/> |

8. If you answered YES, please provide some more details:

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Cancel



## Fathers' experiences of labour and childbirth

### SECTION A: About you and your partner

#### Baby's mother

1. Age of Baby's mother\*

2. Occupation of Baby's mother\*

3. Marital status of Baby's mother\*

Single  Married  Co-habiting  Separated  Divorced

Other, please specify

4. Ethnicity of Baby's mother\*

5. Please indicate highest level of education attained (or equivalent) by Baby's mother\*

GCSE/key skills level 1 or 2/ NVQ level 1 or 2

A-level/key skills level 3/ NVQ level 3 or 4

Bachelors degree

Postgraduate qualification

6. Has the Baby's mother experienced any mental health difficulties?\*

	Prior to the birth	Since the birth
Yes	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>

7. If you answered YES, please provide some more details:

8. Have you or your partner experienced any other traumatic events prior to, or since the birth? \*

Yes  No

9. If you answered YES, please provide some more details:

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Cancel

## Fathers' experiences of labour and childbirth

### SECTION B: Details about the labour and birth

You are welcome to complete this section with your partner

1. How many weeks pregnant was your partner when your baby was born?\*

2. What was your baby's birth date?\*

 dd/mm/yyyy

3. Was your baby:\*

Male  Female

4. Was this the first birth for you and your partner?\*

Yes  
 No

5. How long was the labour\*  
(in hours)

6. How many hours of the labour and birth were you present for?\*

7. Where was the baby born?\*

- Hospital labour ward  
 Hospital birthing centre  
 Midwife-led unit  
 Home  
 Other, please specify

8. Was the birth assisted by any of the following interventions?  
Select all that apply

- Induced  
 Forceps  
 Ventouse (vacuum extraction)  
 Planned caesarean section  
 Emergency caesarean section  
 Episiotomy  
 Other, please specify

9. What pain relief (if any) was given during the labour and birth?  
Select all that apply

- Gas & Air  
 Pethidine  
 Epidural  
 TENS  
 Other, please specify

10. Who else was present during the labour and birth?

11. Did the baby require any special care or intervention?\*

Yes  No

12. If YES, please specify:

13. Did the baby's mother require any medical care or have any antenatal complications?\*

Yes  
 No

14. If YES, please specify:

15. If your baby was delivered in hospital or a birthing centre, how long did Mum and baby stay in hospital?

Mum

Baby

16. Did you experience your partners' labour and/or birth to be difficult, upsetting, or traumatising?\*

Yes  
 No

17. Have you or your partner received psychological support following the birth?\*

Yes  
 No

18. If YES, please provide brief details about the reason for seeking this support & duration of treatment:

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Cancel

**Posttraumatic Stress Disorder Questionnaire**

**(Not included due to copyright restrictions)**

**Edinburgh Postnatal Depression Scale**

**(Not included due to copyright restrictions)**

## Appendix 12: Interview Schedule

<b>Introductions/ Confidentiality</b>	<ul style="list-style-type: none"> <li>• Purpose of interview</li> <li>• Semi-structured – led by your experience</li> <li>• Chronological format</li> <li>• Timings</li> <li>• Confidentiality &amp; limits explained</li> <li>• Right to choose not to answer any questions or to withdraw at any time</li> <li>• Opportunity to ask questions</li> <li>• Rapport building questions (i.e. what they would usually be doing today, talk about the baby)</li> </ul>	
	<b>Key Questions</b>	<b>Further prompts</b>
<b>Antenatal period:</b> <i>We're going to start by thinking about how you were feeling about the labour and birth when [your partner, partner's name] was pregnant...</i>	How were you feeling about the labour and birth before your partner went into labour?	First thoughts about it?  Did you have any expectations for the labour and childbirth when your partner was pregnant?  Partner prompt expectations?
	What thoughts did you have (or images that went through your mind) about the labour and childbirth during the pregnancy?	Concerns/worries?  Role?  <i>Negative thoughts/feelings:</i> Coping Talk to others? Partner's views?
	Do you know how your partner was feeling about the labour/birth during the pregnancy? Did you discuss your feelings/expectations together?	
	Did you do anything specific to prepare for the birth (e.g. books, classes, talking to others)?	Birth plan?

	Is there anything else about the pregnancy/ antenatal period you would like to tell me about? Or anything important that we haven't discussed already?	
<b>Labour &amp; Birth:</b> <i>Now I'd like to ask you about your experience of the labour and birth...</i>	Describe to me your partners' labour and birth.	What was it like for you? Where were you when labour started? How long was the labour? Where did she give birth? Who was present? What was your role? Were there specific things you did or were asked to do?
	How did the experience compare to your expectations?	If different: how do you feel about that?
	How did you feel during the labour and birth?	Emotions when labour began/continued/at birth? Did you expect to feel this way? What influenced you feeling this way?
	How do you think you coped during the labour and birth?	
	Was there anything that helped you cope (antenatally or at the time)?	
	Was there anything that felt unhelpful?	
	<i>Partner:</i> How did your partner experience the labour and birth?	Fit with your expectations of her? If different: how do you feel about that? How would she describe your experience?

<i>Staff:</i>	Tell me about the staff that were present during the labour and birth.	What role did staff play? How did you feel about care/support from staff at the time? Now? How would partner describe support/care?
	How do you think the staff would describe your partners' labour and childbirth?	
<i>Trauma: (When you think back to the labour and birth...)</i>	What are the main things that come to mind?	
	Thoughts/images/key events which go through your mind? (Explore each)	
	Do these thoughts/images come to mind now?	How often does this happen?  When did you first notice this happening?
	What is it like to have these thoughts/images coming to mind?	
	How does it make you feel?	
	How do the thoughts go again? (Distract/go of own accord)	
	Do thoughts/images impact on what you're doing at the time?	
	Anything in particular trigger these	



	thoughts/images?	
	Do you ever feel like you are back in the time of the labour/birth? What is this like?	
	Avoid reminders of your experience of the labour and birth (i.e. people, places, smells, sights, sounds...)?	What if are unable to avoid these reminders?
	More jumpy or alert since the labour and birth?	
	Told anyone else about these thoughts/images? (Partner/others)	How did they react?
	Do you know if/think your partner has had any of these thoughts or images since the labour and birth?	
<b>Postnatal:</b> <i>I'd like us to spend the remainder of the interview thinking about the period since X was born...</i>	How would you say you have been feeling generally since the birth?	
	Has anything happened since X was born that has influenced the way that you think or feel about it?	
	How would you describe how your partner has been feeling generally since the birth?	
<i>Impact:</i>	What effect has the experience had on you since the birth?	(i.e. personal life, work, plans for future children, sleep)  Any positive changes? Negative changes?  Hardest thing since? Most positive thing since?
	Has the experience effected how you feel about becoming a father?	
<i>Relationships:</i>	How would you describe your relationships with others before the labour and birth?	With partner Impact on sexual relationship/intimacy? Friends/family

<i>Coping/Support:</i>	And how would you describe them now?	
	How would you describe your relationship with your baby?	
	Have you been able to talk to others about your experience?	How have they responded? Anything you haven't told them?
	Has your experience impacted on your thoughts and feelings about having more children?	
	How have you coped since the labour and birth?	What has helped? What has made it difficult to cope? How supported? How would partner say coped?
	How has your partner coped herself since the labour and birth?	
	How would you describe yourself now, compared to before the birth?	
	Has your experience contributed to your sense of self as a father?	
	<i>Looking back:</i>	Is there anything that you or others could have done differently to make the experience more positive?
<b>Other life events:</b> <i>It is helpful for me to understand your experience in the context of your life...</i>	Have you ever experienced any other traumatic events?	If so, explore trauma symptoms relating to these
	Would you say there is anything happening in your life at the moment which is causing you a high amount of stress?	

	Was there anything else happening around the time of the birth to make you feel particularly stressed?	
<b>Final questions &amp; debrief:</b>	Is there anything else which is important for me to know about your labour and birth that we have not talked about?	
	If you were going to describe your experience to someone, which are the parts you would really want them to understand?	
	Is there anything you would like to ask about the interview?	
	How are you feeling after talking about those things? Do you have any concerns about the things we have talked about today?	

**Appendix 13: Example transcript with coding**

Transcript	Initial coding	Focused coding
<p>I: Yea, and did you have any images in your mind of what that might have looked like in the moment?</p> <p>P: Um...if I did then they were probably overridden by the images of what actually happened. So...I can't, no, I guess it's just probably more that she would shout at people and tell them they were wrong. I guess....but um that's probably about it really. It was just more a general feeling that she wouldn't be as...um....yea...as calm and rational I guess about decisions, and different steps and what was happening.</p> <p>I: And any other thoughts that you might have had prior to the labour and birth about what it might be like, or what it might be like for you, or anything like that?</p> <p>P: Um....I don't know really, I guess it's kind of, maybe things like...you know the whole hollywood moment of, you know when things happen, and people say this is the most amazing moment of your life, you know, bells and whistles going off and that sort of thing. You know, thinking about, this is probably how I'm going to feel, I feel, I know, I'm guna feel like that but is it going to be like that, that's probably about it. And then, you know, kind of just thinking about...the odd but not really really, making me think about it more now than I did at the time, what it</p>	<p>Finding it difficult to recall antenatal images            Having antenatal images overridden by actual experience            Expecting my partner would shout at people and tell them they were wrong            Fearing partner wouldn't be calm and rational</p> <p>Finding it difficult to recall thoughts/concerns</p> <p>Expecting the birth to be a Hollywood moment; knowing it will feel like the most amazing moment of my life            Wondering if it will be a Hollywood moment; Weighing up expectations and other people's experiences</p>	<p>Antenatal anxiety about the unknown</p>

<p>might be like. Are we going to be sat in a swimming pool bouncing up and down on a ball, singing, or are we you know, is it going to take 3 days, are we guna...and perhaps just thinking about other people's experiences and what they had said, which from other fathers...uh...which is what we do anyway....we don't talk about feelings...it's very little. So, other than people had said things like, yea it's horrific...</p> <p>I: Other fathers?</p> <p>P: Yea...that's all you ever hear about it.</p> <p>I: Ok, so no one elaborated on what horrific might have been like?</p> <p>P: No...and you don't know whether that is because they don't really have permission to say that, if that makes sense, or what it is, but generally...</p> <p>I: Is that something about them not knowing if it's their story to tell?</p> <p>P: Yea, perhaps. Or...it just could be the male trait, or the male friends that I have just don't talk to each other about things like that.</p> <p>I: Ok, and you never were curious to sort of say, how was it horrific or...</p>	<p>Considering what the birth would be like  Holding in mind other people's experiences  Unknown experience  Explaining fathers don't talk about their feelings  Being told it's horrific</p> <p>Hearing it's horrific; Wanting to know more about other fathers' experiences</p> <p>Men not talking about their experiences; male trait; lack of permission</p> <p>Wondering what horrific means  Wondering whether other fathers don't have permission to talk about birth</p>	<p>Desire for information</p> <p>Being unable to tell story</p>
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<p>P: Possibly...but I'm not sure. I probably would have just waited, and probably did find out from my wife.</p> <p>I: About the mothers' story?</p> <p>P: Yea, so she would find out more about my friends' lives from their wives, which still happens now.</p> <p>I: Ok...</p> <p>P: So one of my friends moved house on Friday, I didn't know but she did.</p> <p>I: Ok. So they talk about...</p> <p>P: Wives who weren't friends until very long ago talk about those sorts of things.</p> <p>I: Ok. What's that like?</p> <p>P: I don't know really....sometimes it's...I don't know. Um...</p> <p>I: Like in relation to hearing about the birth and things like that, and then hearing about your friends' male experiences from the wives.</p> <p>P: It is a bit frustrating actually. I guess its a little bit, you know, comparing myself to some of my other friends, that the ones I'm closest to are all relatively masculine in the</p>	<p>Attributing lack of discussion about birth to male traits; wondering if my friends don't talk about personal experiences</p> <p>Being curious about why birth was horrific  Finding out second-hand from wife;  Being envious of women talking more openly</p> <p>Hearing about my friends through my wife</p> <p>Hearing second-hand information about friends from wife</p> <p>Seeing women who have not been friends for long talk openly about personal experiences</p>	<p>Being unable to tell story</p>
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<p>traditional sense of the word, in that we aren't very talkative. I can't remember a time, sober anyway, having a conversation about how anyone feels to any of my male friends. Um...perhaps until I became a father probably, actually.</p> <p>I: So that has changed more recently? Ok...and did you have any thoughts prior to the birth about what your role might be? I know you said you would be there to support...</p> <p>P: Um...practical. So, pre-birth I'm there to make sure we make the right shopping decisions about, you know, cots and buggies and things like that. and you know, I'm organised, make sure I get the right bag and all that sort of stuff, and theres a route plan and communication plans and all that kind of thing. But, um...hold their hand and do as you're told.</p> <p>I: Is there anything else we've not talked about about the antenatal period or how you were feeling before the labour and birth that you think would be important?</p> <p>P: Don't think so....no....not that I can really think of. So...the kind of picture is that everything was good and exciting and the only sort of slight bit of worry was that &lt;partner&gt; was worried about the birth.</p>	<p>Being unsure about feelings</p> <p>Feeling frustrated about lack of knowledge</p> <p>Comparing myself to friends</p> <p>Describing my friends as masculine and not talkative</p> <p>Explaining lack of conversation with male friends</p> <p>Speaking more about feelings with friends since I became a father</p> <p>Anticipating practical role at birth</p> <p>Making practical decisions; being organised; expecting to support wife</p> <p>Expecting to hold her hand and doing as I'm told</p> <p>Experiencing pregnancy as good and exciting</p> <p>Worrying about my partner's worries</p>	<p>Becoming part of parents club</p>
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## **Appendix 14: Example memo**

### **Memo: 'Desire to tell their story'**

Reading through transcripts and initial coding – there is a strong desire for participants to tell their story in the interviews. Listening to the interviews and reading through the transcripts I can also see where I have asked a question and the participant has cut me off to continue telling their story, or has pressed to tell me some information.

For many fathers, it seems like it is the first time they have told their story, they have previously focused on telling the birth story from their partners' perspective, if there have been opportunities to do so. Fathers comment on women having opportunity to talk to each other but men do not discuss feelings or birth. It is like participants are processing their experience during the process of the interview – almost like reliving therapy. This isn't necessarily a bad thing but not an aim of the study, and could impact on results. They have commented at the end of interviews that the interview had been helpful – i.e. 'helpful to process it', 'I've put things into context', 'I realise now a few things I didn't before', 'It wasn't as bad as I thought now I've talked about it', 'It's put things into perspective, it's in the past now'. There seem to be so many barriers to fathers telling their story – it will be important to continue to explore this in subsequent interviews.



## Appendix 15: Table of focused code frequency

(across participants and trauma symptom classifications)

Theoretical code	Focused codes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
		<i>Full</i>	<i>Partial</i>	<i>Crit. A</i>	<i>Crit. A</i>	<i>Partial</i>	<i>Crit. A</i>	<i>Crit. A</i>	<i>Clin. sig</i>	<i>Crit. A</i>	<i>Partial</i>
<b>1. Anxious cognitions leading to sense of threat &amp; disrupted memories</b>	1.1 Antenatal anxiety about the unknown	X	X	X	X	X	X		X	X	X
	1.2 Perceived threat & anxiety during labour/childbirth	X	X	X	X	X		X	X	X	X
	1.3 Ongoing sense of threat postnatally	X	X			X	X		X	X	X
	1.4 Disrupted memories	X	X	X	X	X	X	X	X	X	X
<b>2. Shock of comparing expectations &amp; reality</b>	2.1 Desire for information	X	X	X		X	X	X	X	X	X
	2.2 Enormity of shattered expectations	X	X	X	X	X	X	X	X	X	X
	2.3 Unexpected feelings	X	X	X	X	X	X	X	X	X	X
<b>3. The battle for control to protect &amp; support</b>	3.1 Perceived responsibility	X			X	X	X	X	X	X	
	3.2 Powerless to influence fate	X	X		X	X	X	X	X		X
	3.3 Being a witness unable to help		X					X	X	X	X

Theoretical code	Focused codes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
		<i>Full</i>	<i>Partial</i>	<i>Crit. A</i>	<i>Crit. A</i>	<i>Partial</i>	<i>Crit. A</i>	<i>Crit. A</i>	<i>Clin. sig</i>	<i>Crit. A</i>	<i>Partial</i>
<b>4. Coping with &amp; processing an unexpected reality</b>	4.1 <i>Desire to process the experience</i>	X	X	X	X		X			X	X
	4.2 <i>Adaptive coping strategies</i>	X	X	X	X	X	X	X	X	X	X
	4.3 <i>Maladaptive coping strategies</i>	X	X	X		X	X	X	X	X	X
<b>5. Barriers to processing &amp; coping</b>	5.1 <i>Being unable to tell my story</i>	X	X	X	X			X	X	X	X
	5.2 <i>Feeling excluded</i>	X	X		X	X	X	X	X	X	X
<b>6. Ongoing impact of the experience</b>	6.1 <i>Negative perceptions of own coping</i>	X								X	X
	6.2 <i>Negative impact on family</i>	X	X			X	X		X	X	X
	6.3 <i>Family growth</i>		X		X		X	X		X	X