What are the long-term impacts of a traumatic birth, as experienced by fathers?

Clare Abbey Charman

Submitted in accordance with the requirements for the degree of
Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds
School of Medicine
Division of Psychological and Social Medicine

May, 2022

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

Acknowledgements

I would firstly like to share my great appreciation and thanks to the eight fathers who took part in this study and entrusted me with their deeply personal birth experiences, this project would not have been possible without you. Your narratives have taught me a great a deal, and I have found the level of openness from all those who shared their experiences to be truly touching and inspiring.

I would also like to offer an enormous thank you to my supervisors Dr Amy Russell and Dr Ciara Masterson. There are no words that can express how grateful I am for the huge level of support, guidance and frequently needed reassurance, you have offered me. Thank you for everything, you really have been the most incredible supervisors.

I would also like to thank my amazing friends and family, who have encouraged and supported me throughout my training journey. Thank you for always believing in me and pushing me to never stop chasing my dreams. I would not have gotten through this doctorate journey without each and every one of you, and I am so grateful to have such special people in my life.

Abstract

Introduction: Extensive research has gone into exploring the impact of a traumatic birth on mothers, capturing enduring adverse outcomes, as well as post-traumatic growth. As it is now common that fathers are present at childbirth, it is imperative that paternal experiences of birth trauma are also explored, however literature currently remains limited and no studies focus exclusively on the long-term impact of this experience. The present study aimed to bridge this gap in the literature by gaining an in-depth understanding of the long-term impacts of a traumatic birth on fathers.

Method: A qualitative study involving semi-structured interviews, conducted with eight fathers, who had self-identified as having experienced a traumatic birth, two or more years ago. Interviews were analysed using thematic analysis.

Results: Five themes were identified, each including related subthemes. The five themes were: i) Boxed away as "should not feel", ii) Can't face it again; fear and recovery of having further children, iii) Haven't felt like a "normal dad"; the effects on parenting, iv) The enduring distress, and v) Positive long-term outcomes post-trauma.

Discussion: This study provides new insight into the long-term impacts of a traumatic birth on fathers. Although fathers have a greater presence at childbirth, the perception of this being a maternal experience remains embedded. A traumatic birth can be a highly distressing experience, igniting feelings of fear, helplessness, and guilt. These emotions can have an enduring effect. Traditional masculine ideologies remain prevalent, forming a barrier to some fathers feeling validated in their experience, being able to talk about the event, or seek support. Readiness to access support can take time. A traumatic birth can have varying impacts on a father's mental health and wellbeing, relationships with others, and desire to have subsequent children. Although adverse outcomes can occur, growth following the trauma is also recognised.

Table of Contents

List of Tables

List of Figures

Introduction

The following study explores the long-term impacts of a traumatic birth, as experienced by fathers. This introduction contains a brief description of trauma and recovery before defining, and considering the prevalence of birth trauma. Following this, an overview of the current maternal birth trauma literature will be provided, with a focus on the emotional and psychological impacts of this experience. Next, literature capturing the paternal experiences of a traumatic birth will be presented. Within this, some context around what fathers may experience during the traumatic birth event itself will be provided, as well as what is understood, so far, about the possible long-term impacts of this experience. Finally, the research study aims will be offered. The literature within this thesis will draw on a range of different research disciplines including psychological and social sciences. A glossary of terms used within this thesis can be found in Appendix A.

The Long-Term Impact of Trauma

It is widely recognised that experiencing a traumatic event can have a severe and enduring psychological impact (Joseph & Linley, 2008). Individuals hold fundamental core beliefs and assumptions about themselves and the world, which typically include that the world makes sense, is benevolent, and that the individual possesses self-worth (Janoff-Bulman, 1992). These assumptions aid maintaining a sense of safety and stability, however when a traumatic event occurs, these assumptions can be shattered (Janoff-Bulman, 1992). A traumatic event can be difficult to make sense of and can cause cognitive and emotional reactions. Concepts of assimilation and accommodation, which are frequently referred to in various psycho-social models (e.g. Joseph & Linley, 2005), provide helpful insight into how trauma-related information is processed. The experience of a trauma event can, in some cases, lead to adverse outcomes such as symptoms of anxiety, depression or Post-Traumatic Stress Disorder (PTSD), however it can also lead to positive outcomes such as growth (Joseph & Linley, 2005).

Literature has provided a wealth of insight into both the short and long-term impacts of a traumatic experience. It is important for research to explore recovery and impacts across time, as responses to traumatic events can be diverse, varying and changing over time. For example, Bryant et al. (2015), carried out a study

looking at the long-term trajectory of PTSD following traumatic injury, over a six-year period, and identified five different trajectories. These included a chronic trajectory (PTSD remained high), a recovery trajectory (symptom reduction over time), a resilient group (minimal symptoms reported at any stage), a delayed or worsening trajectory, and also a group where the individuals' symptoms worsened over time but then improved (Bryant et al., 2015). For the group where symptoms worsened over time but then improved, PTSD symptom severity was at its highest two years post-trauma, and improvement was then captured occurring after this time point. These findings capture the diverse journeys individuals can experience following a traumatic event.

When considering what is defined as 'long-term', this can be difficult, and it varies in the trauma literature. For example, some studies do not always clearly define what they mean by long-term or why the time-frames they cover would constitute being longer-term (e.g. Barthel et al., 2020; Hull et al., 2002; Schneider et al., 2012). Schneider et al. (2012), capture adverse outcomes being reported over two years post-trauma, describing the data as long-term. Studies which have focused on examining short and long-term PTSD symptoms following a traumatic event and captured changes in trauma symptoms over time, have interestingly also found substantial gender differences in rates of PTSD symptoms reported, with females experiencing higher rates of symptoms both immediately after a trauma event and at follow up time periods (e.g. Steinglass & Gerrity, 1990). Apparent gender differences in responses to traumatic experiences have also been reported within several other studies (e.g. Ditlevsen & Elklit, 2012; Holbrook et al., 2002; Søegaard et al., 2021). Although it is reported that woman are at a two times greater risk of PTSD than men, these gender differences are not constant and can vary depending on the type of trauma (Ditlevsen & Elklit, 2012). Furthermore, it is important to acknowledge the possibility of gender biases occurring in some measures used to assess distress (Matthey & Agostini, 2017), and that men may also under-report on symptoms of distress they experience (Tolin & Foa, 2006). Acknowledging gender differences in trauma experiences provides support for the present study, as it highlights that the impact of a traumatic birth on fathers may be different to the mothers' experience, therefore requiring independent exploration.

For many years literature has focused on identifying the adverse impacts of trauma, however there is now a growing awareness of, and interest into, what

positive outcomes can occur from such an experience (Sheikh, 2008). Post-traumatic growth (PTG) refers to positive transformations which can occur, as a result of experiencing a traumatic life event (Tedeschi & Calhoun, 2004). A systematic review and meta-analysis exploring the prevalence of moderate to high PTG following a traumatic event, including 26 papers, captured levels of PTG to range between 10% and 77.3% (Wu et al., 2019). Time periods for the development of PTG following a traumatic event vary considerably, with some studies reporting PTG occurring anywhere between two weeks (Frazier et al., 2001), and eight years after the trauma experience (Affleck et al., 1987). Experiences of PTG have been reported within a wide range of trauma literature, including following natural disasters, chronic illnesses, sexual assaults, bereavements, and military combat (Linley & Joseph, 2004). Tedeschi & Calhoun (1996) identify five areas of post-traumatic growth which include new possibilities, relating to others, personal strength, spiritual change, and appreciation for life. PTG has been phrased in different ways within literature, one of which is the term “benefit finding” (Helgeson et al., 2006). A meta-analysis exploring the link between benefit finding and psychological and physical health, found that benefit finding was most highly linked to lower depression and higher positive affect when it had been over two years since the traumatic event (Helgeson et al., 2006). Significant PTG being reported two years post-trauma, has also been captured in other trauma studies (e.g. Su et al., 2020).

The trauma and recovery literature provides examples of negative and positive outcomes. The remainder of this chapter will move to focus specifically on the experience of birth trauma. To set the scene, a brief introduction to the perinatal period and mental health, along with a definition of birth trauma will be presented.

The Perinatal Period and Mental Health / What is Birth Trauma

Childbirth is hoped to be a joyful and exciting event where parents meet their baby for the very first time (Olza et al., 2018; Vischer et al., 2020). However, it is increasingly recognised that positive experiences of birth are not always the case. Childbirth forms part of the perinatal period, a timespan which covers pregnancy through to the first 12 months after birth (NHS England, 2018). It is well evidenced within research that across various stages of the perinatal period, the mental health of one or both parents can be affected. It is estimated that up to 20% of women can

experience a decline in their mental health during the perinatal period (Bauer et al., 2014), with depression, anxiety, and postpartum psychosis being some of the difficulties woman can experience (O'Hara & Wisner, 2014). Paternal mental health difficulties during this time have also been acknowledged, with the prevalence of anxiety during the postnatal period being between 2.4% and 51.0% (Philpott et al., 2019), and the rate of depression during the perinatal period being estimated around 8.4% (Cameron et al., 2016).

Childbirth is an extremely complex event linked to various significant adjustments for parents, which can be perceived both positively and adversely (Parfitt & Ayers, 2009). For some mothers, the experience of childbirth can be traumatic (Baptie et al., 2020; Beck, 2004). More specifically, research has captured as many as 45% of new mothers reporting their birth event as traumatic (Alcorn et al., 2010). Much of the current birth trauma literature has focused on exploring the mother's journey (e.g. Elmir et al., 2010; Fenech & Thomson, 2014; Taghizadeh et al., 2014). However, with societal expectation across most Western countries now being that fathers are to be present at childbirth (Draper, 2003), it is vital to acknowledge that fathers can also experience this event as traumatic (Daniels et al., 2020; Etheridge & Slade, 2017; Inglis et al., 2016). Unfortunately, literature to date exploring and capturing this experience remains scarce.

Minimal research has so far considered the potential differing experiences of a traumatic birth on mothers and fathers, however it is likely that the paternal experience of this event is different, as they experience the birth "vicariously as an observer" (Delicate et al., 2022, p. 41). Literature has captured how mothers and fathers can report different emotions from a traumatic birth. For example, more common emotions triggered within a traumatic birth can be shock and helplessness for fathers, whereas mothers tend to report confusion, anger, feeling violated and humiliation (Nicholls & Ayers, 2007). One study exploring healthcare practitioners' assessment and observations of birth trauma, also highlighted possible gender differences in post-traumatic stress symptoms (PTSS) observed in parents, with 're-experiencing' being most noted in mothers, and 'avoidance' being most noted in fathers (Delicate et al., 2022). This literature provides supporting evidence that it is necessary to explore a father's traumatic birth experience, independent of the mother's.

Being present at childbirth can be experienced positively by fathers, however commonly reported experiences include feeling confused about their role in the birth, ill-prepared for what they witnessed, and feeling helpless (Johnson, 2002). When the birth is experienced as traumatic by a father, this can be devastating, potentially affecting various aspects of their life including their mental health (Daniels et al., 2020); relationship with the mother (Nicholls & Ayers, 2007; White, 2007); and on wanting subsequent pregnancies (Inglis et al., 2016). These areas will be explored in greater depth later in the chapter.

Although some valuable insight into the fathers' experiences of the birth event has been identified, research exploring the long-term impact of a traumatic birth is limited. To date, paternal birth trauma studies (e.g. Elmir & Schmeid, 2022; White, 2007), have tended to recruit across wide timeframes since the birth event, including the perinatal period, and do not always clearly differentiate between the short and longer-term experiences reported. As discussed earlier, responses to a trauma event are known to change over time, so exploring these experiences as they are perceived at a later time point is important. The present study aims to address this gap in the literature and focus on capturing the long-term impacts of a traumatic birth on fathers.

Defining a Traumatic Birth

There is currently no consistently used definition for the term 'traumatic birth', and it is often used interchangeably with other terms, such as 'birth trauma' (Elmir et al., 2010). When attempting to understand what is meant by a traumatic birth experience, responses from those who have gone through it can vary, but may include; experiencing a great loss in sense of control during birth, feeling helplessness or experiencing immense fear around the possible risks to life (Beck, 2004; Elmir et al., 2010; Taghizadeh et al., 2014). Other contributing factors may include unexpected changes in the birthing plan, requiring sudden obstetric intervention, or receiving inadequate care from staff (Daniels et al., 2020; Simpson & Catling, 2016). Therefore, a traumatic birth is highly personal and subjective, and even a birth clinically perceived as straightforward and without any complications, can be experienced as traumatic (Beck, 2004; Thomson & Downe, 2008).

Limited literature looking at the experiences of fathers means that defining a traumatic birth from anyone other than from the mother's perspective is difficult (Greenfield et al., 2016). When exploring currently used definitions for a traumatic

birth, these vary considerably. Some literature available (e.g. NCT, 2018) appear to frequently conflate birth trauma with PTSD. However, it is important to acknowledge that these are separate; PTSD may be an outcome of experiencing a traumatic birth, but not all parents present at a birth they deem traumatic will develop it (Delicate et al., 2022).

Greenfield et al. (2016) highlight how early definitions of birth trauma were commonly centred around physical injury. However, it is critical to acknowledge that childbirth can also be psychologically traumatic (Greenfield et al., 2016; Reynolds, 1997), and newer definitions (e.g. Beck, 2004) have focused on capturing the psychological experience. In a recent definition, the National Institute for Health and Care Excellence (NICE, 2020) defines a traumatic birth as:

> Births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage) and births that are experienced as traumatic, even when the delivery is obstetrically straightforward (p. 44).

The above represents a much more inclusive definition which considers both the physical and psychological experience of birth trauma. However, within this definition, it is suggested that a birth can be physically traumatic whilst not psychologically traumatic. The present study aims to recruit fathers who have experienced a psychologically traumatic birth, irrespective of whether instrumental or assisted delivery was required. Therefore, for the purpose of the present study, the chosen definition for a ‘traumatic birth’ which is felt to be most relatable to fathers’ experiences is:

> The emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature (Greenfield et al. 2016, p. 265).

This chosen definition does not aim to include birth experiences where there has been a loss of life to the mother or child, as it is likely that loss of life during the birth event will trigger significantly different trauma responses such as complex

grief reactions, which is something known to have a long-term impact on parents (Kersting & Wagner, 2012).

Impact of a Traumatic Birth on the Mother

Research to date has captured extensive and valuable insight into the impact a traumatic birth can have on the mother, therefore it is important to explore this literature first to consider some of the possible similar outcomes a father may experience. Historically, research predominantly focused its attention on exploring how content mothers were with their childbirth experience, or on postpartum depression (PPD; also interchangeably referred to as postnatal depression), with limited attention given to other postnatal mental health difficulties or on how a mother's experience of the birth event could be linked to postnatal outcomes (Allen, 1998). However, newer literature has attempted to fill this gap and there is now a wealth of awareness into various aspects, such as the maternal experiences of a traumatic birth and the enduring impact this can have on their mental health and wellbeing (e.g. Beck, 2006; Taghizadeh et al., 2013)

Several factors are thought to increase the risk of a birth being traumatic for the mother, including incidents of obstetric emergency, neonatal complications, adverse experiences of interactions with care staff, and where there is a previous history of mental health difficulties (Simpson & Catling, 2016). A meta-ethnography of ten qualitative studies exploring women's perceptions of a traumatic birth, captured the adverse impact some staffs' approach to care during labour, which many reflected on as being disrespectful and dehumanizing, had on their birth experience (Elmir et al., 2010). The distress of a traumatic birth can be often linked to women experiencing feeling unheard, powerless, invisible and lacking opportunity to give consent (Brown et al., 2022), and this can often be compounded by racial bias (see Markin & Coleman, 2021).

Fenech and Thomson (2014) conducted a meta-synthesis, which included 13 papers, looking at the psychosocial implications of a traumatic birth on the wellbeing of mothers. This research highlighted how a traumatic birth experience can adversely impact a mother's sense of identity and result in intense and enduring psychological and emotional distress. It can also lead to mothers experiencing a profound sense of grief and loss in relation to their perceptions of having a perfect motherhood journey (Fenech & Thomson, 2014). Furthermore, findings from this

study also acknowledged disruption in the family unit, intimacy issues with a partner, difficulties forming a parent-infant attachment, and adverse impacts on subsequent pregnancies, also being possible outcomes following a traumatic birth (Fenech & Thomson, 2014).

Impact on Maternal Mental Health and Wellbeing

Depending on the type of traumatic birth experience (e.g. where obstetric intervention is required), a mother can face many challenges post-birth, including trying to heal physically and, or psychologically, whilst also having to process and adapt to caring for their baby (Priddis et al., 2018). The adverse impact that a traumatic birth can have on maternal mental health is well documented, with some mothers experiencing anxiety, depression, or PTSD (Taghizadeh et al., 2013). The psychological and emotional impact of a traumatic birth can be experienced long-term (Priddis et al., 2018). For example, it is not uncommon for the annual anniversary of a traumatic birth to trigger recurrent distress for many years after the event (Beck, 2006). Women can often feel 'trapped' by the enduring vivid memories, flashbacks and nightmares of the birth trauma they experienced (Elmir et al., 2010).

When considering what time period captures 'long-term' impacts, the maternal literature can vary, with studies reporting mothers experiencing enduring birth trauma related difficulties anywhere from between two years to ten years after the event (Beck, 2006; McDonald et al., 2011). Gottvall & Waldenstrom's (2002) study looking at the impact of birth trauma on future reproduction captured that for women who scored their birth experience as highly negative and did go onto have another child, they tended to wait an estimated median time of 4.2 years until having another, in comparison to 2.4 years for mothers whose experience was perceived as less negative. This study captures the gap between pregnancies representing how long distress can last.

Beck's (2006) qualitative study looking at the anniversary of a traumatic birth event, captured mothers reporting significant distress, including reoccurring feelings of intense anxiety, fear, and loss, which were triggered by the anniversary of the birth, as long as ten years after the birth event. A qualitative study looking at 32 women's views of living a traumatic childbirth experience and aspects related to a birth experience, also captured some mothers reporting ongoing depression two

years post-birth (Rodríguez-Almagro et al., 2019). A study by McDonald et al. (2011), captured some mothers continuing to experience birth-related PTSS, two years post-birth. As maternal PTSD and PPD are both known to be possible outcomes following childbirth (Horsch & Ayers, 2016), these will be explored in greater detail next.

Maternal Post-Traumatic Stress Disorder (PTSD). During a traumatic birth, mothers can experience a range of emotions including fear, shock, and disempowerment, whereas postpartum they more commonly report distress such as anxiety and flashbacks (Hinton et al., 2014). Although said to be a less common sequel (Simpson & Catling, 2016), childbirth related PTSD has received a lot of attention within research (e.g. Ayers et al., 2016; Schobinger et al., 2020). Ayers (2007) defines PTSD as:

> When a person experiences an event during which he or she perceives a threat to his or her own life, the life of a significant other, or his or her physical integrity, and the person responds with intense fear, helplessness, or horror (p. 253)

Symptoms of PTSD include intrusion symptoms (e.g. nightmares, flashbacks), avoidance of trauma-related reminders, changes in arousal and reactivity (e.g. increased irritability) and negative changes to cognition and mood (American Psychiatric Association, 2013). To meet criteria for a diagnosis, symptoms need to have been present for over a month and be causing significant distress or impact to the individual's daily functioning (American Psychiatric Association, 2013). PTSD following a trauma can resolve after a short time, however for some it can have a more chronic trajectory (Santiago et al., 2013).

A meta-analysis of 78 studies reported the prevalence of women who experience postpartum PTSD to be around 3.1% in community samples, and 15.7% in at-risk samples (Grekin & O'Hara, 2014). A meta-analysis exploring the cause of PTSD after childbirth, identified adverse subjective experiences of the birth, requiring an operative birth (cesarean or assisted vaginal), dissociation, and poor levels of support, as being the key birth related risk factors most linked to PTSD (Ayers et al., 2016). Similarly, a recent large scale study, including 916 women, looking as PTSD following childbirth, also captured women scoring higher in PTSD

when childbirth was perceived as distressing, and that requiring a caesarean section can also increase the risk for PTSD post-birth (Ertan et al., 2021). Although some women will experience PTSD, it is vital to acknowledge the significant number of women who do not meet full criteria for a PTSD diagnosis but do still experience PTSS (Ayers, 2004; White et al., 2006).

For women who do experience childbirth-related PTSD, this can have both immediate and long-term implications (Ayers et al., 2006). A longitudinal study looking at childbirth-related PTSD, where a significant number of women identified their birth as traumatic, concluded from a sample of 776, that 5.8% of women met criteria for PTSD six months postpartum (Alcorn et al., 2010). This reduced to 3.1% when controlling for pre-existing PTSD and partial PTSD, as well as anxiety and depression identified as being present during pregnancy (Alcorn et al., 2010). Further studies have also captured cases of PTSD symptoms following traumatic childbirth, continuing for at least 12 months after the event (Ballard et al., 1995). One study exploring maintenance factors of PTSD symptoms following childbirth, captured symptoms of clinically significant distress and PTSD symptoms, in some cases still being maintained two years after the birth (Garthus-Niegel et al., 2015).

Childbirth-related PTSD has been found to have detrimental impacts on the mother-infant attachment (Dekel et al., 2019), and is linked to mothers developing anxious or avoidant attachment styles with the infant (Ayers et al., 2006). Developing these insecure attachment styles is well known to impact on a child's development long-term (Malekpour, 2007). Furthermore, PTSD has been strongly associated with PPD and is linked to high stress levels and difficulties coping following birth (Ayers et al., 2016). Research has also captured postpartum PTSD symptoms at eight weeks to be associated with poorer couple relationship satisfaction at two years post-birth, and this effect being mediated by depression symptoms (Garthus-Niegel et al., 2018).

Maternal Postpartum Depression (PPD). PPD refers to a major depressive episode which is typically experienced by mothers within the first 12 months after birth (Bell & Andersson, 2016), however in some cases these depressive symptoms can persist beyond two years (Goodman, 2004a). Signs and symptoms can typically include low mood, irritability, tiredness, insomnia, negative thoughts, feelings of guilt and hopelessness, and bonding difficulties with the baby

(NHS, 2018). The prevalence of mothers experiencing PPD following a birth is estimated to be between 13% and 19% in Western nations (Gavin et al., 2005; O'Hara & Swain, 1996).

With research predominantly focusing on childbirth-related PTSD, little attention has been given to considering birth trauma and its association with depression. However, a systematic review conducted by Bell & Anderson (2016) highlighted that 11 of 15 studies reviewed found a significant link between birth experience and PPD. One study looking specifically at the association between birth trauma and PPD, included a sample of 650 women, 245 of whom self-defined their birth as traumatic (Chen et al., 2021). The rate of PPD in woman who experienced birth trauma was 42.04%, in contrast to 20.99% of women who did not self-define their birth as traumatic (Chen et al., 2021). This research highlights how a traumatic birth could be a potential risk factor for PPD.

Risks of experiencing PPD are known to be greater when a recent stressful life event has occurred (Robertson et al., 2004). Adverse experiences of childbirth, such as dissatisfaction with level of maternity care and support provided, have been associated with PPD (Mohammad et al., 2011), and a perceived traumatic birth is a potential risk factor for PPD (Chen et al., 2021). A systematic review exploring the impact of PPD on maternal and infant outcomes, including 122 studies, found PPD was linked to poorer maternal quality of life and more adverse psychological and physical health outcomes (Slomian et al., 2019). This study also captured PPD adversely impacting on maternal care for an infant, which subsequently can lead to difficulties occurring in the parent-infant attachment (Slomian et al., 2019). Maternal PPD is a risk factor for prolonged experiences of depression (Netsi et al., 2018), can impact on the mother-father relationship (Robertson et al., 2004), and is associated with poorer mother-infant relationships long-term (Myers & Johns, 2018),

Maternal mental health difficulties can also have a harmful impact on paternal wellbeing, with fathers being likely to experience increased anxiety, stress levels, and low mood (Ruffell et al., 2019). It has been evidenced that the rates of paternal depression are between 24% and 50% when the mother is also experiencing PPD (Goodman, 2004b). A study conducted by Matthey et al. (2000) looking at depressive symptoms in 154 couples across the transition to parenthood, found that at 12 months postpartum, 53% of mothers who were scoring highly on a depression

scale also had a partner who scored highly. Furthermore, literature exploring the impact maternal PPD can have on men and their ways of fathering, has highlighted how some fathers can report feeling their partner is ‘absent’ as a result of the PPD, which can greatly effect family life and impact on various aspects of the fathering experience (Beestin et al., 2014).

Subsequent Births. Another avenue which research has explored has been the impact of a traumatic birth on subsequent births. As highlighted earlier, particularly in first time mothers, a traumatic birth can result in fewer subsequent pregnancies or longer intervals before having another child (Gottvall & Waldenström, 2002; Shorey et al., 2018). An emotive quote captured within a qualitative study looking at mothers’ perceptions of a traumatic birth highlighted the long-term impact this experience can have; “after 8 years, I still remember the fear, it is always in my mind, it is one of the reasons that I don’t want to get pregnant again” (Taghizadeh et al., 2014, p. 34). For some mothers severely affected by a traumatic birth, this can result in the development of ‘secondary tokophobia’, which refers to chronic fear of childbirth, often resulting in the avoidance of future pregnancies (Bhatia & Jhanjee, 2012).

Women who do go on to have further children following a traumatic birth, are thought to be at a greater risk of experiencing psychological distress during the postpartum period of subsequent births (Skari et al., 2002). Furthermore, it is suggested that going on to have another baby after a traumatic birth experience can have the potential to either aid the healing journey or negatively retraumatize the mother (Beck & Watson, 2010). Mothers feeling more in control over subsequent births may aid those births being perceived as positive experiences (Holopainen et al., 2020).

Post-Traumatic Growth (PTG). While adverse outcomes can occur following childbirth, it is important to acknowledge that maternal PTG has also been reported within a few studies (e.g. Beck & Watson, 2016; Beck et al., 2018; Ketley et al., 2022; Sawyer & Ayers, 2009). Beck et al. (2018) conducted a pilot study looking at PTG following a traumatic birth in 30 women, with the mean time of 5.4 years since the event. They found PTG, particularly within the domain of ‘relating to others’ was reported, highlighting that long-term positive outcomes can occur after

birth trauma. Furthermore, an influential qualitative study conducted by Ketley et al. (2022), exploring women's experiences of PTG following a traumatic birth, including a sample of eight participants, captured various aspects of growth being reported, which closely linked to the five PTG domains outlined by Tedeschi & Calhoun (1996), which included new possibilities, relating to others, personal strength, spiritual change, and appreciation for life.

With this valuable broader understanding of some of the immediate and long-term impacts a traumatic birth can have on the mother, literature on the paternal journey following a traumatic birth will next be explored. A thorough literature review of paternal birth trauma studies was carried out (databases searched included PsycINFO & MEDLINE).

Defining Fatherhood

A father has more broadly been defined as "the male or males identified as most involved in caregiving and committed to the well-being of the child, regardless of living situation, marital status, or biological relation" (Yogman & Garfield, 2016, p. e2). When considering the definition of a father, it is important to acknowledge the diversity of fathering within society (Yogman & Garfield, 2016). For example, a father can be a biological, adoptive, foster, or step father (Whitney et al., 2017). An infant being parented by a same sex couple may also have either one, neither or both parents who identify as the father (Yogman & Garfield, 2016). Although not the focus of the present study, it is important to acknowledge the mental health and wellbeing of same-sex parents during the perinatal period, however this topic remains under-researched and requires further attention (see Howat, 2021). For the purpose of this study, a father will be defined as the male father figure who was present at the birth event. By focusing on fathers who self-identify as a male father, this will allow for factors associated with the changes in societal expectations, expansion of traditional masculine ideologies, and male perceptions of help-seeking after a traumatic birth event, to be considered and explored.

Fatherhood and the Male Role Within Childbirth

Masculinity ideologies have been around for decades and "are a body of socially constructed ideas and beliefs about what it means to be a man and against

which men are appraised within their community" (Thompson & Bennett, 2017, p. 47). It is understood that the most "dominant gender ideologies in a given society define the norms for gender roles" (Levant & Powell, 2017, p.18). For years, literature around men's socialisation has conceptualised the father's role within the family system as predominantly being the key breadwinner and disciplinarian parent (American Psychological Association, 2009; Singley & Edwards, 2015). However, from the late 1960s there was a dramatic shift, which meant that traditional perceived masculine roles evolved, and fathers were encouraged to take on a more directly involved and nurturing parental position (Singley & Edwards, 2015).

In Western culture, childbirth was seen as an event which only women went through, aided and assisted by female family members or close friends and midwives (Johnson, 2002). Therefore, when considering the paternal role within childbirth, it was previously commonplace for father not to attend the birth of their child, either in the home or a hospital setting (Davis & King, 2018; Draper, 1997). However, with radically new cultural attitudes around the importance of fathers' increased presence and engagement within the family unit, being at the birth became completely normalised (Daniels et al., 2020; Jomeen, 2017), with at least 90% of fathers in the UK now attending childbirth (Burgess & Goldman, 2018).

Fathers' attendance at the birth nowadays is typically seen as both expected and as highly beneficial to the wellbeing of the mother and infant (Coutinho et al., 2016). Childbirth is seen by mothers as a 'shared experience' and one which they rely and value the father being present for as a source of comfort and support (Olza et al., 2018). To some, it signifies the beginning of fatherhood (Longworth & Kingdon, 2011). However, although societal expectations reinforce men's involvement in childbirth, this can contrast with what men actually experience during the event (Kaye et al., 2014). Fathers can feel confused about their role in the birth and as though they fail to achieve what is expected (Dellmann, 2004). During the perinatal period, fathers can experience difficulties being male within an environment that is focused on the female, and this can impact on their sense of masculinity and what they perceive their role to be (Hambridge et al., 2021).

Whilst acknowledging how common it now is for fathers to be present at childbirth and being aware of the impact a traumatic birth can have on the mother, it is imperative that further research into paternal experiences is conducted.

Impact of a Traumatic Birth on the Father

Current literature providing awareness into the experience and impact of a traumatic birth on fathers, will now be explored. This will begin with some insight into fathers' experiences of being present during a traumatic birth.

The Birth Event

Fathers who attend childbirth can report this event as being a positive and emotionally enriching experience (Chan & Paterson-Brown, 2002; Johnson, 2002; Vischer et al., 2020). However, for some the birth can instead trigger feelings of fear, confusion and vulnerability (Elmir & Schmied, 2022; Hinton et al., 2014). When the birth is experienced as traumatic, fathers can reflect on this as being "the worst experience of their lives" (Elmir & Schmied, 2022, p. 43). Increased presence at childbirth means that fathers are at a far greater risk of experiencing birth-related trauma (Daniels et al., 2020), and experiencing subsequent psychological complications associated with the experience of traumatic events. Qualitative research exploring the paternal experiences of a traumatic birth has captured common themes from the birth event including fathers feeling unprepared for what they experienced in the room, describing a strong sense of loss of control, and feeling significantly marginalised by professionals (Daniels et al., 2020; Elmir & Schmied, 2022; Etheridge & Slade, 2017; Inglis et al., 2016).

A qualitative study by Inglis et al. (2016) looking at paternal mental health following a traumatic birth captured how during this event, fathers felt traumatised by the distress they witnessed their partner in and by the medical interventions they observed. Fathers reported feeling helpless at the hands of medical staff, immobilised and unable to do anything. A powerful quote from a father participating in this study described his experience of the traumatic birth as if tied up "…thrown overboard and slowly sinking to the bottom of the ocean but all you can do is wiggle around. It won't help the situation because there is ultimately nothing you can do…" (Inglis et al., 2016, p. 128). Although fathers can experience immense fear when complications arise during childbirth, they will often report internalising their distress in order to prioritise the needs of their partner (Vallin et al., 2019).

Elmir & Schmied (2016) conducted a meta-ethnographic synthesis looking at fathers' experiences of being present during a complicated and potentially traumatic birth, which included the review of eight studies. This study captured how fathers

longed for more information during the birth but instead felt side-lined and ‘stripped’ of their role of protector, which subsequently triggered feelings of guilt and helplessness. The birth experience subsequently resulted in adverse impacts to the father-mother relationship, fathers reporting being unable to move forward and continuing to experience nightmares and flashbacks, as well as reports of ‘unresolved feelings’ which were linked to not having had the opportunity to talk about the birth (Elmir & Schmied, 2016).

It is acknowledged that fathers can sometimes feel totally unprepared for complications arising and their birth being traumatic, because antenatal classes fail to provide this insight and instead focus far more on what would be perceived as more routine deliveries (Daniels et al., 2020). Fathers often envisage the birth experience to be a shared experience with the mother, however a traumatic birth can mean they instead face feeling completely torn between trying to meet the needs of their partner and baby (Etheridge & Slade, 2017).

Fathers feeling isolated during the birth and unsupported by staff can be a contributory factor to heightened distress (Etheridge & Slade, 2017). When fathers feel ill-informed about what is happening, not included in decision making, or left alone for long periods, this can contribute to the birth experience being traumatic (Daniels et al., 2020). Fathers can reflect on how societal perceptions of the role of males in childbirth have potentially contributed to the negative way they felt staff interacted with them, leading to them feeling unheard and unimportant (Daniels et al., 2020). This may be exacerbated by racism: black fathers can feel that their ethnicity and a perceived disparity in quality of care contribute to the birth being traumatic (Olukotun, 2021). It is suggested that fathers who report better engagement from staff reflect far more positively on the childbirth journey (Elmir & Schmied, 2016), and how this can be a protective factor against paternal postnatal low mood (Daniels et al., 2020). These studies highlight the critical need for health professionals to acknowledge, include, and equally support fathers throughout the birth experience (Elmir & Schmied, 2016).

Post-Birth and Long-Term Impacts

Having considered how fathers can experience being present during a traumatic birth, exploration into the impacts post-birth and long-term will next be provided. This will include consideration into the possible impacts a traumatic birth may have on a father’s mental health, with specific focus on paternal PTSD and

PPD; as well as on the parent-infant attachment and subsequent births. Finally, some consideration into paternal responses to psychological distress will be offered.

To date, there has been little exploration specifically focused on the long-term impact a traumatic birth can have on a father, and most appear to conflate short and long term experiences. Daniels et al. (2020) conducted an online qualitative study, which included a sample of 61 fathers, with a mean time period of 2.8 years since the birth. The study explored experiences of the traumatic birth, the impact this had on various aspects of wellbeing, and what support was received during and after the birth. Several adverse post-birth outcomes were reported, including some fathers experiencing parent-infant bonding difficulties, avoidance of intimacy with partners, and in some cases the development of mental health difficulties. Avoidance of talking about the birth trauma was also noted by fathers and linked to masculine ideologies, stigma, and subsequent prevention of help-seeking in some cases. Although these are important findings, the study used an online qualitative questionnaire to gain information, which was a clear limitation as this meant they were unable to explore important themes which came up in more depth (e.g. the impact on wanting more children), or how some of the difficulties reported had possibly changed over time.

A qualitative study, conducted by Etheridge and Slade (2017), explored the experiences of fathers who had witnessed a traumatic birth and included a sample of 11 fathers (time since birth ranged from two months to six years). This study captured fathers reporting ongoing distress and rumination about the birth, in some cases for years after. Adverse impacts on aspects of their work, such as reduced productivity or difficulties in concentration were also reported. This study also captured perceptions of masculinity inhibiting some fathers' openness to talk about their experience. Impacts on the relationship with partner and infant was also explored, with reports of varying positive and adverse outcomes acknowledged. Although some positive outcomes in terms of relationships were reported, a limitation of this study was that the authors did not appear to directly ask participants whether they felt the traumatic birth had led to positive outcomes more broadly, therefore potentially missing out on capturing other aspects of PTG experienced. Within the study discussed earlier by Inglis et al. (2016), they captured post-birth outcomes including some fathers experiencing elements of PTG, with reports of a deeper connectedness with partners, as well as experiencing a sense of

increased strength in one's own emotional wellbeing. Increased closeness to a partner has also been reported by some fathers in other birth trauma studies (e.g. Daniels et al., 2020; Elmir & Schmied, 2022).

More recently, Elmir & Schmied (2022) aimed to look at the immediate and longer-term impact of adverse birth experiences on 17 fathers, with a time period since the birth ranging from 4.5 months to 20.5 years. This study identified three core themes which included 'worst experience of my life', 'negotiating my place: communicating with health professionals' and 'relationships: growing stronger or falling apart'. These findings, similar to the studies discussed above indicate that the birth event triggers distressing feelings of being out of control, helpless and emasculated. Post-birth, some fathers reported adverse impacts on the marital relationship (e.g. reduced physical intimacy), whereas others reported developing stronger relationships. Some fathers reflected on how their unanticipated role as lead caregiver after the birth, promoted a positive relationship with their infant, however others found the increased pressures upon returning home stressful. This study recruited a small number of fathers from culturally diverse backgrounds, which enabled them to provide some valuable insight into how cultural influences can contribute to some fathers feeling unable to open up about their birth event, with childbirth being perceived as a maternal experience and therefore interpreted as a sign of weakness for a father to externalise their emotions about it (Elmir & Schmied, 2022). This study reported 12 of the 17 fathers had not gone on to have subsequent births, but they did not explore whether or how the traumatic birth may have impacted those decisions.

Reviewing the fathers' birth trauma literature shows that studies include time periods ranging from close after the birth event, to many years later. For example, 2 weeks to 32 years (White, 2007); 2 months to 6 years (Etheridge & Slade, 2017); 4.5 months to 20.5 years (Elmir & Schmied, 2022); and 9 months to 10 years (Nicholls & Ayers, 2007). Daniels et al. (2020) provided a mean time period of 2.8 years since the event, and excluded fathers whose experience was over 10 years, however failed to report on the shortest time period since the birth. Inglis et al. (2016) had no exclusion criteria on time periods, but also did not disclose in their paper the length of time since the births. Therefore, although capturing important findings, a global limitation noted is that they do not comprehensively consider how someone's experience immediately after the birth may differ when some time has passed. A

person's response to a traumatic experience can change over time (Bryant et al., 2015), therefore it is important to explore and clearly differentiate short and longer-term experiences, to provide a better understand of a father's full journey after a traumatic birth event. The present study aims to bridge this gap in the literature by focusing solely on the long-term impact of a traumatic birth experience.

When further exploring possible outcomes after a traumatic birth on a father's mental health, some of the studies discussed above have documented how some fathers can report experiencing symptoms commonly associated with depression, anxiety and PTSD (Daniels et al., 2020; Elmir & Schmied, 2016). In some cases, mental health difficulties following childbirth are reported as longstanding (Hinton et al., 2014). Further consideration into the possible post-birth and long-term impacts of a traumatic birth on fathers' mental health, including paternal PTSD and PPD, will be explored.

Paternal Post-Traumatic Stress Disorder (PTSD). The experience of PTSD is one possible considered outcome for fathers following a traumatic birth (Nicholls & Ayers, 2007). However, it is challenging to capture the rate at which this occurs due to the limited research conducted in this area. That being said, there is a growing acknowledgement that fathers and birth partners can experience PTSD following a traumatic birth, and a new measure for detecting it, the City Birth Trauma Scale (partner version), has been recently developed (Webb, 2021). Further investigation of this measure is required. There is also a need for consideration into how gender, sexuality and other identity variables influence the way birth trauma may be experienced, and for measures to capture these potentially diverse experiences.

A large study by Schobinger et al. (2020) looking at acute stress disorder and PTSD symptoms following childbirth in 419 mothers and 228 fathers, found that 7.2% of fathers and 20.7% of mothers met probable criteria for PTSD, one month post-birth. Interestingly, the study also captured probable PTSD rates to be 20.3% for fathers and 24.3% for mothers whilst the mother was in her third trimester, which the authors thought could have been explained by participants having experienced a previous traumatic birth (13.7%) or previous perinatal loss (21.8%). This suggestive link between previous traumatic birth experiences and increased rates of PTSD symptoms during further pregnancies, captures valuable insight into

the possible long-term impact a traumatic birth event can have on parents who go onto have further children.

Some studies capture low rates of PTSD occurring in men following childbirth (Bradley et al., 2008), and studies which have explored rates of PTSD in both men and women following childbirth have found rates of PTSD symptoms to be higher in woman than men (Schobinger et al., 2020). However, again these low reported rates could be due to the father's subjective beliefs about their role being to prioritise the mother's wellbeing, resulting in their own distress being underreported (Bradley et al., 2008). A qualitative study conducted by Hinton et al. (2014) which explored partners' experiences of 'near miss' events in pregnancy and childbirth, captured how witnessing a partner in a life-threatening event resulted in some fathers experiencing complex and enduring mental health difficulties including PTSD, flashbacks, or depression, which remained for months and years after the event. This study further captured how a traumatic birth experience can impact on fathers wanting subsequent children, with one father reportedly going on to have a vasectomy to avoid ever going through childbirth again (Hinton et al., 2014).

A systematic review and meta-synthesis captured childbirth-related PTSD or PTSS being associated with couple relationship outcomes including reduced engagement in intimacy, relationship tension, negative emotions, lack of support, but also in some cases a strengthening of the relationship (Delicate et al., 2018). Nicholls & Ayers (2007) carried out a qualitative study exploring the impact of childbirth-related PTSD on the relationship of six couples who had gone through a traumatic birth, which captured negative impacts being reported in areas including avoidance of sexual intimacy, conflict, and difficulties in communicating about the birth event together. A study looking at paternal PTSD following a traumatic birth, which included a sample of 21 participants, also found this event negatively impacted on intimacy, with fathers reflecting on the distressing recall of what they observed and being unable to intervene, resulting in them experiencing long-term "sexual scarring" (White, 2007, p. 42). This study captured fathers experiencing an array of PTSD related symptoms, with memories and distress related to the birth remaining longer-term for some, with one participant commenting: "Twenty-one years later the experience remains vivid" (White, 2007, p. 42).

Although the development of PTSD is a possible outcome following childbirth, this is not experienced by all fathers, and symptoms associated with

anxiety can instead be more reported (Bradley et al., 2008). A study exploring exposure to stress during childbirth on aspects including psychological distress, captured low rates of PTSS being reported, however fathers were more affected by anxiety-related symptoms (Zerach & Magal, 2017). It has also been noted within case studies of fathers who have experienced distressing birth experiences that persistent symptoms of anxiety can be reported (Stewart, 1983).

A recent study which explored PTSD following childbirth, found that PPD was significantly linked with childbirth-related PTSD symptoms in both mothers and fathers (Ertan et al., 2021). Interestingly, this study also found that fathers who experienced difficulties bonding with their child, also scored more highly on PTSD symptoms post-birth (Ertan et al., 2021). With paternal PPD following childbirth also being noted in the literature, this will next be explored.

Paternal Postpartum Depression (PPD). Historically PPD has been linked only to women, however there is now increased acknowledgment that fathers can also experience this (Biebel & Alikhan, 2018). Between 1-8% of fathers can experience depression within the first 6 weeks postpartum, and 5-6% at 3-6 months postpartum, irrespective of whether they found the experience traumatic (Bradley & Slade, 2011). Paternal PPD is most prevalent 3-6 months post-birth (Paulson & Bazemore, 2010). In contrast to the sudden onset of PPD commonly seen in mothers, the presentation in fathers can often be more subtle (Melrose, 2010). PPD in men is typically experienced as mild to moderate in severity (Soliday et al., 1999).

There are currently no official criteria for PPD, however being seen as a form of major depressive episode, it is usually diagnosed using DSM-IV (Scarff, 2019). Paternal PPD is typically assessed using measures originally created to assess maternal PPD (Kim & Swain, 2007), such as The Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987). This measure has been identified as being both a reliable and valid measure for assessing PPD in women and men (Matthey et al., 2001). However, a clear limitation of this measure is that it fails to detect the broader range of depression symptoms more typically experienced by men (Matthey & Agostini, 2017). Research has clearly highlighted significant gender differences when it comes to symptoms of depression experienced, with men being more prone

to symptoms such as increased irritability, anger and substance misuse (Martin et al., 2013).

Some research comparing the rate of PPD in mothers and fathers has found the prevalence of this to be higher in women, however paternal underreporting of symptoms is again acknowledged as a possible contributory factor to this difference (Matthey et al., 2000). Also, because measures being used to assess PPD (e.g. EPDS), do not acknowlege the wider range of depression symptoms men can experience (Matthey & Agostini, 2017), this raises the question as to whether fathers who are experiencing PPD are not being identified.

To the best of the author's knowledge, no studies reviewed have specifically looked at the impact that a traumatic birth can have on the development of PPD. However, research has found that fathers who report reduced fulfilment from their birth experience show higher rates of depression symptoms (Greenhalgh et al., 2000). Furthermore, a qualitative study exploring fathers' experiences of PPD and help-seeking behaviour, captured how a number of fathers reflected on their birth experience as being traumatic and felt this was a contributory factor to them developing PPD (Pedersen et al., 2021). With this in mind, alongside insight from the maternal literature, it would seem fair to hypothesise that fathers who experience a traumatic birth are potentially at an increased risk of experiencing PPD.

PPD has been found to impact different areas of the father's daily functioning including causing a decline in short-term and working memory (Pio De Almeida et al., 2012), and can increase a father's risk of suicide (Quevedo et al., 2011). Research has captured how fathers with a history of mental health difficulties are more vulnerable to experiencing PPD, and that the experience of childbirth is likely to exacerbate previous mental health conditions (Wang et al., 2021). Some fathers may also experience postnatal anxiety alongside their symptoms of depression (Bradley & Slade, 2011).

A review conducted by Bradley and Slade (2011), looking at paternal mental health difficulties post-childbirth, highlighted that experiencing symptoms of PPD can impact on the parent-infant interaction. PPD may lead to fathers being more withdrawn and less engaged during interactions with their child (Sethna et al., 2015). It has also been associated with reduced probability that fathers play with their infant outside frequently (Paulson et al., 2006). PPD can also adversely affect a child's emotional and behavioural development long-term, for example, children are

at an increased risk of presenting with behavioural problems at age 3.5 years (Ramchandani et al., 2005).

The studies available which explore the experience of depression after childbirth focus very much on the postnatal period, however it is imperative to acknowledge that depressive symptoms in both fathers and mothers can extend far beyond the 12-month postpartum period. A study conducted by Johansson et al. (2017) exploring depressive symptoms and parental stress in parents, 25 months after birth, found the prevalence of depressive symptoms at this time period to be 11% for mothers and almost 5% for fathers. Interestingly, this study also captured that from those who had scored high for depression, some of these mothers and fathers had also previously accessed treatment for distress at an earlier stage after the childbirth, providing supporting evidence that distress in some cases can be enduring or recurrent (Johansson et al., 2017).

Parent-Infant Attachment. A few studies exploring the experience of a traumatic birth have commented on the impact this experience can have on the father-infant attachment (e.g. Daniels et al., 2020; Elmir & Schmied, 2022; Etheridge & Slade, 2017; Nicholls & Ayers, 2007). Some fathers pre-empt an instant bond with their baby, but instead experience short-term bonding difficulties, which can trigger feelings of guilt and shame (Daniels et al., 2020). Within Nicholls & Ayers (2007) study exploring childbirth related PTSD, some fathers reported responses which would be suggestive of an overprotective and anxious bond.

John Bowlby's attachment theory highlights the importance of a secure parent-infant bond in a child's ongoing mental health and global development (Parfitt & Ayers, 2009). Therefore, it is anticipated that difficulties forming a secure father-infant attachment following a traumatic birth may result in long-term negative outcomes. Unfortunately, research has so far neglected to explore the longitudinal effect a traumatic birth can have on the father-infant relationship. However, as seen within the mother's birth trauma literature, lasting effects to the parent-infant bond are evident (Ayers et al., 2006).

In contrast to more difficult bonding experiences, some studies have captured fathers reporting developing strong bonds with their baby following a traumatic birth, which can be as a result of taking on the unexpected role of primary caregiver upon returning home and having quality time to connect with their infant

(Elmir & Schmied, 2022; Etheridge & Slade, 2017). Furthermore, it has been noted that when difficulties are evident in the mother-infant attachment following a traumatic birth, fathers can sometimes try to compensate for this by providing increased levels of love, comfort and interaction to their infant (Nicholls & Ayers, 2007).

Subsequent Births. Several studies have broadly commented on the impact a traumatic birth can have on some fathers not wanting to consider having further children (Daniels et al., 2020; Hinton et al., 2014; Inglis et al., 2016). Some fathers fear the idea of a future pregnancy or birth again, resulting in them considering or going on to have a vasectomy (Hinton et al., 2014; Inglis et al., 2016). Fathers' avoidance of physical intimacy with partners after experiencing a traumatic birth can also be related to fear of future pregnancy (Daniels et al., 2020; Nicholls & Ayers, 2007).

Some fathers who do go on to have a further child can report increased levels of distress during the pregnancy. For example, a study conducted by Turton et al. (2006) looking at the impact of stillbirth on fathers found that this traumatic experience led to significant levels of anxiety during subsequent pregnancies. Similar findings have also been reported within other stillbirth related studies (e.g. Campbell-Jackson et al., 2014). Although Turton et al.'s study is valuable, by looking specifically at stillbirth experiences, it is not possible to relate this to other types of birth trauma which have not resulted in a loss of life.

Paternal Responses To Psychological Distress: Avoidance of Help-Seeking.

Although fathers can experience long-term emotional distress after birth trauma, it is important to acknowledge that some may feel reluctant to access support and instead utilise avoidance as a coping strategy for trying to manage this (Etheridge & Slade, 2017). One common conceptualisation of what may influence men to navigate away from accessing support stems from ideas linked to male conformity to traditional masculine norms, which suggest men should be emotionally stoic, strong and self-reliant (Seidler et al., 2016; Tang et al., 2014). These masculine norms which strongly reject feminine stereotypes, are likely to contribute to why some men may find it difficult to externalise their emotions and to engage in help-seeking (Lorber & Garcia, 2010). Men who hold more intense beliefs

about traditional masculinity or stigma around mental health, can perceive accessing support as a sign of weakness (Mahalik & Dagirmanjian, 2019), and therefore avoid seeking this help.

Although men do experience emotions such as fear associated with childbirth, they can report it not being in their nature to disclose this out loud and that they feel to do so would only make things worse (Eriksson et al., 2007). Men can also at times avoid seeking support due to the impact of societal perceptions that childbirth is a woman's experience (Jessop & Fox, as cited in Hinton et al., 2014). This closely links to other literature which captures how some men can consider the topic of childbirth as sacred to mothers and therefore a sign of weakness if they were to discuss or display emotion relating to this (Elmir & Schmied, 2022).

Furthermore, it is recognised that fathers can often feel that the emotional needs of the mother take president following a traumatic birth, therefore they internalise their own needs in order to focus on prioritising the support needs of their partner (Shorey & Wong, 2020). Although highly empathic and considerate to the mother, these actions in many ways invalidate the father's experience and reinforce some of the heavily embedded masculine ideologies discussed above. For fathers who do attempt accessing support for their emotional distress following a traumatic birth, some report facing challenges receiving appropriate input, where their experience is validated (Hinton et al., 2014). Research has captured that men who do find it more difficult to open up and express their emotions value online support being available as opposed to just face-to-face support (Rochlen et al., 2004). An example of this could be online support in the form of men-only forums, which wider literature around mens health and wellbeing, has captured can provide a valuable space for some men to discuss and share their experiences (Hanna & Gough, 2018).

Summary

From the literature reviewed, looking at the impact of a traumatic birth on fathers, there has been some influential and invaluable findings drawn so far. Studies capture the experience of a traumatic birth as being a highly distressing event for fathers, with reoccurring themes of feeling unprepared for what they experienced in the room, describing a strong sense of loss of control, and feeling significantly marginalised by professionals, being reported (Daniels et al., 2020; Elmir &

Schmied, 2022; Etheridge & Slade, 2017; Inglis et al., 2016). Fathers can feel 'stripped' of their role of protector, and experience an array of difficult emotions including fear, guilt, and helplessness (Elmir & Schmied, 2016). The distress of a traumatic birth can be enduring, with studies capturing how some fathers can report experiencing symptoms associated with depression and PTSD, following the birth (Daniels et al., 2020; Elmir & Schmied, 2016). Other adverse outcomes following a traumatic birth can include, fathers experiencing difficulties opening up about the trauma (Etheridge & Slade, 2017), reduced engagement in physical intimacy (White, 2007), and father-infant bonding difficulties (Daniels et al., 2020). In contrast to these adverse outcomes, some positive post-trauma outcomes have also been reported, such as fathers reporting increased connectedness with their partner (Daniels et al., 2020; Elmir & Schmied, 2022; Etheridge & Slade, 2017; Inglis et al., 2016), and a stronger parent-infant bond (Etheridge & Slade, 2017).

Although some helpful insight has been provided so far, much of the research does appear to more so focus on the birth event itself, with less depth and attention given to the long-term outcomes. Qualitative studies that have included participants soon after the traumatic birth and also participants for whom the event was years previously, have often collated these experiences together, without there always being a clear distinction made between the two groups of participants, potentially leading to a misrepresentation of what the long-term impacts are. Therefore, the present study aims to bridge this gap in the literature. When exploring the maternal birth trauma literature, it is evident that mothers can experience negative long-term outcomes (Beck., 2006; Taghizadeh et al., 2014), as well as PTG following a traumatic birth (e.g. Beck & Watson, 2016; Ketley et al., 2022). With 90% of fathers now attending childbirth (Burgess & Goldman, 2018), these maternal findings support the need for further exploration of the enduring impact of such an experience on fathers. Therefore, the present study aims to provide a clearer insight into the long-term impact of birth trauma on fathers.

Research Aims and Question

***Research aim*:** To examine fathers' long-term experiences following a traumatic birth. Ongoing adverse outcomes such as mental health difficulties (e.g. Beck, 2006; McDonald et al., 2011; Schneider et al., 2012), as well as experiences of PTG (e.g. Helgeson et al., 2006; Su et al., 2020), have been reported in studies as occurring

two or more years after the traumatic event. The present study will therefore define ‘long-term’ as being anything two years and onwards from the birth experience. The study will explore the impact this experience has had on different areas of the father’s life including their mental health and wellbeing, occupation, relationships, parent-infant bond, and subsequent pregnancies.

Research question: What are the long-term impacts of a traumatic birth, as experienced by fathers?

Method

This chapter will provide an overview of the method used to achieve the study aims. It will firstly offer detail of the methodological approach selected and a rationale for this choice. Following which, a comprehensive account of the study design, how the data was collected and analysed, and the ethical issues considered, will be outlined. This chapter will also provide some insight into my own reflexivity as the researcher.

Methodology

Qualitative methodologies intend to generate knowledge grounded in the "exploration of lived experience and participant-defined meanings" (Willig, 2013, p. 9). They focus on acquiring deep and meaningful data from samples of people, through gaining insight into their views, attitudes, and experiences (Pathak et al., 2013). In contrast, quantitative approaches use numerical data sets and statistical analysis, often focused on investigating cause and effect relationships (Ahmad et al., 2019). Considering the present study aims, using a qualitative approach was identified as being most appropriate.

Semi-Structured Interviews

In line with the qualitative approach, semi-structured interviews were chosen for the present study to provide some consistent flow and structure across the interviews, whilst also enabling there to be the opportunity and flexibility to ask follow-up questions of the participants. Braun et al. (2016) describe semi-structured interviews as being a highly popular and useful method for gathering detailed content about an individual's experience. The interview schedule for this study was developed utilising knowledge gained from wider literature available.

Ontological and Epistemological Position

It is important that the ontological stance of the researcher is considered when contemplating the most fitting methodology of analysis. Looking back on the journey and expansion of various ontological positions, originally there was the understanding within social sciences that we could get at the truth and that an external and objective reality does exist, forming the position of positivism (Willig,

2013). However, soon after there was the recognition that in fact the world can be socially constructed and subjective, therefore forming the position of social constructivism (Taylor, 2018). Since then, there has been various other schools of thought developed, which are positioned between positivism and constructivism, for example, critical realism (Clark, 2008). This mid-point between a lived reality and the social construction of an event is closer to where I am now as a researcher as I understand that whilst there is a reality of the birth, there are also constructed narratives about trauma itself.

Following careful review of different qualitative analysis approaches, Thematic Analysis (TA; Braun & Clarke, 2006) was considered the most appropriate methodological approach to support answering the research question and fitting with my ontological position. My approach to TA is consistent with my position, understanding that accounts of participants are context specific and do not claim to completely represent their real experience. Further rationale for my selection of TA, along with consideration of an alternative approach will be discussed later in this method chapter, under the subheading of analysis.

Reflexivity

Being reflexive is a vital process for enhancing the rigor and quality of qualitative research. There may be various stages during a study where the researcher's own position is not clear, therefore reflexivity is fundamentally a continuous process which enables the researcher to repeatedly explore and challenge themselves to have growth in both awareness and clarity of their own perspectives (Barrett et al., 2020).

Being a female who has not yet gone through a birth experience and therefore less personally connected to the shared experiences of the participants, I have considered how this may have impacted different stages of the research. I feel this did at times impact on the flow of the interviews, as I was not always as familiar with some of the birth event processes or terminology used, therefore capturing my position as an outsider to the birth experience.

In contrast, I have also reflected that having not gone through a birth meant that I did not have any preconceived thoughts or views on what participants were sharing about their journey. I felt in many ways this was highly valuable, as it

enabled me to fully immerse myself into the narratives of the participants without having my own experiences influence my questioning or what I was interpreting from the content received.

Entering this research journey, I was highly passionate about wanting to explore and contribute to what has so far been a poorly considered, yet immensely important topic. However, being a topic focused on the male experience, I have been mindful of my own gender within the context of this study. Although I tried to ensure participants felt comfortable and able to open up about their journey since their traumatic birth, I have reflected on how being a female researcher interviewing male fathers may have impact on participant engagement.

I have considered whether being a female interviewer positively enabled fathers to feel more open to talk about this topic, as some fathers reflected on how men often do not talk about this experience with other men. Conversely, I have reflected on how being a female could have potentially led fathers to worry or experience an element of guilt for talking about the trauma, feeling that I maybe have related more so to their partners' experience. There were numerous times when participants presented an awkward laugh or appeared more reserved when asked about potentially more difficult questions, such as the impact of the birth trauma on intimacy. It is interesting to consider if the dynamic or direction of discussions would have been the same or different, if the interviewer had also been male. I have found utilising space within supervision to explore these considerations to be a valuable process.

Transitioning from being a psychologist in clinical training to a far less familiar role as a researcher was surprisingly difficult at points. I found during interviews that it could be challenging to balance how much time to dedicate to the birth event and when was appropriate to redirect the conversation to the long-term impact. I was very mindful that for some fathers, this was the first time they had felt fully able to open up about the traumatic experience they went through. Therefore, ensuring they felt truly heard, understood and validated was critical. With this in mind, it was difficult at times to redirect away from the birth event toward thinking about the current impact, without feeling I was rushing past a part of the journey which remained very raw and distressing for many of the participants. I also felt it was difficult at points, both as the researcher and for the fathers I interviewed, to

really consider the longer-term effects of the birth trauma, without trying to assume causality.

To support in my personal growth as a researcher, I kept a reflective journal which I made notes in after interviews, so that I could refer back to this when needed. Utilising this, alongside regular discussions within supervision, enabled me to be continuously mindful and aware of my position and impact on the analysis process and interpretation of the results. This reflexivity section forms part of my quality checks, which is discussed later in this method chapter.

Design

Sampling

The study recruited male fathers, irrespective of whether they were the biological father or not, who were physically present for the birth of a child two or more years ago. Participants self-defined the birth event as having been a traumatic experience. When identifying the sufficient number of participants needed to reach saturation within a TA study, Braun & Clarke (2013) provide useful guidelines which considers type of data collected and size of the project. With the present study being a small-scale project conducting qualitative interviews, the guidelines recommend 6-10 participants being recruited (Braun & Clarke, 2013), and this was perceived to be a manageable number to obtain within the thesis time frame.

Inclusion and Exclusion. A summary of the following inclusion and exclusion criteria for this study is presented in Table 1.

For the purpose of this study, all participants were required to be fathers, either biologically (regardless of current relationship to the mother) or non-biologically (current partner of the mother) related to the child. It was essential that the father had been physically present for the birth of the child two or more years ago. In order to not set parameters of what would be defined as a traumatic birth, the birth event needed to be self-defined as traumatic by the father. All participants were required to be over the age of 16 years old so they could independently consent to taking part. There was no upper age limit set for the study.

It is important to acknowledge that there is a diverse range of individuals who may identify as a father present at the traumatic birth of a child. For example, a

same sex couple where one or both individuals identify as the father. It is fundamental to capture and build awareness of all fathers' experiences. However, due to limitations in time and numbers of participants required to ensure a meaningful depth of data is captured, the present study focused solely on the recruitment of male fathers. By doing so, it was hoped that this would allow the study to specifically consider potential themes associated with perceptions of masculine ideologies and evolving societal expectations of the paternal role, and how these may have impacted on the father's journey both during and following the traumatic birth event.

There were no exclusion criteria outlined in relation to type of birth experienced (e.g. natural birth, caesarean section, instrumental). To ensure the traumatic experience reported by the father was directly related to the birth event and not events occurring pre or post-birth, inclusion required the birth to have been at full term (37 weeks or over). Inclusion also specified that if the baby required intensive medical treatment, that this was not self-defined by the father as also having been a traumatic experience. It was also required that the baby did not have any reported significant physical health difficulties following the birth, as ongoing care or rehabilitation may also be traumatic.

Any traumatic birth experiences which had resulted in loss of life to either the mother or child, at any stage during the birthing event, were excluded from the study. It is anticipated that loss of life during the birth event (e.g. stillbirth) would trigger significantly different trauma responses such as complex grief reactions, which literature has highlighted can have a long-term impact on both mothers and fathers (Kersting & Wagner, 2012).

All participants were required to speak fluent English. This was to ensure they were able to fully engage in the comprehensive semi-structured interview which was delivered by an interviewer who was English speaking. Due to limitations in the research budget, it was unfortunately not possible to access an interpreter for the study.

Table 1

Summary of inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
• Father over the age of 16 years	• Father was not present at the birth event
• Father self-identified as a male father	• Baby was born before 37 weeks
• Birth event was self-defined by the father as a traumatic experience	• The baby experienced significant health difficulties post-birth
• Traumatic birth event was two or more years ago.	• Baby required intensive medical treatment which was also self-defined by the father as a traumatic experience. • Loss of life (mother or baby) during the birth • Father non-fluent in English

Patient and Public Involvement and Engagement

This projected gained the valuable support and input from a number of key stakeholders. This included Mark Harris (Midwife and father) and Mark Williams (men's mental health campaigner) who both advised on recruitment strategies and supported with the advertisement of the study on social media. Mark Harris also supported with the reviewing of the study materials (e.g. study flyer, interview topic guide, and social media posts), commenting on the language used and the acceptability to the population being recruited.

The topic guide was informally piloted by conducting a practice interview with someone known to me, who is also a father, to gain insight into the type of data received from the prepared questions and to assess the flow of questions asked. This was an invaluable part in preparing for the interviews as it supported me to think about the order of questions being asked and how the questions were received by the

interviewee. Following the pilot interview, no significant changes were required, and the topic guide was ready for use within the study.

Recruitment

Participants were invited to take part in the study through online advertisement. The Birth Trauma Association, which is a national charity that primarily supports woman who have experienced a traumatic birth event (Birth Trauma Association, 2018), promoted the study via their social media platforms. The study was also advertised on my professional twitter and Facebook page. All posts contained a study flyer (see Appendix B). Within the flyer was a link to the Online Surveys site, which when accessed, provided all those interested in finding out more about the study with an online version of the participant information sheet (see Appendix C) and consent form (see Appendix D). The flyer also made participants aware that for those who consented to taking part in the study and completed the interview, they would receive a £20 Amazon e-voucher as a thank you for their time and contribution.

Participants were able to show interest and consent to being contacted about the study by either completing the online consent form via the Online Surveys site, or by emailing me directly. At this stage, participants were able to indicate their format preference of initial contact (e.g. email or telephone). Once consent to being contacted was received, I either emailed a pre-prepared email or called the participant to arrange a date and time to have a telephone contact to discuss the study in more detail.

During the arranged telephone call with a participant, a full review of eligibility for the study was conducted and the participant was provided with the opportunity to ask any questions they had about the study. All participants had completed the study consent form via Online Surveys. At the end of this initial call, if the participant was still happy to take part and they had met the full eligibility criteria for the study, a date and time to conduct the interview was agreed.

Nine fathers made contact to express interest in taking part in the study. Eight of these met full eligibility for the study and went on to complete the interview. The one remaining father was excluded from the study due to the difficult experiences reported being outside of the birth event. Please see Table 2 in results chapter for participant demographics.

Interview Procedure

Participation in the study involved one-to-one interviews being conducted either remotely via telephone or video call using Zoom. From the eight interviews conducted, seven were carried out over the telephone and one via Zoom. Participants were encouraged to take part in the interview within a private location where they felt able to talk and share their experiences openly. All interviews lasted between 50 – 82 minutes and followed a semi-structured format.

I utilised a topic guide to aid discussion within the interviews (see Appendix E). Themes drawn from the literature review were used to support and inform the development of questions within the topic guide. This aimed to ensure questions asked were kept as open as possible, to promote and enable broad discussions around the diverse experiences of the participants

At the start of each interview, participants were provided with another opportunity to ask questions they had about the study. Consent to taking part in the study was also reviewed to ensure each participant was still happy to continue. Participants were provided with another opportunity to ask questions at the end of the interview, alongside being provided with details of relevant support services available which they could access if they wished too. All telephone interviews were recorded using a Dictaphone, and the Zoom interview was recorded using Zoom's inbuilt recording system.

Ethical Considerations

Ethical Approval

Ethical approval was granted by the University of Leeds School of Medicine Research and Ethics Committee (MREC20-058; see Appendix F). Early in the recruitment process, it became apparent that an amendment was required to the study exclusion criteria. During a telephone screening call, a father shared that their baby required a neonatal intensive care unit (NICU) stay, but that he did not identify this as having been part of the traumatic experience. Originally the study had planned to exclude fathers if their baby had required a NICU admission after birth, in order to reduce the risk of any long-term impacts identified being related to events outside of the birth experience. However, acknowledging that many babies may require an admission to NICU after birth, the amendment enabled fathers who had

their baby immediately go into a NICU to still be included in the study. The amendment instead indicated that if the father's baby required intensive medical treatment following birth which was self-defined by the father as also being a traumatic experience, then they would be unable to take part. This amendment was approved.

Consent

Given that the information about the study was disseminated via social media, participants were able to spend as much time as they wished accessing and considering the study information before contacting the research team. Participants had online access to a copy of the participant information sheet and consent form. Consent forms were completed by participants on the Online Surveys site. Consent was reviewed again on each participant's interview day.

Confidentiality

The participant information sheet detailed to participants how their information would be used following the interview. All interviews were carried out in a private area where only me, as the interviewer, was present at my location. Participants were also encouraged to participate in the interview somewhere private where only they were present. However, this was not always possible, and interruptions did happen during some interviews. Qualitative data from the interviews was anonymised during transcription, removing names, locations and other identifiers. Participants were given a pseudonym to protect anonymity.

Participant Distress

Participants were informed within the participant information sheet and again before beginning the interview of the potential for distress arising due to the nature of the research topic. Participants were given the opportunity to ask any questions and to discuss any concerns with me. Participants were made aware prior to beginning the interview that they have the right to decline any questions which they did not wish to answer. Participants were informed that they had the right to pause or stop the interview at any time. During the interviews, no participants became significantly distressed and none of the eight interviews needed to be paused or stopped.

Withdrawal from the Study

Participants were informed in the information sheet and prior to beginning the interview that they have the right to withdraw their data from the study at any point up until one week after the interview has been carried out, without needing to provide a reason. After this time, participants were made aware that it would not be possible to withdraw their data due to the analysis process having commenced. No participants decided to withdraw from the study.

Data Management

Following each interview, audio recordings were immediately uploaded onto the University of Leeds secure OneDrive. Once the recordings had been checked on OneDrive to ensure they had successfully uploaded, they were then deleted from the Dictaphone or Zoom system. To carry out quality checks of the coding completed, data was shared securely to another member of the research team via OneDrive. Two interviews were transcribed by myself, to aid familiarity with the data. All remaining interviews were transcribed by a paid transcriber based within the university. Interviews were shared securely with the transcriber via OneDrive. Once all transcriptions were completed by the transcriber, they were then returned to me via OneDrive. All transcriptions were anonymised during the transcribing process. All audio recordings on OneDrive have been deleted, with only typed transcripts now remaining securely stored.

Going forward, all e-data (e.g. transcriptions) will be kept in a secure area, as permitted by the University Information Security Policy and kept anonymous (identified only by a pseudonym). Data will remain stored within this secure area until I have completed the Doctorate programme, at this point it will be transferred to the secure folder in the DClinPsychol storage area via OneDrive. The DClinPsychol research coordinator will delete the files three years from the completion of the study.

Analysis

The present study included a non-homogeneous sample of fathers who had experienced birth trauma at least two years ago, who had diverse experiences of the traumatic event and who each defined their own experience of a traumatic birth independent of others. Acknowledging these factors, thematic analysis (TA) was

thought to be the most appropriate qualitative approach as it enabled the study to capture these broad range of fathers' experiences. A distinguishing feature of TA is that it is not bound by any particular theoretical or epistemological framework, therefore allowing for flexibility in the analysis (Braun & Clarke, 2006).

TA is a method which systematically identifies, analyses and reports on repeated patterns within qualitative data (Braun and Clark, 2006), to enable the researcher to explore and gain insight into the shared meanings and experiences of participants (Braun & Clarke, 2012). TA has at times faced criticism, for example Norwell et al. (2017) captured how some argue that TA is a process used by numerous qualitative methods, and is more so a tool to assist analysis, rather than being a standalone qualitative method. However, many researchers maintain that TA is a widely used and respected method, which, when carried out rigorously, can produce highly meaningful and trustworthy findings (Braun & Clarke, 2006; Nowell et al., 2017). Through a comprehensive process of coding data and identifying key themes, the present study aimed to capture valuable insight into the long-term impacts of a traumatic birth experience on fathers.

Alongside the benefits to TA being flexible, it can also incorporate inductive and deductive approaches (Braun & Clark, 2006). Braun and Clark explain how an inductive approach strongly derives themes solely from the data, therefore it typically involves the researcher coding the data without attempting to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. In contrast, a deductive approach is more theory-driven, therefore it uses pre-existing theory to identify themes of particular interest to the researcher. The present study utilised a largely inductive approach. However, it is important to acknowledge the potential influence of theoretical and research literature explored prior to interview.

Alternative Method of Analysis

During the process of deciding on the most appropriate methodological approach for the research question, Interpretative Phenomenological Analysis (IPA) was considered as a possible alternative. IPA is a qualitative approach which focuses on exploring and examining how people make sense of and reflect on life experiences (Smith et al., 2009). IPA is a 'participant-orientated' approach, which displays great interest and sensitivity to the lived experiences of the participants taking part (Alase, 2017). It is an approach frequently used to explore and understand the lived experiences of individuals who have gone through similar

experiences (Alase, 2017). This is a highly valuable method of analysis that could have been a suitable choice for the present study. However, when considering IPA against TA, it was decided that TA allowed better for the heterogenous sample in this study.

Thematic Analysis (TA)

A detailed systematic six stage approach to analysing qualitative data using TA, developed by Braun and Clarke (2006) was followed for the study. These phases are as follows:

Phase 1: Familiarising yourself with the data
Phase 2: Generating initial codes
Phase 3*:* Searching for themes
Phase 4*:* Reviewing themes
Phase 5: Defining and naming themes
Phase 6*:* Producing the report

The first stage involved becoming familiar with the data collected through the process of actively listening to and re-reading interview transcriptions, noticing any patterns which began to emerge. During this stage I also began to make notes of any initial thoughts and reflections on each of the interviews. As most of the interviews were transcribed externally, once they had been received, time was dedicated during this stage to ensuring transcriptions were accurate, and any errors identified in the transcriptions were corrected.

The second stage involved generating initial codes. Codes were often descriptive to begin with, evolving into more refined codes after several reviews and as established patterns continued to develop (see Appendix G for example coding). The third stage involved me developing potential themes from the codes generated in the previous phase. I kept theme ideas generally broad at this stage, whilst beginning to identify and consider which codes would best fit into each of these themes identified. The fourth stage of this analysis involved reviewing and refining the established themes. Within this stage, a thematic map was produced to ensure the themes and related subthemes developed, accurately reflected, and fit with the coded data generated across the data set.

The fifth stage focused on the defining and naming of themes. This stage involved each theme being reviewed in line with the coded data it was representing and the most fitting name or definition for each theme being established. The priority here was for themes to capture a clear and meaningful narrative of the data it was representing. Regular supervision throughout each stage of the analysis process ensured the themes chosen were a true representation on the data collected. Finally, the sixth stage involved producing a report of the results found. This will be presented as the results chapter of this thesis.

Credibility and Quality Checks

Elliott et al. (1999) developed valuable and evolving guidelines surrounding good practice when conducting qualitative research, which captured the importance of completing credibility and quality checks. Several of the steps from these guidelines have been described and outlined below with reference to the current study.

Owning One's Perspective

Elliott et al. (1999) highlights the importance of the researcher owning one's own perspective in qualitative research. To do this, the researcher acknowledges their theoretical orientations and personal anticipations, being also mindful of their own personal values, assumptions and interests and how these could potentially impact on their thoughts and interpretation of the research data. It is important to be aware of these both beforehand and as they become evident during the research. This process of owning my own perspective has been described earlier, within the reflexivity section of this chapter.

Situating the Sample

This involves the researcher delivering a brief description of each participant and their life circumstances, to provide the reader with some context about the participants which may be applicable to the findings. This study has presented these descriptions in the form of pen portraits, which can be found within the results chapter.

Grounding in Examples

Providing example quotes from the data allows the researcher to illustrate both the procedures used in the analysis process and how the interpretations were developed because of these. Within the present study, I ensured that any interpretations (e.g. themes developed) were all clearly shown to be grounded in the data by including several illustrative quotes from the data.

Providing Credibility Checks

Quality Check of Transcriptions. All transcriptions were thoroughly checked for accuracy by listening back to the audio recordings and cross-referencing them against the transcribed documents. Any errors noted on the transcriptions were then corrected to ensure the text was as accurate as possible. In doing so, this supported me to also begin phase one of the thematic analysis process outlined by Braun and Clark (2006), as I was starting to familiarise myself with the data.

Supervision. As part of the research process, frequent (at least monthly) supervision sessions were organised with the two project supervisors. During the analysis process, one transcript was double coded by a supervisor. A supervisor supported the reviewing of one further transcript and both supervisors discussed codes and themes during their development to ensure face validity. Time within supervision sessions was used to explore and finalise the themes identified to ensure they best captured the data meaning.

Results

In the following chapter I will begin by presenting demographic information (see Table 2), and individual pen portraits of all eight participants who took part in the study. Below each individual pen portrait will be a reflection on the interview process. A thematic map (see Figure 1) will then be shown to illustrate the core themes and relevant subthemes which were identified. A table capturing which participants contributed to each of these themes will also be presented (see Table 3). Finally, I will move on to discuss each of these themes and subthemes in more depth, utilising quotes from participants to bring to life what participants shared in their interviews.

Table 2

Demographic information of participants

Participant (pseudonym)	Age	Ethnicity	Education	Partner to mother at time of interview	Number of children	Time since traumatic birth (in years) *all dates approx
Paul	31	White British	Doctorate	Yes	1	2 years
Nigel	35	White British	A-Levels	Yes	3	4 years
Craig	54	White British	Master's Degree	Yes	2	11 years
Sam	32	White British	Bachelor's Degree	Yes	1	2 years
Brad	34	White British	Doctorate	Yes	2	4 years
Luke	49	White British	Doctorate	Yes	2	9 years
Peter	30	White British	A-Levels	Yes	2	3 years
Mark	32	White British	Postgraduate Degree	Yes	2	3 years

Pen Portraits

This section will introduce all eight participants, including some information about their traumatic birth and a description of the interview experience.

Paul

Paul is a White British Male in his early 30's. His interview was conducted two years after his traumatic birth experience. This was Paul's first birth experience. Paul's partner was pregnant at the time of the interview with their second child.

Paul's Birth Experience

Paul's partner went into labour whilst they were at home, at which time all was perceived to be a "*normal*" part of the birthing process. When they arrived at hospital, they remained there for a long period before the medical team advised an epidural. Paul described the labour as lengthy, lasting a total of 37 hours. The medical staff were unable to deliver their baby without assistance, therefore ventouse and forceps were required. Paul described how the forceps resulted in their baby "*taking quite a battering*", leaving him with a bruised eye and marks all around his face. Paul shared the distressing experience of witnessing his partner losing blood and passing out, and how "*that thought will stay with me forever*". Paul described being expected to look after their baby who at that time he had not built a bond with, instead of being there for his partner, which he found difficult. Paul needed to go and support his baby having some tests, however when he returned, he was told his partner had lost consciousness again whilst alone in the room. Paul expressed feelings of guilt for not being there and felt he had let his partner down. Paul reflected on how being the father in the birthing room, he felt *"you are pushed into a corner, there's nothing you can do, you're really helpless*".

Long-term, Paul described how the birth continued to trigger feelings of distress, frustration, and helplessness. The birth impacted on how Paul viewed himself and his role within the family unit. Paul experienced low mood after the birth which improved over time, however had worsened again recently on the lead up to the birth of their next child. The traumatic birth resulted in him not wanting further children, as he did not want to go through a birth again. Paul's current

pregnancy was unplanned and reignited some feelings of fear. Positive long-term outcomes included having a stronger bond with both partner and infant.

Reflection on the Interview

This was the first interview conducted and I did initially feel quite nervous. However, as soon at the interview started, I felt very comfortable talking to Paul and felt the interview flowed well. I found myself noticing that Paul seemed somewhat reserved to talk in depth about some of his journey post-birth at times, however he responded well when I prompted with further questions. I think if I had have felt more confident, I could have, at points, tried to explore some topics in greater depth. I found his story very powerful and was frequently reflecting in my mind as he spoke about the birth, just how difficult it must have felt standing in a room feeling marginalised and helpless. I was pleased at the end of the interview when Paul commented feeling surprised at how open to sharing his experience he had been. I found this was important to me, as I interpreted it to mean Paul felt comfortable and heard within the interview.

Nigel

Nigel is a White British male in his mid 30's. His interview was conducted around four years after the traumatic birth experience. This was his first experience of a birth event, and he is a father to three children in total.

Nigel's Birth Experience

Nigel shared feelings of not really knowing what to expect as it had been his first experience of a birth. Nigel's partner had wanted to be in a birthing suite, however as the labour progressed and complications arose, this was not possible. Whilst in hospital, Nigel described complications being first noticed when the labour appeared to be starting and stopping. Later, it was identified that the baby was not positioned correctly. These complications triggered a significant amount of worry and anxiety for Nigel as he just wanted their baby out safely. The labour was lengthy, and Nigel shared finding himself asking staff "*surely this isn't right?"*, however he was told that everything was normal. Nigel described how "*drastic*" actions then followed, such as his partner's gas and air being removed and her being told to push without these aids. Nigel described how his partner was looking at him

in agony and asking for his help, and how he felt completely helpless, not knowing what to do. Due to staff being unable to deliver the baby naturally, they moved his partner to the operating theatre and carried out a caesarean section. The birth event triggered Nigel to experience strong feelings of guilt and helplessness for how much his partner suffered.

Long-term, Nigel described ongoing distress relating to thinking about how easily things could have been different and how his child could have been greatly harmed due to the medical decisions made by staff. He reported ongoing feelings of guilt relating to the belief that he let his partner down. Nigel reported experiencing low mood and heightened anxiety and reflected on the possible role the birth had played in their development. He also described himself as being an overprotective parent, however felt unsure if this was induced by the traumatic birth or not. Nigel shared that his partner experienced post-natal depression after the birth. He shared that the interview was the most detail he has gone into about the event. He described his feelings about the birth having become "*more numb*" over time. He reported adverse impacts on the couple's relationship, which have improved with time. Nigel and his partner accessed couples counselling, post-birth. Positive post-trauma outcomes included increased empathy towards others and a stronger parent-infant bond.

Reflection on the Interview

Being my second interview conducted, I noticed feeling more comfortable and confident this time to explore certain topics in greater depth. The interview discussions flowed well. I was mindful that Nigel had perhaps not spoken about his birth experience in such detail before, and although it was nearly four years ago, it still felt recent and raw by the way he described it. Therefore, I wanted to ensure I was compassionate in my approach and provided a space where he felt heard and understood. It felt as though a lot of focus had perhaps always been on what his partner had gone through, therefore it was challenging at times trying to sensitively pull away from this and for us to refocus on how this experience had been for Nigel as the father.

Craig

Craig is a White British Male in his early 50's. His interview was conducted around 11 years after the traumatic birth experience. This had been his first experience of a birth event, and he is now a father of two children.

Craig's Birth Experience

The traumatic birth Craig experienced was a lengthy labour, finally involving a forceps delivery due to baby becoming stuck. Recalling their arrival at hospital, Craig described the stress of trying to get parked and the worry of not knowing what to expect. He shared how difficult the birth experience was, being his first time, and not having their parents present to provide support and advice. Craig recalled watching the heart monitor and noticing the times when the heart rate of their baby was declining during times of heightened distress. He described childbirth as being "*incredibly brutal*". Craig remembered the scissors used to cut his partner during the birth and "*the baby's head being crushed*" by the forceps, which triggered a lot of worry. When baby was born, Craig's partner was immediately taken away to receive stitches and he was left to hold their baby. This birth experience triggered an array of emotions including feeling scared, shocked, stressed, but also grateful for the midwives who were there to support.

Long-term, Craig commented that he did not think about the birth now and felt any lasting effect was more "*subtle*". He shared that the traumatic birth did contribute to him initially not wanting further children and the couple delaying having their second child. However, Craig was pleased they did go onto have another. He shared feeling he was a more over-protective parent after the birth, with increased nervousness around hygiene. Craig shared feeling that the birth did adversely impact on physical intimacy. Positive post-trauma outcomes included stronger parent-infant bond, increased appreciation for women, and feeling better prepared for the second birth.

Reflection on the Interview

I felt this interview went well, however it did not seem to flow as naturally as previous ones completed. I noticed feeling more on edge from the beginning, as although Craig had initially said the birth event was traumatic in his screening appointment, this felt less clear at the beginning of the interview, therefore I needed

to review this with him. I was aware that Craig had a much longer time gap since the birth event, in contrast to other fathers I had interviewed, and I noticed that he found it more difficult at times recalling events as clearly. Craig shared another traumatic experience in relation to his child, which was unrelated to the birth, therefore at times I needed to redirect the conversation back onto the research topic. Craig was generally quite open in his responses throughout the interview, and I felt comfortable asking him questions.

Sam

Sam is a White British Male in his early 30's. His interview was conducted two years after the traumatic birth experience. This was his first experience of a birth. Sam's partner was pregnant at the time of the interview with their second child.

Sam's Birth Experience

Sam and his partner had originally planned to have a water birth, however due to complications during the labour, this was no longer possible. Sam's partner was immediately taken to a ward, which was not in their plan and therefore triggered a lot of worry for them. Sam shared how his partner was provided with self-dosing pain relief, which led to her being "*high*" in presentation and Sam needed to make the informed decisions going forward. Sam's mother-in-law was present which he found extremely valuable to support with decision making. Sam recalled the level of pain his partner was in, describing this as "*horrendous*". His partner was advised to push for two hours before it became apparent that baby was not moving due to being incorrectly positioned. At this time a doctor advised that forceps were required to aid in the delivery. Sam described this event as "*very real and raw*", and vividly recalled witnessing the size of the forceps and the amount of blood his partner lost. He recalled watching the blood draining from his partner's face as a very distressing experience. The birth event triggered Sam to experience feelings of guilt and helplessness. However, he also shared how once he knew his partner and baby were both okay, *"positive emotion kind of floods everything*".

Long-term, Sam shared feeling the birth has had a "*relatively minimal*" impact on his life now. However, his partner's current pregnancy has been a trigger for reigniting some of the difficult emotions and memories from the traumatic birth. He described a transition of emotions since the birth, which began with "*sadness*"

and moved to an experience of stress and "*bubbling anger*", which he has focused on addressing in the last year. He felt unsure at times what has related to the birth and what has related to transitioning to parenthood. Sam discussed the detrimental impact of masculine ideologies. The birth trauma has been a contributory factor to Sam currently not wanting further children after the next birth. The traumatic birth impacted on physical intimacy in the first year, but subsequently improved greatly. Positive post-trauma outcomes reported included increased resilience, increased empathy for others, stronger parent-infant bond, and stronger relationships with partner and mother-in-law.

Reflection on the Interview

The interview with Sam felt very relaxed and the overall flow of discussion went well. Sam was very open in his responses, and I really felt how important it was for him to share his birth journey. In some of the other interviews, exploring topics such as the impact of the birth on intimacy were difficult, however I found this less so the case with Sam and he was much more open to sharing his whole journey. Sam commented during the interview that his partner had been nearby and able to hear him talking at points, which he alluded to this triggering some feelings of guilt for sharing what he went through, as he felt it was nothing compared to what she went through. I was mindful to check if it was the right time to complete the interview, however Sam was happy to continue. This comment from Sam led me to reflect on how fathers can internally invalidate their own experience of the birth and worry about the perceptions of others when they do share their experience.

Brad

Brad is a White British Male in his early 30's. His interview was conducted around four years after the traumatic birth experience. This was his first experience of a birth event, and he is now the father of two children.

Brad's Birth Experience

Brad and his partner attended hospital as their baby was past its due date and they had some concerns regarding reduced baby movements. Brad's partner was induced which was a very long process. Brad did not feel their baby was ready to come out when the interventions began. Brad distressingly witnessed his partner in

extreme levels of pain and discomfort, which later was found to be because their baby was in an incorrect position and had become stuck in the birth canal. Brad described a difficult moment where he had not eaten for a long period, and he became lightheaded during the administering of the epidural. Brad faced concerning moments where he witnessed his baby's heart rate declining on the monitors during periods of contractions. Brad's partner was advised she needed to go to theatre to have rotational forceps. Brad found the rapid pace of changes in the interventions undertaken by the medical team to be both overwhelming and distressing. He witnessed his partner losing large amounts of blood and vomiting. He longed for more information from the staff and felt ill-informed regarding the choices available to them. He experienced an array of emotions including frustration and confusion due to the lack of communication, moments of fear at the thought of losing his partner or baby, and feelings of immense joy when his baby was born.

Long term, Brad shared not often thinking about the birth, however he reflected on whether this was connected to avoidance. Brad shared feeling the birth experience did negatively impact his mental health. In the first 18 months post-birth, Brad experienced suicidal ideation, which he disclosed to his partner for the first time during the week of our interview. Brad described experiencing feelings of anger, which have improved over time, however unresolved feelings of "*rage*" remain. Brad found it difficult to disentangle what felt most related to the birth and what related to the early period of becoming a parent. He reported initial bonding difficulties with his infant, as well as some relationship difficulties with his partner, however these both improved greatly over time. The traumatic birth did initially impact on wanting further children, however Brad and his partner did go on to have a further child almost three years later. Brad did not feel the birth had led to any positive outcomes for him.

Reflection on the Interview

This interview flowed well overall. I felt very comfortable talking to Brad and he was very open in sharing his experience of the traumatic birth. Due to the way Brad spoke and the emotion he presented, I really felt how difficult and still very raw this event was for him. Brad shared a story of disclosing to some colleagues that he had experienced a traumatic birth, and how they ultimately responded with laughter. I noticed myself feeling shocked, disappointed and in some ways angry for

him, that he had faced this response, as it highlighted how invalidated fathers can feel in their experience of a birth. Brad shared a difficult period after the birth where he experienced suicidal thoughts and how he had only recently felt able to disclose this for the first time. I was grateful that he had felt able to share this with me during our interview. Brad shared not having felt able to access support until now, four years on. I felt pleased that he was ready to seek support, but it also made me reflect on the potential delay which some fathers can face in feeling able to address the birth trauma they have been through.

Luke

Luke is a White British Male in his late 40's. His interview was conducted nine years after the traumatic birth experience. This was his first experience of a birth event, and he is now the father of two children.

Luke's Birth Experience

Luke's partner needed to be induced early due to the risks associated with her experiencing blood pressure difficulties. Luke reflected on the process of induction and how his partner was left in the hospital bed, with midwifery staff rarely present. Luke witnessed his partner in high levels of pain, which he felt was difficult but also expected. The staff were experiencing difficulties with the delivery, therefore more medical intervention and staff were required. Luke described witnessing his partner undergoing extremely invasive procedures, her pain relief being increased and her losing large amounts of blood. Luke recalled a critical moment of seeing his partner fading in and out of consciousness and him saying to the staff "*this isn't right, there's something going wrong here*". Luke feared for how much blood his partner was losing and found himself asking the medical staff whether enough blood had been prepared for her. Luke's partner was taken to theatre which triggered Luke to feel helpless and unable to do anything. Witnessing things going wrong, he shared that his partners safety was his main priority "*she was the only thing I cared about*". He felt helplessness, fear, and ill-informed as the father in the room.

Long-term, Luke and his partner went through a serious case review regarding the birth, therefore the event remained regularly thought of and spoken

about during this time. In the year post-birth, both Luke and his partner experienced the loss of a parent, which also contributed to their distress at that time. Luke accessed some counselling in relation to these life events. However, he described in the early phase post-birth going into a survival mode, not wanting support but instead wanting to prioritise keeping his family safe. When memories of the birth are re-triggered now, it can provoke difficult feelings such as fear, guilt, and regret relating to wishing he had displayed greater "*assertiveness*". The birth did impact on the decision to have a further child, however with careful planning they did go onto have another. Luke reported some ongoing relational difficulties with his child. Positive post-trauma outcomes included an increased appreciation for life and cherishing family, and increased connectedness with partner.

Reflection on the Interview

This interview was the only interview carried out by Zoom. This did initially trigger some feelings of nervousness as I had done all other interviews via telephone. However, I felt the interview went positively overall. I felt the conversation flowed well and Luke was quite open to talk about his experience. I was aware Luke had talked a lot about the birth during a serious case review following the birth, so I wondered if this had supported him to feel more able to share his experience in the interview. It was difficult at times to hear how this birth event had impacted on his father-infant relationship, and I could see how difficult and distressing this was for Luke to share. I felt it showed great strength that Luke had felt able to talk about this difficult topic as openly as he did. As the interview went on, I also noticed myself reflecting on how much a theme of increased feelings of protectiveness was apparent in many of these fathers' narratives after the births. I found having this interview over Zoom valuable in supporting me to pick up and notice non-verbal cues (e.g. changes in facial expression or eye contact), for things which Luke found more difficult to talk about. This made me reflect on the value of face-to-face interviews and wonder what I perhaps might have missed in the telephone interviews.

Peter

Peter is a White British Male in his early 30's. His interview was conducted around three years after the traumatic birth experience. He is the father of two children. The traumatic birth experience was during the birth of his second child.

Peter's Birth Experience

Peter's birth involved a long labour, of which he experienced feeling marginalised, "*surplus*", and ill-informed throughout. He felt unprepared and dazed by the sudden shift from calmness to rapid panic, where his partner was taken to theatre with little explanation for the concerns which had arisen. Not knowing what was happening and longing for information triggered immense feelings of worry and fear as to whether his partner and baby were okay, but also frustration with regards to the behaviour of staff. He described feeling that "*everyone is too busy for dad*". Peter's partner needed to be prepped for theatre, at which time he was advised to gown up and sit in a room, where he remained alone for around 25 minutes. He felt very unprepared for what he witnessed when he was finally allowed into theatre room. Peter walked into his partner undergoing a caesarean section, without him having been told. Upon the baby being born and his partner still on the operating table being sick, he then distressingly witnessed two members of staff standing over his partner, arguing about the next steps in her care. Peter was then advised to step outside into an unfamiliar room, where he was left feeling *"gobsmacked"*, confused, and not knowing what to do or where to go.

Long term, Peter continues to think about the birth often, and memories are easily re-triggered when going past the hospital, provoking an array of emotions including happiness about having a child but also relief not to be going through it again. Peter shared not wanting to have any further children. He described experiencing hospital related anxiety, linked to feeling ill-informed and unsupported, which he feels the traumatic birth contributed too. The birth impacted on aspects of Peter's self-esteem, for example, particularly soon after the birth, Peter questioned how needed he was as the father. Peter felt the birth did impact on his mental health. He shared experiencing heightened anxiety and panic around his children's safety, which began six months after the traumatic birth. He described periods of bottling his feelings and experiencing occasional, unexpected, overwhelming rushes of emotion. Positive post-trauma outcomes included increased

empathy towards others, increased closeness to partner and strong parent-infant bond long-term.

Reflection on the Interview

I felt the interview overall went well and there was good, relaxed flow in conversation. I noticed myself asking follow on questions more naturally, which I think was a reflection on how many interviews I had previously done, and my confidence having increased. I found it interesting that Peter shared not having noticed experiencing some of his difficulties until six months after the birth event, as I felt this highlighted how diverse a father's journey can potentially be after a traumatic birth and that some may experience delayed responses.

Mark

Mark is a White British Male in his early 30's. His interview was conducted three years after the traumatic birth experience. He is the father of two children. The traumatic birth experience was during the birth of his first child.

Mark's Birth Experience

Mark reflected on this having been a lengthy labour which was very different to the birthing plan they had hoped for. Mark's partner was put on a hormonal drip, which they agreed to reluctantly. Mark's partner was provided with a self-managed pain relief. However, due to her high levels of exhaustion during contractions, she was missing when to press and not receiving the pain relief she needed. Mark's partner had to undergo an episiotomy and forceps delivery, during which Mark witnessed her losing a lot of blood and making highly distressing noises he had never heard before. This period felt particularly long for Mark. He shared feeling helpless and scared, not knowing what was happening. He experienced feelings of guilt relating to being unable to do anything, and like he was "*a spare part*" in the room. Mark did not feel fully informed about each procedure that was happening.

Long-term, Mark felt unsure at times how the birth had impacted different aspects of his life. He shared frequently still thinking about the traumatic birth, which can trigger him to get upset and question what he could have done differently. Mark described himself as previously always being a very laid-back person, however that changed after the birth. He shared feeling far more emotional now.

Mark described a reluctance to open up and talk about the birth event at times, however he felt this has improved with time. He reported feeling more over-protective of his children than anticipated, however was unsure if this was connected to the birth. Mark felt going through a further birth, positively aided his recovery, and increased his openness to having more children. Mark did not directly report any post-trauma positive outcomes, however some drawn from the interview included increased closeness with partner and strong parent-infant bond.

Reflection on the Interview

This was my final interview and one which I found a little more challenging than others in relation to gaining in-depth answers. I felt that Mark found it difficult to open up fully about how he felt and how this experience had impacted him long-term. I noticed feeling that Mark presented as quite shy or anxious when answering questions, for example, occasionally offering a slight laugh within his answers. Due to the short answers Mark often gave, I noticed myself feeling more on edge as to what to try and explore more or what to ask next, which at times led to my questions not always feeling clear and me needing to repeat them. This was the shortest interview completed.

Findings

Following a comprehensive thematic analysis as outlined in the method chapter, five themes were developed. These included: i) Boxed away as “should not feel”, ii) Can’t face it again; fear and recovery of having further children, iii) Haven’t felt like a “normal dad”; the effects on parenting, iv) The enduring distress, and v) Positive long-term outcomes post-trauma. These core themes each include relevant subthemes which will be described in depth below.

Figure 1

Thematic Map

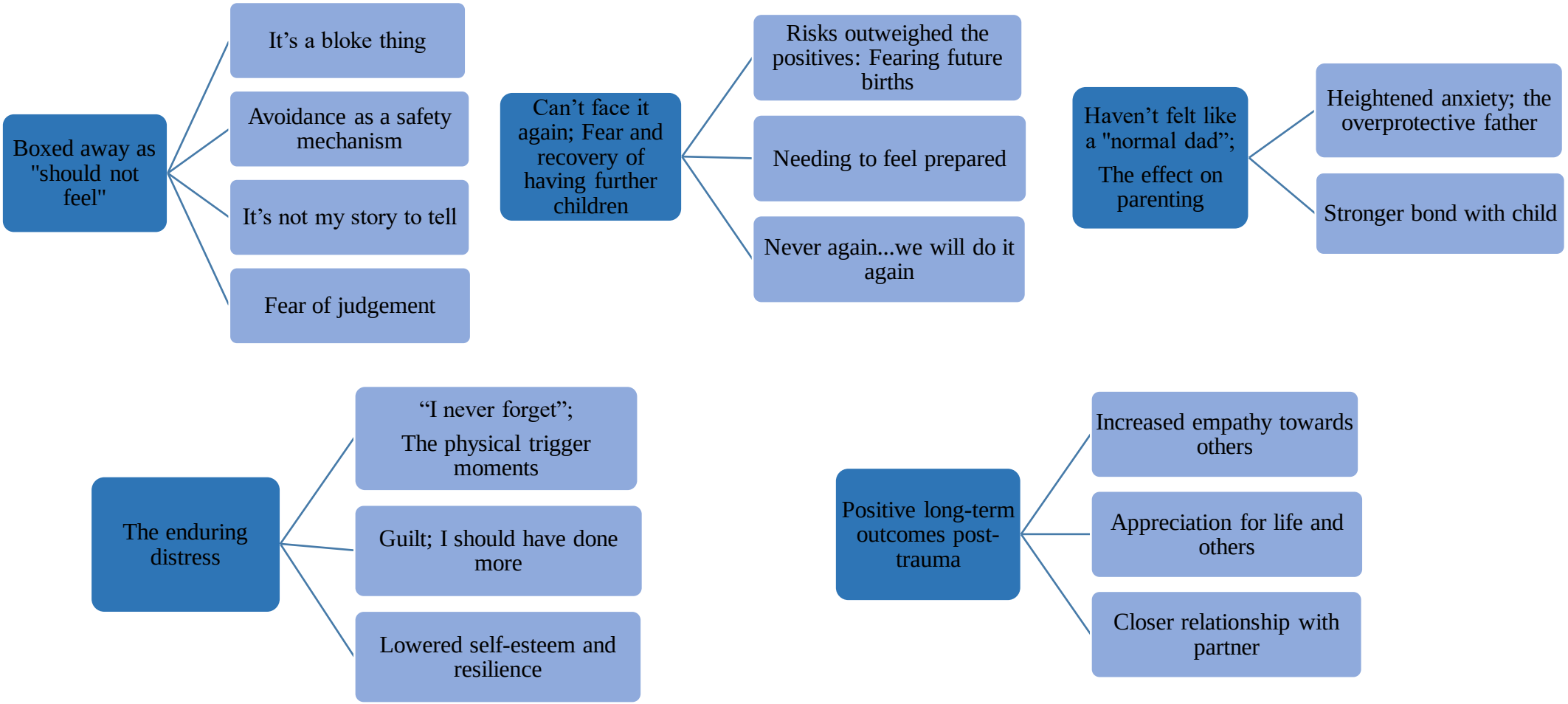

Table 3

Representation of each participant within the themes

Theme	Subtheme	Paul	Nigel	Craig	Sam	Brad	Luke	Peter	Mark
Boxed away as "should not feel"	It's a bloke thing		✓	✓	✓		✓	✓	
	Avoidance as a safety mechanism		✓			✓		✓	✓
	It's not my story to tell			✓	✓			✓	✓
	Fear of judgement		✓		✓	✓		✓	
Can't face it again; fear and recovery of having further children	Risks outweighed the positives; fearing future births	✓			✓		✓	✓	✓
	Needing to feel prepared	✓	✓		✓	✓	✓		
	Never again…we will do it again	✓	✓	✓	✓	✓			✓
Haven't felt like a "normal dad"; the effects on parenting	Heightened anxiety; the overprotective father		✓	✓			✓	✓	✓
	Stronger bond with child	✓	✓	✓	✓	✓	✓	✓	✓
The enduring distress	"I never forget"; the physical trigger moments	✓	✓		✓	✓	✓	✓	✓
	Guilt; I should have done more	✓	✓		✓		✓		✓
	Lowered self-esteem and resilience	✓	✓		✓	✓	✓	✓	
Positive long-term outcomes post-trauma	Increased empathy towards others		✓		✓			✓	
	Appreciation for life and others			✓			✓		✓
	Closer relationship with partner	✓			✓	✓	✓	✓	✓

Theme One: Boxed Away As "Should Not Feel"

This theme captures the array of factors which had significantly impacted on participants feeling able to both openly talk with others and access support for the traumatic birth they have experienced. Within this theme are four subthemes; **'It's a bloke thing', 'Avoidance as a safety mechanism', 'It's not my story to tell'**, and **'Fear of judgement'**.

Subtheme: It's a Bloke Thing

This subtheme depicts the detrimental influence which traditional masculine ideologies have had on participants feeling able to talk about and externalise their emotions in relation to experiencing a traumatic birth. Several participants made multiple references to how embedded perceptions of the male role, both within and outside of the birth event, had led to them frequently internalising their thoughts and feelings about the experience. Sam shared: *"it's the bloke thing again. It it's such a, it's so toxic… when it comes to the general male population there's is no sharing of such things".*

Rather than feeling able to talk freely and openly, participants commented on how men are likely to often bottle their feelings around the traumatic birth experience. Nigel shared that he did not seek out support for himself, explaining one of the factors for this being: *"generally guys are more 'suck it up and see', you know. And just get on with things".* Some participants shared feeling that to communicate how they felt about their traumatic birth experience or to actively seek support for their distress would trigger them to experience difficult feelings of vulnerability, shame or be seen as a sign of weakness:

> *"I think a kind of vulnerability, hard to share. er, and I think in that moment you are incredibly vulnerable…this is all very stereotypical in a way but it is a, a lesson which we teach our sons that they are to be strong and they are to be silent. Er, you know that whole strong and silent kind of thing being the most attractive form…we teach that, and then we, and then we as the sons live it, … we're taught that our vulnerability is not a positive thing it's something to be ashamed of. It's something to be pushed, down and down until it, it gets obliterated" (Sam)*

> *"…you're the protector of the family and you shouldn't feel that way. You know, you shouldn't be…it's like a weakness to seek help because it's not readily offered" (Peter)*

It was a reflection from several of the participants that men do not typically talk to other men about this topic: *"…Just guys out of the pub or just chatting to your friends, you don't really, we don't really cover that topic" (Luke).* However, there were some instances where participants reflected on this discussion feeling more possible and valuable. For example, when two fathers had gone through a similar experience: *"I have one friend umm, who went, went through…similar experience about a year before us… I managed to speak to him about it…which was incredibly valuable…just to kind of feel that sort of shared experience" (Sam).*

Subtheme: Avoidance as a Safety Mechanism

This theme captures how avoidance has at times been used by some participants to maintain feelings of safety and containment. Several participants talked about how they have often tried to block out, or even avoid talking about, their traumatic birth experience to protect themselves from further distress or to try and forget what happened. Nigel shared not wanting to talk about his birth experience, as he feared it would expose him to further detail which he might have not already been aware off: *"I just naturally wanted to do what I've always done and kind of not talk about it, not learn more about it. Naivety is key. And then eventually it will go away".* Brad commented on feeling that he no longer thought about the birth much, however he thought this could be a coping strategy of avoidance as he has actively tried to "push" the birth experience away: *"I generally don't give it a lot of thought and I suppose what's interesting about that is trying to just avoid it in some ways".*

There were varying journeys amongst participants in relation to their openness to talk about their traumatic birth experience over time. Peter talked about how after the birth he noticed himself being more withdrawn from others outside of his close network and how this has continued over time: *"…initially I, you know the way I spoke with other people and my emotions probably became more withdrawn and*

probably still are really…". In contrast, some participants shared how with time, they have felt more able to begin talking about their experience in greater depth:

> *"I wanted to just put it all in a box and just bury it and just move on, cause that's how I generally deal with things…so I've never really gone into too much detail, and this is probably the furthest that I've got into how I've felt about it. And opening up now, I'm happy to do so. Like I said, I feel the anxiety, the butterflies, but its bearable. You know speak to me two years ago I probably would have really struggled with it" (Nigel)*

> *"…I think if I'd seen this research a year or two ago, I probably wouldn't have engaged because I wouldn't have been ready. But now I am… which ties in with me looking for therapy... I'm getting to a point where I'm more able to face it" (Brad).*

Subtheme: It's Not My Story to Tell

This subtheme depicts the difficult journey some participants have faced in feeling able to share their traumatic birth experience, due to embedded perceptions that this is the mother's story to tell, rather than their own. Several participants frequently made use of language within their interview which captured the birth as having been the mother's experience, for example *"she went through all of this" (Mark).* Some participants appeared to invalidate how difficult their own experience of the birth was, by comparing it to how they interpreted their partner's experience to have been. For example, Peter commented: *"…that's pretty much my views on my, my own feelings; there's, there's always people worse off. You know, you might feel bad that you witnessed it, but your* ***partner actually went through it****"[my emphasis]*.

Participants talked about how this was a story which women will often share together, however not in the presence of men. Craig discussed feeling unable to talk with women about his experience due to perceiving this as a topic *"out of bounds really. It's a bit taboo".* Sam openly reflected on how societal views reinforcing this as being a mother's experience, had contributed to him putting his experience in a *"box labelled…should not feel".* Sam went to further comment*:*

> *"…it's also not your story to share, that's in there as well. Again, it, it's that feeling of this isn't about me, this is about my wife; this is about what she went through. So why am I going to go and sit and talk to somebody about what she went through. Because actually it was something I went through as well, but nobody ever, you know nobody ever acknowledges that"*

Subtheme: Fear of Judgement

This subtheme links the themes relating to the impact of masculine ideologies and 'it's not my story to tell'. It describes how fear of judgement from others, also negatively impacted on some participants feeling able to talk about their traumatic birth experience. For some, this fear was related to how others could potentially perceive them as weak if they were to externally show their emotional distress; *"I would be really embarrassed if anybody saw me crying, really embarrassed… I'm protecting myself from that stupid, whatever it is erm, thought that if I talk about it too much, I get upset about it and show weakness" (Nigel).* For others, it was the fear of receiving negative verbal responses from others, and how this would make them feel, which stopped them from being able to share their experience:

> *"…if I turned round to anybody and go, 'God! You know that, that, um, you know going through birth was horrible. It was the worst experience of my life'. You can almost hear the response, 'yeah well I bet it was worse for your wife.'… So you just, you get that pre-emptive guilt and just don't say anything at all" (Sam)*

One participant, Brad, described a difficult experience where he had shared with some colleagues about having gone through a traumatic birth and how one person questioned how this could be traumatic for anyone other than the mother, others responded in return with laughter. Brad reflected on how this now triggers feelings of *"…injustice maybe that, yeah, my experience isn't validated*". Fear of judgment from others was also something that contributed to Peter feeling unable to access support following his traumatic birth:

> *"we think about everyone else's perceptions…what I feel would be 'that's a bit of a selfish thing to do. You know, you've got a young, young partner at*

> *home that's just had a major operation and a baby and you're stepping away to look after yourself. Like, is that right?'…that's probably why I didn't take anything…I'd have probably felt like I was cheating a little bit" (Peter)*

Although participants shared various fears relating to feeling judged if they were to open up about their traumatic birth experience, the one person many wanted to and felt able to openly share their experience with, without fear of judgement, was their partner: *"Oh, I really wanted to talk to her, yeah" (Luke),* and *"I think it's something that my wife and I always do very good at is, is talking, talking through what we've both been through without judgement" (Sam)*.

Theme Two: Can't Face It Again; Fear and Recovery of Having Further Children

This theme describes the difficult thoughts and feelings participants faced when considering having further children after their traumatic birth experience, but also the positive impact having further children had on some participants' recovery journey. Within this theme are three subthemes; '**Risks outweighed the positives; fearing future births', 'Needing to feel prepared',** and **'Never again… we will do it again'.**

Subtheme: Risks Outweighed the Positives; Fearing Future Births

This subtheme captures the various fears which participants shared in relation to considering the option of having further children. For some, the risks far outweighed the positives and meant that going through another birth was just not a consideration. Peter talked about how having another child could have been an option for them, however the safety of his current family unit was a far greater priority to him: *"…it's not worth it to me; we've got a healthy family, happy family, and would I risk it again? No, I just don't think, I couldn't do it".*

For Luke, although he had indeed gone onto have another child, his concerns about future births were solely related to the risks associated to his partner's safety: *"I wasn't bothered about witnessing anything again…I would be happy to see as much blood as you need, you know, that seems to be part of the process…I just didn't want her to be injured or killed".* Mark had also gone on to have another child

and shared how his biggest fears on the lead up to that second birth had been a combination of worry relating to his "*partner … having to go through that whole thing again"* and *"I didn't want to see it again".*

Two participants were currently in the process of expecting their second child and each shared experiencing fears which the new pregnancy had ignited for them. Sam reflected on the difficulties of having gone through a previous traumatic birth, but also on the challenges of just being a parent, and how in combination, this has led to him feeling: *"I'll probably go and have a vasectomy once number two's out…because you know there's a limit to, there's a limit to endurance"*. In contrast, Paul talked about their current pregnancy being unplanned and how it was very much the birth event itself which has led to him not wanting any further children:

> *"I really hope that this is our last. Umm, obviously difficult traumatic birth the first time, c-section, this time. We definitely don't want to umm, have any more and it's not, it's probably not the babies and the children, it is the birth process. I think we always wanted two and then after the birth I didn't want another. Umm, [pause, signs, laughs] this one is an accident so yeah. Umm, it, in some ways made it more difficult because it was like we realised that um, [partner] was pregnant and that just brought everything flooding back again and it was like we didn't want this".*

Subtheme: Needing to Feel Prepared

Several participants described how needing to feel better prepared was a vital component in their journey to feeling able to manage going through another birth experience. A significant part in this process of being more prepared was about wanting to feel assured that a clear plan was in place to make sure any birth related risks were minimised. Luke talked about how *"we both knew we wanted a second child, but we were not going to do it until we could be, we could have enough information and enough safety net around us to do it".* Nigel shared the difficulty of initially having a different view on what the plan should be for a second birth in contrast to his partner, and how his priority was to ensure there was a hospital nearby and medical staff available: "*She actually wanted a home birth, and I, my anxieties were like, please don't put me through that. I want, I want the hospital like right there if there's any problem".* Nigel wanted to make sure they were at hospital

because of how soon the pregnancy was after the traumatic birth, and his partner was still physically healing from that birth.

For some participants, having an elective caesarean section was felt to be the safest option and this was their plan going forward. Brad reflected on how having a planned caesarean section led to a more positive second birth experience "*second time round, knowing we were having a planned section, we always knew it would be an entirely different experience".* The idea of attempting another natural birth provoked a lot of distress for Paul, and he shared feeling strongly that this was not an option he was willing to consider in the planning for his upcoming second birth:

> *"we've got an elective caesarean this time…because of [first] birth being so difficult, um, we-we both agreed it was for the best. To a point where I did say I'd rather terminate this baby than you to have a natural birth because it scares me that much" (Paul).*

Sam described thinking that having gone through a previous birth, he should feel more prepared second time around. However, he felt that the thrust into parenthood had led him to block out a lot of it. Therefore, he did not feel able to prepare himself for the reality of the next birth: *"there's a fear from my perspective of going through it again…I almost know that what I'm preparing myself for isn't the reality. Because the reality will be harder than I am preparing myself for; I just think I've forgotten*"

Subtheme: Never Again…We Will Do It Again

This subtheme depicts the diverse journeys which participants who had gone on to have further children, experienced. For some participants, going on to have a further child after their traumatic birth experience was perceived to be a positive moment in their recovery journey. Mark shared how the experience of a positive second birth enabled him to feel more open to having more children in the future: *"As soon as we had the second one… no doubt because it was a lot more, it was a lot more simpler, it was, yeah, we were up for having more straightaway then"*.

Although going through a traumatic birth experience could provoke feelings of not wanting to go through a birth again, for some this feeling became less dominant and changed with time. It was acknowledged that a traumatic birth experience could contribute to a delay in having further children: *"for a good long time we held…we*

delayed a second child, and in fact I wasn't really interested in a second child at all. Um, but we're very glad we have now" (Craig). Brad described how time played a significant part in restoring his wish to have more children and feeling able to go through the birth experience again:

> *"we're both one of three siblings and we both kind of talked about or fantasised, 'Oh, we'll have three'. And my first son was born, and it was like, 'I am never going through this again'. And as things eased off and time being the great healer that it is, healed in a way that it could. It got to the point where we're gonna have a second"*

Theme Three: Haven't Felt Like a "Normal Dad"; The Effects on Parenting

This theme depicts the significant impact going through a traumatic birth experience had on aspects of participants' anxiety levels, parenting approach and bond with their child long-term. Within this theme are two subthemes; **'Heightened anxiety; the overprotective father'** and **'Stronger bond with child'.**

Subtheme: Heightened Anxiety; The Overprotective Father

Several participants openly shared how following childbirth, they experienced heightened anxiety in relation to their children, resulting in them feeling like a more overprotective parent. Mark reflected on feelings that his level of overprotectiveness was unexpected: *"I'm more protective than I thought I would've been".* Luke described noticing that his responses towards his child can be *"more extreme and more urgent"*.

Some participants shared how heightened anxiety could be triggered by unexpected worry about their children's wellbeing. For example, Peter described how his fears about his children's safety could trigger the same panic he felt during the birth experience. Nigel reflected on feeling that his traumatic birth experience had potentially impacted on him feeling less like a "*normal dad*" and how instead he feels extremely over-protective as a parent:

> *"It's made me really anxious and really over-cautious on er [sighs] worrying about stuff that could happen to the kids. Like worrying what if a car's gonna come off the road and hit me and the pushchair and, or just something horrible's gonna happen to them. I can't just shake that. I don't know if that's just natural or if that would've been natural anyway or if it's been induced from the birth experience but I'm really over-protective of them*" *(Nigel).*

There were differing journeys regarding how participants' anxiety levels towards their children had changed over time. Craig reflected on feeling his levels of over-protectiveness had reduced with time: *"that's adjusted itself to a normal level now"*, whereas Nigel shared feeling his anxiety levels had in fact worsened over time: *"I've got slowly progressively worse…".* Although Nigel reported increased anxiety, he did not feel this was at a level that would require support, and instead reflected on feeling that he needed to just *"learn to kind of let go a little bit…you can't control everything*".

Subtheme: Stronger Bond with Child

This subtheme captures participants' perceptions of how their traumatic birth had affected the bond formed with their child long-term. Many participants shared feeling that the traumatic birth experience had played a significant role in strengthening their father-infant bond. Sam reflected: *"I think it probably made it as much as anything else. Umm, you know it was in a way it was a shared experience: all three went through it".* Nigel similarly shared*: "We've got a great relationship… I think it's probably only made the bond stronger if anything".*

Some participants described feeling that their father-infant bond was formed very quickly, due to the level of interaction required of them in the early stages after the birth. Mark shared: *"I'd no problem bonding with [baby] after the birth quite early on. I think it might have been because as I said before, I was doing a lot of things in the first few weeks, because she wasn't able to".* Paul also reported a similar experience: *"I bonded with him because it was me feeding him, changing his nappy, everything like that. [Partner] couldn't do a great deal. Um, so I think in that way it was positive…we couldn't have a closer bond"*

In contrast, some participants shared finding bonding more difficult in the early stages, however found this greatly improved with time: "*it probably was more challenging until well, again about the six to eight months where things start to get back to normal… that's when I felt more like dad" (Peter).* Brad also shared the positive growth of his parent-infant relationship over time. He initially shared: "*In that first year of life, I hugely struggled to develop a relationship with my son",* however went on to say*: "I don't know what point this would've been; somewhere between one and two, that he was kind of quickly growing into my best friend".*

Although most participants shared a positive outcome in relation to their bond with their child, it is important to capture that this was not the case for all participants. One participant openly talked about the ongoing difficulties he has experienced with his father-infant bond, and how his current reactions in response to his child appear to remain embedded and connected to his traumatic birth experience. Luke openly shared some of the difficult thoughts he can experience when his child is behaving in a way which he interprets are potentially putting others at risk:

> *"You know it's hard to disentangle the birth trauma from [child's] personality and mine. But you do get this sort of feeling of, which is not rational, of, you know, you nearly killed one person, you could kill another. Which is clearly not rational, because it has nothing to do with him" (Luke)*

Whilst Luke's situation is slightly different to the others because the feelings are still raw and present, he did acknowledge improvements in the father-infant bond, over time.

Theme Four: The Enduring Distress

This theme captures the ongoing distress participants continue to face in relation to their traumatic birth experience. Within this theme are three subthemes; **'"I never forget"; the physical trigger moments', 'Guilt; I should have done more',** and '**Lowered self-esteem and resilience'.**

Subtheme: "I Never Forget"; The Physical Trigger Moments

This subtheme captures the events and situations in life that continue to trigger memories of the traumatic birth for participants. Several participants shared that seeing or going into a hospital would trigger memories of the birth. For example, Peter shared: "*if I go to, past the hospital which is literally two miles down the road, it's the first thing I think about is the birth…".* Sometimes memories of the birth would return vividly and result in a participant feeling they were right back in that moment again. Sam described a time when he had returned to hospital after the traumatic birth and the impact of using the same toilet from the birth event had on him: "*it was in the loo that I'd used like while [partner] was in, in that ward and…when you're sort of in that moment, you go, 'blimey! I'm just right back there'… those physical trigger moments".* Sam also shared how his partner's current pregnancy has also been a significant trigger: *"Now moving into, into the second pregnancy…that's been the trigger. That's the thing that's just brought it back because it's that fear of what's going to happen…yeah, it's going, sort of going back into, into that zone".*

For some participants, memories were triggered when they would "*see a birth scene on the television" (Luke)* or something related to children being unwell was played: *"I can't watch anything on TV with poorly children or anything because I do get upset" (Mark)*. For one participant, occasions when he would witness his partner unwell and vomiting remained a significant trigger: *"my partner being sick reminds me of it. She was sick quite a lot during it… she's been sick twice since then, but I remember both times, just thinking it did remind me of the sort of the scene" (Mark).* Brad shared that, as a result of his partner's fourth-degree tear, she has difficulties controlling flatulence, which he described as being *"that little reminder every so often that this is with us".*

It was acknowledged that for several participants. talking about the birth with their partner or others could also sometimes trigger memories and distress about the traumatic birth event they went through. Paul shared:

> *"there's times where we end up discussing it for some reason where obviously we, we get upset. Um, because I suppose in some ways it sort of soured the whole experience obviously, of becoming parents. Umm, I think*

> *especially when other people talk about theirs, their birth experience and you're like, 'no, yeah mine wasn't like that at all'…that can hurt".*

Paul went on to further say: *"I never forget the little boy with the black eye. I mean, whenever that comes up the birth comes up, you do think about it quite a lot…*", and that these memories still trigger feelings of "*helplessness*".

Subtheme: Guilt; I Should Have Done More

Feeling guilt, both during the traumatic birth experience and in the long-term, was shared by several participants. These experiences of guilt were often related to how participants felt about their role within the birth event and how they thought that they did not meet the needs of their partners at that time: *"I just feel like I let [partner] down more than anything. She was doing everything, she was the one suffering; I wasn't suffering. I feel the need to have suffered more" (Nigel).* Regardless of the time passed, Mark reflected on how when memories of the birth were triggered, guilt remained a persistent emotion: *"I still do feel like, I just remember being like useless and sort of like, it is a guilt…the same feelings and I know its three and half years later…but they're still there".*

Guilt was at times closely linked to the subtheme of 'it's not my story to tell' and was a barrier to accessing support: *"I think there's an expectation and a guilt again about how…it's not fair of me to feel anything because I didn't go through it" (Sam).* For some participants, the birth experience had negatively impacted how they perceived themselves and their role as a father:

> *"…it probably made me feel a bit more emasculated, that I can't protect, or couldn't protect and help my family right there and then. And I think that probably links in with the whole going back to work thing in that I wanted to be there to protect them. yeah. There was nothing I could do in that moment, in the room; there was nothing I could do, and I know that but equally sort of the irrational side thinks you should be able to do something*" *(Paul).*

For some participants, they appeared to replay the birth event in their mind, contemplating how they could have said or done things differently in the moment:

"I do still play it, you know when, when this er doctor came and said this, should I have piped up, should I have said something, could all this have been avoided? …she didn't have to be in that much pain for it that was all, because I stepped up and said something, I still think, I do still play it back" (Mark)

"like if you'd gone back in time again, you'd be saying right, I want to see a doctor, I want a doctor to tell me what this means that this pessary has led to these contractions and you know, when I, when, you know, What is, you know, straight after the birth trauma, you know, what is the biggest risk here that I should know about…" (Luke)

Subtheme: Lowered Self-Esteem and Resilience

Several participants shared how the experience of going through a traumatic birth had impacted on various aspects of their mental health and wellbeing long-term. Nigel talked about having experienced anxiety and depression, which although he felt this was triggered by an accumulation of factors, he identified the traumatic birth as being *"the initial massive incident that's caused my resilience to such things to be so low"*. Luke shared feeling that, as a result of his traumatic birth event, he does now experience "*probably a bit more anxiety about the kind of things I'm normally anxious about, but just, just to a level above it"*. Luke commented that his anxiety was worst in the year post-birth and is mostly lower now, but it continues to fluctuate.

Brad disclosed having gone through a very difficult period during the first 18 months after the birth event: *"it impacted on my mental health because it triggered me to have suicidal thoughts".* Brad identified ongoing issues which he feels he needs to access support for, however it is only now that he has feels able to do that:

"I don't know if it's as clear cut to separate the birth experience with that early life, early year…like I say because it was traumatic, because we were so physically and mentally emotionally tired and then my baby didn't sleep, it meant I didn't have any resources or I couldn't draw upon anything. So, like I say I really struggled, like I say with anger. Um, yeah, there, there's a rage that I need to address…" (Brad).

Peter reflected on how his traumatic birth event had contributed to him experiencing low self-esteem and reduced feelings of being needed or important, in contrast to others. However, he also reflected feeling that this had improved with time:

> *"Sometimes…when you see like mum and in-laws with the little one, you feel, you know you do still think, you know is it necessary; was I needed in the room or am I needed now? You-you'll think that because that was the information you were given in that moment; that was the feeling you were given in that moment. So, it doesn't happen often…I think because the little one is nearly three, he can verbalise that he loves me, he can verbalise that he wants me for something or can we play with this together. So you know, you are wanted and needed, but in the early stages it definitely carried" (Peter).*

Theme Five: Positive Long-Term Outcomes Post-Trauma

This theme encompasses some of the core positive outcomes participants found, came from going through a traumatic birth experience. Within this theme are three subthemes; **'Increased empathy towards others'**, **'Appreciation for life and others'** and **'Closer relationship with partner'.**

Subtheme: Increased Empathy Towards Others

Some participants reflected on how going through a traumatic birth experience has led them to have increased awareness and empathy for others. Sam shared experiencing increased empathy towards women: "*I think it's umm, made me more empathetic to umm, to what women have to go through"*. Nigel described that previously he would have been less inclined to offer support to others who might be struggling, however this had changed since his traumatic birth experience:

> *"I think I've learned a lot from it. I've gained a lot of sympathy and empathy that I can pass on to others and advice. It's changed my mindset really. Urm, yeah I can be more sympathetic to er, to people who are struggling" (Nigel).*

Peter described noticing an increase in empathy towards supporting staff at his work, however also acknowledged having been unable to access this support himself: *"it's probably made me more empathetic as a manager to say, 'Look, I can see you're struggling. Take this help.' but I haven't ever taken it myself and I don't know why I haven't".* Peter's difficulties with accessing support for himself were closely linked again with traditional masculine ideologies around a father's role. Peter also shared specific empathy towards other parents who have had a traumatic birth: *"I'm empathic, Sort of I know where you're coming from. It's not easy".*

Subtheme: Appreciation for Life and Others

A couple of participants shared feeling that their traumatic birth experience had positively impacted on their level of appreciation for life and others. Luke described how the experience had been a contributory factor to him reducing his hours at work so he could spend more quality time with his family and how the birth experience had highlighted to him:

> "*how precious and brief life is and that, how you want to spend as much of your time as you can doing things that are valuable and as least time as you can doing unnecessary work or kind of time away from people that you care about" (Luke)*

Mark shared an increased appreciation for his partner following the birth: *"she went through this and absolutely amazing you know. I couldn't have done it you know"*. Craig also spoke about how going through a traumatic birth experience had greatly increased his appreciation for women more broadly and their overall role as a mother:

> *"I think it just meant I was able to appreciate properly how strong woman are and that was valuable, and you can't underestimate that because it made me understand a lot more how mentally strong they can be and put up with that, not just birth but also the whole looking after kids. Very strong" (Craig)*

Subtheme: Closer Relationship with Partner

Some participants described some aspects of their relationships being negatively impacted after the birth, such as increased arguments or reduced engagement in intimacy. However, these aspects did not remain long-term for most:

> "*that first year and a half we argued a lot more and, and again maybe partly from the adjustment from a couple to a, to parents, um, but we argued a lot more… but no we are, I am very pleased that we are a very strong couple… So, no, there's no long-term impact but there was difficulties within the relationship*" *(Brad).*

> *"I suppose at first it was more of a, umm, you know mum's tired, hurting, aching and whatever else. And then it was, you know from my, my standpoint, it was not really wanting too…because of what I'd seen when I walked in the room and seen, you know mid-way through a caesarean section, like, like I don't know. It just completely freaked me out… I think once we got to the six-month mark probably, maybe the eighth month mark, everything slowly started to return to normal" (Peter).*

Most participants commented on feeling that having gone through a traumatic birth had led to them developing a much closer bond with their partners long-term. Luke shared: "*I think it's, it made us to some degree, I mean we were very close anyways, but it made us closer…because of sharing that raw emotional experience".* Sam also commented feeling: *"I certainly have built a very strong relationship with my wife as a result of it".*

Some participants described how their birth experience had led to them feeling able to communicate better with their partner: *"I think we've become a lot more honest and a lot more open and more supportive of each other. I'd say that's a positive out of a traumatic experience"* (*Peter*). Paul reflected on the impact on both his and his partner's parenting: "*I think it made us approach parenting a little bit different…it feels like we have probably been a bit more grateful because of what went through and sort of a closer bond because of what we went through".* Paul also reflected feeling that the bond with his partner following the birth was rare*: "It's almost like a bond we think which most couples don't have".*

Discussion

Within this chapter, the aims of the study will firstly be reintroduced. Following this, the study findings will be discussed in relation to the existing wider literature. The study's strengths and limitation will also be considered. Finally, recommendations for future research and clinical practice will be presented, followed by an overall conclusion.

Revisiting of the Research Aims

The aim of the present study was to gain a greater understanding into the long-term impact of experiencing a traumatic birth for fathers. This study classified 'long term' as a time period of two or more years since the birth event. To answer this research question, remote semi-structured interviews were completed with eight participants, who were all fathers living in the UK and had been present at the birth of their child. Each father self-defined their birth event as a traumatic experience. Fathers were asked a range of questions relating to whether and how they felt their traumatic birth had continued to impact on various aspects of their life including their mental health and wellbeing, work and interests, relationships, and subsequent pregnancies. The qualitative data gained from these interviews were transcribed and then analysed using Braun & Clark's (2006), TA.

Summary and Discussion of Findings

The present study provides new insight into the long-term impact of a traumatic birth on fathers. From the data gained within this study, five key themes were produced; i) Boxed away as "should not feel", ii) Can't face it again; fear and recovery of having further children, iii) Haven't felt like a "normal dad"; the effects on parenting, iv) The enduring distress, and v) Positive long-term outcomes post-trauma. These themes encompass a range of subthemes which encapsulate the ways in which fathers have continued to be impacted by their traumatic birth experience, but also how their post-trauma journey has changed with time. Each of the five key themes will next be discussed in detail, within the context of wider literature.

Theme One: Boxed Away as "Should Not Feel"

Within this theme, participants shared several ongoing barriers which had contributed to them feeling less able to open up to others comfortably about their traumatic birth experience at times. The barriers identified took the form of four subthemes; 'It's a bloke thing', 'Fear of judgement', 'It's not my story to tell', and 'Avoidance as a safety mechanism'.

Participants raised the detrimental influence of traditional masculine ideologies on their ability to express emotions or talk about their traumatic birth, with one describing it as "*toxic*" *(Sam)*. The harmful impact of embedded masculine norms, such as men needing to be stoic, emotionally controlled and self-reliant has also been captured within wider literature (Addis & Hoffman, 2017; Seidler et al., 2016). Externalising feelings of distress can be seen to represent an inability to cope and attributed as weakness (Mahalik & Dagirmanjian, 2019; O'Brien et al., 2005). Research has extensively captured how attempts to uphold and conform to masculine norms, are linked to adverse mental health outcomes (Wong et al., 2017), and can reduce men's willingness to engage in help-seeking behaviour (Mahalik & Bianca, 2021; Vogel et. al., 2011). Help-seeking can be viewed as nonconforming in men and a violation of masculine norms, therefore increasing associated stigma and feelings of threat in relation to self-perception and the possible responses from others (Mahalik & Dagirmanjian, 2019).

The present study captures some of these embedded perceptions, with participants reflecting on how men are taught to be *"strong and silent… vulnerability is not a positive thing, it's something to be ashamed off" (Sam),* and how fear of judgment around the birth trauma can impact on openness to disclose distress: *"I would be really embarrassed if anybody saw me crying, really embarrassed… I'm protecting myself from that…thought that if I talk about it too much, I get upset about it and show weakness" (Nigel).* Fathers feeling restricted in their openness to talk about their traumatic birth experience has also been captured within other paternal birth trauma studies (e.g. Daniels et al., 2020; White, 2007). White (2007) discussed how some fathers would supress their emotions after birth in order to try and maintain a sense of 'holding it together' in the eyes of others, and instead only allowing themselves to break down when in a quiet and private space. Although some literature suggests that more traditional masculine ideologies may be

fading out (Thompson & Bennett, 2015; Wade, 2015), it is evident from the current study that these continue to have a harmful impact on fathers within the context of a traumatic birth.

Some fathers in the present study reflected on how the topic of a traumatic birth was not something men typically talk about, particularly with other men. However, many shared a greater openness to discussing this with their partner. This perception of male-to-male engagement in emotive and vulnerable conversations being more difficult, could be linked to the idea that men can interpret traditional masculinity being most valued by other men and less so by woman (Iacoviello et al., 2022). Although there was a general consensus that participants felt more inclined to open up to their partners, it is important to note that there were some occasions (e.g. where a peer experienced a similar traumatic event), that talking to another male was sought out and valued. This finding supports wider literature exploring men's emotional communication with women and men, which has captured how men can more willingly talk to women they are close with, however there can be conditions where opening up to other men does occur (Gough et al., 2021). The value of engaging with other men who have been through similar birth experiences is a significant finding, however the likelihood of men having this available to them is limited. Not having this paternal connection can lead to fathers feeling very isolated in their experience of a traumatic birth (Hinton et al., 2014). Therefore, it is important for further consideration to be made into how these fathers can connect and in what format they can provide mutual peer-support.

Also interconnected with societal perceptions of childbirth and masculinity was a prevalent and long-term narrative shared by fathers within the present study of feeling that the traumatic birth was not their story to share. Many fathers referred to the birth event as being the mother's experience and something which *"she went through" (Mark)*. Doing this invalidated the father's own experience and appeared to contribute to fathers feeling less inclined to talk about the birth. Similar findings were reported within a paternal birth trauma study conducted by Etheridge & Slade (2017), who noted that fathers expressed feeling that "nothing's actually happened to me" (p. 9), which as a result led to them feeling unworthy of being affected by the birth and reluctant to access support. As captured within other paternal studies, fathers can feel inconsequential within this predominantly female-orientated life-event (Daniels et al., 2020). Fathers report being side-lined and made to feel their

role is solely to be there to support their partner in the birth (Daniels et al., 2020). This is likely to deeply reinforce childbirth as being a mother's experience and could help explain why fathers feel their experience is not valid or important to share. Furthermore, fathers can be more avoidant of addressing their own emotional wellbeing during the perinatal period, as they feel this would be seen as weakness and that it could take attention away from the mother or infant's wellbeing (Rominov et al., 2018). This again affirms embedded paternal beliefs that the priority during the perinatal period is the maternal figure.

Avoidance of talking or thinking about the traumatic birth appeared to be a long-term coping strategy which several participants had engaged with in the present study. Avoidance is known to be a common reaction to a trauma event (Ehlers & Clark, 2000), and is a symptom suggested to be commonly reported by fathers after a traumatic birth (Delicate et al., 2022). Within the present study, reports of avoidance were linked to trying to maintain a sense of safety and containment, with one father reflecting on his avoidance being linked to evading new information about the traumatic birth and wanting the experience to disappear. Etheridge and Slade's (2017) birth trauma study also reported similar findings, with fathers reflecting on engaging in avoidance strategies such as bottling up and boxing away their trauma experience. Avoidance in the form of emotionally detaching the self from emotions or memories relating to a trauma, has also been reported within the maternal birth trauma literature (Allen, 1998; Beck, 2004; Byrne et al., 2017). Within the study by Allen (1998), it was captured that women's distress following birth was sustained when avoidance of thinking or talking about their birth was noted. This finding can be supported by Ehlers & Clark's (2000) influential cognitive model of PTSD, which theorised that cognitive avoidance is a significant maintenance factor in PTSD related symptoms. This wider literature around the role of avoidance can aid in potentially supporting to explain some of the enduring distress fathers continue to experience, and will be further explored later in the discussion.

Theme Two: Can't Face It Again; Fear and Recovery of Having Further Children

This theme captures the difficulties participants faced when considering having further children after a traumatic birth, but also the positive impact having further

children had on some participants' recovery. Within this theme were three subthemes; 'Risks outweighed the positives; fearing future births', 'Needing to feel prepared', and 'Never again… we will do it again'.

Fear relating to subsequent births, particularly the risks associated (e.g. risks to life), were reported by several participants in the present study. In some cases, this fear largely outweighed the perceived positives, and meant that considering further children was not an option. This finding supports literature which has also captured a traumatic birth experience negatively impacting of fathers wanting to go on to have further children (Daniels et al., 2020; Inglis et al., 2016). One participant in the present study explicitly commented on his traumatic birth contributing to a delayed second pregnancy. Traumatic birth experiences leading to mothers not wanting further children, or resulting in a longer interval between births, has also been acknowledged in the maternal literature (Gottvall & Waldenström, 2002; Shorey et al., 2018). Uncertainty around fathers wanting to have further children after a traumatic birth has been linked to fathers questioning their ability to cope (Etheridge & Slade, 2017). Research highlights how the fears associated with going through subsequent childbirth can lead to fathers avoiding physical intimacy with their partners (Daniels et al., 2020; Nicholls & Ayers, 2007). However, this was not a long-term reported finding in the present study. One father in the present study shared considering having a vasectomy to prevent any further pregnancies. This has also been a reported action or consideration of fathers within other paternal birth studies (Hinton et al., 2014; Inglis et al., 2016).

Fathers who had, or were going through the process of having another child at the time of interview within the present study, voiced a need for the subsequent birth to be well planned and for them, as the father, to feel better prepared. This finding appears to be novel within the paternal birth trauma studies reviewed, however it has been acknowledged in the maternal literature. Following a traumatic birth, women generally want to have a greater role in the management planning of future births (Greenfield et al., 2019; Hollander et al., 2019). Holopainen et al. (2020) identified making a clear birth plan, having a planned caesarean section, and even electing to have a home birth against medical advice, as important factors in subsequent births being perceived as more positive by mothers, following a traumatic birth. In an attempt to understand why such factors may help, research

alludes to how a traumatic birth can trigger difficult feelings of being out of control, therefore wanting to avoid this and regain a sense of control in birth-related decisions during subsequent pregnancies is vital for mothers (Greenfield et al., 2019). As fathers can also report feeling out of control during childbirth, and this being a significant factor in the event feeling traumatic (Daniels et al., 2020), it is likely this rationale for engaging in comprehensive planning during subsequent pregnancies also applies to fathers.

Interestingly one father in the present study reflected on the importance of being at hospital for his next birth to reduce risks. However, mothers can sometimes report having an entirely contradictory view, with some pushing for subsequent births to be at home rather than hospital after a traumatic birth, because they attribute hospital as a less safe birthing environment which could lead to a repeated trauma (Jackson et al., 2020). Women can lose trust and reject medical advice about future births because of having a previous traumatic birth, were they have felt unheard, ill-informed and violated (Hollander et al., 2017). The present study therefore captures some potential differences in maternal and paternal views on subsequent births, following a traumatic birth.

The present study's long-term focus captured how in some cases, fear of subsequent childbirths reduced with time, resulting in some participants feeling able to go onto have further children. This is an important finding which captured long-term PTG following a birth trauma. One participant explicitly commented on how having a positive subsequent birth aided their trauma recovery and restored their desire to want to extend their family even further in the future. This finding supports some maternal literature which also captures how subsequent childbirth after a past birth trauma can in some cases be a potential healer (Beck & Watson, 2010).

Theme Three: Haven't Felt Like a "Normal Dad"; The Effects on Parenting

This theme captured the impact going through a traumatic birth experience had on aspects of participants' anxiety levels, parenting approach and bond with their child long-term. Within this theme are two subthemes; 'Heightened anxiety; the overprotective father' and 'Stronger bond with child'.

Several participants in the present study reported increased levels of anxiety and feeling they were a more overprotective parent, following their traumatic birth experience. Other paternal literature has evidenced that experiences of anxiety can be a subsequent outcome following childbirth (Bradley et al., 2008; Stewart, 1983; Zerach & Magal, 2017), and that some paternal anxiety symtoms can be associated with overinvolvement and overprotecteness as a parent (Möller et al., 2015). Studies looking specficially at childbirth-related PTSD, have captured both fathers and mothers displaying responses which are suggestive of an overprotective or anxious bond with their infant as well (Nicholls & Ayers, 2007). Furthermore, it is evidenced within the maternal literature, that mothers report overprotectiveness of their child following a birth trauma experience (Fenech & Thomson, 2014; Horsch & Ayers, 2016; Priddis et al., 2018).

Some fathers in the present study talked about this overprotectiveness being linked to an overwhelming fear related to their infant's safety. With what we know around idealistic perceptions of the father role, such as father as 'protector' (Kaye et al., 2014), and how a traumatic birth can trigger some fathers to feel extremely helpless and unable to live up to these paternal expectations (Elmir & Schmied, 2016), this could provide an explanation for why fathers take on a more overprotective role, in an attempt to compensate for how they felt during the birth. Furthermore, within the maternal literature, Horsch & Ayers (2016) suggest that mothers presenting as more controlling and overprotective following a traumatic birth, could be as a result of hypervigilance, which they reflect as being a symptom of PTSD. It is possible that this is also the case for fathers.

Although participants in the present study felt their overprotectiveness had impacted, at times, on them feeling like a *"normal dad*" (*Nigel*), most reflected very positively on the bond they had formed with their child long-term. Participants clearly commented on feeling that the strength of this bond was attributed to their traumatic birth experience. Positive reports of father-infant bonds following a traumatic birth have also been reported within other studies (Elmir & Schmied, 2022; Etheridge & Slade, 2017). Literature suggests that fathers can reflect on feeling that the growth of their parent-infant bond following a traumatic birth can be as a result of the unexpected role they take as primary caregiver once returned home (Elmir & Schmied, 2022; Etheridge & Slade, 2017). This was also a reported finding in the present study. Within some research, fathers can report a delay in bonding

with their infant immediately after a traumatic birth, but how this improved with time (Daniels et al., 2020). A similar experience was reported by some participants in the present study, therefore capturing how development of bonds can change during the short and long-term periods after birth. One father in the present study described the birth event being a shared experience, which he, his partner and infant, went through together. Similar findings of the birth being perceived as a shared experience and leading to a stronger parent-infant bond has also been captured in the maternal PTG literature (Ketley et al., 2022).

Although positive bonding experiences were reported by most, it is important to acknowledge that one participant in the present study reported some ongoing relational difficulties with his child, nine years on from the birth. These difficulties appeared to stem from the participant's traumatic birth experience. A similar finding was evidenced in Etheridge & Slade's (2017) study, who also reported one father experiencing long-term relationship problems with their infant, nearly seven years post-birth. Literature suggests that symptoms of PTSD postpartum, can be a contributory factor to negative parent-infant bond occurring (Parfitt & Ayers, 2009). In some cases, a traumatic birth experience can continue to greatly affect the father, leaving them feeling emasculated, angry, and irritated at the mother or infant (Elmir & Schmied, 2022). For one father in the present study, an enduring sense of blame towards the infant for the near loss of his partner during the birth appeared evident. A finding not seemingly reported in other studies, but an important topic which would value further exploration.

Theme Four: The Enduring Distress

This theme depicts the enduring distress participants continued to experience as a result of their traumatic birth. Within this theme are three subthemes; '"I never forget"; the physical trigger moments', 'Guilt; I should have done more', and 'Lowered self-esteem and resilience'.

Several participants in the present study reflected on their traumatic birth not being something they frequently thought about in daily life. However, most shared numerous 'physical trigger moments' which reignite their memories of the birth. These could include seeing a hospital, discussing or watching birth related content on television, witnessing their partner vomit, or subsequent pregnancies. External

stimuli triggering memories of a traumatic birth have been reported within both the paternal literature (e.g. Daniels et al., 2020; Etheridge & Slade, 2017; White, 2007), and maternal literature (e.g. Beck, 2006; Nicholl & Ayers, 2007). Beck (2006) carried out an internet-based study recruiting 37 women, which highlighted how the anniversary of a traumatic birth can be a long-term trigger for reigniting difficult memories and emotions such as anxiety, grief and guilt. In some cases, the distress of the anniversary eased with time, however in other cases, no improvements were reported (Beck, 2006). This study captures the varying long-term outcomes of distress when exposed to a trauma-related stimuli, following a traumatic birth. Within the present study, triggers at times seemed to closely interlink with the subtheme of 'avoidance as a safety mechanism', as some participants alluded to engaging in aspects of avoidance of potential triggers (e.g. talking about the birth), to prevent the subsequent distress associated with them. Maternal studies have also captured how mothers can engage in avoidance to prevent reminders of the birth, such as avoiding sexual intimacy (Nicholl & Ayers, 2007). Literature captures how avoidance can contribute to the maintenance of distress associated with a traumatic event (Ehlers & Clark, 2000).

It was clear within the present study that the distressing experience of 'guilt', formed from the birth event, remained raw and prevalent for many participants long-term. Literature has described guilt as a "self-conscious affect that relates to a sense of responsibility and the cause of harm to others" (Lee, et al., 2001, p. 456). Guilt is said to be one of the most common emotional responses experienced following a traumatic event (Young et al., 2021). It has been proposed that guilt partially contributes to the maintenance and persistence of symptoms relating to PTSD, depression, avoidance and low self-esteem (Kubany et al., 1996), symptoms which some participants in the present study indicated experiencing. It is suggested that in order for trauma related distress to improve, experiences of guilt associated with the trauma need to be firstly acknowledged and addressed (Williams, 1988). With this in mind, it would seem imperative for deeper consideration into the experiences of guilt to be explored and for support services to both consider and potentially prioritise this element of a paternal birth trauma experience.

Guilt is an emotional response also captured within other birth trauma literature (e.g. Daniels et al., 2020; Etheridge & Slade, 2017; White, 2007), as well as within studies which have explored midwives' experiences of witnessing a

traumatic birth (e.g. Rice & Warland, 2013). Although guilt can be a commonly reported emotion, the cause for it being triggered can vary. For example, studies capture how guilt can stem from fathers not feeling they have done enough to stand up for their partner during the birth (White, 2007), from experiencing bonding difficulties with their child (Daniels et al., 2020), or from allowing themselves to feel affected by something which they interpreted as being their partner's experience (Etheridge & Slade, 2017). The long-term experiences of guilt reported by participants in the present study appeared to resonate most similarly to those reported by fathers within the studies by White (2007) and Etheridge & Slade (2017). Some participants in the present study continued to question how they responded during the birth, and wished they had done more to support their partner. This type of guilt can commonly be referred to as 'bystander guilt', whereby the trauma survivor experiences regret over what they perceive as failing to help another person during the trauma (Wilson et al., 2006). Participants also talked about their long-term guilt being associated with how they felt about themselves and their role during the birth, with some reflecting on feeling useless. Experiences of guilt appeared enmeshed with masculinity ideologies at times, with one father reflecting on how the birth experience had led to him feeling *"…emasculated, that I can't protect, or couldn't protect and help my family…" (Paul).* Research has captured that when men feel their masculinity is threatened, they can experience increased feelings of guilt and shame (Vescio et al., 2021).

Some participants in the present study talked about how their traumatic birth had negatively impacted on aspects of their resilience, self-esteem, and mental health, long-term. It is well recognised within wider trauma literature that a trauma event can lead to adverse mental health outcomes for the survivor, which can persist long-term (Kuzminskaite et al., 2021; Schneider et al., 2012). Some participants in the present study talked about experiencing symptoms associated with anxiety and depression, which are also mental health difficulties reported within previous paternal birth trauma studies (Daniels et al., 2020; Elmir & Schmied, 2016). The findings from the present study therefore provide some support that these difficulties can, in some cases, continue to be experienced long-term.

One factor which can be a strong protective factor against mental health difficulties following trauma is resilience. Newman (2003) defines resilience as a

"process of adapting well in the face of adversity, trauma, tragedy, threats or other significant sources of stress" (para.3). One participant in the present study who reported experiencing mental health difficulties reflected on his birth experience as being *"the initial massive incident that's caused my resilience to such things to be so low"* (*Nigel*). Research shows that individuals with lower resilience have an increased prevalence of experiencing mental health difficulties (Kermott et al., 2019). Having good psychosocial resources are known to aid in promoting safety and security, which in turn aid maintaining resilience (Matheson et al., 2020). Two psychosocial resources which particularly support promoting resilience are positive coping skills (Campbell-Sills et al., 2006; Matheson et al., 2020) and social support (Southwick et al., 2016). However, as literature has clearly demonstrated, there can be significant male stigma associated with mental health difficulties, leading to an avoidance of some men feeling able to engage in support (Mahalik & Dagirmanjian, 2019). As discussed earlier, avoidance as a coping strategy long-term can potentially have adverse consequences on a person's mental health, as it could prevent engagement in the needed strategies required for recovery (Matheson et al., 2020). Furthermore, engaging in emotion-orientated coping strategies, such as self-blame, are also known to be linked to low resilience (Campbell-Sills et al., 2006). As several participants in the present study reported enduring feelings of guilt and elements of self-blame for the trauamtic birth experienced, not accessing an appropriate level of support for their trauma and engaging in unhelpful coping strategies long-term, could help explain why psychological distress has remained prevalent, at varying degrees, for some individuals.

Interestingly, although avoidance has been a coping strategy which some participants have engaged in, by actively taking part in the study it was evident that, over time, this traumatic experience has become something they have perhaps felt more able to address, explore and share. This is supported by one of the participants' quotes:

> "*…this is probably the furthest that I've got into how I've felt about it. And opening up now, I'm happy to do so. Like I said, I feel the anxiety, the butterflies, but its bearable. You know speak to me two years ago I probably would have really struggled with it" (Nigel).*

This movement from avoidance to openness indicates how responses can change over time for fathers, after a traumatic birth. However, it must be recognised that fathers still engaging in avoidance as a coping strategy, would be less likely to volunteer to take part in a research project like the present one. Acknowledging delays in men responding to a trauma experience is important when considering support services which should be available.

Theme Five: Positive Long-Term Outcomes Post-Trauma

This theme captures some of the positive outcomes participants felt were linked to them going through a traumatic birth experience. Within this theme are three subthemes: 'Increased empathy towards others', 'Appreciation for life and others' and 'Closer relationship with partner'.

As recognised within wider literature, although there is extensive evidence for the negative outcomes a person can experience following trauma, positive outcomes can also occur, which are often referred to as post-traumatic growth (PTG; Tedeschi & Calhoun, 2004). Tedeschi & Calhoun (1996) identify five areas of PTG which included new possibilities, relating to others, personal strength, spiritual change, and appreciation for life. Whilst identifying PTG was not an aim of the current study, it seems that those most frequently described by the participants are 'relating to others', which includes increased compassion for others and greater closeness to others, and 'appreciation for life', which includes appreciating each day and prioritising what is important in life (Tedeschi & Calhoun, 1996).

Most participants in the present study commented on having a much closer relationship with their partner long-term, because of the traumatic birth. One father reflected on the increased closeness to his partner forming as a result of sharing such a *"raw emotional experience" (Luke).* These findings widely support various paternal studies (Daniels et al. 2020; Inglis et al. 2016) and maternal studies (Ketley et al., 2022; Beck & Watson, 2016), which have also found that a traumatic birth experience led to parents reporting deeper connectedness with their partners. The trigger for this increased closeness can vary. For example, Ketley et al. (2022) captured that mothers reported seeing their partner in a new light after the birth trauma, and how they shared a sense of having survived the trauma together. In contrast, a study by Daniels et al. (2020), indicated that the development of

increased closeness with the mother was sometimes linked to the fear of nearly having lost them. Within the present study, alongside participants reporting a closer connection with partners, some also reported a greater appreciation for woman more universally, in their role at birth and as a mother. A similar finding was reported within Elmir & Schmied's (2022) study, where it was felt that going through a traumatic birth *"generates feelings of positive regard for woman in general"* (p. 45).

Previous studies have captured how a traumatic birth experience can in some cases lead to adverse outcomes on the couple relationship, for example in areas such as feeling emotionally disconnected and reduced desire to engage in physical intimacy (Daniels et al., 2020; Elmir & Schmied, 2022; Nicholls & Ayers, 2007; White, 2007). Within the study by White (2007), a theme of 'sexual scarring' was described, within which it was discussed how a traumatic birth could lead to fathers feeling their partner's "body had been invaded and it became the medicalized body" (p. 42). This study also described how the birth trauma experience in some cases, led to couples separating. Within Elmir & Schmied's (2022) study, they reported one father not having engaged in any intimacy, after his birth experience. Within the present study, there were no reports of couples separating, however some participants did report relational difficulties developing initially after the birth, such as increased arguments and reduced engagement in sexual intimacy. An interesting finding from the current study, which does not appear to be widely acknowledged within other paternal studies reviewed, is how most participants reported significant improvements in these areas of reported difficulty, over time. These findings provide some helpful insight into the long-term impact of a birth trauma on some couple's relationships, where difficulties have initially developed but where couples have remained together.

A maternal study conducted by Beck & Watson (2016), which explored PTG after a traumatic birth, reported that alongside mothers experiencing increased closeness with their partner, they also reported deeper connections with friends and found that openness to share the raw details of the birth with friends was vital for growth after the trauma. Reaching out and developing new friendships with other mothers who had also experienced traumatic births was also felt to be a valuable part of recovery (Beck & Watson, 2016). A further study exploring the journey towards resilience after a traumatic birth captured how this event can result in mothers losing their voice, however through talking and listening to others experiences, this

reduced their feelings of being isolated and alone in the experience, subsequently empowering them to restore their voice again (Brown et al., 2022). These studies capture the importance of social connection in promoting recovery and PTG after a traumatic birth. The present study did not identify participants sharing similar experiences with regards to deeper connections with friends, which again is likely to be linked to the impact on masculine ideologies and men feeling this topic is *"a bit taboo" (Craig).* However, some participants did reflect on the value of talking to other fathers who had been through a similar experience. Acknowledging how important social connection is in the role of PTG after birth trauma, it is important that paternal barriers associated with this are explored further and overcome.

A finding that appears to be novel in the present study, is the reported increased level of empathy and compassion towards others, aside from partners, following the traumatic birth. Some participants reflected on how they had become more attuned to other people's distress and were more actively engaged in offering advice and support. When reviewing wider trauma literature, there is limited exploration into trauma experiences and increased empathy. However, one valuable study conducted by Greenberg et al. (2018) looking at empathy in adults following childhood trauma, found that a trauma experience early in life was significantly linked to increased levels of empathy. The study suggested that this trauma experience increased individual's ability to be more attune to other people's psychological and emotional needs, and that this remained a long-term impact (Greenberg et al., 2018). These findings provide some valuable support for the possibility that increased empathy and compassion towards others can be a long-term PTG outcome following a traumatic event.

Within the domain of 'appreciation for life', one father in the present study reflected on *"how precious and brief life is" (Luke),* and how spending more time with family was very important to him, leading to him reducing his hours at work. Appreciation for life following childbirth is a significant area of PTG reported in the maternal literature (Ketley et al., 2022; Sawyer & Ayers, 2009). It is also a PTG domain which is commonly reported within wider trauma research (Zieba et al., 2019). Research suggests that increased appreciation for life and changes in perception of what is truly important, is a common positive outcome for many who have been through a traumatic or adverse experience (Tedeschi & Calhoun, 2004).

Strengths and Limitations

Research which has explored the paternal experiences of a traumatic birth is limited, with little concrete evidence about the long-term impact. What has been found from studies conducted so far is useful in developing insight to the experience from the father's perspective, however they typically include samples of fathers where the time period since the birth ranged from very recent to many years ago. Having such wide time periods, make it difficult to truly dedicate focus and attention, specifically to the long-term impact of such an experience, without it becoming enmeshed in the short-term effects. A key strength of the present study is that it focuses on the long-term impacts.

The study design successfully met the research aims. By using TA for the analysis and following the six-stage comprehensive process outlined by Braun & Clark (2006), it was possible to generate in-depth, rich and meaningful qualitative data, which provides influential contribution to the current paternal birth trauma literature. As outlined in the method section, numerous steps to ensure credibility and quality were carried out . The study recruited eight participants, which research confirms is an appropriate and manageable number for a small scale project like this (Braun & Clark, 2013).

All interviews in the present study were conducted by telephone, except for one which was completed via Zoom call. It could be argued that face-to-face interviews would have enabled me to build a potentially better rapport with participants. However, given the circumstances of the COVID-19 pandemic, and reflecting on how the interviews went overall, I felt that this remote format still enabled me to develop a very good rapport with participants who took part. No participants commented on finding the remote format of the interview impacted on their ability to engage in the interview. I have wondered whether face-to-face interviews might have even adversely affected the data collected, with participants potentially finding it more difficult to open up in this format. However, I am also mindful that by the interviews not being in person, it was potentially not as easily possible for me to respond as effectively to non-verbal cues. For example, during my Zoom interview, I was able to visually pick up and sensitively respond to times the participants use of body language or facial expression was indicating that a topic being talked about was more difficult.

When considering the sample of participants who took part in the study, it is important to highlight that these were all self-reporting highly educated, white males, who had remained with the partner of their baby. By not having a more diverse sample, it is difficult to generalise these findings to the wider population. Furthermore, by only recruiting through social media, the study potentially did not provide an opportunity to reach out to more marginalised groups of fathers who do not engage with social media platforms or paternal birth trauma content within these. However, there were study constraints in terms of the time period which this research needed to be completed by and also a limited research budget, which impacted on it being possible to attempt recruiting more broadly.

During the interviews conducted, many participants commented on the distinct lack of awareness and support available for fathers who have been through a traumatic birth experience. Participants wanted to support promoting better awareness around this experience from the paternal perspective and were pleased to have the opportunity to share their important and powerful birth related narratives within the study.

Further Research

The present study provides invaluable insight into the long-term impact of a traumatic birth on fathers. However, being the only study to the author's knowledge which looks exclusively at the long-term impact of this experience, there is opportunity for further exploration to be done in this area, to both strengthen and broaden the present study's findings. A valuable sequel to the present study would be to recruit a more diverse and larger sample of fathers to further build or expand on the current findings gained.

With this topic being a highly under-researched area, the present study focused on gaining a broad overview of the long-term impact. It would therefore be valuable for a future study to focus on exploring some of the individual themes drawn in greater depth, to further strengthen the understanding and implications behind them. For example, it would be helpful for a study to explore, more comprehensively, the impact of a traumatic birth on fathers' perceptions of wanting further children, both short and long-term. There is some acknowledgement of this being impacted in the paternal literature (e.g. Daniels et al., 2020; Inglis et al., 2016), however this is limited. The present study captured varied journeys relating to whether fathers

wanted subsequent children after a traumatic birth, with some still feeling unable to consider it, whereas others found that as time passed their view changed and they did go on to have more children. With this new insight in mind, it would be beneficial to further explore the factors which have potentially influenced these differing journeys or perhaps whether different types of traumatic births have impacted on this.

The present study explored how participants felt their traumatic birth experience had impacted on aspects of their mental health long-term, however it is important to acknowledge that this was not the sole focus of the study. This study did not use standardised mood measures, therefore findings around mental health are based on subjective reports provided by participants. Symptoms associated with depression and anxiety were reported in the present study. Wider paternal birth trauma literature has also captured fathers reporting symptoms associated with various mental health conditions (Daniels et al., 2020; Elmir & Schmied, 2016). With this in mind, it would be valuable for a future study to delve deeper into capturing the long-term mental health experiences of fathers who have gone through a traumatic birth, potentially utilising standardised measures commonly used to assess mental health difficulties to aid in this exploration.

Another area which would be interesting to explore would be around paternal long-term PTG after a traumatic birth. We know from the literature that mothers can experience PTG after a traumatic birth (Beck et al., 2018; Sawyer & Ayers, 2009), and the present study alludes to elements of PTG occurring as well. However, it would be valuable to explore this in greater depth, potentially utilising a mixed method design, where a PTG quantitative measure is utilised to capture more specific domains of PTG.

Clinical Implications

This research has highlighted how fathers who have experienced a traumatic birth can continue to be impacted by this event in various ways, for two or more years after the birth. These findings have important implications which healthcare services need to consider and address to ensure the needs of fathers are being appropriately met.

Firstly, fathers in the present study highlighted the negative impact traditional masculine ideologies have had on them feeling able to open up and talk about their

traumatic birth experience with others. As recognised in the literature, masculine ideologies can prevent men feeling able to express their emotions and can hugely impede on engagement in help-seeking behaviour. Fathers can often report there being a huge lack of adequate paternal-focused support across the fatherhood journey (Hodgson et al., 2021). Many fathers in the present study reported not being offered any support after their traumatic birth, which seems likely to reinforce this as not being something men require. Furthermore, there are also no routine screening for father's mental health postnatally. It is vital that this poor acknowledgement around paternal experiences changes, as like mothers, fathers are also worthy of support following a traumatic birth.

The NHS long term plan (NHS, 2019, p. 49) introduced the commitment to offer "*fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required…".* Following this, in March 2021, NHS England (2021) published a report entitled: *"Involving and supporting partners and other family members in specialist perinatal mental health services"*. These are positive and welcome steps to fathers' needs being better met by services. However, gaps in support remain evident. For example, what about all the fathers who have a partner who does not access NHS perinatal mental health services? Furthermore, an important finding from the present study is that it may take some fathers a long time (often years), before they feel ready to open up and seek help. Healthcare services need to adjust to this and respond effectively, by ensuring support is available both within the perinatal period, but also outside of this timeframe too. It is also vital that when fathers do feel ready to seek support, they are met with empathy and validation from those they share their experience with. It would likely be beneficial for staff awareness and training to be available in relation to this.

Literature has highlighted the importance of social connection in the role of PTG after birth trauma (Beck & Watson, 2016), however it is acknowledged that some fathers can express an avoidance of opening up to others about their birth experience. It would be valuable for services to explore and understand these barriers further. The present study captured how, for some fathers, connecting with other fathers who have been through a similar experience may be beneficial. It would therefore seem imperative that healthcare services are ensuring these

opportunities, which could be in the form of a paternal peer-support group, are effectively developed and made available. It would be valuable for services to gain feedback from fathers with lived experience, regarding what formats of support would be most valued. What feels key in this process is that healthcare services are making sure they are proactively sharing details of such support with fathers at various stages, including at hospital, through flyers and social media, and during health visitor postnatal home visits. By publicly reinforcing these support services are available, the hope would be that associated stigma is reduced and fathers are supported to not feel alone in their experience, but instead empowered to access this input. Currently, specialist perinatal mental health services in England only take referrals for mothers, however signposting may include primary or secondary mental health services, or local and national voluntary and community organisations (NHS England, 2021). Some well-known voluntary and community organisations offering various forms of support include MIND, DadsNet, Dad Matters, Birth Trauma Association, and Andy Man's Club. These are some of the organisations which fathers could be supported to be aware of and access if appropriate.

Furthermore, being aware of the impact a traumatic birth can have on fathers' long-term mental health and wellbeing, it is important these difficulties are identified and addressed early, to prevent enduring distress being experienced. To achieve this, it is important that during postnatal health visitor appointments, the mental health and wellbeing of fathers is also reviewed, reinforcing that the father is also important, and their experience is validated. This could include the health visitor completing measures, such as the newly developed City Birth Trauma Scale (Partner Version; Webb et al., 2021), which assesses for PTSD in fathers and other partners.

Furthermore, a noted finding in the present study was that fathers frequently experience enduring feelings of guilt. This seems an important aspect of the birth experience for mental health services offering support to fathers, to be attuned to and prioritise addressing. Another finding within the present study related to the impact a traumatic birth could have on fathers wanting subsequent children, or them experiencing heightened distress during a subsequent pregnancy. It would be beneficial for antenatal services to offer direct support and preparation in relation to subsequent pregnancies for fathers.

Conclusion

The present study explored the long-term impact of a traumatic birth on fathers, which has provided useful new insight that adds to existing literature. Through carrying out a comprehensive TA of data collected from eight fathers, five themes were drawn which highlighted how a traumatic birth continued to effect fathers, two or more years after the event occurred. A traumatic birth can result in fathers experiencing varying levels of enduring distress. Most fathers had not accessed any support for their traumatic birth, however several described this experience having impact on various aspects of their mental health and wellbeing long-term. Masculine ideologies appeared prevalent within many of the interview discussions, forming a barrier to fathers feeling validated in their experience, being able to talk about the event, or to seek support. Although some fathers reported not often thinking about the birth now, most reported triggers which could reignite their memories of the birth. In some cases, a traumatic birth continued to negatively impact wanting further children, whereas for others, time aided healing and meant they did go on to have subsequent children. Some fathers felt the birth experience had contributed to them becoming an over-protective parent, however most also felt the birth greatly strengthened their parent-infant bond long-term. Interestingly, several positive long-term outcomes were acknowledged, which included developing a closer relationship with partners, increased empathy towards others and a greater appreciation for life.

References

Addis, M. E., & Hoffman, E. (2017). Men's depression and help-seeking through the lenses of gender. In R. F. Levant and Y. J. Wong (Eds.), *The Psychology of Men and Masculinities* (pp. 171-196). American Psychological Association: Washington, DC.

Affleck, G., Tennen, H., Croog, S., & Levine, S. (1987). Causal Attribution, Perceived Benefits, and Morbidity After a Heart Attack: An 8-Year Study. *Journal of Consulting and Clinical Psychology*, *55*(1), 29–35. https://doi.org/10.1037/0022-006x.55.1.29

Ahmad, S., Wasim, S., Irfan, S., Gogoi, S., Srivastava, A., & Farheen, Z. (2019). Qualitative v/s. Quantitative Research- A Summarized Review. *Journal of Evidence Based Medicine and Healthcare*, *6*(43), 2828–2832. https://doi.org/10.18410/jebmh/2019/587

Alase, A. (2017). The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach. *International Journal of Education and Literacy Studies*, *5*(2), 9-19. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devilly, G. J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine*, *40*(11), 1849–1859. https://doi.org/10.1017/S0033291709992224

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, *16*(3), 107–108. https://doi.org/10.1080/02646839808404563

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2009). *The Changing Role of the Modern Day Father.* https://www.apa.org/pi/families/resources/changing-father

Ayers, S. (2004). Delivery as a Prevalence, Risk Traumatic Event: Postnatal Treatment for Factors, and Posttraumatic Stress Disorder. *Clinical Obstetrics and Gynecology*, *47*(3), 552–567.

Ayers, S. (2007). Thoughts and Emotions During Traumatic Birth: A Qualitative Study. *Birth, 34*(3), 253–263. https://doi.org/10.1111/j.1523-536X.2007.00178.x

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-

traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine*, 46, 1121–1134. https://doi.org/10.1017/S0033291715002706

Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health and Medicine*, *11*(4), 389–398. https://doi.org/10.1080/13548500600708409

Ballard, C., Stanley, A. K., & Brockington, I. F. (1995). Post-Traumatic Stress Disorder (PTSD) after Childbirth. *British Journal of Psychiatry, 166*, 525–528. https://doi.org/10.1192/bjp.166.4.525

Baptie, G., Andrade, J., Bacon, A. M., & Norman, A. (2020). Birth trauma: The mediating effects of perceived support. *British Journal of Midwifery, 28*(10), 724–730. https://doi.org/10.12968/bjom.2020.28.10.724

Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to … be reflexive when conducting qualitative research. *The Clinical Teacher, 17*(1), 9–12. https://doi.org/10.1111/tct.13133

Barthel, D., Göbel, A., Barkmann, C., Helle, N., & Bindt, C. (2020). Does Birth-Related Trauma Last? Prevalence and Risk Factors for Posttraumatic Stress in Mothers and Fathers of VLBW Preterm and Term Born Children 5 Years After Birth. *Frontiers in Psychiatry*, *11*, Article 575429. https://doi.org/10.3389/fpsyt.2020.575429

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). The costs of perinatal mental health problems. *Centre for Mental Health and London School of Economics.* https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/costsofperinatal.pdf

Beck, C. T. (2004). Birth Trauma: In the Eye of the Beholder. *Nursing Research*, *53*(1), 28–35. https://doi.org/10.1097/00006199-200401000-00005

Beck, C. T. (2006). The Anniversary of Birth Trauma, Failure to Rescue. *Nursing Research*, *55*(6), 381–390. https://doi.org/10.1097/00006199-200611000-00002

Beck, C. T., & Watson, S. (2010). Subsequent Childbirth After a Previous Traumatic Birth. *Nursing Research*, *59*(4), 241–249. https://doi.org/10.1097/NNR.0b013e3181e501fd

Beck, C. T., & Watson, S. (2016). Posttraumatic Growth After Birth Trauma: 'I Was

Broken, Now I Am Unbreakable". *MCN Americal Journal of Maternal/Child Nursing, 41*(5), 264-271. https://doi.org/10.1097/NMC.0000000000000259

Beck, C. T., Watson, S., & Gable, R. K. (2018). Traumatic Childbirth and Its Aftermath: Is There Anything Positive? *The Journal of Perinatal Education, 27*(3), 175–184. https://doi.org/10.1891/1058-1243.27.3.175

Beestin, L., Hugh-Jones, S., & Gough, B. (2014). The impact of maternal postnatal depression on men and their ways of fathering: an interpretative phenomenological analysis. *Psychology and Health, 29*(6), 717–735. https://doi.org/10.1080/08870446.2014.885523

Bell, A. F., & Andersson, E. (2016). The birth experience and women's postnatal depression: A systematic review. *Midwifery, 39*, 112–123. https://doi.org/10.1016/j.midw.2016.04.014

Bhatia, M., & Jhanjee, A. (2012). Tokophobia: A dread of pregnancy. *Industrial Psychiatry Journal, 21*(2), 158-159. https://doi.org/10.4103/0972-6748.119649

Biebel, K., & Alikhan, S. (2018). Paternal Postpartum Depression. *Journal of Parent and Family Mental Health, 1*(1), Article 1. https://doi.org/10.7191/parentandfamily.1000

Birth Trauma Association (2018). *The Birth Trauma Association (BTA). https://www.birthtraumaassociation.org.uk/*

Bradley, R., & Slade, P. (2011). A review of mental health problems in fathers following the birth of a child. *Journal of Reproductive and Infant Psychology, 29*(1), 19–42. https://doi.org/10.1080/02646838.2010.513047

Bradley, R., Slade, P., & Leviston, A. (2008). Low rates of PTSD in men attending childbirth: A preliminary study. *British Journal of Clinical Psychology, 47*(3), 295–302. https://doi.org/10.1348/014466508X279495

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.) *APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological* (pp. 57–71). Washington, DC: American Psychological Association.

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide*

for Beginners. London: Sage.

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In B. Smith & A. C. Sparkes (Eds.), *Routledge Handbook of Qualitative Research in Sport and Exercise* (pp. 191–205). London: Routledge.

Brown, A., Nielsen, J. D. J., Russo, K., Ayers, S., & Webb, R. (2022). The Journey towards resilience following a traumatic birth: A grounded theory. *Midwifery, 104,* Article 103204. https://doi.org/10.1016/j.midw.2021.103204

Bryant, R. A., Nickerson, A., Creamer, M., O'Donnell, M., Forbes, D., Galatzer-Levy, I., McFarlane, A. C., Silove, D. (2015). Trajectory of post-traumatic stress following traumatic injury: 6-year follow-up. *British Journal of Psychiatry, 206*(5), 417–423. https://doi.org/10.1192/bjp.bp.114.145516

Burgess, A. & Goldman, R., (2018). *Who's the bloke in the room? Fathers during pregnancy and at the birth in the United Kingdom (Full Report).* Contemporary Fathers in the UK Series. Marlborough: Fatherhood Institute.

Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery, 51*, 1–11. https://doi.org/10.1016/j.midw.2017.04.017

Cameron, E. E., Sedov, I. D., & Tomfohr-Madsen, L. M. (2016). Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. *Journal of Affective Disorders, 206,* 189–203. https://doi.org/10.1016/j.jad.2016.07.044

Campbell-Jackson, L., Bezance, J., & Horsch, A. (2014). "A renewed sense of purpose": Mothers' and fathers' experience of having a child following a recent stillbirth. *BMC Pregnancy and Childbirth, 14,* Article 423. https://doi.org/10.1186/s12884-014-0423-x

Campbell-Sills, L., Cohan, S. L., & Stein, M. B. (2006). Relationship of resilience to personality, coping, and psychiatric symptoms in young adults. *Behaviour Research and Therapy, 44*(4), 585–599. https://doi.org/10.1016/j.brat.2005.05.001

Chan, K. K. L., & Paterson-Brown, S. (2002). How do fathers feel after accompanying their partners in labour and delivery? *Journal of Obstetrics and Gynaecology, 22*(1), 11–15. https://doi.org/10.1080/01443610120101628

Chen, Y., Ismail, F., Xiong, Z., Li, M., Chen, I., Wen, S. W., & Xie, R. hua. (2021). Association between perceived birth trauma and postpartum depression: A

prospective cohort study in China. *International Journal of Gynecology and Obstetrics*, 1–6. https://doi.org/10.1002/ijgo.13845

Clark, A. (2008). Critical realism. In L. Given (Ed.), *The sage encyclopedia of qualitative research methods* (pp. 168-170). Thousand Oaks, CA: Sage.

Coutinho, E. C., Antunes, J. G. V. C., Duarte, J. C., Parreira, V. C., Chaves, C. M. B., & Nelas, P. A. B. (2016). Benefits for the Father from their Involvement in the Labour and Birth Sequence. *Procedia - Social and Behavioral Sciences*, *217*, 435–442. https://doi.org/10.1016/j.sbspro.2016.02.010

Cox, J., Holden, J., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *150*(6), 782–786. https://doi.org/10.1192/bjp.150.6.782

Daniels, E., Arden-Close, E., & Mayers, A. (2020). Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma. *BMC Pregnancy and Childbirth*, *20*, Article 236. https://doi.org/10.1186/s12884-020-02902-2

Davis, A., & King, L. (2018). Gendered perspectives on men's changing familial roles in Postwar England, c.1950-1990. *Gender and History*, *30*(1), 70–92. https://doi.org/10.1111/1468-0424.12333

Dekel, S., Thiel, F., Dishy, G., & Ashenfarb, A. L. (2019). Is childbirth-induced PTSD associated with low maternal attachment? *Archives of Women's Mental Health*, *22*(1), 119–122. https://doi.org/10.1007/s00737-018-0853-y

Delicate, A., Ayers, S., Easter, A., & McMullen, S. (2018). The impact of childbirth-related post-traumatic stress on a couple's relationship: a systematic review and meta-synthesis. *Journal of Reproductive and Infant Psychology*, *36*(1), 102–115. https://doi.org/10.1080/02646838.2017.1397270

Delicate, A., Ayers, S., & McMullen, S. (2022). Health-care practitioners' assessment and observations of birth trauma in mothers and partners. *Journal of Reproductive and Infant Psychology*, *40*(1), 34–46. https://doi.org/10.1080/02646838.2020.1788210

Dellmann, T. (2004). "The best moment of my life": a literature review of fathers' experience of childbirth. *Australian Midwifery*, *17*(3), 20–26. https://doi.org/10.1016/s1448-8272(04)80014-2

Ditlevsen, D. N., & Elklit, A. (2012). Gender, trauma type, and PTSD prevalence: a re-analysis of 18 nordic convenience samples. *Annals of General*

Psychiatry, *11*(1), 26–26. https://doi.org/10.1186/1744-859X-11-26

Draper, J. (1997). Whose welfare in the labour room? A discussion of the increasing trend of fathers' birth attendance. *Midwifery*, *13*(3), 132–138. https://doi.org/10.1016/S0266-6138(97)90003-6

Draper, J. (2003). Blurring, moving and broken boundaries: Men's encounters with the pregnant body. *Sociology of Health and Illness*, *25*(7), 743–767. https://doi.org/10.1046/j.1467-9566.2003.00368.x

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/S0005-7967(99)00123-0

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215–229. https://doi.org/10.1348/014466599162782

Elmir, R., & Schmied, V. (2016). A meta-ethnographic synthesis of fathers' experiences of complicated births that are potentially traumatic. *Midwifery*, *32*, 66–74. https://doi.org/10.1016/j.midw.2015.09.008

Elmir, R., & Schmied, V. (2022). A qualitative study of the impact of adverse birth experiences on fathers. *Women and Birth*, *35*(1), e41–e48. https://doi.org/10.1016/j.wombi.2021.01.005

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing*, *66*, 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Eriksson, C., Salander, P., & Hamberg, K. (2007). Men's experiences of intense fear related to childbirth investigated in a Swedish qualitative study. *Journal of Men's Health and Gender*, *4*(4), 409–418. https://doi.org/10.1016/j.midw.2005.10.002

Ertan, D., Hingray, C., Burlacu, E., Sterlé, A., & El-Hage, W. (2021). Post-traumatic stress disorder following childbirth. *BMC Psychiatry*, *21*, Article 155. https://doi.org/10.1186/s12888-021-03158-6

Etheridge, J., & Slade, P. (2017). "Nothing's actually happened to me.": The experiences of fathers who found childbirth traumatic. *BMC Pregnancy and Childbirth*, *17*, Article 80. https://doi.org/10.1186/s12884-017-1259-y

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': A meta-

synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery*, *30*(2), 185–193. https://doi.org/10.1016/j.midw.2013.12.004

Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and Negative Life Changes Following Sexual Assault. *Journal of Consulting and Clinical Psychology*, *69*(6), 1048–1055. https://doi.org/10.1037/0022-006X.69.6.1048

Garthus-Niegel, S., Ayers, S., von Soest, T., Torgersen, L., & Eberhard-Gran, M. (2015). Maintaining factors of posttraumatic stress symptoms following childbirth: A population-based, two-year follow-up study. *Journal of Affective Disorders*, *172*, 146–152. https://doi.org/10.1016/j.jad.2014.10.003

Garthus-Niegel, S., Horsch, A., Handtke, E., von Soest, T., Ayers, S., Weidner, K., & Eberhard-Gran, M. (2018). The impact of postpartum posttraumatic stress and depression symptoms on couples' relationship satisfaction: A population-based prospective study. *Frontiers in Psychology*, *9,* Article 1728. https://doi.org/10.3389/fpsyg.2018.01728

Gavin, N. I., Gaynes, B. N., Lohr, K. N., Meltzer-Brody, S., Gartlehner, G., & Swinson, T. (2005). Perinatal depression: A systematic review of prevalence and incidence. *Obstetrics and Gynecology*, *106*(5), 1071–1083. https://doi.org/10.1097/01.AOG.0000183597.31630.DB

Goodman, J. H. (2004a). Postpartum depression beyond the early postpartum period. *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *33*(4), 410–420. https://doi.org/10.1177/0884217504266915

Goodman, J. H. (2004b). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing*, *45(1)*, 26–35. https://doi.org/10.1046/j.1365-2648.2003.02857.x

Gottvall, K., & Waldenström, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *BJOG: An International Journal of Obstetrics and Gynaecology*, *109*(3), 254–260. https://doi.org/10.1111/j.1471-0528.2002.01200.x

Gough, B., Robertson, S., & Luck, H. (2021). Engendered Expressions of Anxiety: Men's Emotional Communications With Women and Other Men. *Frontiers in Sociology*, *6,* Article 697356. https://doi.org/10.3389/fsoc.2021.697356

Greenberg, D. M., Baron-Cohen, S., Rosenberg, N., Fonagy, P., & Rentfrow, P. J. (2018). Elevated empathy in adults following childhood trauma. *PLoS ONE,*

13(10), Article e0203886. https://doi.org/10.1371/journal.pone.0203886

Greenfield, M., Jomeen, J., & Glover, L. (2016). What is traumatic birth? A concept analysis and literature review. *British Journal of Midwifery*, *24*(4), 254-267. https://doi.org/10.12968/bjom.2016.24.4.254

Greenfield, M., Jomeen, J., & Glover, L. (2019). "It can't be like last time" - Choices made in early pregnancy by women who have previously experienced a traumatic birth. *Frontiers in Psychology*, *10*, Article 56. https://doi.org/10.3389/fpsyg.2019.00056

Greenhalgh, R., Slade, P., & Spiby, H. (2000). Fathers' coping style, antenatal preparation, and experiences of labor and the postpartum. *Birth*, *27*(3), 177–184. https://doi.org/10.1046/j.1523-536x.2000.00177.x

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review*, *34*(5), 389–401. https://doi.org/10.1016/j.cpr.2014.05.003

Hambidge, S., Cowell, A., Arden-Close, E., & Mayers, A. (2021). "What kind of man gets depressed after habing a baby?" Fathers' experiences of metnal health during the perinatal period. *BMC Pregnancy & Childbirth, 21*, Article 463. https://doi.org/10.1186/s12884-021-03947-7

Hanna, E., & Gough, B. (2018). Searching for help online: An analysis of peer-to-peer posts on a male-only infertility forum. *Journal of Health Psychology*, *23*(7), 917–928. https://doi.org/10.1177/1359105316644038

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology*, *74*(5), 797–816. https://doi.org/10.1037/0022-006X.74.5.797

Hinton, L., Locock, L., & Knight, M. (2014). Partner experiences of "near-miss" events in pregnancy and childbirth in the UK: A qualitative study. *PLoS ONE*, *9*(4), Article e91735. https://doi.org/10.1371/journal.pone.0091735

Hodgson, S., Painter, J., Kilby, L., & Hirst, J. (2021). The experiences of first-time fathers in perinatal services: present but invisible. *Healthcare*, *9*, Article 161. https://doi.org/10.3390/healthcare9020161

Holbrook, T. L., Hoyt, D. B., Stein, M. J., & Sieber, W. J. (2002). Gender differences in long-term posttraumatic stress disorder outcomes after major trauma: Women are at higher risk of adverse outcomes than men. *Journal of Trauma*, *53*(5), 882–888. https://doi.org/10.1097/00005373-200211000-00012

Hollander, M., de Miranda, E., van Dillen, J., de Graaf, I., Vandenbussche, F., & Holten, L. (2017). Women's motivations for choosing a high risk birth setting against medical advice in the Netherlands: a qualitative analysis. *BMC Pregnancy and Childbirth*, *17*, Article 423. https://doi.org/10.1186/s12884-017-1621-0

Hollander, M., de Miranda, E., Vandenbussche, F., van Dillen, J, & Holten, L. (2019). Addressing a need. Holistic midwifery in the Netherlands: A qualitative analysis. *PloS One*, *14*(7), Article e0220489. https://doi.org/10.1371/journal.pone.0220489

Holopainen, A., Stramrood, C., Van Pampus, M. G., Hollander, M., & Schuengel, C. (2020). Subsequent childbirth after previous traumatic birth experience: Women's choices and evaluations. *British Journal of Midwifery*, *28*(8), 488–496. https://doi.org/10.12968/bjom.2020.28.8.488

Horsch, A., & Ayers, S. (2016). Childbirth and Stress. In G. Fink (Eds.), *Stress: Concepts, Cognition, Emotion, and Behaviour* (pp. 325-330). Acedemic Press, https://doi.org/10.1016/B978-0-12-800951-2.00040-6

Howat, A. H. T. (2021) *Exploring non-birth mothers' experiences of perinatal anxiety and depression: understanding the perspective of the non-carrying parent in sam-sex parented families.* [Doctoral thesis, University of Leeds]. White Rose eTheses Online.

Hull, A. M., Alexander, D. A., & Klein, S. (2002). Survivors of the Piper Alpha oil platform disaster: long-term follow-up study. *British Journal of Psychiatry*, *181*(5), 433–438. https://doi.org/10.1192/bjp.181.5.433

Iacoviello, V., Valsecchi, G., Berent, J., Borinca, I., & Falomir-Pichastor, J. M. (2022). Is Traditional Masculinity Still Valued? Men's Perceptions of How Different Reference Groups Value Traditional Masculinity Norms. *Journal of Men's Studies*, *30*(1), 7–27. https://doi.org/10.1177/10608265211018803

Inglis, C., Sharman, R., & Reed, R. (2016). Paternal mental health following perceived traumatic childbirth. *Midwifery*, *41*, 125–131. https://doi.org/10.1016/j.midw.2016.08.008

Jackson, M. K., Schmied, V., & Dahlen, H. G. (2020). Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia. *BMC Pregnancy and Childbirth*, *20*(1), 254–254. https://doi.org/10.1186/s12884-020-02944-6

Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. New York: Free Press.

Johansson, M., Svensson, I., Stenström, U., & Massoudi, P. (2017). Depressive symptoms and parental stress in mothers and fathers 25 month after birth. *Journal of Child Health Care*, *21*(1), 65–73. https://doi.org/10.1177/1367493516679015

Johnson, M. (2002). An Exploration of Men's Experience and Role at Childbirth. *The Journal of Men's Studies*, *10*(2), 165–182. https://doi.org/10.3149/jms.1002.165

Jomeen, J. (2017). Fathers in the birth room: choice or coercion? Help or hindrance? *Journal of Reproductive and Infant Psychology*, *35*, 321–323. https://doi.org/10.1080/02646838.2017.1361124

Joseph, S., & Linley, P. A. (2005). Positive Adjustment to Threatening Events: An Organismic Valuing Theory of Growth Through Adversity. *Review of General Psychology*, *9*(3), 262–280. https://doi.org/10.1037/1089-2680.9.3.262

Joseph, S., & Linley, P. A. (2008). *Trauma, Recovery and Growth: Positive Psychological Perspectives on Posttrauamatic Stress*. New Jersey: John Wiley & Sons, Inc.

Kaye, D. K., Kakaire, O., Nakimuli, A., Osinde, M. O., Mbalinda, S. N., & Kakande, N. (2014). Male involvement during pregnancy and childbirth: Men's perceptions, practices and experiences during the care for women who developed childbirth complications in Mulago Hospital, Uganda. *BMC Pregnancy and Childbirth*, *14*, Article 54. https://doi.org/10.1186/1471-2393-14-54

Kermott, C. A., Johnson, R. E., Sood, R., Jenkins, S. M., & Sood, A. (2019). Is higher resilience predictive of lower stress and better mental health among corporate executives? *PLoS ONE*, *14*(6), Article e0218092. https://doi.org/10.1371/journal.pone.0218092

Kersting, A., & Wagner, B. (2012). Complicated grief after perinatal loss. *Dialogues in Clinical Neuroscience*, *14*(2), 187–194. https://doi.org/10.31887/dcns.2012.14.2/akersting

Ketley, R., Darwin, Z., Masterson, C., & McGowan, L. (2022). Women's experience of post-traumatic growth following a traumatic birth: an interpretive phenomenological anaylsis. *Journal of Reproductive and Infant Psychology,*

https://doi.org/10.1080/02646838.2022.2070608

Kim, P., & Swain, J. E. (2007). Sad Dads. *Psychiatry*, *4*(2), 35-47.

Kubany, E. S., Abueg, F. R., Brennan, J. M., Haynes, S. N., Manke, F. P., & Stahura, C. (1996). Development and Validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment*, *8*(4), 428–444. https://doi.org/10.1037/1040-3590.8.4.428

Kuzminskaite, E., Penninx, B. W. J. H., van Harmelen, A. L., Elzinga, B. M., Hovens, J. G. F. M., & Vinkers, C. H. (2021). Childhood Trauma in Adult Depressive and Anxiety Disorders: An Integrated Review on Psychological and Biological Mechanisms in the NESDA Cohort. *Journal of Affective Disorders*, *283*, 179–191. https://doi.org/10.1016/j.jad.2021.01.054

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, *74*(4), 451–466. https://doi.org/10.1348/000711201161109

Levant, R. F., & Powell, W. A. (2017). The Gender Role Strain Paradigm. In R. F. Levant & Y. J. Wong (Eds.), *The Psychology of Men and Masculinities* (pp. 15-43). American Psychological Association: Washington, DC.

Linley, P. A., & Joseph, S. (2004). Positive Change Following Trauma and Adversity: A Review. *Journal of Traumatic Stress*, *17*, 11–21. https://doi.org/10.1023/B:JOTS.0000014671.27856.7e

Longworth, H. L., & Kingdon, C. K. (2011). Fathers in the birth room: What are they expecting and experiencing? A phenomenological study. *Midwifery*, *27*(5), 588–594. https://doi.org/10.1016/j.midw.2010.06.013

Lorber, W., & Garcia, H. A. (2010). Not supposed to feel this: Traditional masculinity in psychotherapy with male veterans returning from afghanistan and iraq. *Psychotherapy*, *47*(3), 296–305. https://doi.org/10.1037/a0021161

Mahalik, J. R., & Dagirmanjian, F. R. (2019). Working-Class Men's Constructions of Help-Seeking When Feeling Depressed or Sad. *American Journal of Men's Health*, *13*(3), 1-13. https://doi.org/10.1177/1557988319850052

Mahalik, J. R., & Di Bianca, M. (2021). Help-seeking for depression as a stigmatized threat to masculinity. *Professional Psychology, Research and Practice*, *52*(2), 146–155. https://doi.org/10.1037/pro0000365

Malekpour, M. (2007). Effects of attachment on early and later development. *The*

British Journal of Developmental Disabilities, *53*(105), 81–95. https://doi.org/10.1179/096979507799103360

Markin, R. D., & Coleman, M. N. (2021). Intersections of gendered racial trauma and childbirth trauma: Clinical interventions for Black women. *Psychotherapy*. https://doi.org/10.1037/pst0000403

Martin, L., Neighbors, H., & Griffith, D. (2013). The Experience of Symptoms of Depression in Men vs Women: Analysis of the National Comorbidity Survey Replication. *JAMA Psychiatry, 70*(10), 1100–1106. https://doi.org/10.1001/jamapsychiatry.2013.1985

Matheson, K., Asokumar, A., & Anisman, H. (2020). Resilience: Safety in the Aftermath of Traumatic Stressor Experiences. *Frontiers in Behavioral Neuroscience, 14*, Article 596919. https://doi.org/10.3389/fnbeh.2020.596919

Matthey, S., & Agostini, F. (2017). Using the Edinburgh Postnatal Depression Scale for women and men—some cautionary thoughts. *Archives of Women's Mental Health*, *20*(2), 345–354. https://doi.org/10.1007/s00737-016-0710-9

Matthey, S., Barnett, B., Kavanagh, D., & Howie, P. (2001). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners. *Journal of Affective Disorders*, *64*(2), 175–184. https://doi.org/10.1016/S0165-0327(00)00236-6

Matthey, S., Barnett, B., Ungerer, J., & Waters, B. (2000). Paternal and maternal depressed mood during the transition to parenthood. *Journal of Affective Disorders*, *60*(2), 75–85. https://doi.org/10.1016/S0165-0327(99)00159-7

McDonald, S., Slade, P., Spiby, H., & Iles, J. (2011). Post-traumatic stress symptoms, parenting stress and mother-child relationships following childbirth and at 2 years postpartum. *Journal of Psychosomatic Obstetrics and Gynaecology*, *32*(3), 141–146. https://doi.org/10.3109/0167482X.2011.596962

Melrose, S. (2010). Paternal postpartum depression: How can nurses begin to help? *Contemporary Nurse*, *34*(2), 199–210. https://doi.org/10.5172/conu.2010.34.2.199

Mohammad, K. I., Gamble, J., & Creedy, D. (2011). Prevalence and factors associated with the development of antenatal and postnatal depression among Jordanian women. *Midwifery*, *27*(6), e238–e245. https://doi.org/10.1016/j.midw.2010.10.008

Möller, E. L., Majdandžić, M., & Bögels, S. M. (2015). Parental Anxiety, Parenting

Behavior, and Infant Anxiety: Differential Associations for Fathers and Mothers. *Journal of Child and Family Studies*, *24*(9), 2626–2637. https://doi.org/10.1007/s10826-014-0065-7

Myers, S., & Johns, S. E. (2018). Postnatal depression is associated with detrimental life-long and multi-generational impacts on relationship quality. *PeerJ, 6,* Article e4305. https://doi.org/10.7717/peerj.4305

NCT. (2018, November). *Traumatic birth and post-traumatic stress disorder*. https://www.nct.org.uk/labour-birth/you-after-birth/traumatic-birth-and-post-traumatic-stress-disorder

Netsi, E., Pearson, R. M., Murray, L., Cooper, P., Craske, M. G., & Stein, A. (2018). Association of persistent and severe postnatal depression with child outcomes. *JAMA Psychiatry*, *75*(3), 247–253. https://doi.org/10.1001/jamapsychiatry.2017.4363

Newman, R. (2003). *Resilience and psychology: a healthy relationship.* American Psychological Association. *https://www.apa.org/monitor/julaug03/pp*

NHS. (2018, December 10). *Symptoms - Postnatal Depression.* https://www.nhs.uk/mental-health/conditions/post-natal-depression/symptoms/

NHS. (2019). *The NHS Long Term Plan*. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NHS England. (2018). *The Perinatal Mental Health Care Pathways NHS England and NHS Improvement.* https://www.england.nhs.uk/publication/the-perinatal-mental-health-care-pathways/

NHS England. (2021, March). *Involving and supporting partners and other family members in specialist perinatal mental health services – Good practice guide*. https://www.england.nhs.uk/wp-content/uploads/2021/03/Good-practice-guide-March-2021.pdf

NICE. (2020). *Antenatal and postnatal mental health: clinical management and service guidance* (NICE Guideline CG192). https://www.nice.org.uk/guidance/cg192

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology*, *12*(4), 491–509. https://doi.org/10.1348/135910706X120627

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal*

of Qualitative Methods, 16, 1-13. https://doi.org/10.1177/1609406917733847

O'Brien, R., Hunt, K., & Hart, G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate": Men's accounts of masculinity and help seeking. *Social Science and Medicine, 61*(3), 503–516. https://doi.org/10.1016/j.socscimed.2004.12.008

O'Hara, M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression - a meta-analysis. *International Review of Psychiatry, 8*(1), 37–54. https://doi.org/10.3109/09540269609037816

O'Hara, M. W., & Wisner, K. L. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice and Research: Clinical Obstetrics and Gynaecology, 28*(1), 3–12. https://doi.org/10.1016/j.bpobgyn.2013.09.002

Olukotun, O. (2021). *Black fathers who experienced the birth of their baby as traumatic: a qualitative study.* [Doctoral thesis, University of Essex]. http://repository.essex.ac.uk/31266/

Olza, I., Leahy-Warren, P., Benyamini, Y., Kazmierczak, M., Karlsdottir, S. I., Spyridou, A., Crespo-Mirasol, E., Takács, L., Hall, P. J., Murphy, M., Jonsdottir, S. S., Downe, S., & Nieuwenhuijze, M. J. (2018). Women's psychological experiences of physiological childbirth: A meta-synthesis. *BMJ Open, 8,* Article e020347. https://doi.org/10.1136/bmjopen-2017-020347

Parfitt, Y. M., & Ayers, S. (2009). The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology, 27*(2), 127–142. https://doi.org/10.1080/02646830802350831

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in Clinical Research, 4*(3), 192. https://doi.org/10.4103/2229-3485.115387

Paulson, J. F., & Bazemore, S. (2010). Prenatal and Postpartum Depression in Fathers and its Association with Maternal Depression: A Meta-analysis. *JAMA: The Journal of the American Medical Association, 303*(19), 1961–1969. https://doi.org/10.1001/jama.2010.605

Paulson, J. F., Dauber, S., & Leiferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. *Pediatrics, 118*(2), 659–668. https://doi.org/10.1542/peds.2005-2948

Pedersen, S. C., Maindal, H. T., & Ryom, K. (2021). "I Wanted to Be There as a Father, but I Couldn't": A Qualitative Study of Fathers' Experiences of

Postpartum Depression and Their Help-Seeking Behavior. *American Journal of Men's Health*, *15*(3), 1-13. https://doi.org/10.1177/15579883211024375

Philpott, L. F., Savage, E., FitzGerald, S., & Leahy-Warren, P. (2019). Anxiety in fathers in the perinatal period: A systematic review. *Midwifery*, *76*, 54–101. https://doi.org/10.1016/j.midw.2019.05.013

Pio De Almeida, L. S., Jansen, K., Köhler, C. A., Pinheiro, R. T., Da Silva, R. A., & Bonini, J. S. (2012). Working and short-term memories are impaired in postpartum depression. *Journal of Affective Disorders*, *136*(3), 1238–1242. https://doi.org/10.1016/j.jad.2011.09.031

Priddis, H. S., Keedle, H., & Dahlen, H. (2018). The Perfect Storm of Trauma: The experiences of women who have experienced birth trauma and subsequently accessed residential parenting services in Australia. *Women and Birth*, *31*(1), 17–24. https://doi.org/10.1016/j.wombi.2017.06.007

Quevedo, L., Da Silva, R. A., Coelho, F., Pinheiro, K. A. T., Horta, B. L., Kapczinski, F., & Pinheiro, R. T. (2011). Risk of suicide and mixed episode in men in the postpartum period. *Journal of Affective Disorders*, *132*(1–2), 243–246. https://doi.org/10.1016/j.jad.2011.01.004

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. G. (2005). Paternal depression in the postnatal period and child development: a prospective population study. *The Lancet*, *365*(9478), 2201–2205. https://doi.org/10.1016/S0140-6736(05)66778-5

Reynolds, J. L. (1997). Post-traumatic stress disorder after childbirth: The phenomenon of traumatic birth. *Canadian Medical Association Journal (CMAJ)*, *156* (6), 831–835.

Rice, H., & Warland, J. (2013). Bearing witness: Midwives experiences of witnessing traumatic birth. *Midwifery*, *29*(9), 1056–1063. https://doi.org/10.1016/j.midw.2012.12.003

Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: A synthesis of recent literature. *General Hospital Psychiatry*, 26(4), 289–295. https://doi.org/10.1016/j.genhosppsych.2004.02.006

Rochlen, A., Land, L., & Wong, Y. (2004). Male Restrictive Emotionality and Evaluations of Online Versus Face-to-Face Counselling. *Psychology of Men & Masculinity*, *5*(2), 190–200. https://doi.org/10.1037/1524-9220.5.2.190

Rodríguez-Almagro, J., Hernández-Martínez, A., Rodríguez-Almagro, D., Quirós-García, J. M., Martínez-Galiano, J. M., & Gómez-Salgado, J. (2019). Women's perceptions of living a traumatic childbirth experience and factors related to a birth experience. *International Journal of Environmental Research and Public Health*, *16*(9), Article 1654. https://doi.org/10.3390/ijerph16091654

Rominov, H., Giallo, R., Pilkington, P. D., & Whelan, T. A. (2018). "Getting help for yourself is a way of helping your baby:" Fathers' experiences of support for mental health and parenting in the perinatal period. *Psychology of Men and Masculinity*, *19*(3), 457–468. https://doi.org/10.1037/men0000103

Ruffell, B., Smith, D. M., & Wittkowski, A. (2019). The Experiences of Male Partners of Women with Postnatal Mental Health Problems: A Systematic Review and Thematic Synthesis. *Journal of Child and Family Studies*, *28*(10), 2772–2790. https://doi.org/10.1007/s10826-019-01496-4

Santiago, P., Ursano, R., Gray, C., Pynoos, R., Spiegel, D., Lewis-Fernandez, R., Friedman, M., & Fullerton, C. (2013). A systematic review of PTSD prevalence and trajectories in DSM-5 defined trauma exposed populations: intentional and non-intentional traumatic events. *PLoS ONE*, *8*(4), Article e59236. https://doi.org/10.1371/journal.pone.0059236

Sawyer, A., & Ayers, S. (2009). Post-traumatic growth in women after childbirth. *Psychology and Health*, *24*(4), 457–471. https://doi.org/10.1080/08870440701864520

Scarff, J. R. (2019). Postpartum Depression in Men. *Innovations in Clinical Neuroscience*, *16*(5-6), 11–14.

Schneider, J. C., Trinh, N. H. T., Selleck, E., Fregni, F., Salles, S. S., Ryan, C. M., & Stein, J. (2012). The Long-Term Impact of Physical and Emotional Trauma: The Station Nightclub Fire. *PLoS ONE*, *7*(10), article e47339. https://doi.org/10.1371/journal.pone.0047339

Schobinger, E., Stuijfzand, S., & Horsch, A. (2020). Acute and Post-traumatic Stress Disorder Symptoms in Mothers and Fathers Following Childbirth: A Prospective Cohort Study. *Frontiers in Psychiatry*, *11*, Article 562054. https://doi.org/10.3389/fpsyt.2020.562054

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, *49*, 106–118.

https://doi.org/10.1016/j.cpr.2016.09.002

Sethna, V., Murray, L., Netsi, E., Psychogiou, L., & Ramchandani, P. (2015). Paternal Depression in the Postnatal Period and Early Father-Infant Interactions. *Parenting, Science and Practice*, *15*(1), 1–8. https://doi.org/10.1080/15295192.2015.992732

Sheikh, A. I. (2008). Posttraumatic growth in trauma survivors: Implications for practice. *Counselling Psychology Quarterly*, *21*(1), 85–97. https://doi.org/10.1080/09515070801896186

Shorey, S., & Wong, P. Z. E. (2020). Traumatic Childbirth Experiences of New Parents: A Meta-Synthesis. *Trauma, Violence, and Abuse*, 1–16. https://doi.org/10.1177/1524838020977161

Shorey, S., Yang, Y. Y., & Ang, E. (2018). The impact of negative childbirth experience on future reproductive decisions: A quantitative systematic review. *Journal of Advanced Nursing*, *74*(6), 1236–1244. https://doi.org/10.1111/jan.13534

Simpson, M., & Catling, C. (2016). Understanding psychological traumatic birth experiences: A literature review. *Women and Birth*, *29*(3), 203–207. https://doi.org/10.1016/j.wombi.2015.10.009

Singley, D. B., & Edwards, L. M. (2015). Men's perinatal mental health in the transition to fatherhood. *Professional Psychology: Research and Practice*, *46*(5), 309–316. https://doi.org/10.1037/pro0000032

Skari, H., Skreden, M., Malt, U. F., Dalholt, M., Ostensen, A. B., Egeland, T., & Emblem, R. (2002). Comparative levels of psychological distress, stress symptoms, depression and anxiety after childbirth-a prospective population-based study of mothers and fathers. *BJOG: An International Journal of Obstetrics and Gynaecology*, *109*(10), 1154–1163. https://doi.org/10.1111/j.1471-0528.2002.00468.x

Slomian, J., Honvo, G., Emonts, P., Reginster, J. Y., & Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's Health*, 15, 1-55. https://doi.org/10.1177/1745506519844044

Smith, J., Larkin, M., & Flowers, P. (2009). *Interpretative phenomenological analysis : theory, method and research*. London: SAGE.

Søegaard, E. G. I., Kan, Z., Koirala, R., Hauff, E., & Thapa, S. B. (2021). Gender

differences in a wide range of trauma symptoms after victimization and accidental traumas: a cross-sectional study in a clinical setting. *European Journal of Psychotraumatology*, *12*, Article 1975952. https://doi.org/10.1080/20008198.2021.1975952

Soet, J., Brack, G., & DiIorio, C. (2003). Prevalence and Predictors of Women's Experience of Psychological Trauma During Childbirth. *Birth*, *30*(1), 36–46. https://doi.org/10.1046/j.1523-536X.2003.00215.x

Soliday, E., McCluskey-Fawcett, K., & O'Brien, M. (1999). Postpartum affect and depressive symptoms in mothers and fathers. *American Journal of Orthopsychiatry*, *69*(1), 30–38. https://doi.org/10.1037/h0080379

Southwick, S, M., Sippel, L., Krystal, J., Charney, D., Mayes, L., & Pietrzak, R, H. (2016). Why are some individuals more resilient than others: the role of social support. *World Psychiatry*, *15*(1), 77–79. https://doi.org/10.1002/wps.20280

Steinglass, P., & Gerrity, E. (1990). Natural Disasters and Post-traumatic Stress Disorder Short-Term versus Long-Term Recovery in Two Disaster-Affected Communities. *Journal of Applied Social Psychology*, *20*(21), 1746–1765. https://doi.org/10.1111/j.1559-1816.1990.tb01509.x

Stewart, D. (1983). Psychiatric symptoms following attempted natural childbirth. *Canadian Medical Association Journal*, *127*, 713–716. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1874954&tool=pmcentrez&rendertype=abstract

Su, Y. J., Chow, C. C., Yen, C. I., & Chuang, S. S. (2020). Posttraumatic Growth Among Burn Survivors 2 Years After the 2015 Formosa Fun Coast Water Park Explosion in Taiwan. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(1), 11–19. https://doi.org/10.1037/tra0000458

Taghizadeh, Z., Irajpour, A., & Arbabi, M. (2013). Mothers' response to psychological birth trauma: A qualitative study. *Iranian Red Crescent Medical Journal*, *15*(10), Article e10572. https://doi.org/10.5812/ircmj.10572

Taghizadeh, Z., Irajpour, A., Nedjat, S., Arbabi, M., & Lopez, V. (2014). Iranian mothers' perception of the psychological birth trauma: A qualitative study. *Iranian Journal of Psychiatry*, *9*(1), 31-36.

Tang, M. O. T., Oliffe, J. L., Galdas, P. M., Phinney, A., & Han, C. S. (2014). College men's depression-related help-seeking: A gender analysis. *Journal of Mental Health*, *23*(5), 219–224. https://doi.org/10.3109/09638237.2014.910639

Taylor, S. P. (2018). Critical Realism vs Social Constructionism & Social Constructivism: Application to a Social Housing Research Study. *International Journal of Sciences: Basic and Applied Research*, *37*(2), 216–222.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*(3), 455–471. https://doi.org/10.1002/jts.2490090305

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*, *15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01

Thompson, E. H., & Bennett, K. M. (2015). Measurement of masculinity ideologies: A (critical) review. *Psychology of Men and Masculinity*, *16*(2), 115–133. https://doi.org/10.1037/a0038609

Thompson, E. H., & Bennett, K. M. (2017). Maculinity Ideologies. In R. F. Levant & Y. J. Wong (Eds.), *The psychology of men and masculinities* (pp. 45-74). American Psychological Association: Washington, DC.

Thomson, G., & Downe, S. (2008). Widening the trauma discourse: The link between childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics and Gynecology*, *29*(4), 268–273. https://doi.org/10.1080/01674820802545453

Tolin, D. F., & Foa, E. B. (2006). Sex Differences in Trauma and Posttraumatic Stress Disorder: A Quantitative Review of 25 Years of Research. *Psychological Bulletin*, *132*(6), 959–992. https://doi.org/10.1037/0033-2909.132.6.959

Turton, P., Badenhorst, W., Hughes, P., Ward, J., Riches, S., & White, S. (2006). Psychological impact of stillbirth on fathers in the subsequent pregnancy and puerperium. *British Journal of Psychiatry*, *188*(2), 165–172. https://doi.org/10.1017/CBO9781107415324.004

Vallin, E., Nestander, H., & Wells, M. B. (2019). A literature review and meta-ethnography of fathers' psychological health and received social support during unpredictable complicated childbirths. *Midwifery*, *68*, 48–55. https://doi.org/10.1016/j.midw.2018.10.007

Vescio, T. K., Schermerhorn, N. E. C., Gallegos, J. M., & Laubach, M. L. (2021). The affective consequences of threats to masculinity. *Journal of Experimental Social Psychology*, *97*, Article 104195. https://doi.org/10.1016/j.jesp.2021.104195

Vischer, L. C., Heun, X., Steetskamp, J., Hasenburg, A., & Skala, C. (2020). Birth experience from the perspective of the fathers. *Archives of Gynecology and Obstetrics*, *302*, 1297–1303. https://doi.org/10.1007/s00404-020-05714-z

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, *58*(3), 368–382. https://doi.org/10.1037/a0023688

Wade, J. C. (2015). Measurement of masculinity ideologies: A commentary. *Psychology of Men and Masculinity*, *16*(2), 137–140. https://doi.org/10.1037/a0038988

Wang, D., Li, Y. L., Qiu, D., & Xiao, S. Y. (2021). Factors Influencing Paternal Postpartum Depression: A Systematic Review and Meta-Analysis. *Journal of Affective Disorders*, 293, 51–63. https://doi.org/10.1016/j.jad.2021.05.088

Webb, R., Smith, A. M., Ayers, S., Wright, D. B., & Thornton, A. (2021). Development and Validation of a Measure of Birth-Related PTSD for Fathers and Birth Partners: The City Birth Trauma Scale (Partner Version). *Frontiers in Psychology*, *12*, Article 596779. https://doi.org/10.3389/fpsyg.2021.596779

White, G. (2007). You cope by breaking down in private: Fathers and PTSD following childbirth. *British Journal of Midwifery*, *15*(1), 39–45. https://doi.org/10.12968/bjom.2007.15.1.22679

White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology*, *24*(2), 107–120. https://doi.org/10.1080/02646830600643874

Whitney, S. D., Prewett, S., Wang, Z., & Chen, H. (2017). Fathers' Importance in Adolescents' Academic Achievement. *International Journal of Child, Youth and Family Studies*, *8*(3/4), 101-126. https://doi.org/10.18357/ijcyfs83/4201718073

Williams, T. (1988). Diagnosis and treatment of survivor guilt: The bad penny syndrome. In J. P. Wilson, Z. Harel, & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp. 319–336). New York, NY: Plenum Press.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd ed.).

Maidenhead: Open University Press.

Wilson, J. P., Drožđek, B., & Turkovic, S. (2006). Posttraumatic Shame and Guilt. *Trauma, Violence & Abuse, 7*(2), 122–141. https://doi.org/10.1177/1524838005285914

Wong, Y. J., Ho, M. R., Wang, S., & Keino Miller, I. S. (2017). Meta-Analyses of the Relationship Between Conformity to Masculine Norms and Mental Health-Related Outcomes. *Journal of Counseling Psychology, 64*(1), 80–93. https://doi.org/10.1037/cou0000176.supp

Wu, X., Kaminga, A. C., Dai, W., Deng, J., Wang, Z., Pan, X., & Liu, A. (2019). The prevalence of moderate-to-high posttraumatic growth: A systematic review and meta-analysis. *Journal of Affective Disorders, 243*, 408–415. https://doi.org/10.1016/j.jad.2018.09.023

Yogman, M., & Garfield, C. F. (2016). Fathers' roles in the care and development of their children: The role of pediatricians. *Pediatrics, 138,* Article e20161128. https://doi.org/10.1542/peds.2016-1128

Young, K., Chessell, Z. J., Chisholm, A., Brady, F., Akbar, S., Vann, M., … Dixon, L. (2021). A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events. *Cognitive Behaviour Therapist, 14,* Article e26. https://doi.org/10.1017/S1754470X21000192

Zerach, G., & Magal, O. (2017). Exposure to stress during childbirth, dyadic adjustment, partner's resilience, and psychological distress among first-time fathers. *Psychology of Men and Masculinity, 18*(2), 123–133. https://doi.org/10.1037/men0000048

Zieba, M., Wiecheć, K., Biegańska-Banaś, J., & Mieleszczenko-Kowszewicz, W. (2019). Coexistence of post-traumatic growth and post-traumatic depreciation in the aftermath of trauma: Qualitative and quantitative narrative analysis. *Frontiers in Psychology, 10,* Article 687. https://doi.org/10.3389/fpsyg.2019.00687

Appendix A:
Glossary of Terms

Caesarean section or C-section: an operation used to deliver a baby through an incision made in the mother's abdomen and uterus.

Episiotomy: A surgical cut made in the perineum (tissue between the vagina and anus) during childbirth, to aid in the delivery.

Forceps delivery: type of assisted vaginal delivery. Forceps (smooth, curved metal instruments) are positioned around the baby's head and used to aid guiding the baby out of the birth canal.

Perinatal period: time period which covers pregnancy and the first year after birth.

Postpartum: after childbirth

Postpartum depression (PPD): Depression experienced following childbirth. Also commonly referred to as postnatal depression.

Post-traumatic growth (PGT): The experience of positive change, occurring as a result of a trauma experience.

Post-Traumatic Stress Symptoms (PTSS): PTSS as a response to a traumatic event can present in four main areas: re-experiencing (intrusion of unwanted trauma-related memories), negative alterations in cognition and mood, avoidance of trauma-related thoughts or external reminders, and alterations in hyperarousal.

Post-Traumatic Stress Disorder (PTSD): The diagnostic criteria for PTSD is met if symptoms from each of the four areas (outlined above in PTSS), are reported and persistent for at least one month.

Thematic Analysis (TA): described by Braun & Clark (2006, p. 79) as "a method for identifying, analyzing and reporting patterns within data".

Neonatal intensive care unit (NICU): hospital unit providing intensive medical care to babies who are premature or unwell.

Ventouse delivery: type of assisted vaginal delivery. A ventouse (also referred to as a vacuum cup), is a plastic or metal cup which is attached to a suction device by a tube. The cup fits securely around the baby's head and the clinician uses this to gently pull the baby out of the birth canal.

Appendix B:
Study Flyer

Research study

What are the long-term impacts of a traumatic birth, as experienced by Fathers?

UNIVERSITY OF LEEDS

Background

The birth of a child is hoped for and experienced by many parents to be a joyful and momentous time. However, it is becoming increasingly recognised that for various reasons during the birthing event, some parents may reflect on this experience as having been traumatic.

An influential amount of research has gone into understanding the impacts of a traumatic birth on the mother's mental health and wellbeing. However, research exploring the father's experience currently remains limited.

The present study aims to promote gaining a better understanding into some of the long-term impacts a traumatic birth can have on fathers, 2 or more years post-event.

Participants who complete the study will receive a £20 amazon voucher as a thank you for taking part

What is involved?

Participants will take part in an interview lasting about an hour. The interview will involve answering questions about the birth experience and how this has impacted on you long-term.

Location

Interviews can be conducted remotely over the telephone or by video call at a time suitable for you

Are you eligible?

We are looking to recruit male fathers who were present at the birth of a child, 2 or more years ago, who would self-define this experience as traumatic.

To find out more about the study, please copy and paste the link below into your internet browser. Here you will be able to access more information about the study and details about how to take part

https://leeds.onlinesurveys.ac.uk/thesis-fathers-birthtrauma

Researcher: Clare Charman Email: umcac@leeds.ac.uk

V1.0. 23/1/2020

Appendix C:
Participant Information Sheet (Online Surveys Version)

Study: What are the long-term impacts of a traumatic birth, as experienced by Fathers?

Page 1: Participant Information Sheet

Study: What are the long-term impacts of a traumatic birth, as experienced by Fathers?

You are being invited to take part in a research study. Before you decide to take part, it is important for you to understand why the project is being done and what it will involve. Please take some time to read the following information carefully and discuss it with others if you wish. Please also feel free to contact us if there is anything that is not clear, or you would like more information.

What is the purpose of the study?
The aim of this research is to gain insight into the long-term journey of fathers who have experienced a traumatic birth, looking specifically at the impact this has had 2 or more years following the birth event. The study aims to explore the impact this experience has had on different areas of a father's life such as their mental health and wellbeing, occupation, relationships, parent-infant bond, and subsequent pregnancies.

What do we mean by 'traumatic birth'?
We are looking to recruit male fathers who were present at the birth of a child, 2 or more years ago, who would describe their experience of this event as having been traumatic. For the purpose of the study, we will be specifically looking to recruit fathers whose traumatic experience **did not** result in loss of life to the child or mother during the birth event, or where the child has experienced any significant long-term health difficulties post birth, because this is a different experience.

Why have I been chosen?
You have been asked to take part in this study as we believe you may be a father who has experienced a traumatic birth.

Do I have to take part?

No. Taking part is entirely voluntary. If you would like to take part, you will be given a consent form to read through and complete. However, if you do not wish to take part, you can do so without needing to give a reason.

What if I agree to take part but then change my mind?
If you decide to take part but change your mind during or after the interview, your information can be withdrawn from the study up to one week after the interview has been completed. This can be done by contacting Clare Charman by email at: umcac@leeds.ac.uk

What happens if I do decide to take part?
If you agree to participate in the project, we will arrange for the interview to be carried out remotely either by telephone or video call, at an agreed time which is convenient for you. The interview will last approximately 45-60 minutes and will involve talking about the long-term impact experiencing a traumatic birth has had on different aspects of your life.

Will I be recorded and what will happen with my information?
The interview will be recorded using a Dictaphone and the recording will be transferred to a secure drive. Once the interview has been written up (transcribed) the audio recording will be deleted. Data collected in this study will be used to write a doctoral thesis which will then be published on White Rose E-Thesis online', which holds electronic copies of theses from the University of Leeds. The results of the study will also be shared at conferences and be written up into articles for publication in journals. You will not be identified in any documents published from this study.

All other data collected will be stored for 3 years after the completion of the study on a secure, password-protected computer server managed by the Doctorate in Clinical Psychology Training programme after which it will be deleted in full accordance with the GDPR. For more information regarding the use of personal data in research, please see the University of Leeds' Privacy Notice for Research.

Are there any benefits for taking part?
For all participants who take part and complete the interview, a £20 amazon voucher will be offered as a gesture of thanks. It is also important to highlight how influential and valuable hearing about your journey is and how this will support in contributing to current literature promoting better awareness around the father's experience of a traumatic birth.

Who do I speak to if I have any questions or want to take part in the study?
If you have any further questions about this project, or would like to take part, please contact Clare Charman at: umcac@leeds.ac.uk. Alternatively, you can also contact either Dr Ciara Masterson at: c.masterson@leeds.ac.uk or Dr Amy Russell at: a.m.russell@leeds.ac.uk.

Following contacting us, we will arrange a telephone call with you where we can discuss the study further and answer any questions you have. If you meet eligibility for the study and would like to consent to take part, we will then arrange a time suitable for you to complete the interview.

Who has reviewed the study?
This study has been reviewed and given a favourable opinion by The University of Leeds, school of Medicine Research Ethics Committee on 17/05/2021, ethics reference MREC 20-058.

What if I have a complaint?
We think this is unlikely to happen, but if it does you can contact any of the research team on the email addresses provided within this participant information sheet.

Thank you for taking the time to read through this information sheet

Clare Charman | Psychologist in Clinical Training | umcac@leeds.ac.uk

Dr Ciara Masterson | Supervisor | c.masterson@leeds.ac.uk

Dr Amy Russell | Supervisor | a.m.russell@leeds.ac.uk

Clinical Psychology Training Programme
Leeds Institute of Health Sciences
Level 10 Worsley Building | Clarendon Way
University of Leeds | Leeds | LS2 9NL

Appendix D:
Consent Form (Online Surveys Version)

Page 2: Consent Form

Please read each of the below statements and tick 'yes' if you agree to the statement

1. I confirm that I have read and understand the information sheet provided to me explaining the above research project and I have had the opportunity to ask questions about the project. ✱ *Required*

- ○ Yes

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time up until the point of the interview being transcribed (one week after) without being required to provide a reason for withdrawing. In addition, should I not wish to answer any particular questions, I am free to decline.

- ○ Yes

3. I agree to take part in the interview and for content from this to be used in the write-up of this thesis study. I understand that quotes from the interview may be used within the write-up of this study, however all identifiable information will be removed, and my anonymity will be preserved.

- ○ Yes

4. I consent to the interview being recorded and transcribed for the write-up of the study

- ○ Yes

5. I understand that members of the research team may have access to my responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in any reports that result from the research.

- ○ Yes

6. I agree to take part in the above project

- ○ Yes

7. Date of participant giving consent:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

(dd/mm/yyyy)

8. Participant full name:

9. Please provide your contact number and/or email address below. *(This information is required so that we can contact you to arrange the interview).*

Appendix E:
Topic Guide

Title: What are the long-term impacts of a traumatic birth, as experienced by Fathers?

Introduction:

Good morning/afternoon, my name is Clare Charman and I am a Trainee Clinical Psychologist. I'm contacting you regarding a recent research study you had shown some interest participating in. The research study is exploring the long-term impact of a experiencing a traumatic birth on fathers. Following reading information about the study and having a recent call together to talk further about the study, you consented to taking part in the interview we have arranged to do today.

I would like to ask you some questions about the traumatic birth experience you went through and how this has continued to impact on your life now. The interview should take no more than an hour to complete.

Consent:

The topic of this study if one which may be very sensitive to some and talking about your traumatic experience may trigger some distressing memories or feelings. If you feel you would like to stop or re-arrange the interview at any point, just let me know.

If during the interview there are any question you would prefer not to answer, that is absolutely fine, just let me know and we will move onto the next question. If there are any questions which you feel are unclear or you are unsure on the answer, please just let me know and I will try my best to reword this, or again we can just move into the next question if you would prefer.

If you are still happy to participate, all of your details and responses will to stored securely and remain anonymous. Following the interviews completed, I will be writing a report on the findings. In this report, no identifiable data will be made available.

You have the right to withdraw at any time during or after we have finished the

interview (up until a week after the interviews have been conducted).

Would you like to ask any questions at this point?

Do you consent to take part in the study?

If Yes:	Thank you for agreeing to participate **(proceed to the interview)** **Date of verbal consent:**
If No:	I would like to thank you for your time speaking with me today.

Interview topic guide:

1. **What interested you about the study?**

2. **Can you tell me a bit about the traumatic birth experience you went through?** *(prompts: how long ago? First or subsequent child? What was the pregnancy like (e.g. complications, social stressors)? Establish: if still a partner to the pregnant woman, if biologically the baby's father. What did you find most difficult about being present in the room? What emotions do you recall experiencing? Do any particular moments of the experience stay in your mind the most? Can you remember what the staff said to you?)*

3. **What support, if any, following the traumatic birth did you access?** (Prompts: *what was your experience of accessing support? Did anything impact on you feeling able to seek further help?)*

4. **How has this birth experience continued to impact on your daily life now?** (*prompt: do you ever think about the birth? what feelings does it trigger now for you? Has it effected your work / friendships / hobbies in anyway?)*

5. **How has it impacted on your mental health and wellbeing?**

(have you experienced any emotional difficulties which you attribute to having gone through a traumatic birth? Do you attribute the birth to any positive mental health outcomes?)

6. **How would you describe the impact this experience has had on your relationship with your partner?** *(prompts: has it had any positive or negative impacts? Has it impacted on any aspects of your communication e.g. openness to talk about the event? on aspects of intimacy? Has this changed at all over time? Do you ever talk about it?)*

7. **How would you describe the impact this experience has had on your relationship with your child?** *(prompts: Did the birth effect your experience of bonding with your child? Has this changed in any way over time? Do you feel your relationship would feel any different now if you had experienced the birth differently?)*

8. **Has this experience made a difference to you having more children?** *(Prompts: did it impacted how you felt about having more children? What emotions are triggered when you think now about going through another birth? Have you had more children? – If so, did your experience have any effect on pregnancy and birth of other children?)*

9. **What, if any, would you say have been the most positive outcomes of having gone through this traumatic experience?**

10. **Is there anything else you think people should understand about the experience and its long-term effects?**

That is now the end of the interview. thank you for your time.
At this stage I would like to ask if you have any questions following completing this interview? How are you feeling after talking about some of these things today?
Optional depending on response:
Some may find talking about a difficult experience like this may trigger some difficult or upsetting feelings. Therefore, I would like to offer some information

about support services which are available, so that you can access some support after today's interview if you would like too. would that be ok?

- **Birth Trauma Association: 01264 860380 (Mon-Friday 10-5.30pm)**
- **Samaritans contact number: 116123**
- **GP (if interviewer feels the presenting distress would be best supported by a GP)**

At this stage I would like to thank you again for your time today and for sharing your experience. If you have any questions following today, please do not hesitate in getting in contact with me.

provide information about voucher
Research interviewer will gather demographic information (e.g. age, occupation, education, number of children) as the interview goes on. Anything which has not been possible to gather during the interview questions will be asked at the end of the interview questions.

Age	
Home location	
ethnicity	
Marital status - Still with mum?	
occupation	
Level of education	
Number of children	
Time since birth	
Biological parent	

Appendix F: Ethical Approval

RE: MREC 20-058 Study Conditional Approval

M Rachel De Souza [Medicine] on behalf of Medicine and Health Univ Ethics Review
Mon 17/05/2021 13:48
To: Clare Charman
Cc: Amy Russell [LIHS];Ciara Masterson;Medicine and Health Univ Ethics Review

Dear Clare

MREC 20-058 - What are the long-term impacts of a traumatic birth, as experienced by Fathers?

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and on behalf of the Chair, I can confirm a conditional favourable ethical opinion based on the documentation received at date of this email and *subject to the following condition/s which must be fulfilled prior to the study commencing:*

1. **For our records we need sight of the participant information to be placed on the online surveys (screen shots or .pdf is fine) even if it is a duplication of the PIS/consent – also please provide the link to the survey**

2. **C19 - Please clarify that all personal information (retained so the participant can receive their e-voucher) will be stored separately from the research interview data**

The study documentation must be amended where required to meet the above conditions and submitted for file and possible future audit.

Once you have addressed the conditions and submitted for file/future audit, you may commence the study and further confirmation of approval is not provided.

Please note, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.

Please retain this email as evidence of conditional approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://ris.leeds.ac.uk/research-ethics-and-integrity/applying-for-an-amendment/ or contact the Research Ethics & Governance Administrator for further information on FMHUniEthics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Best regards
Rachel
On behalf of Dr Anthony Howard and Dr Naomi Quinton, co-Chairs, SoMREC

~~~~~~
Rachel de Souza, Lead Research Ethics & Governance Administrator, The Secretariat, University of Leeds, LS2 9NL, r.e.desouza@leeds.ac.uk
~~~~~~

Appendix G:
Example Coding

Participant quotes	Codes
"…this is definitely one that I have, I have put in a box labelled umm, umm, you know should, should not feel. Umm, you know because it is, it's so fundamentally as far as society's concerned, not about me, and, and I think, and I think, as much as, as much as I said at the beginning, and said again, I believe that mental health of fathers is not dealt with well at all. Umm, even saying that, there is a core thing, a core thing within me to say that, you know that I can't let go of which is that I am second. I am…you know the father's role is to be there for the mother kind of thing…and as a result, it is not fair of me to feel those things; it's not fair for me to talk about this. It's just it's not even that that's a conscious thing; it's just that's where it is, that's the box it's in. So, to actually kind of talk about that wouldn't feel natural" *(Sam)*	Boxed away trauma Impact of societal views Not my story Men's mental health is neglected Traditional beliefs of the father role Second best / less important guilt for feeling Feelings perceived as selfish? Unfair to disclose Unnatural to share
"I don't want to go through that situation again of not knowing, worrying, you know. And my partner and me have discussed um, other babies, having another baby, and whatever and I've said it's, I don't want to go through it again; I don't want to have to go through all that again because it, it's, it's too much stress. I've not got an easy job as it is; and I don't want to have to go through all of that again and feel the way that I felt afterwards and enduring. So, it's not something I wanna do again" (*Peter*)	Don't want to go through it again Avoidance of further births Birth triggered high stress Impact of wider life Fear of retriggering difficult feelings The enduring distress
"…my partner being sick reminds me of it, she was sick quite a lot during it and I don't know. It does, it just reminds me when she has been I think she's been sick twice since then, but I remember both times, just thinking it did remind me of the sort of the scene…" *(Mark)* "…I still do feel like, I just remember being like useless and sort of like, it is a guilt, it just brings it back. The same feelings and I know its three and half years later. I'm not sure what I could've done but they're still there. . . yeah. It is literally still the same thing when the feelings back then are still the same feelings now" *(Mark)*	Physical trigger moments Memories retrigger distress Enduring guilt Feeling useless Questioning actions Same feelings retrigger