Paternal experiences of birth trauma – An evidence review commissioned by the National Childbirth Trust[1]

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Introduction

- Birth trauma is understood as physical or emotional suffering during birth, often (though not always) associated with significant complications, negative reactions or emergency procedures occurring during the birthing experience, and it can lead to significant and lasting distress (Elmir et al., 2010). According to Daniels et al., contributory factors to birth trauma may include sudden changes to the birth plan due to complications; emergency caesarean; post-birth difficulties; inadequate care received from staff or a general feeling of lack of control (Daniels et al., 2020). However, feelings of trauma may be experienced during or after births that appear to have been more routine as well (White 2007).

- Birth trauma has been examined extensively in mothers but the vast majority of fathers (around 95%) in the UK are present during birth (Draper et al., 1997; Redshaw and Henderson, 2013) and evidence increasingly suggests that birth trauma can affect them too (Delicate et al, 2020). Knowledge of the experiences and effects of traumatic birth on fathers remains limited (Elmir, 2013; Hindon et al., 2014; Jessop and Fox 2011) and support for fathers witnessing traumatic births is sparse (Daniels et al., 2020). In one study, 50% of the practitioners surveyed indicated that they assessed mothers for birth trauma, only 26% assessed partners for the same (Delicate et al., 2020a).

- This review covers a range of evidence regarding fathers and birth trauma including fathers' experiences of traumatic birth; the aftermath of the experience; difficulties with the ways new fathers can be positioned by society; and interactions between Healthcare Professionals (HCPs). The review finishes with recommendations and implications for the healthcare support.

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Fathers experiences of traumatic birth

- According to Delicate and colleagues (2020b) evidence suggests that 20-40% of women report experiencing their birth as traumatic (also see Ayers et al., 2018). Meta-studies suggest that post-traumatic stress symptoms (PTSS) have been identified as prevalent in 17% of women following birth (Dekel et al. 2017), while 4% are diagnosed with full post-traumatic stress disorder (Yildiz et al 2017). It should be noted that studies can differ in how exactly they measure such conditions and in their geographical breadth, with a greater concentration of research in the global north. Key symptoms in the aftermath of traumatic birth experiences can include re-experiencing, avoidance, hyperarousal, and negative alterations in mood.

- Research on the prevalence of birth trauma among fathers remains limited. While Ayers and colleagues indicate a figure of up to 5% for PTSD itself (Ayers et al 2007), a survey of health practitioners by Delicate et al (2020a) indicated such professionals had identified broader symptoms of traumatic birth in 25% of 'partners', as against 34% of new mothers.

- Studies indicate that experiences of traumatic births among fathers can centre on feelings of extreme distress (Harvey and Pattinson, 2012; Kuschel, 2014; Thomson-Salo, et al., 2017) and acute feelings of fear for the safety of both mother and infant (Hinton et al., 2014; White, 2007). Feeling of powerlessness, helplessness and loss of control amidst such traumatic situations also are reported to be common (Daniels et al., 2020; Hinton et al., 2014) and connect to fathers' role as witness and spectator in the birthing room, and a tendency to feel side-lined, with little information or support from medical staff (Etheridge and Slade, 2017; White, 2007; Daniels et al., 2020; Harvey and Pattinson, 2012).

- Feeling abandoned, excluded or isolated at particular points also can contribute to fears and uncertainties, whether though being left alone during traumatic parts of the birth (e.g. while their partner is prepared for or undergoing surgery) or afterwards (Etheridge and Slade, 2017; Hinton et al., 2014; Thomson-Salo et al., 2017).

- Evidence suggests that fathers' experience of such emotional extremes can be particularly difficult to cope with as a result of an intense pressure they feel during such moments to control or hide their reactions and feelings while witness to their partner's distress (Etheridge and Slade, 2017). This has been connected to their positioning by health care professionals and various others in the role of supporter (Hodkinson and Das 2021) and feeling confused as to their role, 'forgotten' or side-lined at different points during the process (Arnold et al., 2012; White, 2007).

Fathers after traumatic birth

- Following traumatic childbirth, fathers can suffer from mental health difficulties impeding their everyday functioning and, in some cases, may develop post-traumatic stress symptoms (Daniels et al., 2020; Etheridge and Slade, 2017; Harvey and Pattison, 2012; White, 2007). PTSS observed in fathers in Delicate et al's (2020a) study of practitioners centred on avoidance and hyper-arousal but birth trauma can

also connect to broader symptoms of depression (Ayers et al., 2016; Hinton et al., 2014; Ionio et al., 2016) or anxiety (Dikmen-Yildiz et al., 2017; Ionio et al., 2016).

- In addition to the direct impact of birth trauma, the pressure on fathers sometimes can be compounded by finding themselves with significantly enhanced care responsibilities shortly after a traumatic birth during mothers' recovery (Daniels et al., 2020; Hinton et al., 2014; Thomson-Salo et al., 2014) as well as caring for the mother (who, in addition to physical recovery, may be suffering from her own mental health difficulties) (Thomson-Salo, 2014; White, 2007);

- Mental scarring from traumatic births can lead to relationship difficulties (Delicate et al., 2018; Delicate et al., 2020b; Garthus-Niegel et al., 2018) and can also affect fathers' ability to bond with their new baby (Finger et al., 2009; Wong et al., 2009; Daniels et al., 2020). Men can also experience psychological 'sexual scarring' related to the triggering of recurring images of the mother's medicalised, traumatised body (White, 2007) or may avoid sex because of fears about another pregnancy (Daniels et al., 2020). Moreover, Iles and colleagues (2011) show that traumatic stress symptoms in fathers are associated with the development of comparable symptoms in mothers. This may impact both partners' interactions with one another and with their children, with implications for infant development (Kim and Swain, 2007; Paulson and Bazemore, 2010; Ramchandani et al., 2011)

- The conviction among fathers that their feelings of trauma are unjustified or invalid is consistently identified in studies (Daniels et al., 2020; Etheridge and Slade, 2017; Hodkinson and Das 2021) and can lead to reinforcement of men's negative perceptions of their ability to cope and spirals of guilt. This connects to broader questions about the impact of how fathers are positioned, which we address in the next section.

Masculine expectations and 'toughing it out'

- Gendered expectations and the ways in which fathers are positioned in the perinatal period as marginal yet stoic supporters can have a significant impact on fathers' experiences of birth trauma and their ability to cope (Etheridge and Slade, 2017, Freitas et al., 2016; Hodkinson and Das 2021; Vogel et al., 2014). Being positioned (by health care providers, family, peers and others) as secondary participants and stoic, masculine supporters of their partners can create significant internal conflict for fathers between intense emotional responses and their perception of what is expected of them, both during and after birth (Etheridge and Slade, 2017; Rochlen et al., 2010).

- Studies indicate fathers often feel compelled to hide their emotions both during and after birth, 'toughing it out' in order to prioritise support for and attention to the mother and thereby fulfil their own role as supportive fathers (Daniels et al., 2020; Hodkinson and Das, 2021). White et al (2007) point out that this perceived compulsion to bury intense feelings amidst emotional turmoil can lead to acute feelings of shame and humiliation (also see Daniels et al., 2020).

- Men in a broader sense can have difficulties reaching out to support networks for mental health difficulties (Vogel et al., 2014), sometimes avoiding communicating

about their problems in social circles out of fear this could negative impact people's perceptions of them and such pressures may be particularly acute for new fathers in light of the perceived greater importance of their partner's experiences and wellbeing (Daniels et al., 2020; O'Brien et al., 2017). Fathers experiencing emotional turmoil can feel they are failing as a father and a man (Miller et al, 2011) and that their feelings are invalid, resulting in spirals of guilt (Daniels et al., 2020; Etheridge and Slade, 2017; Hodkinson and Das 2021). Whilst many feel the need to express and talk about their experience and emotions, they can often find it extremely difficult to do so (Harvey and Pattinson, 2012).

Preparation and support

- Awareness and understanding of the way in which men can be affected by birth trauma is limited and perinatal advice, support and health care is minimal, with fathers often addressed as supporters whose own experience is rarely a point of focus (Burgess and Goldman 2018).

- Fathers frequently report feeling treated by heath care workers and others as a secondary parent (Etheridge and Slade 2017), or as an unwanted spectator (White, 2007), making them feel peripheral and separated from the process (Harvey and Pattinson, 2012; Kowlessar et al., 2013). According to Steen et al (2011), fathers find themselves occupying a confusing and undefined space between 'patient' and 'visitor', leaving them feeling excluded and fearful.

- Fathers report not having felt adequately prepared for the possibility or impact of traumatic birth, with antenatal class curriculae and other support materials perceived to have focused largely on standard or even ideal birth situations rather than preparing parents for all eventualities (Daniels et al., 2020; White, 2007). More generally, fathers often are not sufficiently informed or prepared for the range of challenges becoming a father might entail for them, including the possibility of trauma and other mental health difficulties (Elmir, 2013; Fägerskiöld, 2008; Jones et al., 2019; Vallin et al., 2019).

- Studies also indicate that limited and sometimes insensitive communication between HCPs and fathers can sometimes exacerbate difficult paternal birth experiences, leaving fathers confused, unsupported and only partially aware of the situation (Hinton et al., 2014; Harvey and Pattinson, 2012). The lack of information flow to fathers features in various studies of fathers' experiences of traumatic births, exacerbating fears and feelings of helplessness (Etheridge and Slade, 2017; Daniels et al., 2020, White, 2007). Similarly, fathers can report feeling somewhat ignored by midwives and offered little emotional support during critical situations (Harvey and Pattinson, 2012) or even treated insensitively (Etheridge and Slade 2017; Daniels et al., 2020; Poh et al., 2014).

- Following traumatic birth, fathers tend to report having received little to no support or opportunities to talk about their feelings with health professionals, despite feeling that they would have benefitted from the chance to discuss their emotions (Daniels et al., 2020, Harvey and Pattinson, 2012). This is of particular importance for fathers

because of the difficulties they can have regarding their struggles as legitimate or speaking to partners or families (ibid., Hodkinson and Das 2021).

Recommendations

- During the antenatal period, both parents should be informed and prepared for a range of birth scenarios and their challenges, including the possibility of traumatic births and the potential impact they can have on the mental health of fathers and mothers (Daniels et al., 2020; Gage and Kirk, 2002; White, 2007). As part of this, notwithstanding the need to keep risks and challenges in perspective, fathers should be prepared for the specific potentially challenges of occupying the role of witness and supporter during traumatic birth situations. Such information and support could be delivered gently, proportionately and sensitively via antenatal classes and points of contact with health care providers, as well as via leaflets and online information.

- Perinatal healthcare professionals and others who support new parents should be trained to be as inclusive of fathers as possible and treat them as co-parents rather than merely visitors or supporters. Training should also focus specifically on the mental health challenges fathers can face, including those related to witnessing a traumatic birth, as well as the importance of calm and controlled communication in helping fathers to cope (Burgess and Goldman 2018; Daniels et al., 2020; Ionion et al., 2016).

- Effective assessment of birth trauma for both parents needs to be developed to facilitate support for mental health problems that may result from this in the postnatal period (Delicate et al., 2020; Nilver et al., 2017). Ideally, assessment and support should not be limited to those with experience of objective obstetric complications, given that birth trauma reflects subjective experience and may not always be apparent to professionals (Ayers et al., 2016; Delicate et al., 2020).

- It is important to ensure that in cases of traumatic birth, support and information are available and easily accessible for both parents (Harvey and Pattinson, 2012; Daniels et al., 2020). Post-natal visits by mid-wives and heath visitors form a key contact point and may offer a valuable opportunity to provide initial information and support. Such support might include emphasis on couples and their relationship, given that postnatal mental health illnesses of one partner can be comorbid with another, with potential to worsen the family's wellbeing and children outcomes (Burgess and Goldman, 2018; Delicate et al., 2020b).

- Given the challenges struggling new fathers can face disclosing their emotions to those close to them (Hodkinson and Das 2021) and their limited access to networks of other parents (Brooks and Hodkinson 2020;), it would be valuable to develop antenatal and postnatal groups designed specifically for men in order to enable them to share their experiences and create support networks (Bruno et al., 2020; Mitchell and Chapman, 2002; O'Brien et al., 2017; White, 2007).

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