Black fathers who experienced the birth of their baby as traumatic: a qualitative study

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A thesis submitted for the degree of Doctorate in Clinical Psychology

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April 2021

ACKNOWLEDGEMENTS

First and foremost, I would like to express my sincerest gratitude to the fathers who took part in my research. Thank you for taking the time to participate in this study and for sharing your stories with me. I feel privileged to have met with you all and I hope that I have given your voices the amplification and exposure that they deserve.

Thank you to Dr Frances Blumenfeld and Dr Andy Sluckin for supporting me whilst undertaking this research. I would also like to thank Dr Jan Smith who played an instrumental part in helping me to take my ideas off the ground and who was able to sit with me whenever doubt crept in. Your input has been invaluable. I would also like to extend my appreciation to Make Birth Better who helped to advertise for participants and connected me to other relevant organisations. The work that you do as a network is invaluable to lives of the families who are affected by birth trauma.

To my wonderful friends and family who stood by me and waited patiently as I spent countless nights pouring my heart into this thesis – thank you. Thank you for understanding when I was too busy to meet up or overwhelmed with reading. I promise now that I will never say no to another social invitation.

And lastly, to J.A. Your endless support, patience, and encouragement is what saw me through to this point - '*Onwards and upwards, always'.*

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Research Summary

Aims: The aim of the present research was to explore the experiences of Black fathers who have experienced a birth that was traumatic for them and to establish what their nuanced and specific needs are.

Background: The research into birth trauma is new but has mainly focussed on the experiences of women. In recent years, the focus has widened to explore the experiences of men who attend childbirth. The research that has explored the experiences of men have largely included participants from White ethnic backgrounds, with the lived experiences of men minority ethnic backgrounds marginalised. Statistics indicate that as recent as 2015, Black women are four to five times more likely to die in childbirth (Knight et al., 2020; Knight et al., 2018) and Black babies at 50% higher risk of perinatal mortality (National Health Service [NHS] England, 2016). The study explored the experiences of Black men partnered with Black women.

Methodology: A critical realism approach was used to qualitatively explore the experiences of Black men who experienced a birth that they felt was traumatic for them. Purposive sampling recruited 10 participants who identified as Black men and participated in semi-structured interviews.

Results: Thematic analysis was used to interpret three main themes and eleven sub-themes: ‘The experience of the birth’, ‘Race and disparities in quality of care’, and ‘Coping with trauma’.

Conclusion: Fathers highlighted that their ethnicity and the perceive differential treatment by staff influenced the appraisal of birth as traumatic. This reflects previous findings of fathers feeling excluded from childbirth and adds a further racial element as identified by participants. Implications for clinical practice and further research are identified.

CHAPTER ONE: INTRODUCTION

Chapter Overview

The aim of this chapter is to provide a background to the present study based on relevant literature and theoretical perspectives. Firstly, the definition and prevalence of birth trauma will be outlined. Secondly, the current research on mothers' experiences of birth trauma will be presented, with reference made to the negative experiences of mothers from minority ethnic backgrounds in maternity services. Thirdly, the important terminologies for the present paper will be defined, including race, ethnicity, and intersectionality, leading to a critical of discussion of institutional racism in the United Kingdom (UK). Reference will be made to the racial and ethnic disparities that have been highlighted in the research, leading to an outline of theories of race-related stressors related to trauma. Following this, the experiences of people from minority ethnic backgrounds who have utilised health services in America and the UK will be explored, concluding with a specific focus on Black women who have been identified as being disproportionately at risk of maternal mortality in both countries. Further, the experiences of fathers from minority ethnic backgrounds in maternity services will then be considered, with the collective grouping of their experiences being critically appraised and justification for the focus on the experiences of Black fathers presented. Current government initiatives in maternity care and related policies will then be highlighted, followed by an overview of parental mental health in the perinatal period and research into fathers' experience of birth trauma. Finally, this chapter will present a thematic synthesis of the existing literature of fathers who have experienced trauma following witnessing the birth of their child. Considering these findings, a rationale will be presented for conducting the present research, and the research question will be posed.

Birth Trauma

Childbirth is said to be a highly joyful experience and a universally celebrated event for women and their families (Ebirim et al., 2012; Vivilaki & Antaniou, 2009). However, pregnancy and the process of childbirth can affect women physically, emotionally, and psychologically (Dekel et al., 2017; McKinnon, 2020; Olza et al., 2018). Research suggests that between 10 and 20% of women develop psychological difficulties during pregnancy or within the first year of giving birth (Bauer et al., 2014), with depression (Gibson et al., 2009; Slomian et al., 2019; Woody et al., 2021) and anxiety (Ali, 2018; Heron et al., 2004) being identified as the most common psychological disorders.

Research suggests that some women may experience childbirth as traumatic (Ayers & Pickering, 2001; Elmir et al., 2010; Ertan et al., 2021; Lapp et al., 2010; McKenzie-McHarg et al., 2015; Yildiz et al., 2017). The definition of a traumatic birth experience is distinguished between psychological definitions of trauma, versus physical birth trauma as defined by obstetric standards (Iizuka et al., 2018). These definitions will now be explored further. According to the Diagnostic and Statistical Manual of Mental Health Disorders, 5th edition (DSM-V), the definition of psychological trauma requires "witnessing actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association [APA], 2013, p. 271). In the case of birth trauma, this can be contextualised as actual or perceived threat to the life of the mother and/or their baby during childbirth (Ayers et al., 2018; Beck, 2004; Beck & Watson, 2010). Conversely, physical birth trauma has been defined as a physical injury that occurs to the either the mother or the infant as a result of mechanical forces during the childbirth, such as the use of forceps or vacuum to assist delivery (Dumpa & Kamity, 2021; McKinlay et al., 2008; Parker et al., 2005; Wen et al., 2018). According to this medicalised definition of trauma, a birth that has resulted in injury to either the infant or mother, is classified as traumatic and can be remedied by implementing

medical treatment procedures (Abedzadeh-Kalahroudi et al., 2015). However, it is argued that although obstetric wounds can heal with time, psychological wounds can linger even after apparent physical healing has occurred (de Graaff et al., 2018). It is suggested that the experience of birth trauma, as contextualised by obstetric and psychological definitions is complex, and the two may not occur simultaneously. Supporting this, research has found that obstetric complications during delivery do not always result in psychological trauma in mothers (Boorman et al, 2014; MaClean et al., 2000; van Reenen & van Rensburg, 2015). Further, a seemingly 'normal' birth with no obstetric complications has been reported to be perceived as traumatic by women (Beck et al., 2013). This indicates that what constitutes a traumatic birth may be subjective and does not rely on obstetric complications occurring to be perceived as traumatic.

The National Institute for Health and Care Excellence introduced the concept of a traumatic birth into their guidelines in 2014, including both physical and psychological elements of trauma, defining it as "births, whether preterm or full term, which are physically traumatic (e.g., 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" (National Institute for Health and Care Excellence [NICE], 2014).

It is worth noting that many studies that have explored birth trauma, have used definitions according to the criteria for post-traumatic stress disorder (PTSD). This will be discussed in further detail in the next section.

According to the DSM-V, PTSD is a trauma and stressor-related disorder following direct or indirect exposure to, or witnessing of trauma (APA, 2013). PTSD is characterised by the following indications over a period of at least one month: intrusive symptoms; persistent avoidance of stimuli associated with the traumatic event; marked changes in arousal and

reactivity associated with the traumatic event; and negative cognitions and mood (APA, 2013, p. 271). Childbirth is qualitatively different from other traumatic stressors in many ways: it is an anticipated event (L.King et al., 2017); it is viewed by society as positive (Horsch & Ayers, 2016); the mother may fear for her life and/or that of her (unborn) baby (Wijma et al., 1997), and expectations and desires to have more children force women back to the trauma (Holopainen et al., 2020). For these reasons, other labels have been suggested for PTSD after childbirth, which will be explored next.

In line with the DSM-V criteria for PTSD (APA, 2013), some authors have defined birth trauma as PTSD that occurs as a result of the childbirth experience, either from complications, injury, or negative reactions during the birthing experience (Shaban et al., 2013). This has been labelled as PTSD following childbirth ([PTSD-FC], Ayers et al., 2008; McKenzie-McHarg et al., 2015; Poote & McKenzie-McHarg, 2015; Sjömark et al., 2018; Yildiz et al., 2017) or childbirth-related PTSD ([CB-PTSD], Dekel et al., 2017; Thiel et al., 2021), which has been used to a lesser-used extent. Evidence suggests that PTSD-FC may be best conceptualized by two symptom clusters of birth-related symptoms (e.g., re-experiencing the birth) and general PTSD symptoms (e.g., hyperarousal) (Ayers et al., 2009; Ayers et al., 2018; Handelzalts et al., 2018; Nakić Radoš et al., 2019).

Studies have also shown that birth trauma is more strongly related to the subjective experience of childbirth than objective events (Ayers et al., 2016; Slade, 2006), however only a small number of studies have subjectively defined birth trauma. Definitions have included experiencing a loss of control during the childbirth and expecting a bad outcome (Henriksen et al., 2017; Hollander et al., 2017b), and an emotionally traumatic childbirth that has caused ongoing distress (Elmir et al., 2010).

It is apparent that there is no consensus on the conceptualisation of birth trauma and it can range between experiencing distress to birth-related PTSD. Studies have indicated that

"trauma is in the eye of the beholder" and should be defined by the person experiencing it (Beck et al., 2013; Beck, 2004, p. 35). Overall, the researcher argues that the experience of birth trauma may be best understood in line with psychological definitions of trauma and that the woman's subjective perception of childbirth is of primary importance. For these reasons, in the present study, it was decided that the term birth trauma would be self-defined by participants, as has been done by previous studies (Greenfield et al., 2016; Koster et al., 2019). This was decided in order to shift from diagnosis and to allow for trauma to be discussed in terms that are meaningful to the affected person.

The prevalence of birth trauma is difficult to establish as it has been used interchangeably with PTSD (Delicate et al., 2020a). A number of papers suggest that between 20 and 48% of women experience their birth as traumatic (Ayers et al., 2018; Ford & Ayers, 2011; Taghizadeh et al., 2013), with approximately 1.9 to 4% of women developing childbirth-related PTSD (Soet et al., 2003; Yildiz et al., 2017). As there is no single definition of birth trauma, there also is no consistent method of measuring it. In the research, measurement has ranged from asking women if they perceive their birth to be traumatic, to using measurements based on DSM-5 (APA, 2013) diagnostic criteria for a traumatic event such as the City Birth Trauma Scale (CBTS) (Ayers et al., 2018; Delicate et al., 2020a). It is argued that the diversity of the assessment methods used to measure the birth experience increases the complexity of studying this phenomenon.

It is important to recognise the impact of sub-threshold symptomatology, where individuals do not meet the full criteria for a diagnosis of PTSD but still experience distress (McKenzie-Harg et al., 2015). Although no consensus exists on the definition of sub-threshold PTSD (McLaughlin et al., 2015), it has been most usefully defined as when an individual presents as meeting two or three of the DSM-V Criteria B-E (re-experiencing, avoidance, negative alterations in cognition or mood, or hyperarousal) (McLaughlin et al.,

2015). Studies have shown that sub-threshold symptoms may still negatively impact on the mothers' functioning, and there possibly remains a need for therapeutic intervention, demonstrating the need to focus on distress as opposed to solely diagnosis (McKenzie-Harg et al., 2015).

Research indicates that suicide is one the leading causes of deaths as a result of factors relating to pregnancy and the postnatal period in the year after childbirth, (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE], Knight et al., 2020). Studies also indicate that PTSD is a risk factor for suicide (Bentley et al., 2016; Fox et al., 2021). Depression and anxiety after childbirth have been thoroughly investigated and explored, however less attention has been given to traumatic responses to birth (Vesel & Nickasch, 2015). The researcher argues that more attention needs to be given to birth trauma that may have similar long-lasting and far-reaching implications as other mental health difficulties in the perinatal period.

The upcoming section will outline psychological theories of birth trauma and the risk factors associated with developing it.

Psychological theories of birth trauma

Research into birth trauma has been largely atheoretical, although theories into PTSD and stress have been identified as relevant (McKenzie-Harg et al., 2015).

PTSD and stress.

Lazarus and Folkman's (1984) transactional theory of stress and coping postulates that stress arises when the perceived threat to an individual is high, and their coping ability is perceived to be low. It can be argued that the threat of injury or death is high during childbirth due to the mother's lack of responsibility during the labour and their position as a patient and not medical professional, resulting in them perceiving their ability to cope to be

low. This provides a suggestion for why mothers may experience a birth as stressful which may lead to appraising it as traumatic. Supporting this, Ayers et al. (2016) found that PTSD after birth was associated with poor coping and increased stress.

Diathesis stress model

The diathesis-stress model outlines that there is an interaction between an individual's predisposition to vulnerability and exposure to stressful experiences (McKeever & Hiff, 2003). Recent diathesis-stress models have postulated that pre-trauma individual risk factors (i.e., the diatheses) contribute to the vulnerability to a situational trauma (Bomyea et al., 2012). According to this model, the less withstanding the individual's diathesis, the lower the severity of the trauma needed to initiate PTSD (Gandubert et al., 2016). This model has been used to propose a model of postpartum PTSD (Ayers, 2004; Ayers et al., 2016), and may be used to help account for differences in why some women report experiencing birth trauma, whilst others do not, despite having seemingly similar deliveries. The risk factors for experiencing a birth as traumatic will be explored in the next section of this paper.

Risk factors

Several studies have suggested that there is a number of risk factors that can interact to affect women's experiences of childbirth and can result in the experience being appraised as traumatic. Prenatal risk factors, risk factors during delivery and postnatal risk factors will be discussed below.

Prenatal risk factors

Studies have shown that previous abortion (Sentilhes et al., 2017), past experience of mental health difficulties (Simpson & Catling, 2015), severe fear of childbirth and a history of trauma have been identified as psychological risk factors for developing a traumatic response to childbirth (Dekel et al., 2017; Verreault et al., 2012). It is worth noting that the study by Verreault et al. (2012) was conducted on a sample of Canadian women, therefore generalisability is questioned, however the systematic review by Dekel et al. (2017) included 36 studies across 15 countries and reported similar results. Conflicting findings have reported that nulliparous women (i.e., those having their first child) were more at risk of PTSD (Söderquist et al., 2002), however when mode of delivery was controlled for, the effect of parity was removed.

Taken together, it can be argued that birth trauma may be the consequence of an unprocessed pre-existing PTSD which then becomes symptomatic following childbirth (Sentilhes et al., 2017), rather than the events that occur during delivery.

Risk factors during delivery

High levels of physical pain during labour has been associated with birth trauma (Soet et al., 2003), which has also been found in women who have had multiple children (Ballard et al., 1995). Studies have also reported that having obstetric birth complications can lead to a traumatic response to birth, such as an assisted vaginal or emergency caesarean section birth (Ayers et al., 2016; Chabbert et al., 2021; Ertan et al., 2021). It is suggested that this is because assisted delivery can indicate to the mother that there is a threat to either her life and/or that of her baby. The methodological approach to obtaining this data can be questioned as the research by Ayers et al. (2016) and Chabbert et al. (2021) were based on a meta-analysis and systematic review respectively, and the individual quality of the studies

included varied, as well as the studies' diverse measures of similar constructs. Further, the study by Ertan et al. (2021) utilised a survey method to obtain data, therefore the findings should be interpreted with caution.

Low satisfaction regarding support from partners (Andersen et al., 2012; Ayers et al., 2016; Chabbert et al., 2021), and feeling adequately cared for and listened to by healthcare staff during delivery, have been associated with the appraisal of birth as traumatic (Creedy et al., 2000; Henriksen et al., 2017; Menage, 1993; Olde et al., 2006; Soet et al., 2003). Supporting this, a systematic review conducted by Patterson et al. (2019) found that across studies, negative perceptions of interactions with care providers was a significant predictor of PTSD-FC. However, as the studies were synthesised by a single reviewer with a potential for bias to the presentation of the findings, caution must be taken when interpreting the results.

Violations of expectations and lack of control during delivery have been consistently associated with appraisal of birth as traumatic (Czarnocka & Slade, 2000; Lyons et al., 1998). Control in the research on traumatic birth experiences has referred to the ability to make decisions during the birth (Greenfield et al., 2016; Thomson & Downe, 2010). Research into the role of perceived control in childbirth has generally found that increased perceived control is associated with less pain medication usage and more fulfilment, satisfaction, and emotional well-being after birth (Green & Baston, 2003). However, the studies employed basic unidimensional measures of control based on Likert scales, whilst childbirth can be viewed as a multidimensional experience. These measures may not capture fluctuations in perceived control during childbirth, where medical decision may be made and changed at any point based on clinical need.

Postnatal risk factors

It is noted that there has been a lack of research into postnatal factors associated with birth trauma following childbirth. Postnatal pain has been associated with PTSD after birth (Creedy et al., 2000), but this has not been a consistent finding (Czarnocka & Slade, 2000). Overall, it can be suggested that the diatheses of women who have a history of trauma and a subjective negative experience of birth due to a lack of control, violation of expectations, or poor support from healthcare staff and/or their partners, combined with pain experienced during labour can result in them being more susceptible to developing a traumatic response to birth.

Mothers' experience of birth trauma.

Most research on birth trauma focusses on the mother's experience (Taghizadeh et al., 2013). Qualitative studies have found that women's experience of birth trauma have identified negative interactions with care providers as being a key factor in the experience of trauma (Elmir et al., 2010; Reed et al., 2017; Thomson & Downe, 2010). The research indicates that for mothers, birth trauma has a number of implications on the mother and her relationships, including a perceived reduced bond with her baby and the consequent difficulties with breastfeeding (Beck & Watson, 2008; Dekel et al., 2018; Garthus-Niegel et al., 2017), and relationship difficulties with their partner (Garthus-Niegel et al., 2018). However, studies exploring the associations between birth trauma and mother-infant bonding have reported inconsistent findings, with some studies reporting an association between birth trauma and bonding (Cook et al., 2018; Dekel et al., 2018; Parfitt & Ayers, 2009), and others failing to find this association (Nakić Radoš et al., 2020).

It can be argued that the inconsistent findings may be the result of the variation in the conceptualisation of birth trauma. A limitation of these studies is that they measured mother-

infant bonding using quantitative measures which may not give enough insight about mothers' bond with their babies, due to having to select predefined and predetermined answers. It is viewed that clinical interviews may have provided more in-depth insight into the experience of the mother-infant bond. A further criticism is ethnic homogeneity of the sample across studies, with most participants being from White ethnic backgrounds. It is argued that the impact of birth trauma on the mother-infant bond has not been extensively examined in minority ethnic populations. The next section of the paper will consider this further.

Race, ethnicity, and birth trauma.

Research has indicated that the experiences of expectant mothers from minority ethnic backgrounds are significantly different in comparison to expectant mothers from White ethnic backgrounds, reporting that they were more likely to perceive their treatment by professionals as discriminatory (Watson & Downe, 2017). Taking the focus on the experiences of people from minority ethnic backgrounds necessitates understanding some key concepts, which is where the researcher now turns. Given that the researcher is interested in looking at the experiences of Black men, the upcoming sections will now consider the concepts of race, culture and ethnicity in relation to how people from various groups are categorised in the UK. Following this, racism will be outlined and discussed in relation to theories of race-related stressors that may contribute to the perception of an event as traumatic. Finally, the importance of considering intersectionality when considering the experiences of people from minority ethnic backgrounds will be outlined, with a focus on how their distinct identities intersect and contribute to different experiences.

The definitions of race, ethnicity, and culture.

When considering literature on people from Black, Asian and minority ethnic backgrounds, it is important to consider the concepts of 'race', 'ethnicity' and 'culture', to differentiate between the terms and their various derivatives which are often used interchangeably as though synonymous (Bhopal, 2004). In the absence of distinct definitions of these terms, it can be argued that one's ability to comprehend the processes and identify the best means of resolving the underlying problems regarding minoritised[1] populations, will remain limited (Ballard, 2002). This can be reflected in the NHS Better Births paper, which proposed a five-year plan to improve outcomes of maternity services in England (NHS England, 2016). In the paper, a recommendation has been made for clinicians to tailor interventions based on cultural differences, with the main example being that of language (NHS England, 2016). Although language barriers are more likely in minority ethnic groups due to English not being the primary spoken language(Zangi, 2015), statistics of Black mothers in the UK who have higher rates of maternal mortality (Knight et al., 2020), and for whom English is typically a first language (Bagley, 1979), suggest that we must look beyond culture as the primary target for intervention. This will be discussed in a later section of the paper.

Race is argued to be a socially and politically defined construct used to classify people into distinct racial types based on imagined genetic differences between people (Fernando & Keating 2008). The notion of race being determined by biological differences has been widely discredited (Baker et al., 2017; Jorde & Wooding, 2004; Yudell et al., 2016). It is argued that constructions of race vary widely across societies (Grosfoguel et al., 2015). On

[1] The term, "minoritised," calls attention to the institutional processes through which religious, racial, and cultural groups are rendered into a minority rather than presuming this status based on prior or inherent identity.

the other hand, ethnicity is argued to be contextual, related to group identity and a sense of belonging to a particular group informed by cultural, historical, or religious affiliations (Desmond & Emirbayer, 2009; Fernando, 2004; Mason, 2000). It is argued that ethnicity creates distinctions and identities within racial groups, e.g., 'Asian' could refer to someone from a number of Asian countries, including Singapore, China and Indonesia, denoting cultural differentiation (Desmond & Emirbayer, 2009). For this reason, it is viewed that race and ethnicity cannot be separated from each other (Brubaker et al., 2004), although unlike 'race', ethnicity is argued to be fluid and individuals can navigate multiple ethnic identities depending on the degree to which the identity is stigmatised (Fernando, 2004).

Lastly, culture has been defined as involving specific group practices, values and beliefs that are contextual and evolving (Fernando, 2010). Within research, it has been argued that people from White ethnic backgrounds are placed as the normative position, with 'White culture' identified as the cultural norm (Nolte, 2007), and other cultures subjugated in comparison (Odusanya et al., 2017). It can be argued that the racial minoritisation and collective grouping of people from ethnic backgrounds that are not White, is an example of this (Fernando et al., 2005). The classification of ethnicities and the grouping of minority ethnic people using collective terms will be explored further in the next section.

***Classification of ethnicity*.** In England and Wales, ethnic groups are categorised according to the 2001 Census, which distinguishes between the 18 'broad' and 5 'detailed' ethnic groupings (Office for National Statistics [ONS], 2001), as shown in Table 1. Due to the White ethnic group being defined as the largest ethnic group in England and Wales, the remaining groups are viewed as ethnic minorities (Race Disparity Unit, 2020b). There are two main terms used to group people from minority ethnic backgrounds: Black, Asian, and Minority Ethnic (BAME) has been used to describe people who experience disadvantage or are discriminated against by virtue of their physical appearance or skin colour, including White minorities (Aspinall, 2021; Institute of Race Relations, 2018), whilst Black and Minority Ethnic (BME) has been used to refer to people who still experience disadvantage, but are from non-White cultural and ethnic backgrounds (Institute of Race Relations, 2018).

The use of the terms 'BAME' and 'BME' have been debated as an all-encompassing, collective label to describe people who are not White, and has been argued to not consider the wide range of unique identities that are encompassed within the ethnic groups (Aspinall, 2020). It is argued that the collective labels ignore the different geographical, behavioural, social and cultural backgrounds of individuals (Khunti et al., 2020). Throughout this paper, the researcher will use the term 'minority ethnic' when discussing people who identify as being from minority ethnic backgrounds because this is a term that is widely used in British society and healthcare research (Aspinall, 2020; Black British Academics, n.d.) and is a term that was deemed as more appropriate by the researcher. Where published studies have used the term 'BAME' to describe participants, this is the term that the researcher will adopt, however if the ethnic group of concern has been differentiated by researchers, this will be highlighted. The researcher acknowledges the controversy around using the 'BAME' term, which is currently being debated by the Commission on Race and Ethnic Disparities and is under scrutiny about whether it should be abolished (Mohdin & Walker, 2021, para. 2).

Table 1.

Classification of ethnicity according to the 2001 UK census

Broad ethnic groups	**Detailed ethnic groups**
White	English, Welsh, Scottish, Northern Irish or British Gypsy or Irish Traveller Any other White background
Mixed or Multiple ethnic groups	White and Black Caribbean White and Black African White and Asian Any other Mixed or Multiple ethnic background
Asian or Asian British	Indian Pakistani Bangladeshi Chinese Any other Asian background
Black, African, Caribbean, or Black British	African Caribbean Any other Black, African, or Caribbean background
Other ethnic group	Arab Any other ethnic group

***Intersectionality*.** Originating from the work of Black feminism, the intersectionality framework postulates that every person's identity consists of multiple social categorisations e.g., race, class, religion, gender, geographic location, and sexual orientation (Crenshaw, 1991). According to the framework, these social categories are not independent and unidimensional but multiple, interdependent, and mutually constitutive (Crenshaw, 1991; Cuadraz & Uttal, 1999). The intersectionality framework considers the interconnecting and conflicting dynamics of these various identity distinctions, and postulates that the multiple social categories intersect at the micro-level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro social-structural level (e.g., racism, sexism or heterosexism) (Bowleg, 2012; Cho et al., 2013; Rice et al., 2019).

Acknowledging the existence of multiple intersecting identities is important in understanding the complexities of health disparities for populations from multiple historically oppressed groups. These groups include ethnic minorities, people who identify with a sexual orientation that is not heterosexual, low-income people, and those with disabilities (Bowleg, 2012). For the present study, intersectionality, and the specific intersect of ethnicity and gender, is important to consider due to the focus on the experiences of Black men. The upcoming sections will explore racism within the UK with reference to the experiences of people from minority ethnic backgrounds.

Racism. Racism is defined as a system of oppression that is based on ethnic and racial categories and domination, where one group is designated as superior and the other(s) as inferior, resulting in the use of the perceived differences to justify inequity, exclusion, or domination (Bulhan, 1985; Kendall & Hatton, 2002). Racism is suggested to occur at both micro and macro levels of society, where it is developed through specific beliefs and behaviours, and perpetuated and maintained through the structures and procedures of institutions (Burke & Harrison, 2000). Racism has been recognised as a social determinant of health and a cause of ethnic inequalities in health (Williams & Mohammed, 2009). The present study will consider institutional racism in the UK, as the phenomena of interest is the experience of birth in a health context that occurs within the institute of the NHS.

Institutional racism within the UK. Institutional racism in the UK has been described by the Stephen Lawrence Inquiry (Home Office, 1999), as a collective failure of an organisation to provide appropriate services to people because of their ethnicity. It is argued that institutional racism involves attitudes and behaviours that disadvantage minority ethnic groups through prejudice, discrimination, and racist stereotyping (Home Office, 1999).

Institutional racism and systemic ethnic inequalities in England have been especially identified in NHS mental and physical health services. Studies have highlighted the disproportionate diagnosis of serious mental illness in people from minority ethnic backgrounds (Bhui et al., 2018; Halvorsrud et al., 2019) and Black people found to be four times more likely than White people to be sectioned under the Mental Health Act (Department of Health & Social Care, 2021), and to have contact with the criminal justice system prior to treatment, despite no consistent evidence of increased risk of violence (Bhui et al., 2015). Additionally, publications regarding COVID-19 have highlighted the disproportionate effect of COVID-19 on people from minority ethnic backgrounds who were found to have higher death rates between 1.7 to 3.5 times higher than White British people (Kirby, 2020).

Further, there have been suggestions that the NHS is institutionally racist, with staff from minority ethnic backgrounds being found to be less likely to be awarded senior grade roles and more likely to experience bullying, grievances, and disciplinary action (Kline, 2014; (Workforce Race Equality Standard [WRES], 2020). Adding to this, a report has found that doctors from minority ethnic backgrounds were twice as likely as White doctors to feel pressured to see patients in high-risk settings without adequate personal protective equipment during the COVID-19 pandemic (Kirby, 2020). Lastly, studies have indicated that patients have reported being treated differently to their White counterparts, which will be discussed in an upcoming section. For these reasons, it can be suggested that institutional racism is a unique source of stress impacting the mental health of those from minority ethnic backgrounds (Chakraborty et al., 2010; Klonoff et al.,1999).

The following section will refer to theories around stress and PTSD to understand the potential impact of racism and other race-related stressors on people from minority ethnic backgrounds.

Psychological theories of birth trauma considering race-specific factors

***Differential Exposure Hypothesis*.** Gibson (2014)'s Differential Exposure Hypothesis postulated that individuals in disadvantaged social status groups are exposed to more stressors than those occupying advantaged social status groups. Research suggests that people from minority ethnic backgrounds are disadvantaged because of the social prejudice and systemic oppression that they have experienced (van Wormer & Link, 2016), and although a minority in the UK, people from minority ethnic backgrounds are overrepresented in statistics of unemployment (Department for Work and Pensions, 2014; ONS, 2021), the UK prison population (Ministry of Justice, 2020) and more recently, in the death toll for COVID-19 (Khunti et al., 2020; Kirby, 2020).

***Racism-related stress*.** Research suggests that racism may be a unique stressor for people from minority ethnic backgrounds. Seaton (2003) found that due to racism, African Americans experienced more stressful events compared to White European Americans. Clark et al. (1999)'s biopsychosocial model postulates that the perception of an environment as stressful results in psychological and physiological stress responses that are influenced by socioeconomic factors and psychological factors. The model identified racism as a significant stressor for African Americans and argued that over time, these stress responses influence health outcomes. Supporting this, studies have indicated that stressful life events and race-related stressors impact on the psychological and physical health of African Americans (Utsey et al., 2008). Research has found that African Americans tend to have higher rates of stress-related diseases (e.g., heart disease, cancer), with more negative outcomes in comparison with other ethnic groups (Brondolo et al., 2009; Geronimus et al., 2010). It is argued that these health disparities may originate from African Americans' chronic exposure to race-related stressors (Bowen-Reid & Harrell, 2002; Pieterse & Carter, 2010). Although

the literature on race-related stressors is dominated by US-based studies, a paper in the UK has found similar findings, with people belonging to ethnic groups who perceived racial discrimination, experienced poorer mental and physical health in comparison to those who did not report this (Hackett et al., 2020). However, caution must be taken from interpreting the results as participants were able to attribute their experience to other forms of mistreatment (e.g., sexism),

It can be suggested that racism as a chronic stressor can make an individual more susceptible to developing a traumatic response to events. Studies have indicated that chronic stress can contribute to PTSD symptoms after exposure to a traumatic event, and alter the patterns of cortisol, the steroid hormone that is responsible for mediating the "fight or flight" response to stressful situations (McEwen, 2007). It has been indicated that reduced cortisol is associated with chronic exposure to stress and can be used as a biomarker of the stress response (Hajat et al., 2010). Supporting this, research studies have found that Black women and men have reduced cortisol levels in comparison to same-age White counterparts (Allen et al., 2019; Hajat et al., 2010; Samuel et al., 2018), with reduced cortisol levels associated with poorer physical and mental health. It is worth noting that across the studies, participants reported differences in smoking habits and sleep schedules, which may have influenced the levels of cortisol levels found (Cohen et al., 2019). Though, research has linked smoking (Sims et al., 2016) and poor sleep (Slopen et al., 2016), as a coping mechanism for racial discrimination. However, participants were not asked explicitly about race-related stressors, suggesting that other factors may be associated with the findings. Further, participants were aged between 45 and 90, suggesting caution in generalising the results to younger populations.

Taken together, it can be hypothesised that exposure to substantial stressors many Black men face, such as racism and discrimination, may accelerate a trauma response to a

potentially traumatic situation. For this reason, it can be suggested that a difficult birth may be more likely to be perceived as traumatic by Black people, due to chronic stressors resulting in increased sensitivity to adverse experiences (Bomyea et al., 2012;). However, the researcher is aware that there are no published studies that have explicitly examined this.

A limitation of Clark et al. (1999)'s biopsychosocial model is that it does not consider individual resilience factors which could influence how individuals respond to stressful events. A limitation of the supporting research studies are that they refer to African Americans who live in the United States (US), and the researcher argues that the US and UK are structurally and systematically different due to the differences in their history and lived experience, (e.g., colonisation and slavery) (Morgan, 2007). However, the focus on African Americans only highlights the lack of literature on Black British people, especially men.

The upcoming sections will outline the research into the experiences of people from minority ethnic backgrounds who have used health services in the US and UK, respectively. Due to the focus on birth trauma for this paper, the experiences of women have been highlighted.

The experiences of people from minority ethnic backgrounds

Experiences in the US.

Experiences in physical health services. An extensive number of studies have shown that there are ethnic disparities in pain management by healthcare providers in the US. Research has found that in accident and emergency departments, Hispanic and Asian patients were less likely to have their pain assessed and given pain medications in comparison to patients from White ethnic backgrounds (Kennel et al., 2019). Hewes et al. (2017) reported that adult and child patients from minority ethnic backgrounds received pain medication less often than White patients in traumatic injury services. In a study that explicitly reported the experiences

of African Americans who experienced trauma injuries, Young et al. (2013) found that African American patients were 50% less likely to receive morphine, a pain relief medication, in comparison to White patients. It is worth noting that in Young et al. (2013)'s study, not all patients were asked to give a pain score and scores between ethnic groups were not compared, suggesting that White patients may have given a higher pain score. However, the finding of an ethnic disparity in pain management has been consistently found in studies on migraines, back and abdominal pain, with this disparity of African Americans being less likely to receive pain mediation evident across both adults and children (Dickason et al., 2015; Johnson et al., 2013; Shah et al., 2013; Tamayo-Sarver et al., 2003). It can be suggested that these differences may be understood in terms of medical professionals holding a belief of race/ethnicity being a biological construct which indicates biological differences between people from different ethnic groups. This is supported by Waytz et al. (2014)'s study which found that most participants assumed that people of African American descent feel less pain than White people. However, caution must be taken when generalising these findings as the sample consisted of White undergraduate students.

***Experiences in mental health services*.** Research has indicated the people from minority ethnic backgrounds have less access to mental health services, are less likely to receive the treatment that they need and more likely to receive poor quality care when they received treatment (Office of the Surgeon General US, 2001). Studies have also found that women from minority ethnic backgrounds were less likely to receive mental health treatment for perinatal mental health difficulties compared to White women (Chang et al., 2016; Geier et al., 2015; Glasheen et al., 2015). Salameh et al. (2019) reported similar findings, even when employment status, income and health insurance were controlled. A study by Kozhimannil et al. (2011) also found that although African American and Hispanic women took a longer time

to initiate treatment, they were less likely to receive follow-up care once discharged. It has been suggested that poor recognition for mental health difficulties in minority ethnic populations may influence help-seeking behaviours (Zuvekas & Fleishman 2008) which may explain the delay in initiating treatment, however does not appear to explain the disparity in the lack of follow up care.

Experiences in maternity services.

Studies indicate that racial and ethnic disparities exist in maternal outcomes and health care quality (American College of Obstetricians and Gynecologists, 2015). Morris and Schulman (2014) found that women from minority ethnic backgrounds were more likely to experience anaesthesia failure and for this to be ignored by healthcare professionals. Participants in the same study also reported that concerns about anxiety were not taken seriously by doctors. Glance et al. (2007)'s study found that privately insured African American women were less likely to receive epidural anaesthesia than uninsured White women after having a caesarean. Further, Johnson et al. (2019) found that after a caesarean birth, African American and Hispanic women were evaluated for pain less frequently, and despite reporting higher pain scores, were found to receive less pain medication in comparison to their White counterparts. Similarly, a study by Badreldin et al. (2020) found despite reporting similar pain scores, African American and Hispanic women were less likely to receive a pain assessment and have access to pain medication than White women. A criticism of this study is that it grouped together the experiences of Asian and Hispanic women, which were then presented as a homogenous experience. It is important to consider the interaction of race and gender, as well as other facets of identity that may have interacted, such as class, as they may have had an indirect adverse effect on health (Bowleg, 2012).

Studies have highlighted the phenomenon of 'superhumanization', which involves depriving people of human character and attributes (Waytz et al., 2014) and incapable of experiencing pain (Gray & Wegner, 2009). It has been suggested that this process involves representing others as nonhuman. In the study by Waytz et al. (2014), participants associated African American targets with superhuman qualities (e.g., mysticism and magic), quicker than human words (e.g., person, individual, and citizen). Although this finding can be viewed in the context of previous research which explored beliefs held by medical professionals about the pain threshold of Black women (Jomeen & Redshaw, 2013; Lyons et al., 2008). However, the participants were White undergraduates who were given the task under artificial conditions, and caution must be taken in generalising these findings to professionals and other people outside of the study setting.

Potential biases and beliefs among healthcare providers about Black people have been explored. Unconscious bias is defined as the product of associations made outside of conscious awareness (i.e., stereotyping) that lead to the negative treatment of groups of people based on characteristics such as race, gender, and age (FitzGerald & Hurst., 2017). Since as early as the 16th century, there has been an overarching belief that Black people's bodies are biologically and fundamentally different from those of their White counterparts (Hogarth et al., 2019). Implicit racial biases manifest within our society, with pain perception in medical practice being just one of many examples of this.

Research by Hoffman et al. (2016) reported trainee physicians in the US held false stereotypical beliefs about biological differences between White and African American people. In the study, the trainees rated hypothetical African American patients' pain as being lower and they were less likely to be prescribed pain medication. Another study by Calabrese et al. (2014) found that medical students were less likely to prescribe medication to prevent

human immunodeficiency virus (HIV) infection in hypothetical African American patients in comparison to White hypothetical patients. Further, a review of published studies by Shavers at al. (2012) found that when health-care professionals held stereotypes, their attitudes could lead to discrimination in provision of care and in health outcomes for patients, contributing to health disparities amongst minority ethnic clients.

The assumptions people make have a wide range of implications for how people are treated in society, particularly Black women (Rosenthal & Lobel, 2011). Studies also indicate that medical providers who are under pressure may rely on stereotypes to make decisions (Kunda & Spencer, 2003).

Although reporting significant findings, as the healthcare system in the US is based on an insurance-based system (McKillop et al., 2018), caution must be taken when generalising the findings to the UK healthcare system, where healthcare is free and not determined by insurance class or ability to pay. However, parallels can be made to the alleged 'postcode lottery' in the UK, where it has been argued that there are geographical variations in the provision and quality of public services and it may be argued the healthcare may be determined by the geographic location in which one lives (Graley et al., 2011; Russell et al., 2013). This has been found in studies looking at responses to cardiac arrests out of hospital (Lyon et al., 2004), access to cancer treatment (James et al., 2004), and access to surgery (Nasr et al., 2008). Although this may suggest that there may be potential discrimination against minority ethnic people who are more likely to live in densely populated, low socioeconomic status areas (Kirby, 2020), the author is not aware of any research studies that directly support a direct link between the two.

Additionally, the accounts were retrospective in nature and data were obtained by looking at medication charts and reported pain scores, which could have been subject to data-entry errors. Further, many of the studies included medical students as participants and involved

the use of hypothetical clients. It can be argued that such studies lack generalisability to real-life applications of serious medical decisions being made that have consequences on people's lives.

The experiences of African American women

A study by Edwards et al. (2020) found that the risk of premature births was associated with maternal clinical factors such as hypertension and social factors including race, ethnicity, and socioeconomic status, with African American women more likely to deliver prematurely. The findings from this paper suggests that the experiences of women in maternity services may intersect with gender, class, and ethnicity and this may have serious implications for the wellbeing of the mother and her baby. However, it is worthy of note that the women were already at medical risk from premature birth. Additionally, the sample size was small, consisting of only 12 participants, suggesting caution in generalising to wider populations. The upcoming sections will review the experiences of African American women specifically.

Studies have indicated that African American women were more likely to report psychological distress during pregnancy due to racial discrimination and believed that this would have a negative impact on their pregnancy and baby (Dove-Meadows et al., 2020). Supporting this, studies have found that African American women who reported experiencing racial discrimination were associated with having low-weight premature babies (Braveman et al., 2017; Giurgescu et al., 2011; Giurgescu et al., 2018; McLemore et al., 2018). This finding highlights the perception of some African American mothers who believe that they experience unique stressors due to their ethnicity.

A US-based study reported a higher rate of maternal mortality among African American women across income (Singh, 2010) and education levels (Petersen et al., 2019).

Studies have also found that African American women were three times more likely to die from common pregnancy complications and preventable causes than White women, despite similar prevalence rates (Louis et al., 2015; Tucker et al., 2007). Further, a study by Srinivasjois et al. (2012) found that couples of mixed ethnicity parentage were at higher risk for adverse pregnancy outcomes when the mother was African American. Taken together, it appears that African American women and their babies may be significantly more at risk of serious adverse pregnancy outcomes, in comparison to other women from minority ethnic backgrounds, as well as White women.

The following section will outline and explore the experiences of people from minority ethnic backgrounds who have used health services within the UK, concluding with a focus on the experiences of Black women.

Experiences in the UK.

***Experiences in physical health services*.** Unlike in the US, it is evident that the research in the UK into racial disparities in healthcare in relation to treatment for pain in the UK is no as extensive, which emphasises a need for exploration. However, ethnic inequalities in physical health generally in the UK has been widely documented (DOH, 2009; Karlsen & Nazroo, 2010; Smith et al., 2000). Research indicates that individuals from minority ethnic groups are more likely to report poorer general health compared to people from White ethnic backgrounds (Smith et al., 2009) and to report more chronic illnesses (Harding & Balarajan, 2000). Individuals from minority ethnic backgrounds have also reported lower levels of dissatisfaction with services (Pinder et al., 2016), longer waits for appointments (Mead & Roland, 2009) and have been found to have experienced higher rates of patient safety events in hospitals (Chauhan et al., 2020).

It has been argued that these inequalities in health are caused by social and economic inequalities underpinned by ethnicity (Nazroo, 2003).

Experiences in mental health services. Studies show that people from minority ethnic backgrounds are less likely than White British people to contact their GP about mental health difficulties and to be referred for specialist mental health services (Memon et al., 2016). Research has indicated that people from minority ethnic backgrounds were also less likely to access mental health services for trauma and other mental health problems (Gavrilovic et al., 2005). Further, studies have shown that reported barriers to accessing services include cultural competence of clinicians (Mclean et al., 2003) and cultural models of illness (Knifton et al., 2010).

However, once in contact with mental health services, studies have shown that people from minority ethnic backgrounds are more likely to report negative experiences of services and poorer outcomes (Synergi, 2018). Research indicates that people from minority ethnic backgrounds use alternatives to formal mental health services, such as their social networks (Memon et al., 2016) or spirituality, especially in Black communities (Breland-Noble et al., 2015; Reed & Neville, 2014). A study by Memon et al. (2016) found that men from minority ethnic backgrounds described their ability to deal with problems in ways associated with their ideas of masculinity e.g., pride and strength, and did not view services as being “for them”. Others noted that they did not know how to access help. Further, participants who did seek help, expressed annoyance at having to explain the realities and experiences of being a person from a minority ethnic background. The conclusions from this study reported the same findings for both women and men, however participants suggested that men from BAME backgrounds were less likely to talk about their difficulties with mental health professionals in comparison to women. A criticism of this study is that it only looked at people from

minority ethnic backgrounds who lived in Brighton, England. It can also be argued that the sample was homogenised on the basis of membership to a minority group, without consideration of age, social class or educational background.

A limited number of studies have investigated the experiences of mothers from minority ethnic backgrounds who have accessed perinatal mental health services. Studies have suggested that although women from minority ethnic backgrounds have a higher incidence of common mental health disorders during the perinatal period, such as anxiety and low mood, compared to the majority White population (Prady et al., 2016a), these mental health disorders are less likely to be detected and treated (Cooper et al., 2010; Prady et al., 2016b). A study by Jankovic et al. (2020) found that women from minority ethnic backgrounds had lower access rates to community perinatal mental health services and a higher proportion of involuntary admissions under the Mental Health Act[2]. The study also found that when these women did receive treatment, they had fewer session cancellations in comparison to White women. This indicates that access to rather utilisation of services may be a problem for these women, although due to it being a quantitative study using previously collected national data, the exact reasons for difficulties utilising services need further exploration. Studies have highlighted barriers to perinatal mental health services for women from minority ethnic backgrounds in the UK, including language/cultural barriers, unclear referral policy and stigma (Sambrook et al., 2019; Watson et al., 2019), as well as stereotypes of being strong, as has been found in women from Black African and Caribbean cultures (Kalathil, 2011).

Experiences in maternity services. Studies have found that mothers from minority ethnic backgrounds were less likely to report that they felt as though they were always treated

[2] The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

respectfully and involved in decisions around their care or treated with compassion (Henderson et al., 2013; Jomeen & Redshaw, 2013) and more likely to report discrimination (Watson & Downe, 2017) and racism (Lyons et al., 2008). Research has also shown that healthcare professionals' attitudes had a significant impact on how mothers from minority ethnic backgrounds experienced maternity care (McLeish & Redshaw, 2019) and has been cited as a barrier to help-seeking for perinatal mental health difficulties (Watson & Soltani, 2019). However, the study by McLeish and Redshaw (2019) looked at mothers who had multiple disadvantages, including socio-economic disadvantage and physical health problems, therefore did not strictly examine ethnicity. Further, the systematic review by Watson and Downe (2017) only examined the experiences of Romani women, and the study by Watson and Soltani (2019) utilised a survey method, which may have limited the experiences able to be shared by participants. However, a strength of these studies is that combined, they sampled a large group of women from over 13 different minority ethnic backgrounds, accounting for varied life experiences.

Research indicates that there are a number of stereotypes that exist about women from minority ethnic backgrounds during the labour process, which has been found to influence midwives' judgements when interacting with them, including that minority ethnic women are too demanding, have a lower pain threshold, were more likely to make a fuss about pain and were "different [to them]" (Bowler, 1993, p. 158; Jomeen & Redshaw, 2013; Lyons et al., 2008). References were also made to adapting to different cultural expectations being and language barriers impacting on workload (Lyons et al., 2008). As research indicates that impersonal staff attitudes and poor support from healthcare staff are risk factors for birth trauma, these are important findings to consider. (Mannava et al., 2015).

There are a number of limitations of the aforementioned research studies. The study by Jomeen and Redshaw (2013) used secondary analysis from a survey conducted three years prior to obtain their data; it can be argued that changes in social, cultural or political norms may have occurred in this time, potentially resulting in investigators misinterpreting the original data (Ruggiano & Perry, 2019). Further, the study by Lyons et al. (2008) occurred during a period (2002-2003) where the ethnic profile in Ireland had experienced a significant change from being relatively homogeneous White Irish population to a more multi-ethnic demographic. It can be argued that the experiences shared by the healthcare providers who participated in the study, and their perceptions of minority ethnic women, may not be representative of other healthcare providers who have lived and worked in areas where cultural and ethnic diversity may have long existed since the second world war, such as in England (Ashcroft & Bevir, 2017; Thane, 2010) and may have had more exposure to different populations of people. However, the researcher is also aware that exposure is not synonymous with understanding and tolerance, and that one can still hold stereotypical views despite extensive experience with and exposure to the group of reference (Kunda & Spencer, 2003).

Taken together, it is evident that there may be ethnic inequalities in access to, provision of and experience of services. It is noted that previous studies have ignored the heterogeneity of ethnic groups, with few research studies distinguishing between the experiences of Black people from those of Asian and other backgrounds. Research also suggests that African American women may experience unique, chronic stressors that other ethnicities do not, such as living in poorer geographical areas, exposure to racism and racial discrimination (Mustillo et al., 2004) and increased risk of both maternal and infant mortality (Giurgescu, 2018), which has also been found in Black women in the UK (Knight et al.,

2020). Due to this highlighted disparity, the next section will refer to the specific experiences of Black women in the UK who have utilised health services, and will make reference to the disproportionate maternal mortality rate of Black women, as has been found in UK research and reviews.

The experiences of Black women in the UK.

Within the 2016 NHS Long Term Plan, there is a statement which proclaims that "having a baby is now safer than 10 years ago" (NHS, 2016, p. 46). However, existing evidence suggests that minority ethnic women in the UK and their babies are at a higher risk of adverse perinatal outcomes compared with the White population overall (ONS Childhood, Infant and Perinatal Mortality in England and Wales, 2014). Studies have shown that women from minority ethnic backgrounds have been found to be more at risk of their baby dying in the womb, or soon after birth, with stillbirth and neonatal mortality rates both around 60% higher than for babies of White ethnic backgrounds (Draper et al., 2020). Inquiries into maternal deaths in the UK over the last seven years also found that Black women were four to five times more likely to die in childbirth than Asian and White women (Knight et al., 2020; Knight et al., 2018), which was two times higher than the statistics reported in the US (Louis et al., 2015; Tucker et al., 2007). Additionally, the statistics indicated that babies who are Black or Black British, had a 50% higher risk of perinatal mortality compared to babies who were from a White ethnic backgrounds (NHS England, 2016). This supports that view that ethnicity may be a significant risk factor for maternity mortality rates as opposed to culture, which was suggested as a key focus for improvement by a review into improving maternity care in the UK (NHS England, 2016). The connection between risk and poverty is also clear, with women living in the most deprived areas reportedly having an 80% higher risk of their baby dying (Draper et al., 2020) and people from minority backgrounds being 50% more likely to live in poverty

(Social Metrics Commission, 2020). This supports the importance of considering intersectionality on health outcomes, in this case, the intersect between gender, class and ethnicity and the varying levels of privilege that each of these identity distinctions hold (Crenshaw, 1991). However, as the medical treatment under the NHS is free for all who are lawfully settled and resident in the UK (GOV UK, 2021, para. 4 & p.7), unlike the insurance-based healthcare system in the US (McKillop et al., 2018), there are questions around the significant disparity in the maternal and infant mortality rates between Black, Asian and White women when care should be equal. Further, these statistics support the notion that Black women are especially at risk of adverse pregnancy outcomes and highlights the complex relationship between ethnicity and perinatal health outcomes. However, it is noted the reasons underlying the racial disparity in maternal morbidity and mortality appear to be complex and are not yet fully understood.

As of February 2021, a government group has been established to explore the role of racial injustice in maternity services in the UK (BirthRights, 2021). The 2016 National Maternity Review report highlighted that services require improvements in tailoring interventions to mothers, in light of their cultural differences, such as language and lifestyle choices (NHS England, 2016), to improve communication between healthcare staff and mothers from minority ethnic backgrounds. Research has indicated that poor communication due to language barriers can lead to the stereotyping of ethnic minority women and for them to be identified as "the other" (Bowler,1993, p. 158; Robinson, 2002). However, it can be suggested that intervention is required past the level of considering language and lifestyle choices in the care of these women.

Research has found that Black mothers in the UK felt that they were less likely to be offered treatment when experiencing mental health difficulties related to the perinatal period, in comparison to White mothers and were less likely to be asked about their mental health (Edge,

2010; Edge & Rogers, 2005). Both factors were cited as barriers to engaging with services (Edge, 2010). No singular or sufficient explanation has been given to explain the perceived disparity between the experience of Black and White mothers, however it has been argued that it may be due to psychosocial factors prevalent in society, such as social deprivation, discrimination (Karlsen et al., 2003; Wallace et al., 2016). It is noted that the psychosocial factors suggested by these studies are based on a sample of African American women living in the US, due to research in the UK looking at differential outcomes being sparse. However, inequalities in both healthcare access and support have been identified in participants in the UK (Prady et al., 2016b; Sambrook et al., 2019; Watson et al., 2019).

Statistics indicate that 0.77% (n=213,326) of married or co-habiting couples in mixed-sex relationships in the UK consist of a Black man partnered with a Black woman (ONS, 2020). As Black women and babies have been identified as being at a higher risk of mortality (Draper et al., 2020; Knight et al., 2020; NHS England, 2016), it appears logical to be curious about the experience of Black men. As the criteria for psychological trauma includes witnessing the critical event, it is argued that partners are also at risk of birth trauma (Nicholls & Ayers, 2007). In the case of Black women who are disproportionately more at risk, it can be viewed that exploring the experiences of Black men partnered with Black women, is important. To the best of the researcher's knowledge, there has only been one published study on Black women's experience of traumatic births (Adewuya et al., 2006), however this was conducted in Nigeria and only measured PTSD-FC symptoms.

It is important to consider the father, as research indicates optimum mental wellbeing of the father helps regulate the mother to manage, as well as supports the baby (Fletcher et al., 2016). The following sections will explore the presence of men at childbirth, with reference made to paternal mental health difficulties that can occur in the perinatal period and the

experiences of men from minority ethnic backgrounds who have accessed maternity services with their partners.

Presence of men at childbirth in the UK.

There have been historical changes around the presence of men at childbirth. Prior to the 1960s, hospital rules and regulations prohibited fathers from participating in or being present at the childbirth (King, 2017). This was framed in gendered terms, with childbirth historically being conceptualised as feminine, and not a masculine thing for men to be involved with (King, 2013; Lewis, 2002). A separation of fathers from childbirth and infant care remained important to constructions of masculinity before the 1960s (King, 2013), with British social policy historically focussed on fathers' responsibilities to support and provide for their families, rather than on their caring role and being involved in responsibilities related to child-rearing (Lewis, 2002).

Research indicates that between 1960 and the end of the 1970s, a shift occurred from being men being present at childbirth as a minority, to a majority, with 70 to 80% of men present during childbirth by the mid-1980s (Hinton et al., 2014; Kiernan & Smith, 2003; King, 2017; Redshaw & Henderson, 2013). This was suggested to be indicative of a new belief in the role of husbands as emotional and practical support for their wives, and furthermore, in their rights and responsibilities as fathers (Davis & King, 2018; King, 2017). It has been suggested the social changes that had encouraged a change in men's role in home births contributed to this shift and led to men's presence during labour becoming the norm (King, 2017). Studies show that men are now encouraged to accompany their wives for antenatal programmes and participate in labour (Plantin et al., 2011), with their attendance now expected by their partners and health professionals (Draper et al., 2003). Most recently,

statistics indicate that 98% of male partners attend the childbirth in the UK (Hinton et al., 2014; Kiernan & Smith, 2003; Redshaw & Henderson, 2013).

Being present at childbirth can have a number of meanings and functions including supporting their partner and witnessing their baby being born (King, 2017; Kunjappy-Clifton, 2008), advocating for their partner, and liaising with healthcare professionals (Kunjappy-Clifton, 2007). Studies also show that male partners play a critical role in caring for and supporting women and new-borns during the postnatal period, which in turn impacts on long-term health, coping ability and postnatal adjustment of the mothers (Ayers et al., 2006; Erlandsson & Lindgren, 2011; Ramchandani et al., 2005). Further, research has indicated that fathers being present at the birth and involved during labour has been associated with improved women's postnatal health and breastfeeding rates (Redshaw & Henderson, 2013). However, studies have also found that fathers report feeling helpless, useless, and unable to see their partner in pain and being unable to do anything about it (Kunjappy-Clifton, 2008). The upcoming sections will explore how fathers from minority ethnic backgrounds have experienced maternity services.

Minority ethnic fathers and experiences of maternity services.

A UK paper reported that fathers from minority ethnic backgrounds were less likely to suggest feeling supported by staff during the labour process than White fathers and did not feel involved in their partner's pregnancy or pregnancy care (Singh & Newburn, 2000). The same study also reported that younger men from minority ethnic backgrounds were more concerned about labour and how their partner would cope with the pain, in comparison to White British men of a similar age and wanted more information than was given to them (Singh & Newburn, 2000). The findings from this study suggest that the negative experiences with healthcare professionals may lead to more concerns around danger and potential threat

during labour in fathers from minority ethnic backgrounds. It is worthy of note that the study explored the experiences of men across age, ethnicity, number of previous children and social class. This suggests that the experiences reported by fathers may reflect the intersection of these aspects of identity and should be considered.

A study by Edwards et al. (2020) looked at the experiences of American men from minority backgrounds who were partnered with women from minority backgrounds who had utilised maternity services. The men in the study described experiences of discrimination, and mistrust of professionals, reported having poor communication with healthcare providers and believed that their partner had received different treatment based on their type of insurance.

A limitation of these studies is that they have group together the experiences of fathers from minority ethnic backgrounds without distinguishing their individual experiences. For these reasons, it may be difficult to consider how these results translate to Black fathers who may have needs that are distinct from men from other minority ethnic backgrounds. The upcoming section will outline why the differences that exist between people from minority groups must be considered and highlight the focus on Black men for the present research study.

The focus on the Black father. As 'ethnic minority' is not a homogenous group and encompasses diverse groups of individuals who identify as Black, Asian or other ethnicities that are minoritised (Aspinall, 2021), it was acknowledged that there was tremendous diversity of cultures that existed within the minority ethnic group. People from minority ethnic groups have been identified as underrepresented in clinical and health research (Hussain-Gambles et al., 2006). It has been suggested that one reason for this is because they are 'hard to recruit' to research (Matsuda et al., 2016). Researchers suggest that this may be due to stereotypical attitudes of researchers who may assume that there may be a language

barrier and difficulty with transport to participate in a study (Redwood & Gill, 2013) as well as eligibility criteria imposed by researchers (Jolly et al., 2005; Wendler et al., 2006). Although the latter studies explored participation in medical research, the findings are applicable to participation in psychological studies. Together, these findings suggest that the underrepresentation of minority ethnic people from research may be the result of the actions of the researchers rather than unwillingness on the part of the potential participants. Further, studies indicate that people from minority ethnic backgrounds will participate in research when the study is directly relevant to them and their community, with clear explanations of what participation involves (Gill et al., 2013; Ejiogu et al., 2011).

Research suggests that that there may be a vulnerability to trauma that is associated with ethnicity (Jomeen & Redshaw, 2013). There is evidence that people from minority ethnic backgrounds experience trauma differently (Marsella, 2010; Marsella, 1993). Marsella (2010) argues that culture influences the perception, experience, clinical expressions, and treatment responses to trauma. This is described as culture shaping psychosocial aspects of trauma responses, such as the role of destiny or fate in determining the perception of distressing events, culpability of an event, resources used to mediate responses to a traumatic event, religious-related belief systems and standards of normality, abnormality and deviance (Marsella, 2010). It can be viewed that people who come from a Black ethnic background and culture may have idiosyncratic ways of processing, making meaning of and coping with trauma that differ from those who come from different cultural backgrounds. For this reason, it is important to explore how men from Black ethnic backgrounds experience trauma.

It is indicated that Black men may be particularly disadvantaged in comparison to other minority ethnic groups, and there are differences in the type and intensity of stressors Black men face that are specific to the intersect of their ethnicity and gender (Ellis et al., 2015). Focusing on the experiences of minority ethnic men collectively, would risk masking

the individualised experiences of Black men. Studies have shown that African American fathers in the US have reported high rates of everyday racism, including slights, prejudice, and discriminatory behaviours, which were experienced as additional potent sources of chronic stress (Dunkel Schetter et al., 2013). There is also evidence of gendered racism, for example the stereotype that Black men are dangerous (Smith et al., 2007).

The mental health care pathways for Black male service users are disproportionately characterised by hospital admission under a section of the Mental Health Act (Audini & Lelliot, 2002); overdiagnosis of schizophrenia and psychosis; overuse of psychotropic medication; difficult staff-service user interactions and over-representation in medium and high secure facilities (Fernando et al., 1998). A study by Keating and Robertson (2004) involving minority ethnic services users with a high percentage of Black men, found that the Black service users were generally also less likely to be referred for and receive psychotherapy, psychological treatments, counselling, or other alternative treatment. The same study also found that Black services users who utilised mental health services held a perception that mental health services replicated experiences of racism and discrimination, stating that services responded to them in a way which mirrored the oppressive dimensions of other aspects of their lives, such as the education system, contact with police and the criminal justice system. The impact of this resulted in limited trust, engagement, and delayed help-seeking behaviour.

It can be viewed that the involvement of the police during the process of sectioning adds a criminalisation element to the process and further highlights the ethnic inequalities to mental health care pathways (Bhui et al., 2018). It is hoped that by identifying Black fathers who may be struggling in the early stages, it may prevent compulsory admission, chronic severe mental health difficulties and enable Black fathers to access services with less involvement with the police and criminal justice system.

A report by Parliament's joint human rights committee found that overall, 64% of Black people do not believe their health is as protected by the NHS (Clear View Research, 2020) and specifically, 47% of Black men reported a belief that the NHS does less to help them than their White counterparts. This present research is important as it will help to explore ways the NHS can better target such populations who have been disillusioned by the service. Taken together, it is understandable why Black people may be apprehensive about seeking support for mental health difficulties.

A potential avenue for this research was to examine men of any ethnicity partnered with Black women, who due to their increased mortality risk (Knight et al., 2020) could be argued to have a birth that is traumatic. However, as the research shows that Black men are particularly disadvantaged by society and are underrepresented in the literature concerning birth trauma, the researcher decided to focus on Black men specifically. For this study, the term 'Black' is used to refer to men who identify as being from Black African, Black Caribbean or any other Black British background. There remains something of an invisibility of Black mens' experiences; an awareness of which could help in understanding how the interface between service users and healthcare providers is negotiated. The little research that has been conducted on Black men has mainly been conducted in the US with men who identify as African American and there is evidently a gap in the research looking at Black men who live in the UK. It is imperative for researchers to include adequate numbers from underrepresented groups in their research studies. In doing so, researchers can then study health issues specifically affecting the sociocultural context of underrepresented populations to determine the most appropriate forms of intervention and health care delivery for them (Matsuda et al., 2016).

Black fathers continue to be a group with little research into their experiences of both fathering and mental health difficulties (Bocknek et al., 2014). There has been sparse

research into the experiences of Black men partnered with Black women. A study by Vedam et al. (2019) found that women regardless of ethnicity, who were partnered with Black men, were more likely to report mistreatment in maternity care. This mistreatment included loss of autonomy, receiving no response in requests for help and being shouted at or threatened. This suggests that the presence of Black men may result in unfavourable outcomes in maternity care for pregnant women. A criticism of this study, as with much of the literature on ethnicity and disparities in maternity care, is that it consists of an American sample and may not be generalisable to a British sample in the context of the British healthcare system. However, as similar maternal mortality statistics and adverse pregnancy outcomes in Black women have been reported in both the UK (Knight et al., 2020; Knight et al., 2018) and the US in African American women (Louis et al., 2015; Tucker et al., 2007) in comparison to White women, it can be argued that despite having different healthcare systems, ethnicity appears to still be a significant predictor for maternal mortality across both countries, therefore the specific healthcare system may have a minor role.

National guidelines on perinatal mental health

The importance of the father's role in child development have been highlighted and there are initiatives to engage and involve fathers. The NICE guidelines for antenatal and postnatal care recommend that practitioners offer advice and support to women who report birth as traumatic, including psychological intervention and to consider that their partner may also be affected and require help (NICE, 2014). The importance of support addressing the needs of women, partners and the relationships between them and their infant have been highlighted too (NHS England, 2015). The guidance highlights that this support can come from a range of healthcare professionals, including midwives, general practitioners, or specialist mental health practitioners (Ayers & Shakespeare, 2015).

Government initiatives

While the available evidence suggests that rates of mental health problems amongst new fathers and the wider impacts on their families are widespread and persistent, UK policies for maternal and child health services do not currently address the need of services for men (Baldwin & Bick, 2018). The 'Five Year Forward View for Mental Health' aims to transform mental health services in the UK and identifies the need to improve perinatal mental health as a strategic priority for the NHS (NHS, 2016). The NHS Long Term Plan (NHS, 2019) builds on the commitments outlined in the Five Year Forward View, and plans have been introduced to work towards offering fathers and partners of women who are accessing specialist perinatal mental health services, an assessment for their mental health, and signposting them for support where needed (NHS, 2016). This highlights that progress has been made towards considering the impact on the partner, however, it is important to note that fathers who do not have unwell partners, may also need support. The 2016 National Maternity Review report also suggested that clinicians should consider the additional support that fathers also need, although it did not explicitly state what these might be (Better Births, NHS, 2016).

In 2005, the Department of Health proposed an initiative to deliver race equality in mental health care (Department of Health [DOH], 2005). The aim of the initiative was to the development of better mental health services to meet the needs of England's increasingly diverse population, and was devised based on three main catalysts for change: more appropriate and responsive services; community engagement; and better information (DOH, 2005). However, it is apparent that there may still be differences in how services are experienced by people from minority ethnic backgrounds. By having a nuanced

understanding of what Black men need, clinicians may be better able to provide more accurate and ethnically sensitive assessment methods.

Paternal mental health during the perinatal period. The perinatal period is defined as the onset of pregnancy to 12 months postpartum (NHS England, n.d.). Perinatal mental health problems include mental health difficulties that both occur during pregnancy, and pre-existing conditions that may relapse or recur in pregnancy or the postpartum year (Tripathy, 2020). Current models of perinatal mental healthcare primarily focus on the expectant mother's physical health needs and marginalise or completely negate those of the expectant father (National Collaborating Centre for Mental Health, 2018), and the wellbeing of men during the perinatal period being historically been under-researched (Paulson & Bazemore, 2010). This is believed to be the result of the magnitude of research where the mother is assumed as being the primary caregiver and the relationship between mother and infant suggested to have the most impact on developmental outcomes for the child (Biaggi et al., 2016; Hernández-Martinez et al., 2008).

A focus on the mental health of the father is important, as research has found that some men are susceptible to developing mental health difficulties following the birth of a child (Bradley & Slade, 2011; Philpott et al., 2017). Many of the studies have focussed on paternal post-natal depression and anxiety (Bradley & Slade, 2011; Goldstein et al., 2019; Philpott et al., 2017). Studies have shown that 4 to 18% of expectant fathers experienced symptoms of anxiety during pregnancy and in the weeks following delivery (Leach et al., 2016). Research has also found that 8 to 10% of fathers experience depression between the first trimester and one-year post-partum (Cameron et al., 2016) in comparison to 10 to 15% in mothers (Woody et al., 2021).

Research undertaken on paternal mental health in the perinatal period shows that poor paternal mental health can have a negative impact on child emotional and behavioural development, as well as attachment (Ramchandani et al., 2011; Rominov et al., 2016). This suggests that well-being in fathers following childbirth is critical for the child's development (Smorti et al., 2020). Research on paternal trauma responses to birth however, is limited. Studies suggest that fathers as well as mothers can be traumatised by the birth that they witnessed (Nicholls & Ayers, 2007). Supporting the suggestion of fathers can also have a trauma response to a birth that they witnessed, Schobinger et al. (2020) found 57% of 228 fathers present at the birth of their baby born without serious complications presented with symptoms of PTSD one-week post-birth, with 7.2% still presenting with symptoms one month postpartum. Additionally, research has found that healthcare practitioners perceive that 25% of birthing partners (i.e., fathers) are affected by the birth (Delicate et al., 2020b). A meta-synthesis by Bohren et al. (2019) reported that birth partners, including fathers, were deeply affected by witnessing a woman's pain during labour, and described feelings of frustration, fear, and helplessness. This suggests that by fathers being a birth partner and witnessing a difficult birth, their risk of having a traumatic response to childbirth may be increased. For these reasons, it is important to explore the experiences of fathers who have experienced a traumatic birth.

Previous research on fathers' experience of birth trauma

A number of meta-syntheses concerning fathers' experiences have been conducted, including the transition to fatherhood and fathers' role with their child (Chin et al., 2011; Goodman, 2005); fathers' experience of maternity care in the period from pregnancy to delivery (Steen et al., 2012); fathers' experience of their partner's labour and the birth of their baby (Etheridge & Slade, 2017; Johansson et al., 2015); and fathers' experiences of

obstetrically-complicated births that were potentially traumatic (Elmir & Schmied, 2016). A review by Vallin et al. (2019) looked at fathers' psychological health and experiences of social support during unplanned childbirth complications. Most recently, Shorey and Wong's (2020) metasynthesis explored the traumatic childbirth experiences of new parents.

To date, there has not been a general review of fathers' experiences of births which were perceived to be potentially traumatic, that included births that were not uncomplicated or births where it was not the father's first child.

A scoping search was completed of the available literature which revealed a lack of representation of fathers from a minority ethnic background in the research area. For this reason, the following qualitative metasynthesis was conducted to draw upon the existing literature and make parallels with what Black fathers may have experienced. It is evident that the mental health and wellbeing needs and experiences of fathers from different ethnic and cultural backgrounds are largely unknown (Baldwin et al., 2019).

SYSTEMATIC REVIEW

Fathers' experiences of births that they perceived to be traumatic

Overview. Research into the experiences of Black fathers who have had a birth they believed was traumatic, has not yet been extensively studied. The aim of this review is therefore to identify and synthesise studies which have explored the experiences of fathers, regardless of ethnicity, who have experienced a birth, either complicated or uncomplicated, that they believed was traumatic for them, with a view of highlighting gaps in the literature.

Design. A qualitative design was used to explore the in-depth experiences as reported by fathers. A qualitative design was deemed to be appropriate in exploring the aim of the study because qualitative research is associated with exploring more descriptive data (Harper & Thomson, 2012). It was decided that a quantitative review would not be suitable because studies utilising quantitative methods would not allow for an in-depth examination of the phenomenon of interest (Walsham, 2006). In conducting the review, PRISMA guidelines were adhered to, to ensure methodological rigour (Moher et al., 2009).

Methods

Search Terms. The SPIDER framework (Cooke et al., 2012) was used to create search terms by determining the: sample, phenomenon of interest, design, evaluation, and research method. These search terms were clustered and truncated using the Boolean operators of "OR" and "+".

Search Strategy. Searches were carried out in January 2021 using EBSCOHost (including PsycINFO, MEDLINE, PsycARTICLES and CINAHL Complete), Web of Science and PubMed. Reference lists of relevant papers were scrutinised for additional studies, yielding two additional papers.

Screening and Selection. Screening and selection were conducted in a stepped process according to PRISMA guidelines (see Appendix A). Results were initially filtered by excluding articles that were not published in peer-reviewed journals, articles that were not in English, and articles that were duplicates. This was done using filtering tools within the databases. Filtering then continued in stages, beginning with screening by titles, then 71 abstracts and, finally, 26 full-text papers. Once this screening process had been completed, the references of the finalised articles were then hand-searched for any additionally relevant literature (Armstrong et al., 2005).

The inclusion criteria for this screening process required that articles were primary research exploring the qualitative experiences of perceived traumatic births from the perspective of the father. A scoping search revealed a number of studies into the experiences of childbirth from fathers from African and non-western countries, however as the title and abstract did not report a traumatic birth, they were excluded. Where research did not primarily or exclusively focus on these criteria, they were still included if appropriately distinguishable findings were part of the article. Due to the niche nature of the present research, studies that took place outside of the UK were included.

The exclusion criteria for this screening process disregarded articles that were not primary research, such as editorials, unpublished theses or reviews. Articles exploring mothers' experiences or both members of the parental couple where the experiences of the father could not be easily distinguished were also excluded. Research papers where the birth

was not reported to be perceived as traumatic were not included. Studies that looked at home births were not included as it was viewed that the experience could be subjectively different to that in a hospital setting (Walsh, 2007). This was based on research which suggested that the physical birth environment, attitudes and beliefs of the woman and resources available may influence the process of childbirth at home and impact the physiological process of giving birth (Walsh, 2007).

Papers that focused exclusively on fathers' experience of an infant in neonatal care or involved neonatal or partner death were not included. This was decided because the experiences of bereavement, loss and sickness adds a complexity to the experience of trauma. Research that was quantitative was excluded as the focus of this research was on qualitative experience. Further, systematic reviews, meta analyses and meta syntheses were excluded from this review.

Quality Appraisal. After the screening and selection process, to effectively appraise the studies included in the review, quality assessment was undertaken using the Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (CASP, 2018). The CASP tool assesses the methodological quality of studies against 10 indicators. Unlike other qualitative research checklists, the CASP tool does not yield a score for papers.

Synthesis. The findings from the selected studies were analysed using Thomas and Harden's (2008) method of thematic synthesis. Thematic synthesis is an adaptation of 'thematic analysis', as developed by Braun and Clarke (2006), focused on secondary data synthesis and provides a set of established techniques for the identification and development of analytic themes in primary research data (Thomas & Harden, 2008). Thematic synthesis allows for primary themes to be translated, and for similarities and differences between

studies to be explored (Noblit & Hare, 1988). Thematic synthesis follows three stages: i) line by line coding; ii) developing descriptive themes; and iii) generating analytical themes (Thomas & Harden, 2008). The development of 'descriptive themes' focuses on the text of the selected articles, whilst the process of generating 'analytical themes' involves the researcher interpreting the findings of the primary studies and generating new explanations or hypotheses. Text labelled as 'Findings' or 'Results' were included in the synthesis. In studies using mixed methods, only text related to the aims of the research were used. Where studies looked at the experiences of couples; attention was only paid to text clearly specified as being made by the fathers or highlighted as 'all participants'.

The six articles included in the synthesis were imported into a specialist software, NVivo12, and synthesised electronically. A line-by-line analysis using an inductive approach was used to identify initial codes data from each article, according to its meaning and content. Line-by-line coding allowed for the translation of concepts between studies and the development of descriptive themes. As the researcher progressed through coding each article, a coding frame was developed, comprising codes derived from the data. New codes were developed, with the coding frame added to or adjusted when necessary. Following this, all text that had been given a code was examined to check consistency of interpretation. Codes were then grouped into descriptive themes that captured the patterns in the data across studies. The relationship between the identified codes was then considered in condensing the codes into analytical themes. This involved 'going beyond' the primary reported data by synthesising findings across the respective studies and interpreting their meaning in relation to the systemic review research question.

Reflexivity. The aim of this review is to explore fathers' experiences of births that were traumatic for them. The synthesis was conducted by the researcher who has not yet had

children, nor been a witness to a person in labour, which may have influenced how the results were interpreted. The researcher also identifies as female and is interpreting the experiences of males.

Results

Search results. The database searches returned a result of 466 studies. After screening and selection, 6 studies met the inclusion and exclusion criteria. Of these 6 studies, 1 looked at the experience of child-related PTSD in couples (Nicholls & Ayers, 2007), which by its' nature focused on the experience of both the mother and the father. In the analysis section of the aforementioned study, the experiences of the father were clearly labelled by the researchers and separated from the experiences of the mothers and was therefore included in the synthesis. Overall, the qualitative experiences of 192 fathers were identified across three countries: the UK, Australia and New Zealand. The characteristics of the 8 articles are presented in Appendix B.

Quality appraisal. All the studies included in the synthesis met the majority of the requirements of the CASP Qualitative Research Checklist (see Appendix C) (CASP, 2018). Five out of six of the studies included failed to consider the relationship between the researcher and the participants, however it was not believed that this would impact on the quality of the studies as the authors were researchers as opposed to clinicians. The study that did consider the researcher-participant relationship (Elmir & Schmied, 2021), had authors who were midwives by profession, who in the study, asserted their roles as researchers to both avoid being viewed as health practitioners by participants, but also to allow the reader to include this in their appraisal of the research.

Analysis and synthesis. A thematic synthesis was conducted, and 6 analytical themes were interpreted: i) fathers are spectators to childbirth; ii) expectations versus the reality of childbirth; iii) men are there to support their partner; iv) birth trauma impacts relationships; v) the memories last; vi) help is for the woman, not the man.

Theme one: '*Fathers are spectators to childbirth'.* This theme relates to the feelings reported by participants about not feeling involved or in control during the birth that was traumatic for them. There were four sub themes within this: 'control taken away'; 'lack of communication and involvement'; 'seeing it all'; and 'abandonment and isolation'.
Fathers across articles spoke about a perceived lack of control over the birth situation being a significant contributory factor to perceiving the birth as traumatic as they believed there was little they could do (Daniels et al., 2020; Inglis et al., 2016; Nicholls & Ayers, 2007), and the unease felt allowing healthcare professionals to be in charge when they were usually in control (Etheridge & Slade, 2017). The distress experienced with this shift in control was also reported (Daniels et al., 2020). There were differences in how participants made sense of the lack of communication from staff and how this was experienced by fathers. This ranged from interpreting the lack of communication as a suggestion of danger or threat to life for mother and/or baby (Etheridge & Slade, 2017), which exacerbated feelings of distress (Inglis et al., 2016), to feeling content with minimal information being communicated, as it meant that the wellbeing of their partner and baby were being prioritised (Daniels et al., 2020; Elmir & Schmied, 2021). Others believed that it meant that their views regarding decisions about their partner and baby were not being considered, which took away their perceived role as an advocate for their partner (Elmir & Schmied, 2021; White, 2007).

Witnessing the process of childbirth was traumatising for fathers, as they saw more of the medical procedures used to assist the birth than their partner (Inglis et al., 2016), and they

mirrored the distress that their partner was in, highlighting that their partner had been anaesthetised, but they had not (Etheridge & Slade, 2017). Some shared that being a witness and not a physical participant, meant that the memory of the trauma was more vivid (White, 2007) and they regretted seeing as much as they did (Elmir & Schmied, 2021).
Being left alone was cited as a contributory factor to experiencing a birth as traumatic (Daniels et al., 2020), with the isolation increasing feelings of anxiety and uncertainty (Etheridge & Slade, 2017).

Theme two: '*Expectations versus the reality of childbirth'.* This theme relates to the preconceived knowledge and beliefs fathers held around the process of childbirth, compared to what they were confronted with in the delivery room. These beliefs were interpreted into two subthemes: 'what you're not told' and 'missing a magical moment'. Firstly, fathers across studies shared that antenatal classes focused on standard deliveries that created idealised experiences of what childbirth would be like (Daniels et al., 2020). This appeared to be a contributing factor to the feelings of unpreparedness reported by fathers, when the labour did not go as expected (Etheridge & Slade, 2017), not knowing if a labour was 'normal' or not (Elmir & Schmied, 2021), leading to feelings of frustration and uncertainty (Inglis et al., 2016). Secondly, as a result of not feeling prepared, fathers expressed missing out on what they had imagined would be a "fulfilling experience" and a joyful first moment with their baby (Elmir & Schmied, 2021; Etheridge & Slade, 2017), with dreams fathers had of the birth of their baby "coming to an end" (White, 2007).

Theme three: '*Men are there to support their partner*'. This theme relates to participants' understanding of the role of men in childbirth and the appropriateness and acceptability of showing an emotional response to a traumatic event. These experiences were

interpreted into two subthemes: ‘your partner and baby come first’ and ‘putting feelings aside’. Firstly, fathers described labour as being a “female-dominated experience”, which was communicated linguistically and symbolically by staff, for example not having facilities available for men in the delivery area (Daniels et al., 2020; Etheridge & Slade, 2017). Some fathers described their role as “undervalued” (White, 2007) and shared that they were only acknowledged when supporting their partner (Daniels et al. 2020). Following the traumatic birth, fathers expressed their need to take on caring responsibilities for their partner to allow them to recover (Elmir & Schmied, 2021). A difficult split between caring for their partner and attending to their newborn baby was also shared by participants, who struggled with negotiating the time divide (Etheridge & Slade, 2017).

Secondly, fathers discussed the acceptability of emotional responses to the traumatic birth. Some fathers described “being a man” as being quiet and not discussing emotional responses to trauma (Daniels et al., 2020) and made reference to “cultural influences” which impacted on why men are not able to show emotions (Elmir & Schmied, 2021). Beliefs around their partner’s trauma being greater than their own were also expressed (Daniels et al., 2020), as well as “protecting” their partner from further distress by suppressing their own distress (Etheridge & Slade, 2017) and being “the rock” of the family to keep things together (Inglis et al., 2016). The difficulty in supressing emotions was highlighted, with some fathers expressing feelings of “guilt, humiliation and helplessness” (White, 2007) and others sharing that avoiding processing their emotions caused them to “fall to pieces” (Etheridge & Slade, 2017). Conversely, fathers in one article discussed the importance of “being together” with their partners in processing their emotions (Nicholls & Ayers, 2007).

Theme four: ‘*Birth trauma impacts on relationships.’* This theme relates to participants’ experiences of how a birth that was traumatic for them impacted on the newly

formed and existing relationships that they had around them. These experiences were interpreted into two subthemes: ‘my partner’s response influenced our relationship’ and ‘bonding with my baby’. Firstly, evaluations of the relationship post-birth were reported by most studies, with the relationship either being strengthened by the traumatic birth or breaking down because of it (Daniels et al., 2020; Elmir & Schmied, 2021; Inglis et al., 2016; Nicholls & Ayers, 2007). In these studies, the potential loss of their partner was a means of having a greater appreciation for them. It appeared that feeling supported by and connected to their partner who had given birth and being able to talk about the traumatic birth, was central in maintaining the relationship (Etheridge & Slade, 2017). When this was absent or either partner withdrew as a means of coping, or used work as an escape, communication broke down and both emotional and physical intimacy was affected (Elmir & Schmied, 2021; Nicholls & Ayers, 2007). Secondly, participants reported developing a bond with their baby after the birth as they were not physical carriers and physical connection was established during pregnancy (Elmir & Schmied, 2021). Some expressed shame at the delayed nature of this bonding as they expected it to be instant and intense (Daniels et al., 2020). Secondly, the impact of the birth on the father-baby bond was clear, with fathers reporting long-term difficulties with emotional intimacy and expressing a desire to not have any further children (Daniels et al., 2020; Etheridge & Slade, 2017; Inglis et al., 2016; Nicholls & Ayers, 2007). Some fathers however, reported strong bonds with their baby, having been required to adopt the “unexpected” role of primary carer upon returning to the family home which they believed would have been afforded to their partner (Elmir & Schmied, 2021; Etheridge & Slade, 2017). It was shared by some fathers that these unexpected caring responsibilities “excluded them from their (work) colleagues” and they struggled to cope (Daniels et al., 2020).

Theme five: '*The memories last.'* This theme relates to participants' experiences of the lasting psychological and emotional impact of the traumatic birth. These experiences were interpreted into two sub-themes: 'everyday reminders' and 'things aren't what they used to be'. Firstly, participants described experiences synonymous with PTSD, such as nightmares, flashbacks, and hyperarousal, that would be triggered by doing everyday activities and lead to memories of the traumatic event (Daniels et al., 2020; Elmir & Schmied, 2021). Fathers reported avoidance to prevent the memories from re-appearing (Etheridge & Slade, 2017; White, 2007), however these strategies were described as not working well (Daniels et al., 2020) and the memory of the event was reported in one study to be "very vivid" 21 years later (White, 2007). Secondly, articles reported changes to participants' personal and professional lives following the traumatic birth. Some articles reported the development of mental health difficulties, such as obsessive-compulsive disorder (Daniels et al., 2020). Others reported an inability to engage in activities that previously gave them pleasure and "going into a dark place" (Inglis et al., 2016). The development of some of these difficulties were described as "gradual" (Elmir & Schmied, 2021), "lingering" and "front and centre" in their lives (Etheridge & Slade, 2017). Fathers in two studies shared the experience of "psychological scarring" because of the traumatic event, resulting in an avoidance of sex with their partner and marital consequences (Nicholls & Ayers, 2007; White, 2007).

Theme six: '*Help is for the woman, not man.'.* This theme relates to participants' beliefs about what support to process the trauma and subsequent difficulties consisted of, and who this support was targeted at. These experiences were interpreted into two subthemes: 'the woman needs it more' and 'coping with what happened'. Firstly, participants in some of the studies shared that their partner needed support "more" as she was the person who had physically experienced the birth (Daniels et al., 2020), and they felt it was their responsibility

to “get on with it” (Etheridge & Slade, 2017). This feeling of their partner’s mental health needs being a priority was said to be exacerbated by healthcare professionals minimising the impact of birth on the father from as early as pregnancy. One study highlighted that antenatal classes only obtained and recorded depression scores in mothers (Daniels et al., 2020) and in another, following the traumatic birth, the participant’s partner was offered counselling and antidepressants whilst he was advised to “have a beer” to cope with what happened (Inglis et al., 2016). Fathers also reported “rarely” being asked how they were, in comparison to their partner who was asked more frequently (Inglis et al., 2016). Secondly, papers looked at how participants coped with the traumatic birth. Across articles, the importance of the surrounding social network was identified in playing a crucial role in fathers’ adjustment to the aftermath of the traumatic event. Some fathers identified the difficulty in talking about the birth to friends and people in their community, which meant they “suppressed” their need to seek help (Daniels et al., 2020; Elmir & Schmied, 2021). Implicit messages received from friends and family appeared to be key in how safe fathers felt to express their distress and to seek support. In one study, fathers shared that they received implicit messages from their friends that they should “pull themselves together” and “forget” what happened (Etheridge & Slade, 2017), however in another study, fathers reported feeling “encouraged” when they received social and emotional support from their loved ones when they sought help (Inglis et al., 2016). A trust in God was also highlighted as a coping mechanism during the childbirth (Inglis et al., 2016), however did not refer to the use of faith and spirituality as a way of coping in the aftermath of the traumatic birth. Across studies, it was evident that participants wanted help to cope with their trauma. A number of participants sought help for their distress, some of whom paid privately and accessed help early (Daniels et al., 2020), whilst others reached a significant level of distress prior to seeking support (Etheridge & Slade, 2017). The difficulty in not being offered or signposted support by healthcare professionals was cited as

a barrier that prevented men from seeking help (Daniels et al., 2020). Further, some fathers expressed a desire to have received peer support from other fathers who had experienced a similar traumatic event (Daniels et al., 2020).

Discussion

The present thematic synthesis reviewed the experiences of fathers who experienced a birth that was traumatic for them and revealed six themes. The themes identified reflect a shared experience reported by fathers across different countries and contexts, about a childbirth that was traumatic for them. This review provides an insight into the experience of subjectively traumatic childbirth from the perspective of the father. Firstly, the experiences reported reflect findings from previous research that fathers viewed childbirth as a "female event" (Jessop & Fox, 2011) and are viewed as secondary to the mother during labour whose main role is to provide support (Shapiro, 1987). This had an impact on fathers' experience of loss, control and perceived invisibility, which appears to have contributed to the appraisal of the birth as traumatic, as has been found in previous studies (Hinton et al., 2014). In the present review, the perception of being secondary to the event by fathers was reported to have impacted their ability to express their distress and seek support. This has been highlighted previously in other studies, where seeking support was suggested to be in contradiction to societal expectations (Jessop & Fox, 2011; Johansson et al., 2015).

The impact of healthcare professionals' failure to meet the emotional and support needs of fathers has also been identified by researchers and was replicated in the findings of this review (Harvey & Pattison, 2012). As fathers expressed a desire for peer support, it appeared that knowledge of others who may share the same feelings or experiences as the fathers could be powerful in helping them to process and cope with their trauma. Secondly,

the review suggests that due to the positioning of men as spectators during the labour and their proximity to the trauma, their memories of the trauma were vivid (Elmir & Schmied, 2021; White, 2007). Studies indicate that trauma memories play a key role in the development and maintenance of PTSD (Ehlers & Clark, 2000). It was evident from the articles, that the experience of birth trauma had long-lasting impacts on fathers who reportedly experienced symptoms synonymous with PTSD and frequently re-lived the memories of the traumatic event. Thirdly, the review provides support for the impact of traumatic births on men's relationship with their partner and the bond that they have with their baby (Parfitt & Ayers, 2009). Fourthly, the review highlights that there may be a discrepancy between what is discussed during antenatal classes and what may actually occur during labour, with unpreparedness being a key concern highlighted by fathers. Finally, there are direct parallels in the findings reported in studies included in the synthesis with previous research which reported that mothers found it hard to find support or appropriate forums in which to discuss their feelings following a traumatic birth (Ayers et al., 2006).

Strengths and limitations. As the research on birth trauma has historically centred around the perspective and experience of the mother, this review is believed to be the first of its kind in considering the impact of a traumatic birth on the father. The present review builds on previous research and meta syntheses, by contributing the perspectives of fathers who had experienced either obstetrically complicated or 'straightforward' births that they believed were traumatic for them. The findings from the review further support the idea that childbirth is a mutually shared experience for a couple, and as such can be potentially traumatic for both parents. The review also highlights the significant gaps in the research area around the experiences of fathers from minority ethnic backgrounds. The studies were only conducted across three countries: the UK, Australia and New Zealand. Further, the participants in the studies included in the review were predominantly from White backgrounds, and where

participants were from other backgrounds, their experiences were grouped together with that of the majority. It can be argued that the generalisability of these findings remains limited to White men. For this reason, the perspective of fathers from minority ethnic backgrounds, who witnessed a traumatic birth, remains largely under researched and unknown. Further, as the review was carried out by a single researcher, the risk of bias was increased.

Problem statement

It is evident that there is a dearth of research and understanding into fathers from minority ethnic backgrounds who have experienced a traumatic birth. From the studies that have been conducted, although not intended to be generalisable, they are arguably not representative of the diversity of fathers. It appears that fathers from minority ethnic backgrounds are largely unrepresented in the research on birth trauma. Ethnicity is important to consider in the construction of trauma and fatherhood, and the potential intersections with perspectives concerning paternal mental health during the perinatal period (Giurgescu & Mirsa, 2018). It is not appropriate to group the experiences of all men from minority ethnic communities as being the same, due to the differences that exist between people from minority groups (Aspinall, 2021). For this reason, the present research aimed to solely focus on exploring the experiences of Black men. There are historical and contemporary social and cultural forces that differentiate the experiences of Black and White men. Research indicates that Black fathers experience significantly higher chronic stress in comparison to White fathers (Dunkel Shetter et al., 2013). The researcher argues that as ethnicity and gender are intertwined, they intersect to shape the quantity and type of the stressors that people experience (Griffith et al., 2013). The experiences of Black fathers need to be explored to understand their experiences which have been unheard, and to explore if there is a disparity

between how Black men and those from other ethnic backgrounds, experience birth trauma. May (2014) argues that "privilege often leads to 'blank spots". It is hoped that the exploration of the experiences of Black men will encourage a dialogue which moves away from objective reality and universal experience of childbirth (Leap, 2009), and one that is the benchmark standard and based on the experience of White middle-class people who are viewed as the normative subject position in which other ethnicities are appraised and against (Hall et al., 2001; Odusanya et al., 2017; Rice et al., 2019; Weber & Parra-Medina, 2003). There is a fear that adopting a colour-blind approach may mean that subtle cultural issues inherent to being a Black man, may be missed, as has been found with Black mothers (Edge, 2010).

As mental health professionals, we aim to provide person-centred care tailored to individuals, in considering their personal characteristics. Cultural competency is now advocated and seen as essential in clinical practice (Casas et al., 2016; Sue et al., 2009; Tao et al., 2015) and is part of the standards of practising professional psychology (APA, 2017a, 2017b; British Psychological Society [BPS], 2017). It is crucial that mental health interventions account for culture (La Roche & Lustig, 2012).

Aims & objectives

The present study will address the following aims:

- To explore the experiences of Black British fathers who have experienced a birth that was traumatic for them
- To establish what the nuanced and specific needs are of Black British fathers, to provide a more holistic and tailored service to their needs.

CHAPTER TWO: METHOD

Chapter Overview

The present research explored Black fathers' experience of a birth that they felt was traumatic for them using an exploratory qualitative paradigm and a critical realist position. This chapter will provide an outline of the research process and will provide justification for the qualitative paradigm and methodology used. The procedure of recruiting for and conducting the research will then be outlined. Further, considerations around ethical issues that were relative to both the participants and researcher will then be discussed. Finally, plans for the dissemination of the research in appropriate psychological journals will be outlined.

Personal methodological reflection

Through the process of conducting this research, I was mindful of my relationship to the community of which I was exploring the experiences of participants. Considerations of being an 'insider' to the participants because of my race, an outsider due to my gender, as well as researcher due to my profession, were prominent in my reflections of how the data was collected, analysed and interpreted. This is discussed in depth in Chapter Four.

Philosophical Framework

The foundation of conducting research is rooted in the underlying philosophical framework that the research is grounded in. The philosophy of research can be positioned within theories of ontology, which refers to beliefs about the fundamental nature of social reality and what someone believes to be factual (Bryman, 2001; Bryman, 2008), and epistemology (Lincoln & Guba, 1985), which is concerned with how reality is captured or known (Carson et al., 2001). It is argued that identifying the ontological and epistemological positions are essential for adopting the appropriate research and data analysis methods that

are parallel with the positioning (Howell, 2013). The upcoming sections will provide details of the ontological, epistemological and methodological frameworks adopted in the present study. Finally, an explanation about why a critical realist position was adopted by the researcher will be presented.

Ontology

The ontological position exists on a continuum with two opposing ends: realism, the perspective of an objective reality at one end, and relativism, the perspective of multiple realities, at the other (Braun & Clarke, 2013; Hammersley & Atkinson, 2007). The critical realist position sits between the realist and relativist polarised ends, and asserts that there is a world independent of human beings, and also that there are deep structures in this world that can be represented by scientific theories (Alvesson & Skoeldberg, 2002, p. 16).

The researcher believes that reality is multiple and relative (Hudson & Ozanne, 1988) and therefore cannot be captured using quantitative methods which would not allow for an in-depth examination of the phenomenon of interest (Walsham, 2006). From the researcher's standpoint, there is no single objective truth, and the multitude of realities depends on the individuals' subjective experience (Capaldi & Proctor, 2005).

Epistemological position

Epistemology is the relationship between the researcher and the reality, and how this reality is captured or known (Carson et al., 2001). Once the ontological position has been established, epistemology enables an understanding of how knowledge is acquired, conceptualised and communicated in a way that is aligned with the researcher's worldview of what reality is (Scott & Usher, 2010). The epistemological position of the researcher involves

assumptions about what constitutes as knowledge or "proof" within a discipline (Kuhn, 1970) and as such, informs the theoretical perspective, methodology and subsequent method used in research, as well as the lens through which analysis will occur (Crotty, 1998; Howell, 2013). The epistemological continuum exists on a range between two dichotomies: positivism, the belief that reality is discovered through research study, and interpretivism, which postulates that reality is not objective and is created through constructed meanings (Lincoln & Guba, 1985; Robson, 2002). The next section will outline and consider the positivist, interpretivist, and critical realist epistemological positions in relation to how best knowledge about reality and the world is acquired. Further, an outline for why a critical realist position was adopted will be presented.

Positivism, interpretivism and critical realism.

Positivism is considered a form of empiricism and is based on the assumption that there is an 'objective reality' that is constant and available to access through study (Lincoln & Guba, 1985). Epistemologically, positivists believe there is a separation between the researcher and the world, with the world existing independently of the researcher's presence (Bryman 2008, Howell 2013). The central ideas of positivism emphasise control, prediction and measuring phenomena (Bryman, 2008) and systematize the knowledge generation process using quantitative research methods and experimental testing that generate hypotheses using deductive reasoning to test for provable "laws" (Ryan, 2018, p. 15). Positivism is concerned with using empirical and objective means to "uncover and present truth" (Henning, et al., 2004, p. 17). The positivism perspective has been criticised for its belief that reality and knowledge can easily be captured and generalised in a context-free form (Guba & Lincoln 1994).

Interpretivism is often viewed as anti-positivism (Flick 2014), due to its opposing perspective about the theory of knowledge and how reality can be viewed. Interpretivists argue that reality is not objective and highlights the multiplicity of truths that are historically and culturally situated (Robson, 2002). According to the interpretivism perspective, language and consciousness shapes reality and people are active agents in shaping their realities (Myers, 2009; Robson, 2002). Contradictory to positivism, interpretivism postulates that there is no single correct route or particular method to knowledge (Willis, 1995) and according to the interpretivism epistemological perspective, as reality is only knowable through socially constructed meanings, there is no shared reality (Ritchie & Lewis, 2003). Interpretivists also postulate that the understanding of the world is informed by social, political and ideological contexts (Braun & Clarke, 2013, p.30). Interpretivism is associated with meaning-oriented qualitative research methods such as unstructured interviews and participant observation, where attempts are made to understand phenomena through the meanings that people assign to them (Deetz, 1996; Reeves & Hedberg, 2003). Interpretivists argue that it is not possible for researchers to be completely removed from their own values and beliefs when conducting research, ergo these factors inform the way in which data is collected, interpreted and analysed (Ryan, 2018).

Positioned between the two extremes of the positivism and interpretivism epistemological positions is critical realism which postulates that social reality lies somewhere between these two extremes and incorporates elements of both (Bhaskar, 1979). Critical realism is a philosophical position that stipulates that the social world is conceived as having ontological depth, with three levels of reality: the observable; the actual (hidden from immediate interaction but observable in principle); and the realm of the real, comprising of unobservable structures, even in principle (Bhaskar, 1979). Critical realism explains that the world and

knowledge of it varies by the individual as different aspects of reality are experienced (Bhaskar, 1979). Critical realism does not state that reality is socially constructed as postulated in interpretivism, it instead postulates that the individual's ideas of what reality is, is what is socially constructed (Bhaskar, 1979). Critical realists view of causation is different to that of interpretivists. Critical realism shares the same view with interpretivism that social phenomena are concept-dependent and need interpretive understanding, however, unlike interpretivism, it does not exclude causal explanation (Sayer 2000). In the next section, adoption of a critical realist position by the researcher will be presented.

Theoretical position of the researcher

In the current study, the researcher adopted a critical realist position. The critical realism philosophy highlights that reality cannot be understood without social context (Bhaskar, 1979). The researcher agrees with this philosophy and will make the assumptions that social context provides the lenses through which we interpret and make sense of our experience. The experience of Black men perceiving a birth to be traumatic cannot be understood without contextualising their experiences of being Black and in England. White middle-class men have long established the guidelines for knowledge and their construction of knowledge regarding what the world is, and how it is represented can be taken as absolute truth (Code, 1991), however the researcher argued that they should not be. More specifically in the research of fathers' experience of birth trauma, the absence of Black men in the research demonstrates how the experience of black men has been marginalised and neglected. The researcher was interested in conducting research that would give voice to the experiences of Black men which have not yet been considered by previous studies into the experience of

birth trauma. A critical realist approach will consider how race and ethnicity can impact on the meaning of how the traumatic birth was experienced.

Qualitative versus quantitative methodology. Methodology is concerned with how the researcher will investigate and acquire knowledge, and is based on ontology and epistemology (Creswell, 2007). Research paradigms can be broadly conceptualised as qualitative, quantitative, and mixed methods (Kuckartz, 2014). There are fundamental differences between quantitative and qualitative methodologies that lie in the different philosophies and epistemologies of the two approaches rather than the methodological techniques alone (Yanchar & Westerman, 2006).

Positivist philosophy which uses quantitative methods, assumes that knowledge is learned through experimental methods, therefore quantitative methodology often aims to test a priori hypotheses, establish causality or, quantify the phenomena which is studied (Robson, 2002; Harper & Thompson, 2012). Quantitative methodologies also focus on describing data and building knowledge through statistically significant findings and constructing statistical models (Neuman, 2014).

Alternatively, qualitative methodologies focus on meaning and interpretation of events (Carter & Little, 2007) and can provide a robust methodological framework where subjective in-depth personal experiences can be studied. Interpretivist philosophy disagrees with positivist approaches which postulate that knowledge is objective; instead arguing that knowledge is subjective, multiple and socially constructed (Hudson & Ozanne, 1988; Robson, 2002) and utilises qualitative measures to learn knowledge (Deetz, 1996; Reeves & Hedberg, 2003). It can be viewed that this difference of epistemological assumptions encapsulates the primary difference between the two methodologies.

Rationale for a qualitative design. There is a dearth of research into the exploration of fathers' experience of birth trauma. The studies that have been done have only included participants from a White ethnic background. Guba (1981) suggests that researchers should select the paradigm whose assumptions are best met by phenomenon being investigated. The aim of the research is to develop an account of birth trauma from the experience of Black men who have been underrepresented in the research. For this reason, adopting a qualitative methodology was justified in order to gain insight into the experience of Black men. By using a qualitative method, access can be granted to the personal world of the participants more than a quantitative measure could. As the purpose of the research was to investigate and explore the subjective experiences of participants, it was decided that a qualitative method would be best suited.

Due to the sensitivity of the research area, it can be viewed that the experience of a trauma cannot accurately be captured by quantitative methods. It could be argued that quantitative measures may be suitable for measuring psychological distress in relation to the traumatic event, however the numeric data collected would lack the information necessary to answer the objectives of the present study, which was to find out what the experience of the trauma was, and the aftermath effects of help-seeking. Qualitative research is a method which focuses on understanding meaning and subjective experiences (Willig, 2012). Qualitative methods can garner detailed accounts of personal experience and processes (Harper & Thomson, 2012).

Qualitative research can provide a unique and robust theoretical and methodological framework where subjective, personal experiences can be studied in ways that would be limited within quantitative research methodologies (Denzin & Lincoln, 2000). Using pre-defined answers on questionnaires limits the amount of knowledge that could be gained and

understood. Additionally, the lack of information concerning men's experiences limits the responses that could be put forth to men to choose from.

It is highly important to consider the methodology's appropriateness in meeting the aims of the study (Howitt, 2010). A qualitative methodology was chosen for the present research due to the lack of previous research on the topic area looking at fathers who identify as Black. There is a danger of a single story in not representing Black men in research and having their experiences heard and stories shared – that of which would not be validly and sensitively captured by quantitative methods.

Consultation. For the duration of the research project, the researcher liaised with field supervisor Dr Jan Smith, who served as a psychologist and lead for the Parliamentary Working Group on birth trauma, on the research project. Consulting experts is postulated to be one method of gaining the knowledge required to seek understanding of the study phenomenon (Krauss et al. 2009, Rabionet 2011).

Data collection methods. There has been a general lack of research into men's experiences of mental health difficulties in the perinatal period, and more specifically the experience of Black men. For the current research, it was determined that new data is required in this area and therefore data collection was essential. For the present study, both focus groups and interviews were considered. Due to the coronavirus pandemic that began in early 2020 and the government guidelines that restricted face-to-face contact amongst people, the virtual use of these two methods were subject to consideration.

Focus groups. The use of focus groups in research can provide rich, interesting and valuable data of a target group (Kidd & Parshall, 2000; Barbour & Kitzinger, 1999). It has often been noted that in organising focus groups, they should be homogenous (e.g., race and gender) to increase participant comfortability and to increase participant compatibility to encourage free-flowing conversation (Morgan, 1998). Focus groups have been noted to be valuable in gaining insight from minority ethnic communities (Culley et al., 2007). Particularly in exploring negative experiences, such as racism, focus groups might give the opportunity for participants to speak about experiences when they are identified as common problems as opposed to isolated individual experiences (Kitzinger, 1995). This is supported by Greenwood et al. (2014) who found that participants in ethnically homogenous focus groups were more likely to say that ethnicity influenced their perceptions of social care services compared with heterogenous focus groups consisting of participants from various ethnic groups. A previous study similar to the present research, which looked at the experiences of men from minority ethnic backgrounds partnered with women at social and medical risk of premature birth, utilised focus groups however, did not comment on any strengths or limitations of using this method (Edwards et al., 2020).

Due to COVID-19, researchers introduced guidance on how to conduct focus groups remotely, which indicated minor adjustments such as a smaller group and a co-moderator to support with potential technical issues (Dos Santos Marques et al., 2020). Dos Santos Marques et al. (2020) suggested that there were benefits of focus groups being conducted remotely, which included flexibility of when the group occurs, allowing participants to be in a relaxing environment (i.e., in their own home), and the ability for the virtual group to be accessible for people from wide geographic locations, which would allow for a greater pool of participants. The limitations of using focus groups for the research topic were considered. It was viewed that using the format of a focus group could run the risk of group effects, bias,

and influence if all the participants were seen together to discuss their experiences (Asch, 1951). Additionally, although the participants were presented as a homogenous group (i.e., Black men), the aim of the research was to explore individual experiences of a difficult birth, as opposed to community understandings of a difficult birth (Culley et al., 2007). The researcher considered the possibility that each man could have a nuanced experience of birth trauma, despite their shared identity as Black men. Considering the possible theme of race and racism, which can be perceived as a sensitive topic to most people, it was hypothesised that there may be potential for challenging views within the group, in order to provide a consensus (Liamputtong, 2011). Further, the research by Dos Santos Marques et al. (2020) reported that male participants were less likely to join and participate in virtual focus groups. Taken together, for these reasons, it was decided that interviews may be a more appropriate data collection method rather than focus group. This will be discussed further in the next section.

Interviews. The interview method has been described as the most direct, research-focused interaction between researcher and participant (Kazmer & Xie, 2008) and is also one of the most commonly used data collection method in qualitative research (Taylor, 2005). It has been suggested that the interview method is a prime way of exploring lived experiences (Spradley, 1979). There are three main types of interview methods for collecting information: structured, semi-structured and unstructured interviews. The difference between the three methods is the amount of control that the interviewers intend to have over participant responses (Berg, 2007). Semi-structured interviews are used to elicit specific in-depth information about specific topics using pre-determined questions whilst allowing for a degree of flexibility and deviation from the script, based on nuanced responses from participants (Berg, 2007).

Research indicates that semi-structured interviews are the most frequently used interview method in qualitative research due to its flexibility and versatility (DiCiccoBloom & Crabtree, 2006; Kallio et al., 2016). The semi-structured interview technique provides participants with guidance on what to talk about (Gill et al., 2008), and allows the interviewer to explore issues brought forward by the interviewee using guided follow-up and probing questions (Britten, 2006; McGrath et al., 2018). Research suggests that the semi-structured interview technique is beneficial for allowing issues that are meaningful for the participant to be discussed, which allows for diverse perceptions to be expressed (Cridland et al., 2015; Quraishi & Philburn, 2015). As the present study research topic area is small and has not been investigated in depth before, semi-structured interviews were determined as beneficial for answering this research question to allow for a full breadth of exploration of experiences.

Taken together, this demonstrates the role qualitative research can have in this research area. The next section of this paper will present the study materials used for the research study.

Research materials.

Study recruitment poster. To recruit participants to the present research study, a poster advertising the study (see Appendix D) was created.

Participant Information Sheet. The participant information sheet (see Appendix E) was created and contained further information on what the aims and objectives of the study were, what participation would involve, as well as the inclusion and exclusion criteria and how to contact the researcher. Participants were required to read this document prior to considering participating in the study.

Consent form. The purpose of the consent form (see Appendix F) was to provide a written account of the agreement from participants to participate in the present study.The

consent form included information about how data would be obtained, securely stored during the research process and then destroyed after a period of five years. Participants were also informed about their right to anonymity and how this would be established and maintained by the researcher to ensure that participants would not be identifiable from the responses given in the interviews. Ethical considerations around the right to withdraw from the research and to decline answering any question asked were also highlighted in the consent form, which is in line with the BPS code of research ethics guidelines (BPS, 2014).

Interview topic guide. An interview guide is defined as a list of questions which direct the conversation between the researcher and participant(s) towards the research topic (Cridland et al., 2015). The topic guide covers the main topic areas of the study (Taylor, 2005). The present study utilised a semi-structured interview topic guide (see Appendix G).

Procedure

Recruitment procedure. Prior to commencing the research, ethical approval for the project was granted by the University of Essex Research Ethics Committee in May 2020 (see Appendix H). Study recruitment posters seeking participants for the research study were advertised by the Make Birth Better Network, including on their website and social media platforms. The Make Birth Better network is a collective of parents, maternity workers and academics who bring together lived experiences and extensive professional knowledge of birth trauma and vicarious trauma. The aims of the network are to raise awareness of birth trauma, offering support to affected parents and by doing research into the experience of birth trauma (Make Birth Better, 2018). Recruitment posters were also advertised by the researcher on a social media account that was specifically created for the research project and following

numerous pages centred around wellbeing during the perinatal period, to increase the likelihood of recruitment due to the greater reach of the account.

Participants who responded to the study recruitment poster were sent an email response where they were thanked for expressing interest in participating in the study and were asked to provide a telephone contact number that they could be contacted on for a telephone screening appointment. The email response also contained the Participant Information Sheet which informed the participant that a telephone screening appointment would be conducted to confirm that the participant met the eligibility criteria and to ensure that potential participants were not scoring on the higher end of the IES-R (Horowitz et al., 1979, Weiss & Marmar, 1996) as it could impact on their ability to participate in the interview and could be indicative of a need for therapy. Participants who scored above the cut-off score of 33 were advised to speak to their GP about their difficulties and were made aware that they would not be suitable to participate in the study. The telephone screening included one question to assess for criterion A2 of the diagnostic criteria for PTSD (DSM IV-R, APA, 2000): “At some point during the childbirth I experienced intense feelings of fear, helplessness or horror”. The researched decided to use of the criterion A2 in accordance with the DSM-IV (APA, 2000), as research has shown that removing the criterion can result in more births being classified as traumatic (Boorman et al., 2014; Devily et al., 2014). As it is common for witnesses to childbirth to perceive the process as potentially threatening and not have any symptomatology associated with it (Ayers, 2004), the researcher wanted to ensure that there was a clear element of fear that was felt in participants who experienced the birth as traumatic.

Participants who met the eligibility criteria were then asked to provide a telephone contact number and preferred days and times for a Skype or Zoom interview. All participants

were asked if they would like a copy of the interview questions prior to the interview date, so that they had the opportunity to screen the questions and discuss any of the items that they may not want to answer. The researcher considered how the opportunity to see the interview questions may have influenced responses, however it was determined that this transparency was needed to enable any worried or anxious participants the opportunity to communicate what felt safe or unsafe for them to share in the interview.

Data collection. Ten in-depth interviews were conducted. Participants were contacted for interview at the preferred times they had indicated online, and interviews were audio recorded using an encrypted Dictaphone, as well as the recording option on the Zoom program. To begin, participants were asked to confirm they had understood the information provided on the information sheet which outlined the purpose of the research and what would be expected of them; reminded of their right to withdraw at any point without consequence, and also asked to confirm that they wished to continue with the study. Participants were also given an opportunity to ask any questions. Interviews then proceeded following the semi-structured schedule.

At the end of the interview, the researcher gave participants another opportunity to ask questions. Participants were reminded of the information given prior to participation and were made aware that if they needed psychological help due to the traumatic birth or if any distress was caused as a consequence of the interview, they would be signposted to the Make Birth Better network for support. This support would involve the clinical psychologist and psychiatrist at Make Birth Better who would speak to the participant and signpost them to where they could receive the appropriate clinical support. Participants were also reminded of the researchers' contact details should they have had any questions or require further

information after the interview. At the end of each interview, the researcher made notes reflecting on the experience of interviewing and being in the role of interviewer, which were considered during the analysis.

Rationale for Choosing Present Study's Methodological Approach.

The researcher decided to select a quantitative tool to measure trauma symptoms in participants as a way of interpreting participants' objective trauma response in relation to their subjective reports of the birth that was traumatic for them. Several measures of PTSD symptoms after birth in birth partners have been developed. These measures will be detailed below to highlight why the Impact of Events Scale- Revised ([IES-R], Horowitz et al., 1979, Weiss & Marmar, 1996) was selected as the most appropriate measure for the present study.

The City Birth Trauma Scale ([CBTS]Ayers et al., 2018) was designed to measure birth-related PTSD, however at the time of data collection, the development of the measure for use with fathers and birth partners (Webb et al., 2021), was not readily developed. The Post-traumatic Stress Disorder Questionnaire ([PTSD-Q], Czarnocka & Slade, 2000), was also considered, however had only been used in two studies on birth partners and was not designed to measure PTSD following birth (Iles et al., 2011). Another measure, the Perinatal PTSD Questionnaire ([PPQ], Callahan & Borja, 2008), measuring perinatal PTSD used with fathers and birth partners (Janis et al., 2017) was considered, however it appeared that the items did not cover diagnostic criteria for PTSD.

After reviewing the available measures, the IES and IES-R were considered as the two most appropriate measures. These will be discussed further below, concluding with why the IES-R was selected for the present study. The IES (Horowitz et al., 1979) is a questionnaire used to measure participants' subjective level of trauma. This measure was

considered for the present study as it has been used successfully in studies exploring the experiences of birth partners (Ayers et al., 2007; Gürber et al., 2017; Winter et al., 2018). However, the IES was developed prior to the release of the DSM-III criteria of PTSD (APA, 1980) and was constructed with the two subscales of intrusion and avoidance (Horowitz et al., 1979). The IES has also received criticism for falling short as a measure covering the diagnostic criteria for PTSD according to the DSM (Joseph, 2000). It can be viewed that the IES-R, (Horowitz et al., 1979, Weiss & Marmar, 1996) (see Appendix I) is a more appropriate measure as it contains additional items to the IES related to the hyperarousal symptoms of PTSD that correspond directly to 14 of the 17 DSM-IV symptoms of PTSD (Weiss & Marmar, 1996). The properties of the IES-R will be discussed further below.

The IES-R measure consists of 22 items, which participants rate on a 5-point scale from 0 (Not at all) to 4 (Extremely) based on how distressed they had been by their difficulties over the past seven days in relation to a specific trauma. Higher scores indicate more severe symptoms: scores of 24 or more suggest that these symptoms are of clinical concern (Asukai et al., 2002), scores of 33 and above represents the cut-off for a probable diagnosis of PTSD (Creamer et al., 2002) and scores of 37 and above indicate difficulties severe enough to potentially suppress immune system functioning (Kawamura et al., 2001)

The IES-R has been found to have high internal consistency (alpha=0.96) (Creamer et al., 2002) and good concurrent and discriminative validity (Beck et al., 2008). This measure has been used in previous childbirth studies (Abdollahpour et al., 2017; Denis et al., 2011; De Schepper et al., 2016; Gökçe İsbİr et al., 2016; Goutaudier et al., 2012; Lemola et al., 2007), thus the validity and reliability of its' use as a measure of trauma has been strongly supported. Further, the IES-R has been demonstrated to have good reliability (intrusion mean α=0.86; avoidance mean α=0.82) and validity (Sundin & Horowitz, 2002).

Designing the interview topic guide. The process of designing the interview topic guide began by engaging in a consultation with the members of the Make Birth Better network and Dr Andrew Mayers, who both have extensive experience of working directly with affected fathers. The interview employed the use of a topic guide that was developed from existing literature and from previous research in which fathers experience of birth trauma had been explored (Etheridge & Slade, 2017). The topic guide from Etheridge and Slade (2017)'s study was used for reference for the present study as the two research studies had similar objectives. The topic guide for present research paper was discussed, and feedback was provided that the questions and the order they appeared in were appropriate and did not need adjusting.

Data analysis methods. There are numerous methods of analysing qualitative data. Interpretative Phenomenological Analysis (IPA) and Thematic Analysis (TA) have been highlighted as two main approaches appropriate for analysing semi-structured interviews (Coolican, 2014). These two approaches will be outlined and considered below, concluding with the reason that TA was selected as the data analysis method for the present research.

Interpretative Phenomenological Analysis (IPA). IPA is a qualitative analysis approach that aims to provide detailed examinations of personal lived experience (Smith et al., 2009). IPA has a greater focus on analysis between cases and allows the researcher to acknowledge specific areas of interest prior to beginning analysis. IPA tends to analyse individual cases in greater depth before attempting any integration between cases, with a greater focus on individual characteristics (King, 2004). IPA is bound to a pre-existing theoretical framework and phenomenological epistemological position (Smith et al., 2009).

For this reason, IPA was deemed inappropriate for the present research study due to its idiographic focus (Smith, 2008). Additionally, a key principle of IPA is highlighting the individuality of experiences (Smith et al., 2009). Due to the lack of research on Black fathers' experience of birth trauma, it was decided that a more specific focus on patterns across participants was most important. Further, IPA also typically requires a smaller sample size of between 3 and 6 participants (Smith et al., 2009). As the present study had a sample size of 10, it was determined that TA would be a more suitable data analysis method.

Thematic analysis. TA is one of the most used techniques in qualitative data analysis methods (Bryman & Bell, 2011). TA is a qualitative method for uncovering a collection of themes and patterned responses of meaning across all participants within a dataset (Braun & Clarke, 2006). There are many ways to approach thematic analysis (Javadi & Zarea, 2016). As the aim of the research was to look at the experience of Black fathers as a homogenous group, it was decided that TA would be the most appropriate data analysis method. Unlike IPA, TA is not tied to an epistemological or theoretical perspective and can be applied to critical realism amongst many other approaches (Braun & Clarke, 2006).

In line with Braun & Clarke (2006), the reflexive approach to TA was used, as opposed to coding reliability of codebook. The analysis was driven by the data and content of the interviews, with a focus on understanding the experiences of Black men who had experienced a traumatic birth. Links and meanings were also made between codes that emerged from the data, as a way of semantically identifying surface meanings of the data (Braun & Clarke, 2006 p. 84). Due to the present research study being an area that has received little research, an in-depth analysis of the entire data set was conducted, as opposed to focusing on individual experiences and characteristics, as has been suggested by Braun & Clarke (2006).

Credibility of Analysis. Due to the potential for misinterpretations of the data as a result of influence by the researcher's own position, the following measures were taken to minimize the likelihood of bias and to ensure credibility of the data. Yardley's (2000) paper, outlines criteria to improve credibility of qualitative research; steps were taken from this paper and implemented in the study. Both a research and reflective log were kept by the researcher in order to provide context for the interviews and to note any pertinent information mentioned. Once the interview transcripts had been anonymised, initial codes were generated and were shared with the researcher's supervisor for the purpose of a credibility check. The researcher made use of peer supervision to ensure the themes identified related clearly to the participants' accounts.

Trustworthiness of the data. Validity and reliability are commonly examined in quantitative and qualitative research when assessing credibility (Ryan-Nicholls & Will, 2009). Qualitative research validity can be assessed based on trustworthiness (Shenton, 2004). Trustworthiness refers to the degree of confidence in the data, interpretation and methods used in a research study (Lincoln & Guba, 1985; Polit & Beck, 2014). It is argued that the aim of establishing trustworthiness is to confirm that the data found in qualitative research is "worth paying attention to" (Lincoln & Guba, 1985). There are five main criteria used to establish trustworthiness: i) credibility, which refers to whether the findings accurately represent the data; ii) transferability, which refers to whether the findings from the data can be extrapolated to other settings, people and contexts; iii) confirmability, which examines if the findings are impacted by researcher bias; iv) dependability, whether the findings are consistent and sustainable over time; and v) authenticity, which refers to the extent to which researchers have fairly shown a full range of realities (Lincoln & Guba, 1985).

To enhance credibility of the study a member checking strategy was used. This involved conducting follow up interviews with two of the participants, to validate the data was already gathered and to check the themes and sub-themes that emerged. The participants agreed that the interview transcripts were an accurate representation of what was shared in the interview and that the themes and subthemes reflected the overarching ideas of the experience that they shared.

Participants. Initially, a purposive sampling strategy was used in order to select participants who could provide in-depth insight into the research issue (Patton, 2002). Purposive sampling is the deliberate selection of participants due to specific characteristics or experience (Patton, 1990; Strauss & Corbin, 1998) and has been found to be appropriate for research with minority groups (Etikan et al., 2016). Purposive sampling was used as the present research study aimed to specifically explore the experiences of Black men who had experienced a birth that was traumatic for them. Following an initial call for participants, another method of sampling was used to increase numbers as only minimal numbers of expression of interest were received by the researcher. The use of snowball sampling was considered. Snowball sampling is a convenience sampling method, which involves asking participants who express an interest in participating in a study to pass on the study details to other suitable potential participants (Polit-O'Hara & Beck, 2006). Snowball sampling was determined as being a suitable method to recruit more participants, due to feedback received from participants who had been recruited to the study who shared that they knew of people who had shared similar experiences of a birth that they felt was traumatic for them and would be interested in participating. A sample size of 10 to 15 has been suggested as sufficient for a doctoral-level thesis (Braun & Clarke, 2006).

Inclusion criteria. Participants needed to identify as 'Black', which referred to being from African or Caribbean backgrounds according to collection and classification of ethnic group, national identity and religion data used in the UK (ONS, 2001). Participants were required to be partnered with Black women due to the findings from the MBRRACE report which stated that Black women were more likely to die in childbirth (Knight et al., 2020). Participants also had to be 18 years or above to take part in the research. This inclusion criterion ensured that the participant was of adult age. Participants also needed to have subjectively experienced a traumatic birth within the last 10 years. This was decided upon to widen the access rate for potential participants. Fathers who were present in the building where the perceived traumatic birth occurred, were to be included. Being a resident in the UK was also stipulated as part of inclusion criteria to account for potential extraneous factors linked to experiencing a birth outside of the participant's home country. As constructions of race vary widely across societies (Grosfoguel et al., 2015), the focus of the research was on the contextual specificities of the experience of Black men in the UK. Participants were also included in the study who described a trauma response to the birth with intense feelings of "fear, helplessness or horror" according to criterion A2 of DSM-IV (APA, 1994).

Exclusion criteria. Participants who did not identify as Black according to the 2001 Census (ONS, 2001) were excluded from the present study. Participants who did meet the ethnicity criteria but were not partnered with Black women were not eligible for participation in this study. Participants who experienced psychological difficulties for any other reason than a perceived traumatic birth were also not eligible for the research. Fathers who experienced the death of the partner or baby were also not eligible for the research due to the sensitive nature of the traumatic event. Participants whose partners had a diagnosis of a psychotic disorder (including schizophrenia) were not included also as it was decided that

this may have influenced their experience, perception and memory of the birth due to the recognised impairments across a number of cognitive domains including attention and working memory (Bowie & Harvey, 2006).

Ethical considerations.

Informed Consent. Consent was obtained directly from the participant via a written consent form. Participants required to complete, sign and return the informed consent form prior to participating in the research. Participants were encouraged to contact the researcher if they had any questions related to their participation in the research after reading the participant information sheet. Participants were also given the opportunity to ask questions prior to the interview. Interviews took place only once a written consent form had been completed and returned electronically by the participant. Verbal and written informed consent to participate in the study was gained from all participants.

Confidentiality and anonymity. Participants were required to share their demographics during the interview, which listed their age, occupation, ethnicity, and the number of children that they had. Data from participants were securely stored on a password-protected folder on the M Drive at the researcher's university that was only accessed by the researcher and their supervisors. Pseudonyms were then assigned to each participant, which would be used for writing up the data. Names of people, healthcare settings, e.g., hospitals, midwifery clinics and any other identifiable information were removed. If completely changing the name impacted on how the sentence or phrase uttered by the participant was understood, an alternative name was given instead. During the process of transcribing the interview, each transcript was given a unique code number, where only the researcher was aware of the corresponding name identifying the participants. The interviews were recorded

using an encrypted Dictaphone and via Zoom, then uploaded on the M Drive, before being transcribed. The researcher then deleted the original file from the Zoom platform.

Participants were provided with information regarding the limits of confidentiality on the information sheet that they read before consenting to participate in the study. If participants were to disclose any information where the participant themselves or other people were at risk of harm, the participant was made aware (where possible) that the information would have to be shared with appropriate parties e.g., Social Services, Police, Safeguarding Team.

Participants were also given an opportunity to discuss with the researcher any concerns they may have regarding the recording of the interview, confidentiality and/or other aspects of the study. Participants were informed that the recordings would be utilised only for the purpose of the present research study, although would be kept securely for a period of 5 years, with only the researcher and the research supervisors having access to the recorded data.

Researcher safety issues. In the initial stages of the study preparation, it was anticipated that participants would be given the choice of completing the interview either via Zoom or face-to-face, based on preference. During the research process, the COVID-19 global health pandemic occurred and resulted in all interviews being conducted via Zoom due to social distancing guidelines and lockdown restrictions. Due to the remote nature of the interview method, no safety issues related to the researcher were identified.

Risk of harm to participants. Due to the sensitive nature of the research area, it was acknowledged that participants could experience distress, or be re-traumatised by talking

about their experiences. As it was anticipated that most of the participants would not have accessed help, due to the lack of psychological support for them at present, it was apparent that the research could be involving participants who have possibly not yet dealt with their trauma before being interviewed. Participants who were negatively impacted or re-traumatised by any part of the research process were provided with the contact details of Dr Rebecca Moore and Dr Emma Svanberg from the Make Birth Better network, who were able to signpost clients to where they could provide clinical help.

The participants were considered to be vulnerable as they had witnessed something they perceived as traumatic. The research indicates that witnessing trauma can lead to several mental health difficulties, such as depression, anxiety, sleeping difficulties and stress (Do et al., 2019; Marvaldi et al., 2021; Torjesen, 2019). Engaging with vulnerable participants was viewed as necessary for the present research study as there is a dearth of research, and therefore understanding, of Black fathers who experience birth-related trauma. By interviewing the affected fathers, the researcher aimed to develop an understanding of their experiences and to explore what plans and measures could be put in place to provide Black fathers access to the support that they may need.

It was expected that the participants may experience a level of distress during the interview due to participants being required to reflect on and discuss an experience that they felt was very traumatic for them. In order to manage any distress that may occur in the interview, an emotional continuum scale rated between 0 and 100 was used (see Appendix J) The researcher checked in regularly during the interview to understand how the participants were feeling emotionally. If a participant gave a rating of more than 60, a short 5-minute break was offered before either continuing once the break was finished or postponing the interview to another day. In the event of any participants experiencing any lasting difficult emotions as a result of participating in the interview, access was granted to two senior mental

health practitioners (the clinical psychologist and psychiatrist at Make Birth Better) who were able to signpost the participants to where they could receive clinical help.

Participants were also able to take short breaks during the interview if they wished to do so and were made aware that they were able to refuse to answer any questions that they did not feel able to answer. Participants were made aware that if they had experienced any discomfort or distress as a result of taking part in the study, they would be given time to discuss any concerns with the researcher at the end of the interview. After the interview, participants were provided with a list of useful counselling and support services which they might have found helpful. None of the research participants required breaks in the interview, however one participant did request further mental health support, which was given.

Dissemination. The present research study is being submitted as a thesis in partial fulfilment of the University of Essex Doctorate in Clinical Psychology.

At the end of each interview, the researcher offered to provide either an electronic or hard copy of the study findings participants. The author aims for the findings from the study to be disseminated across perinatal services, and more importantly to commissioners, in order to raise awareness of paternal mental health, particularly after experiencing a traumatic birth. It is hoped that the findings from the present study will be published in the following journal – "BMC Pregnancy and Childbirth". A copy of the research project will also be provided to the Make Birth Better network to distribute where appropriate. It is anticipated that this research will be presented at relevant conferences on perinatal mental health, also.

CHAPTER THREE: FINDINGS

Chapter Overview

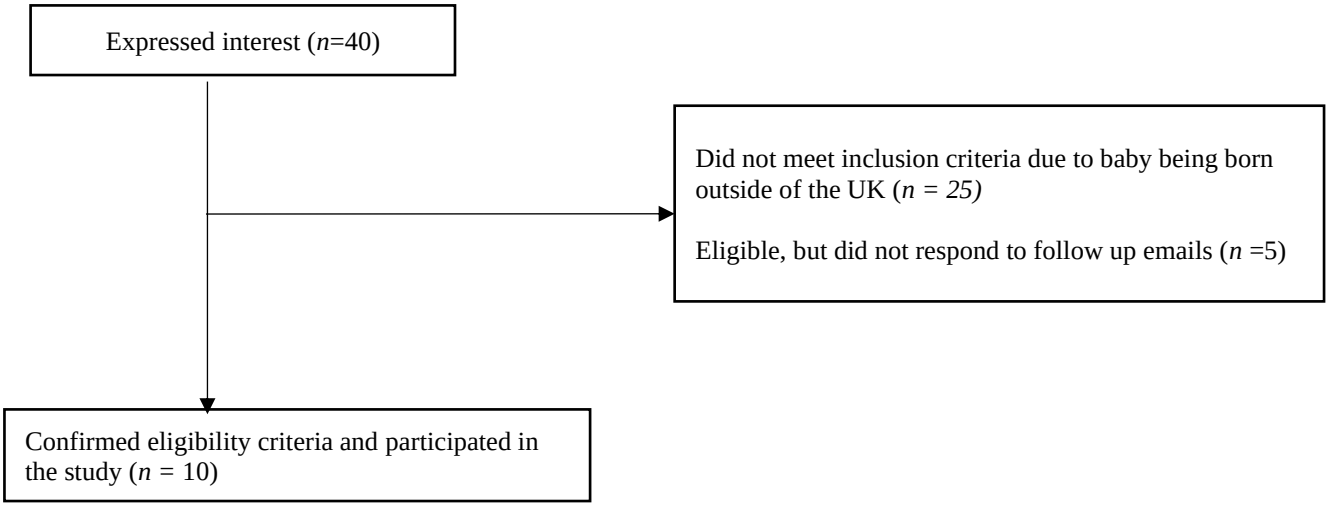
This chapter presents the results from the present research study. The demographic characteristics of the participants will firstly be presented. Secondly, the themes and sub themes will be outlined. Themes will then be expanded upon using verbatim extracts taken from interview transcripts with the participants. In order to preserve anonymity, any identifiable information was redacted, and pseudonyms used instead.

Participants

After advertising for people to participate in the study, a total of 40 people expressed interest (see Figure 1). Participant information sheets were then sent to the interested people to confirm that they met the eligibility criteria. Of those who expressed interest, 25 did not meet the inclusion criteria due to their baby not being born in the UK. A further 5 interested people did not respond to follow up emails that were sent by the researcher. The remaining 10 participants confirmed that they met the criteria and were still interested in participating in the study.

Figure 1.

Participant flow chart



The sample consisted of 10 males aged between 26 and 53 years old. The mean age was 33 (SD = 8.44). All participants self-identified as Black British (*n*=8 Black African; *n*=2 Black Caribbean). Their demographic information (age, ethnicity, child their birth trauma related to, and occupation) is presented in Table 2. The participants appeared to be a socioeconomically homogenous group and were all employed in professional occupations. The IES-R scores are presented in Table 3.

Interviews

The duration of the interview ranged from 18 minutes to 58 minutes. The mean interview duration time was 37 minutes.

Table 2.

Demographics of the study sample

Participant	Age	Ethnicity	Birth No	Time since birth	Occupation
Junior	36	Black British/ African Origin	Second child	2 years	Team Lead in the NHS
Mustafa	33	Black British/Caribbean Origin	First child	4 years	IT Consultant
Tayo	25	Black British/ African Origin	First child	2 years	Registered Nurse
Daniel	28	Black British/ African Origin	First child	6 years	Trainee Health Psychologist
Kelly	33	Black British/African Origin	First child	6 years	Fitness Instructor
Marcus	*27*	Black British/ African Origin	First child	12 months	Project Manager
Ade	30	Black British/ African Origin	First child	18 months	IT Engineer
James	53	Black British/Caribbean Origin	First child	17 years	Business Consultant
Tunde	28	Black British/ African Origin	First child	9 months	IT Data Analyst
Pierre	26	Black British/ African Origin	First child	12 months	HR Consultant

Table 3.

Impact of Events Scale-Revised scores

Participant	**Total IES-R score**	**Intrusion Subscale (mean)**	**Avoidance Subscale (mean)**	**Hyperarousal subscale (mean)**
Junior	1	0	0.13	0
Mustafa	33	1	2	1.5
Tayo	37	1.6	2.63	0.5
Daniel	0	0	0	0
Kelly	70	3.1	3.13	3.3
Marcus	59	2.9	2.38	2.83
Ade	47	3.25	0.75	2.5
James	0	0	0	0
Tunde	12	0.63	0.63	0.33
Pierre	30	1.5	1.88	0.5

Thematic analysis

From the 10 interviews that were conducted, 3 main themes and 11 sub themes were identified in the analysis. The themes and sub themes are presented in Table 4.

Table 4

Themes and sub-themes

Theme	Sub-theme
The experience of the birth	Witnessing pain
	I thought that my partner and baby were going to die
	Powerless and helpless
	Conflicting communication with staff
	Men don't show emotions
	Not entitled to complain
Race and disparities in quality of care	Black people's pain is not believed
	Quality of care dependent on your race and that of the healthcare staff
Coping with the trauma	My partner's mental health was prioritised over mine
	Therapy doesn't fit Black men or the culture
	I don't understand what therapy does or how it works

Theme One: The experience of the birth. The first theme looks at the overarching experience of the difficult births as described by participants. There was a shared feeling amongst participants of having no sense of agency and not being in control of the birthing experience for themselves and for their partner. Although they were physically present at the birth, the participants mainly described the experience as though they had been bystanders. There are 6 subthemes contained in this.

The first sub-theme, '*witnessing pain',* represents the emotional turmoil the participants felt as they were unable to support their partner in going through the physically challenging experience of giving birth, made even more difficult as the births were complicated. The second sub-theme, '*I thought that my partner and baby were going to die',* reflects the feelings of loss, mourning and fear the participants experienced during the difficult birth. The third sub-theme, '*powerless and helpless',* relates to the feelings expressed by the participants that they were a shadow in the room who had no control over what was happening and did not feel heard during the experience. The fourth sub-theme, '*conflicting communication with staff",* explores the negative experience participants felt they had when communicating with the healthcare staff who were involved in the birth experience. The fifth sub-theme, '*men don't show emotions,* explores participants' views on emotionality and masculinity and the belief that they had to conceal how affected they were by the birth. The sixth sub-theme, '*everything worked out in the end, I feel like I shouldn't complain',* relates to the processing of making sense of conflicting feelings around being traumatised by the birth experience but not wanting to do anything further due to the positive outcome.

1.1 '*Witnessing pain'*

Many participants reported the distress that they experienced whilst observing their partner in pain during the traumatic birth. They described having difficulty observing aspects of the birth, particularly in an emergency situation, for example the blood loss. Some shared their intense discomfort at being unable to alleviate the pain their partner was experiencing, which all participants described as causing a great deal of emotional pain for them. Mustafa uses a metaphor of the heart to describe the intense reaction that he had to his wife's pain and when she fainted:

> *"My wife in just the most pain she's ever dealt with and just crying for help. And that was just like, scrunching my heart up into pieces and seeing her drop on the floor was difficult."* (Mustafa)

Ade added to this and illustrates the lasting impact witnessing his partner in pain had on him, in discouraging him from going through the process of childbirth again:

> "*You could see, you know, the blood and guts and everything like that and then yeah…worried about my missus well-being, because obviously she's being cut open and all the rest of it…it was quite intense to see and experience. Seeing your partner in distress like that as well…it is a painful experience and is one of the things that sort of deters me from going through that again*" (Ade).

When concerns about the amount of pain their partners were in was reported to healthcare staff, participants reported that their concerns were not taken seriously. Tunde expressed his frustration that nothing was being done as his partner begged for help:

> "*There was a lot of...even when she was at 9 inches...[response from doctors] "let's wait and see. And if you're [partner] still in pain then we will". How much longer do we need to wait like it's quite clear, and she's in pain*" (Tunde).

Mustafa highlights that his partner's pain was almost seen as performative:

> "*My wife was screaming the whole labour ward down…there was just no urgency even when we told the nurses that she was in trouble. We weren't making it up, she can hear screaming. This isn't a performance. She needs help now. And we got ignored*" (Mustafa).

It appeared that this lack of response to a call for help played a role in why the event was viewed as traumatic by participants.

1.1. '*I thought that my partner and baby were going to die'.*

When describing their experience of the traumatic birth, most participants reported a belief that either their partner, or their baby, were going to die. Junior spoke about how he began evaluating whether he wanted to save his partner or his unborn baby:

> "*I think I'm thinking more about if she will make it through… I was thinking "I don't care if we lose the baby, you know, just make sure that she is fine". And I was thinking about you know, everything I was thinking about was around the end result. Whatever, whatever they needed to do. Just make sure that she [my wife] is okay. I just didn't want them to kill her. I will deal the repercussion of that. Rather than lose her and have the baby*" (Junior).

Mustafa and Ade spoke about the distress of the changes in the readings of medical equipment around them. In the absence of maternity staff explaining what the output meant, participants interpreted what they were seeing as their partner being in potential imminent danger:

> "*The heartbeat just disappeared off of the monitor. Which I can't even describe the feeling to you but like I was thinking that I was already going through the stages of loss and mourning because it was terrible*." (Mustafa)
>
> "*Seeing the heart meter to just, you know, go up really, really high and stop flashing and making noises…it was a very very traumatic experience*." (Ade).

1.3 *'Fathers are powerless, helpless and ignored'.*

The feeling of being powerless and ignored by healthcare staff during the traumatic event was reported by most participants. Participants described not feeling seen or being included by professionals and not being able to support their partner. Participants spoke about being excluded from the decision-making process:

> "*I could not do anything about what was going on and I felt helpless. That was the most difficult bit. I didn't know how she was feeling, she was smiling at me at one point but I wondered if she was hiding it (how she felt)…So yeah, in a way it was me being completely helpless and not being able to do anything*." (Mustafa).

> "*I just felt like I was outside of everything. You know, I just wasn't involved as part of it, you know? I just felt like I was there on the side, if anything*." (Tayo).

Other participants spoke about feeling unable to protect and support their baby and how this impacted on them:

> "*It is crazy for me to stand there and watch my child basically go through that pain…it took the power away from me because I couldn't do anything. I'm just standing there watching and basically comforting him when he opened his eyes and looked at me*." (Kelly).

> "*I felt helpless when it happened because my son's basically flatlined and as this guy [self] is supposed to be Superman for him. I couldn't do anything about it. I have to leave him for frankly, these, these strangers to keep them alive and that's already taken away from what I thought I was supposed to be as a father*." (Tunde)

It is apparent that some fathers view their role as one of protecting their child and felt they failed in doing so when they were not included in conversation with treating clinicians or able to physically support when the emergency occurred. When asking healthcare professionals about what was going on during the difficult birth, Junior reported that he was 'kept in the dark' and reported that he was repeatedly ignored:

> "*I understand that it is the woman carrying the baby and you know, the final say would be hers… she didn't get pregnant on her own. So it's kind of like, actually, you know, yes, you know, tell me about what is going on*." (Junior)

The impact of being ignored for this father resulted in him feeling as though he did not have a say in what happened to his baby despite both parents being involved in creating the baby.

1.4 '*Conflicting communication with staff'.*

All participants recognised that the traumatic birth they experienced resulted in extra pressure on staff to mediate the situation. Some participants expressed dissatisfaction with the responses that they received from staff. Not only from not being informed about what was happening with care, but also the reported insensitive interactions staff had with the participants and their lack of empathy. Marcus described feeling left to manage themselves and were not given information about what was going on:

> "*I didn't know what they're doing... I didn't know if it was going well that's it...there's literally no communication. A lot more a lot more explanation, a lot more empathy would have been good…Recognising that this is the first time I have gone through this definitely would have helped*." (Marcus)

Mustafa shared how the staff interactions with his partner were negative. He gives an example of when after his wife had her traumatic childbirth experience, one of the nurses tending to the family was more concerned about his wife's hygiene than acknowledging the extended traumatic experience that she had just been through:

> "*The nurse was asking my wife, "oh, have you had a shower? Why haven't you changed your clothes?" and my wife was like "What the fuck are you talking about? I've been in labour for four days, I mean I can't feel my right leg. I've been on drugs for the past, however many days so like nothing. I've got no energy, nothing". And this nurse was just "you should've had a shower" looking at my wife disgusted*." (Mustafa)

Other participants openly reflected about whether they would have wanted to know the full extent of the risks and dangers. Tunde drew on his background in biomedical sciences and expressed a conflict between his parental responsibility of wanting to know what was happening to his baby after he was taken from his unconscious partner and wanting to respect the medical judgements being made:

> "*No communication at all…I don't know, I'm not sure what it would have done. So if you tell me that my baby has flatlined does that cause hysteria? Panic? Which makes me want to interfere?...A part of me that's the medical side of me said you know what, I guess it's fine, but the father side of me is like, why are you not telling me what is going on with my child*." (Tunde).

James reported a different experience from the other participants and expressed that the healthcare staff had excellent communication with him and kept him informed about all that was going on. He explained that when the complications around the birth were told to him, staff did so in a caring way:

> "*So we had all these kind of unfavourable outcomes that were kind of thrown out us, but in a in a nice manner it wasn't, you know, throw away comments. It was sitting down with us and talking us through it and providing the support that. What you would expect from a NHS hospital and support staff, they were incredibly caring*." (James).

1.5 '*Men don't show emotions'*

Many of the participants described the need to prioritise the wellbeing of their partner and baby and conceal the extent of how distressed they had been by the difficult birth. Junior spoke about ongoing feelings of anger that he was unsure of the source of, whilst Marcus highlighted his belief that men need to support their partners and not be distressed:

> "*I was getting really, really angry. Which really isn't me…I wasn't just angry one day; I was constantly angry…something we explored was if it could be related to the birth. I think probably there was a lot going on that I didn't know about we actually ended up splitting up…I started to think if there was a link to that [the birth]*." (Junior)

> "*You have got to be the man in these situations. You have to be the top guy and get things done. You have to be there for your child now, no time to wallow in your emotions, I guess*." (Marcus)

Mustafa added to this, expressing that the role of a father at childbirth is only to support their partner:

> "*I think it's like your wife has one job. And that's the focus on the labour and your role [as a man] is to make sure that she is supported and comfortable*." (Mustafa)

Kelly shared that he did not feel it was appropriate to focus on his distress when his newborn son was still at risk:

> "*I just thought to myself, what's done is done…It's not time to think about myself and what I went though, it is now basically just time to basically make sure he's [newborn son] good at the moment*." (Kelly)

Tunde spoke about not feeling that he had space to express the full extent of his despair of not knowing what was happening to his baby due to the need to comfort his partner, whilst Tayo shared that he felt unable to express his distress due to his interactions with the healthcare staff:

> "*My child's not breathing and I have to carry on like comforting you [wife] when I kind of feel like I need comfort at this time and I'm the one that has information I'm the one that knows what's going on. You [wife] have no idea what's gonna happen yet. Yeah, it's typical who cares for the carer sort of thing*." (Tunde)

> "*I kind of just keep away and kept to myself. I didn't really want to speak to people. I didn't really feel like I could talk to anyone about how I was feeling especially how, you know, I'd already been judged... I felt like people [the staff] were being judgmental."* (Tayo)

1.6 '*Not entitled to complain'.*

When discussing the aftermath of the traumatic birth, there was a shared feeling amongst participants that they couldn't dwell on what happened as their babies and partners ended up safe and well. The fathers spoke about prioritising the health of their partner and baby over their need to complain about their experience. Junior shared that he contemplated making a complaint due to how poor he experienced care in relation to the difficult birth, however changed his mind after he met his newborn daughter:

> "*I was actually going to make a complaint. But when Daisy came out, you just forget all of that and think "you know what, I will just leave it*." (Junior)

Marcus discussed ‘pushing the traumatic birth to the back of his mind’ as a means of coping with what happened and focusing on the health of his partner and newborn instead. Adding to this, James and Pierre shared that the health and wellbeing of their partner and wellbeing was priority and overshadowed the traumatic experience that they had endured:

> “*My mind focused on the fact that she's [newborn daughter] here. Now I need to try to push it to the back of my mind. I know my way of coping. Making sure that her mom was alright as well was my priority*.” (Marcus)

> “*So…You don't.... when you have a favourable outcome, you don't focus on the negatives. You just think about the positives… the most important thing is that, both mother and baby came out, healthy, and I think that's the best outcome in that certain scenario*.” (James)

> “*I feel like regardless of how what happens during the pregnancy and birth for as long as your baby's here she's alive. She's healthy, mom's healthy, you're always going to be happy. Always going to feel relief. You're always going to feel, you know, happy emotions, regardless of what's kind of going on*.” (Pierre)

Theme Two: Race and quality of care. The second theme explores participants’ reports of how they believed their race was involved in the treatment and quality of care that they received, with comparisons made to other couples around them. The theme represents the experiences of participants who reported that their quality of care was negatively impacted because of their race and highlights the comparisons participants made between

their experience compared to expectant parents of other races. It includes consideration of the race of healthcare professionals who were either the same or different race to them. The first sub-theme, '*Black people's pain is not believed,'* is related to accounts given by participants where they viewed their partner's or baby's pain as not being taken seriously due to their race. The second sub-theme, '*Quality of care dependent on your race and that of the healthcare staff*', highlights the discrepant treatment participants perceived that they received in comparison to expectant couples who were not Black and outlines how this was impacted by the race of the healthcare staff. This sub-theme also presents descriptions from participants on how they believed they had to, as Black men, change their presentation in order to receive 'good care' from healthcare staff.

2.1 '*Black people's pain is not believed,'.*

Although all participants described distress at seeing their partner in pain, a small minority of participants identified this observable pain in their partner as being something that was underestimated in Black people:

> "*So it's a thing where like Black people obviously are seen as strong and that we can go through pain and whatnot. It made me think to myself now wait, hold on. So they think that because we are Black that we can go through pain? Is that what it was*?" (Kelly)

The newborn son of Kelly was required to have injections after he was born. In discussions, Kelly questioned whether the doctors were being too abrupt with his son as healthcare professionals held a belief that Black people, including children, could tolerate more pain than White people. Tunde describes how his partner was questioned repeatedly when she

expressed that her epidural had failed and expressed his concern with the amount of times her cries for help were questioned:

> "*They gave her an epidural and she says she can feel still feel [the pain] and they kind of questioned it a bit too much for my liking …From a human point of view, it just sounded like okay, we know what we're doing over you knowing how you feel. …I can't say whether it was racially motivated or not because it was one experience I had…but from things I've heard from other friends and stuff like that, it sounds like you know, that's what they [professionals] do*." (Tunde)

This revealed a concern held by Black men that their partners' pain is not responded to due to presumptions held by staff around high pain tolerance in Black people:

2.2 *'Quality of care dependent on your race and that of the healthcare staff.*

Some participants shared that they believed the quality of care they received was based on their race and the race of the treating clinicians. Some fathers touched on the stereotypes, and the narrative of absent Black fathers was also explored in the interviews. Tayo shared that he believed healthcare staff were behaving in a judgmental manner towards him due to their own presumptions about the nature of his relationship with his partner:

> "*It was almost like eyes of judgmentalness. Like [the healthcare staff were thinking] "oh yeah here another Black guy who has got another girl pregnant", you know, some of the looks I was getting was just unbelievable and just made us feel so so uncomfortable, you know, like I can't imagine this happening to anyone. They made*

> *me judge myself, it really affected me… it affected the connection I have with my child, it really messed me up*." (Tayo)

Tunde recognises this stereotype and added to this and explains that involving fathers early in the childbirth experience can help to change the narrative and allow the space for Black fathers to bond with their children and remain present in their lives:

> "*It honestly opens up like what's clear within my [Black] community, especially in the realm of like single parenthood … If we can get a father involved in their child's development as much as possible and he feels that connection from early, then hopefully… he will remain in that child's life*." (Tunde)

The strong bond between father and baby is evident in this sample. Junior and Ade spoke to the close relationship they have with their children:

> "*Taiwo [baby] will literally come and sit down with me when I sit down. She is so close [with me]. Sometimes I look into her eyes and I know that she sees me. There is a strong bond between us*." (Junior)

> "*My daughter is one of the most beautiful things I've ever seen…I'm glad I did [it]. It is a blessing and I wouldn't change it at all*." (Ade)

Marcus also shared this feeling and mentions attempts he made to prevent the close relationship with his child developing due to fear of losing her however, spoke about how he was unable to prevent it happening:

> “I didn't want to be vulnerable and open myself to her [baby] in case I lost her from something traumatic again but then the love that I feel for her is overwhelming and I couldn't do that if I tried.” (Marcus)

Other participants shared that the concerns they raised about their partner or baby were received more negatively in comparison to concerns expressed by fathers who were not Black. Kelly describes how when he raised concerns about the treatment of his baby, he was perceived to be aggressive and raising his voice, resulting in him being threatened with being removed from the hospital, whilst a father who was believed to be from a White ethnic background and had been acting in the same manner, received a more favourable response from staff:

> “*We are not angry we are not aggressive but now it's a thing where us being a certain way which is us being passionate, for some reason you take that as me being angry and whatnot… It’s like it's not fair…You're seeing them tell other [White] people, "calm down. Just relax"… [for me] there was no calm down. It was a "if you continue to raise your voice and be aggressive and angry and I will have to ask you to leave the hospital". So why is it that I see these people act in the exact same way as me a different colour, they're getting treated differently*?” (Kelly)

Daniel shared that his concerns were not taken seriously and questions if whether the intersection of being from a deprived part of London as well as young parents may have played a part too. Pierre builds on this and describes how staff appeared to be more attentive to expectant couples who were not Black, including taking less time to respond to those

couples when they pressed the emergency buzzer for support and in their interactions with them:

> "*We were just two young, Black people from South London…maybe in a room that's all they [healthcare staff] saw in these two young people. You know, South London "Who are they?" kinda thing... I'm not saying that they intentionally you know, didn't do anything because I am Black. Yeah, just that, maybe, you know, they would have taken us a bit more seriously, or you know listened a bit more*." (Daniel)

> "*I could see that you know, they were a lot more attentive to the other couples that were there. There was an Asian couple and there was a White couple as well. And I felt as though they were a lot more attentive, they were dealing with them differently they spoke to them differently. Whenever they press the buzzer they were straight there, but with us things they take a little bit longer. My girlfriend was in pain. They didn't really you know come straight away*." (Pierre)

Mustafa discussed his experience of being in a support group that he attends for Black parents where other Black couples disclosed similar experiences to ones that he had during labour. Daniel, who works for the NHS, reflected on his experience of the birth years later and recognised some aspects of the treatment that he and his family received that may have been race-related:

> "*We do have friends who are different ethnicities who went to the same hospital who had a fairly positive experience. And the friend who had the negative experiences was also Black…Although there's never been a thing to point to and say "this has been race-related", the gut feeling was that it definitely was because the shared experiences [of friends of the same ethnicity] in these groups is ridiculous*." (Mustafa)

> "*I've gotten older you know, read and read and, you know, seeing the impact of medicalised racism and systemic institutional racism in the NHS and also how Black women are five times more likely to die during childbirth…I have noticed all of that now*." (Daniel)

Ade shared a different view and believed that he and his partner were treated more favourably because of the interracial nature of their coupling and their expectant baby:

> "*We actually were shown a lot of love. I think because my missus is oriental and I am Black. So it's quite a rare mix. So the term I like to use is 'Blasian' but everyone was very curious to see, you know what, Isabella [expectant baby] would look like. So I think we were shown a lot of love and attention more so than of other parents*." (Ade).

Participants rated the quality of care they received to be better when they were 'of colour' i.e., from a minority ethnic background. Tunde outlined how Black healthcare staff went above and beyond to ensure that he felt involved in the childbirth process:

> "*I definitely felt included lot more with Black healthcare professionals, bringing daddy in…there were a few non-Black healthcare professionals...I think there was one White nurse who brought us in but no it was the much older Black healthcare professionals who we actually came across by quite a bit, who were very much like "daddy you are a part of this process, you need to be involved". …Yeah, there was definitely a lot more compassion and almost felt a lot more familiarity, almost like I see you like my son and daughter*." (Tunde)

James highlights that he was unsure how the quality of care may have been different as in his experience, he had all healthcare professionals of colour:

> "*Because we had professionals of colour… It didn't feel as though we were treated less fairly based on our colour, probably because we were treated by people of colour too*." (James)

Participants also shared how they believed they had to adapt how they came across so that they would be viewed positively and receive good care. Pierre spoke about how he had to adjust how he spoke and presented himself so that he would not be viewed as threatening. He also makes comments about how his experience in the hospital reflects what happens in wider society:

> "*I don't want to be the angry Black guy that's you know, just going off on one so I kind of just had to tone it down and keep my cool…If I if I speak with a steady tone it comes across straight away as being aggressive and it makes you kind of tone yourself down…In everyday life. I have to adjust myself. It's not even just about being in the hospital…At work I have to look at the way I'm coming across, making sure I'm not saying certain things the way I would tell my friends. Get on the bus, you know, getting on the train dealing with everyday people. It's like that. So, of course, it being in a hospital just enhance it by 10*." (Pierre)

Insight from Kelly added to this, where he shared that he has learned how to compose himself for the next time he is met with a difficult scenario, in order to have his concerns heard and to receive the care that his family needs:

> "*Now I know how to, like, you know, I know how to confront that situation. I won't be hostile like that now, [I will say] 'you can't be doing that. Not sure of that. Please can you just take easy'*." (Kelly)

Theme Three: Coping with the trauma. This theme related to the notion of therapy as being something that was 'not for Black people' shared amongst participants, as well services not being visible and the female partner's mental health being given priority. The process of coping with the traumatic birth was outlined by all participants as being something that they struggled with and sought to do so using practical strategies or by turning to their faith. The first sub-theme, '*My partner's mental health was prioritised over mine',* relates to the perception by participants that their reaction to the difficult birth was not thought of as important in comparison to their female partner and outlines the absence of mental health support that was offered to them. The second sub-theme, '*I don't understand what therapy does, or how it works',* highlights the lack of understanding from participants around what therapy can do to alleviate distress. The sub-theme also outlines reasons why participants are hesitant about speaking to professionals. The third sub-theme, '*therapy doesn't fit Black men or the culture',* reflects participants explanations about why therapy is alien to them and demonstrates beliefs around a Eurocentric view of therapy and a preference for faith and spirituality as a means of coping with a traumatic event.

3.1 *'My partner's mental health was prioritised over mine'.*

When discussing the impact of the traumatic birth on their mental wellbeing, participants described how the mental health of their female partner was given precedence over theirs. Junior and Tayo shared their frustration that because the father is perceived as not having physically given birth, not much focus is given to the possibility that he may be vicariously traumatised by the experience. Marcus refers to the earlier discussed notion of men feeling like they must put their distress aside after experiencing trauma, however, highlights the importance of the father acting as a cradle for the family:

> "*I think, it is more for the hospital to think about how to support fathers… I think that the changes need to come from the hospital being inclusive and including the fathers. At the end of the day, you know, they will be the ones who deal with the repercussions not them…I'm the one dealing with the aftermath of it*." (Junior)

> "*I think that's where there's a flaw with childbirth, people don't realise the effect it has on the father as well. Okay, we're not the ones that push. We aren't the ones that go through labour and everything, but you know that it still has a psychological effect on us*." (Tayo)

> "*You're the dad, you go, you gotta be the strong one. So basically, the concern is on the mother which is understandable, but fathers hold the family and fathers matter too*." (Marcus)

A lot of the fathers also spoke about the feeling that healthcare staff supported this belief, as Tunde illustrates below:

> "*Nobody spoke to me about anything. Yeah. It was short and sweet... Like obviously it is not about me. But yeah, [I was] definitely not considered frankly like... [the treating clinicians thought] there's no way this could have affected me, it's not about you. You just come and support her because it's about her*." (Tunde)

Alongside reporting that the wellbeing of their partner was prioritised above theirs, participants discussed the invisibility they perceived of mental health services. Tayo spoke about only his partner being made aware of mental health support and nothing being told to him:

> "*I would only get support through her like she would have to tell me what support I could go for…I didn't know what was available to me…Obviously, being my first child. I've never really known about it so unless you know… So, let's say she didn't speak to me about it then no one would have spoken to me*." (Tayo)

3.2. *'I don't understand what therapy does, or how it works'.*

Discussing the participants' understanding of therapy and the process of it revealed a lack of knowledge around it and ideas around how it may be damaging. This was highlighted as a barrier to participants seeking support after experiencing a traumatic birth. Participants highlighted a lack of understanding about mental health and shared misconceptions about what happens in therapy. Junior shared that his professional identity as a senior health care professional in the NHS prevented him from engaging properly in therapy when he sought it out, even though his specialism was in mental health:

> "*As healthcare professionals, we feel like "we are experts, we don't need it". I know what you're going to tell me. And that's the truth. What are you going to tell me that I don't know*?" (Junior)

This suggests that men who hold professional identities, especially in healthcare, may be apprehensive about therapy as the shift from service provider to patient may be a difficult transition. Tayo and Daniel expressed a lack of knowledge about how therapy can work to help someone to process their distress:

> "*I don't know how they can help me. I don't know what they can say to me to make me feel better*." (Tayo)

> "*I didn't have a good understanding about mental health…at the time I didn't think I needed and I don't think I need any, you know, mental health support*." (Daniel)

Participants spoke about the reliance on recommendations from other people before understanding how therapy works and seeking sessions for themselves. Mustafa highlighted a dependence on other people to share the process of therapy and understanding how it works. Marcus outlined his aversion to therapy based on narratives that others had shared about how therapy can be damaging:

> "*I don't hear enough experiences from people who have gone to therapy to understand*." (Mustafa)

> *"[People] have said that therapists plant thoughts in your head and false memories or interpret something you have said and then make it seem like something worse or very traumatic when it is normal where you are from talking to like a friend*." (Marcus)

Pierre also shared his lack of knowledge about mental health services and that he wouldn't have known how help could have been given to him:

> "*There isn't there isn't enough knowledge or advice out there about for a lot. For example, don't know where to start to go to get a therapy session. So, in that sense, I guess. Yeah, they could probably do more in terms of putting the awareness of therapy and how it helps you and what it can do for you out there*." (Pierre)

A fear of what could be uncovered should one engage in therapy, was a worry shared by Tunde:

> "*I definitely know that I'm scared of what I might uncover about myself. I know there's a deep, deep rooted trauma*." (Tunde)

3.3. '*Therapy doesn't fit Black men or the culture.'*

Narratives around therapy not being aligned with Black men or their culture were shared by participants. Participants spoke about therapy not being something that was spoken about in their communities and believing that all therapists are of White ethnicity. Should participants seek support, they highlighted the importance of speaking to someone who they didn't have to explain the experience of being a Black person to and emphasised that they would prefer to speak to someone who 'got' them. This is illustrated by Marcus:

> "*I'll be more willing to [have therapy], just because it would be someone that can relate to me and I'll be able to relate to them rather than someone who grew up in a totally different environment and what is basically foreign."* (Marcus)

Mustafa added to this and spoke about how he found social support in a group specifically for Black fathers to explore their experiences of being Black, a parent and ideas of masculinity in the modern world:

> "*I'm now in a Facebook group [name redacted] and the WhatsApp group. And I go to their weekly meetings and weekly calls and I'm finding that it is very helpful. There are a few guys on there that kind of relate to my experiences and it's been really, really positive and my wife is trying to do Mums group as well*." (Mustafa)

Pierre shared that in his upbringing, therapy was not something that was spoken about and outlined why this means Black Nigerian men may not consider it, due to not being a part of the culture:

> "*It's just something that we as Nigerians probably don't do, and we don't know that, as in you wouldn't ever expect my mom and dad to say "oh we are going to marriage therapy" or something like that, they would sort of just deal it themselves. They have an issue they will talk or argue it out. So we, I feel as though as Nigerian Black men, we don't really come from that so we wouldn't turn to that [therapy], you know*." (Pierre)

Marcus added that emotional responses to distress is not something that is discussed in certain cultures in London:

> "*The culture that I grew up in south London, the man has to be the man you can't cry you can be sad you can feel your emotions they are seen like a weakness or things like you can't handle it*." (Marcus)

Turning to faith and spiritual leaders was highlighted by some participants as a type of support to cope with the distress of the traumatic birth, as an alternative to therapy. There appeared to be feelings of a higher power being responsible for alleviating pain and an unquestioning reliance on this. Mustafa talked about speaking to his pastor to release the shame that he felt regarding his response to the birth:

> *"[The pastor said] God empowers us. It's his message. Yeah, and it seems like he gave you guys [the participant and his partner] the strength you need to get past the obstacles. Other people have things to answer for because they did not do their best, and they should have done much better. And you know everything that you felt was real. Shame. Don't feel ashamed of the stuff that you felt*." (Mustafa)

Daniel and Pierre shared their use of prayer whilst in the hospital to lift the distress that they were experiencing during the traumatic birth:

> "*I'm a Christian. So I'll pray and it feels like a weight has been lifted off my shoulders, because it just feels like you know it's in God's hands, it's no longer in my hands, it's in God's hands. A weight has been lifted off of my shoulder. That's usually*

what I do...which is why I don't see...I can't think of anything else that I could do that would be, you know as successful." (Daniel)

"*I did reach out to God. Through you know, this prayer within myself and just asking God to make sure everything's okay and make sure she's well, that sort of thing.*" (Pierre)

CHAPTER FOUR: DISCUSSION

Chapter overview

This final chapter will review and discuss the findings of the present research in relation to the existing literature on mens' experience of birth trauma. Firstly, the main findings will be presented in relation to existing literature and psychological theory. Secondly, the strengths and limitations of the research will be presented and discussed. Thirdly, the implications of the present study findings will be considered in relation to policy, clinical and research contexts. Following this, recommendations will be made. Finally, a detailed reflexive account made by the researcher in considering their position as a relatively young, Black, female trainee clinical psychologist without children, who is a minority in both her profession and the society in which she lives in will be presented.

Main findings

Statement of findings. The study aimed to investigate the experience of Black fathers who experienced a birth that was traumatic for them. The present study is believed to be the first of its kind that focussed specifically on the experience of Black fathers. Ten participants shared their personal experiences. A thematic analysis was conducted and revealed three main themes and eleven sub-themes within them relating to such experiences.

Participants shared their experiences of being present during the birth of their baby that they felt was traumatic for them and described the experience as being that of powerlessness and helplessness. Witnessing their partner in pain, having a fear of their partner and/or baby dying and having poor communication with maternity staff, were all highlighted as factors that contributed to experiencing the birth as traumatic. The fathers expressed a view of birth as a female-dominated experience that was physically directed with

their partners in mind, and as such disclosed that they did not feel permitted to share their trauma response to the birth. Ideas around masculinity and the acceptance of men expressing emotions were also highlighted by participants.

The perception of a disparity in quality of care based on ethnicity was raised by most fathers. Participants shared that they did not believe their concerns about risk to their partner or unborn baby were listened to and highlighted concerns around their Black partner's pain not being taken seriously. Participants discussed the need to change their appearance and way of communicating (i.e., code switching[3]), to avoid the negative stereotypes associated with Black men e.g., that of the "angry black man", and made contrasts with fathers who were not Black, who did not have to make this adjustment in order to be received well by professionals. Two participants reported views that were distinct from other participants and did not believe that the quality of care they received was compromised due to their ethnicity or that of their partner, with one participant reporting that they believed the care they received was actually better as staff were intrigued by the interracial coupling of the participant and his Asian partner. These two experiences demonstrate that not all participants reported ethnicity or racism as being a factor that contributed to their negative experience of maternity services or the traumatic birth, suggesting that other aspects of the situation was experienced at traumatic.

When describing methods of coping with the traumatic birth, participants shared similar beliefs that both during and after the traumatic birth, professionals prioritised the mental well-being of their partner over theirs. Fathers shared not feeling considered by maternity staff and highlighted the importance of their mental health in being a support for the family. The interactions with maternity staff appeared to support this belief in fathers, as

[3] Code-switching involves adjusting one's style of speech, appearance, behavior, and expression in ways that will optimize the comfort of others in exchange for fair treatment, quality service, and employment opportunities. Research suggests that code-switching often occurs in spaces where negative stereotypes of Black people run counter to what are considered "appropriate" behaviors and norms for a specific environment.

support was not offered to them, or was only available through their partner accessing support for themselves. A narrative around therapy not "being for" Black men, was also shared, with formal therapy being described as absent from Black communities and in their upbringing. These beliefs were also strengthened by participants' comments about the lack of knowledge about what therapy consisted of and concerns around potentially having to explicitly explain the experience of being a Black man to a professional who would not understand the nuances and racialised experiences. A preference for informal support from other fathers was highlighted, with some participants sharing a need to receive support from other people who understood what it meant to be a "Black father".

Relevance to existing literature and psychological theory. This section will present the main findings in relation to existing literature and psychological theory. The findings from the present study are similar to that found in other studies exploring fathers' experience of traumatic births. In line with previous studies, fathers in the present study reported not feeling involved or included in the birth experience or in control of the experience (Daniels et al., 2020; Etheridge & Slade, 2017; Inglis et al., 2016; Nicholls & Ayers, 2007) which left them feeling side-lined (Elmir & Schmied, 2021; White, 2007). Participants in the current study also felt unable to express their distress at the traumatic birth due to protecting their partner's wellbeing and viewing their responsibility "as a man" to put their needs secondary to their partners. This is similar to findings from previous articles where fathers described concealing their distress as a "protective" measure for their partner (Etheridge & Slade, 2017) and conducive to "keeping the family together" (Inglis et al., 2016). Studies have indicated that the father's position as a 'supporter' and 'protector' is part of the socially dominant conception of masculinity in contemporary Western societies (Draper, 2003; Locock & Alexander, 2006). It is suggested that this focus on men's role as supporters does not encourage them to think about and prioritise their own feelings. The researcher argues that

more needs to be done to change this narrative to allow men to feel as though expressing their distress in response to a difficult birth does not compromise the role of 'protector', which they see as a desirable part of their identity (Smith, 1999a).

The experiences shared in the present study were highlighted as factors that contributed to the birth being appraised as traumatic. The shared commonality of the findings of the present research and that of previous studies suggests that these may be common experiences for all fathers who perceive a birth as traumatic, independent of ethnicity. However, there appeared to be race-related stressors identified by the participants in the present study, that have not been reported in prior research. The idea of race-related stressors being a contributory factor in the appraisal of events as traumatic has been suggested by Clark et al. (1999)'s biopsychosocial model. A UK study found that Black services users in a sample held a perception that mental health services replicated experiences of racism and discrimination that they had in wider society (Keating & Robertson, 2004). This suggests that racism may be a daily and chronic stressful experience for Black men. However, as the participants in the present study were not directly asked about their experiences of racism, it can only be speculated that this may have influenced their childbirth experience.

Qualitative studies have found that women's experience of birth trauma have identified interactions with caregivers as being a key factor in the experience of trauma (Elmir et al., 2010; Thomson & Downe, 2010). In the present study, it appeared that the perceived threat to life of the mother and/or baby was exacerbated due to healthcare professionals' perceived "unwillingness" to respond to the concerns raised by Black families during labour and being perceived to respond more positively to couples who were not Black. Studies have reported the discrepancies in medical professionals' responses to White women and women from minority backgrounds reporting anaesthesia failure (Morris & Schulman, 2014). More specifically, the risk of Black British women and babies dying in labour has

been strongly highlighted in the research (Knight et al., 2020). Previous research has also the 'superhumanization' of Black people (Waytz et al., 2014) and have suggested that this process results in the perception of Black people as incapable of experiencing pain (Gray & Wegner, 2009) and is supported by studies which have explored beliefs held by medical professionals about the pain threshold of Black women (Jomeen & Redshaw, 2013; Lyons et al., 2008). Fathers in the present study made reference to friends and family members who had reported similar negative experiences between healthcare providers and their Black pregnant partners. It appeared there was a shared consensus amongst some of the fathers in the present study about healthcare professionals perceived lack of urgency and concern in response to Black women reporting pain, which was believed to be due to their partner's ethnicity (i.e., being a Black woman). This has been reflected in the literature, where a disparity between beliefs about pain tolerance in Black and White patients have been reported by medical professionals (Badreldin et al., 2020; Dickason et al., 2015; Johnson et al., 2013; Morris & Schulman, 2014; Shah et al., 2013; Tamayo-Sarver et al., 2003; Waytz et al., 2014).

In a circumstance such as childbirth, where there is a high risk of perceived, and in some cases actual harm to either mum and/or baby (Knight et al., 2020), one can see how this lack of response by healthcare staff may contribute to the experience of the childbirth as being traumatic. This finding is in line with previous research in America which found that African American women were less likely than White women to be given pain medication after childbirth, and less likely to have their concerns taken seriously (Glance et al., 2007; Johnson et al., 2019) and American men from minority ethnic backgrounds partnered with minority women who reported experiences of discrimination, a mistrust of healthcare professionals and believed that their partner had received different treatment in comparison with women who were not from a minority background (Edwards et al., 2020) . The present study is one of the first to highlight the perceived response from healthcare staff to childbirth-

related pain in Black women in the UK, however it is noted that this has been from the perspective of the father as opposed to the mother. The current research contributes experiences of differential treatment and stereotyping by professionals to the literature on traumatic births. Themes from the present research supports findings from previous research into experiences of birth trauma from the perspective of the father, while adding critical understanding of specific experiences for Black men.

It appeared that some of the participants perceived maternity health services to replicate the experiences of discrimination felt within wider society. The experiences of Black men can be situated within Bronfenbrenner (1979)'s ecological systems theory. The model postulates that there are four main systems of influence: i) the microsystem (the individual); ii) the mesosystem, which are settings where the individual has direct contact (e.g., family, neighbourhood, work); iii) the exosystem, which are settings where events may occur that impact the happenings in the individual's immediate environment; and iv) the macrosystem, which consists of generalised patterns of ideology and organization of social institutions common to a particular culture or subculture and contains institutions such as the government and the economy. The macrosystem is postulated to influence the social, cultural, and historical aspects of an individual (Bronfenbrenner, 1979). The theory proposes that interactions between individuals and their social environment are reciprocal and states that behaviour both impacts and is impacted by the levels of influence (Bronfenbrenner, 1979). The ecological systems theory can be used to outline the disparate lived experiences between Black and White men. Black men are more likely to have a lower socioeconomic status and report more experiences of racism (Dunkel Schetter et al., 2013; Seaton, 2003)

Taken together, the present study has provided an understanding of how negative interactions with care providers due to racial bias can influence Black fathers' perceptions of trauma. This is in line with previous findings into mothers' experience of birth trauma which

identified negative interactions with care providers as being a key factor in the experience of trauma (Elmir et al., 2010; Reed et al., 2017; Thomson & Downe, 2010).

Bond with baby. In the literature, the impact of a traumatic birth on the parent-baby bond has reported inconsistent findings, with some studies indicating that mothers who experienced birth trauma had a perceived reduced bond with their baby (Cook et al., 2018; Dekel et al., 2018; Parfitt & Ayers, 2009), whilst others reported no impact (Nakić Radoš et al., 2020). Focussing specifically on fathers, some studies have reported a positive bond between father and child, following a traumatic birth (Elmir & Schmied, 2021; Etheridge & Slade, 2017), whilst others have reported long-term difficulties with emotional intimacy and expressing a desire to not have any further children (Daniels et al., 2020; Etheridge & Slade, 2017; Inglis et al., 2016; Nicholls & Ayers, 2007). The findings from the present study found that the fathers reported a strong relationship with their child. It is evident that the evidence of the impact of birth trauma on the father-infant bond is inconsistent and may be the result of different coping strategies used to process the traumatic birth.

In the present study, one of the fathers highlighted how the development of the father-baby bond was hindered by the approach and attitude of the treating clinicians, which he described as "judgemental" due to an assumption made about his relationship with his partner. Although this experience was only reported by one participant, it highlights the potential significance of the attitude and approach of healthcare practitioners on fathers.

Help-seeking and therapy. In line with a previous article where faith and spirituality were identified as a means of coping with the childbirth (Inglis et al., 2016), some participants in the present study reported similar beliefs around turning to faith and spirituality for guidance and support. Most of fathers in the present study cited reasons around culture and ethnicity as a barrier to seeking support. Participants in the present study shared that they did not believe there was a cultural fit between Black men and therapy,

reflecting on the absence of structured talking spaces to think about problems from their upbringings and within their communities. Some of the participants in the study shared a desire to have more informal support within a group where their identity as Black men would be valued and understood. The expression by participants of wanting support that reflected and incorporated their needs as Black men, highlights the importance of considering intersectionality and using an intersectional lens when developing and delivering services. The participants of the present study were Black fathers who had experienced a difficult birth, suggesting that there may be specific factors of what it means to be a Black person that were tied into their experience.

It appeared that the belief of therapy not being "for" Black people was linked to the lack of awareness and knowledge that participants expressed about how to seek support from mental health services. Participants raised concerns around therapy and shared the beliefs that they had around what it was, including a belief that it involved "planting false memories". Participants reflected on their upbringings; one participant expressed a need to feel understood by someone who was familiar with the experience of people from marginalised communities i.e., someone of a similar ethnic background. Others spoke more explicitly about accessing group support aimed at Black men that appeared to be a better cultural fit. These findings are in line with previous research which has identified a lack of cultural competence of clinicians (Mclean et al., 2003) and cultural models of illness (Knifton et al., 2010) as barriers to help seeking. Previous studies identified fears around mental health services replicating experiences of racism and discrimination (Keating & Robertson, 2004), which were not expressed in the present study. However, unlike the Keating & Robertson (2004) study which sought to explore the relationship between Black communities and mental health services, the present study was exploratory did not explicitly ask questions about experiences of racism and discrimination in society due to the objective of

understanding participants' experiences without being suggestive about what these experiences could consist of.

Taken together, it appears that concerns around what therapy consists of, is still a barrier to help-seeking. It can be viewed that services may need to adopt a more culturally sensitive approach in the marketing of services and to the services themselves, to first encourage Black men to access the service, and then in the delivery of the service, to maintain engagement. Further, reflection by teams is encouraged to reflect on the diversity of their workforce and considering if the clinicians on teams are representative of the communities in which they serve.

Birth trauma severity. The IES-R (Weiss & Marmar, 1997) is not a diagnostic tool, however, can be used to indicate if a person has experienced symptoms of post-traumatic stress. Seven out of the ten participants reported scores on the severe end of the scale. Of these seven participants, one participant obtained a score which was suggestive of PTSD and indicated that his difficulties might be a clinical concern (Asukai et al., 2002), and one participant reported a score that was in the range suggestive of a probable diagnosis of PTSD (Creamer et al., 2002), and five participants reported scores which would be high enough to potentially suppress their immune system functioning (Kawamura et al., 2001). This was particularly interesting as most of the participants reported "getting on" with life and prioritising the wellbeing of their partner and baby. This finding of the severity levels recorded by participants encourages a conversation around the identification and measurement of birth trauma by whom and using what measures.

Strengths and Limitations

Study sample. Although the study sample was varied in age and profession, the socioeconomic status of the sample group is homogeneous and within the middle-class bracket, with all the participants occupying professional occupations. Considering the intersectionality framework (Crenshaw, 1991), it could be argued that the experiences shared may not reflect those of Black men from a lower social class or those from the upper end of the socioeconomic scale. As most of the participants were from London, which is a diverse city, and experienced the traumatic birth in a London hospital, it can be suggested that the findings may not be true for Black men living outside of London or those whose child born in a hospital setting outside of the capital or in a more rural setting. The majority of the participants were Black African of Nigerian descent. The views of Black Caribbean men, Black African men who are not Nigerian and those of mixed and other ethnicities who identify as Black (e.g., Black Latino) were not represented in this study.

Further, all but one of the participants were first time fathers even though recruitment sought to capture the experiences of fathers regardless of their number of children. The views presented in the research around a traumatic birth could possibly reflect a lack of preparedness for the experience of childbirth and all that it entails and different results may have been obtained, if participants were partnered with multiparous women (i.e., not their first experience of childbirth). However, the participant who was not a first-time father still expressed experiences congruent with the other participants who were first-time fathers and research with women participants has found that multiparous women have still reported subjective traumatic birth experiences. Previous research has explored the impact of prior

traumatic childbirth on women's experience of subsequent childbirth (Beck & Watson, 2010; Holopainen et al., 2020), however to the best of the researcher's knowledge, there has not been any research conducted which has explicitly explored the impact of a prior non-traumatic childbirth experience on the appraisal of a subsequent birth as traumatic, concerning either women or men.

Research method. As an underrepresented research area, the use of a qualitative method was beneficial for the study's aims to understand the experienced of a group of people who are largely underrepresented in the literature on birth trauma. Qualitative methodology is often used when the area is new and under researched (Hammarberg et al., 2016). It appeared to benefit the study to utilise one-to-one interviews as opposed to focus groups as was initially considered, due to the varied experiences of the participants. During the interviews, a minority of the participants expressed views around 'not seeing racism'. As the majority of the participants cited ethnicity and racism as contributory factors to their negative experience, the researcher believes that this view of 'not seeing racism', could possibly have been suppressed by the participants if a focus group method had been selected, or the view could have been challenged extensively by other participants who have expressed discriminatory experiences and felt invalidated, if this view was shared.

Time passed since trauma. The length of time since the traumatic event varied from 8 months to 17 years. Thus, it is possible that the participants' perceptions had changed, or they may have forgotten aspects of their experiences. However, the vividness of the descriptions, the richness of detail and the raw intensity of the emotions that were expressed in the interviews, suggest that trauma is not temporal and the length of time since the traumatic event may not be synonymous with the intensity of the response to it (Blix et al., 2020). Participants who had experienced the traumatic birth years prior, recalled their

experience in as much depth and with equal emotion as participants where the trauma occurred more recently.

Race of researcher/interview. The researcher was the same race as the participants of the study. 'Researcher-as-insider' refers to the phenomena where the researcher carries out a topic related to them or a topic related to a group that they are associated with (Unluer, 2012). Goffman (1955) postulates that minority ethnic participants may scale down their expressions to sensitive questions in order to avoid embarrassing an interviewer of the majority group (i.e., White) to protect the 'conversational bridge' and maintain the flow of the interview. Being a researcher insider appeared to circumvent this as the participants appeared to be very open in their responses and rich information was gathered.

Stanfield (1994) argued that only researchers who have emerged from the life worlds of their participants can adequately capture their experiences. A key advantage of insider research is said to be the 'pre-understandings' the researcher brings to the design of the study (Brannick & Coghlan, 2007). Although highlighted as a strength, this is presented as a limitation in the current study. As a researcher, I found that I did not ask as many follow-up questions with content tied to race as I was viewed as an insider by both myself and the participants due to the culturally specific nuance and subtlety. An example of this is the stereotype of the "angry black man". This term was used by some of the participants to describe how they believed they could be perceived by staff present at the hospital. Being an insider researcher, I understood the term but did not consider asking participants to elaborate on their understanding of the term for the readers of this paper who may not be as familiar. Also, the stereotype may have meant different things to the men than it did to me as a researcher. As a Black woman, I held the assumption that there was one understanding of the stereotype when there may be many. In order to mitigate the potential impact on how I interpreted the findings of the study, I involved my supervisors, who were not from a Black

ethnic background, in the process of data analysis to review the interpretations that I had made of the data.

Implications and recommendations

Clinical. The findings from the present study have clinical implications for maternity and perinatal services. The researcher argues that a critical step in understanding the complexities of health disparities for populations from multiple historically oppressed groups is recognizing how systems of privilege and oppression intersect at the macro level and result in inequalities. The researcher would recommend for clinicians in these services to undertake formal training on unconscious bias to explore and understand how ones' own assumptions and beliefs about others can affect behaviour and decision making. This training would be useful for practitioners to utilise when engaging with populations who belong to multiple historically oppressed groups. This is in line with the Royal College of Midwives (RCM) Race Still Matters programme (RCM, 2020) which aims to train all RCM staff to recognise and challenge racism.

As participants in the present study identified a preference for speaking to someone who understood the challenges they faced because of their race, the researcher would recommend for Black fathers to be signposted to the Black African and Asian Therapy Network (www.baatn.org), where they would have the opportunity to be allocated a Black therapist, should they desire this. However, the researcher recommends that it is still the responsibility of all practitioners and clinicians, regardless of ethnicity, to develop and deliver anti-racist and cultural responsive training and practices that support communities of colour accessing and utilising mental health services and maternity services. People from White ethnic backgrounds form 89% of the population in England (GOV UK, 2020), which is also

reflected in the ethnicity statistics of those occupying senior and very senior manager roles within the NHS (GOV UK, 2021b; WRES, 2020) The researcher argues that it would be unfair to expect people from minority ethnic backgrounds to be solely responsible to undertake this work when they themselves may also face disadvantage.

Support initiatives are currently only offered to mothers who have experienced a complicated birth (NHS, 2016). With men being unlikely to seek support, the researcher recommends that services should offer both support and intervention to all fathers. The role of clinical psychology in the delivery of perinatal mental health services was outlined in the 2016 BPS report (BPS, 2016); clinical psychologists can offer training and supervision to healthcare staff on the nuances of recognising trauma in men, and by promoting a trauma-informed way of working. The researcher also recommends that at the point of assessment, clinical psychologists who may engage with families who have experienced a difficult birth experience should assess both the mother and the father equally. Research has indicated that fathers' mental health has an impact on child development (Ramchandani & Psychogiou, 2009; Rominov et al., 2016) and focusing on fathers' wellbeing can both increase protective factors and reduce risk factors for developing psychological difficulties which can impact the whole family. Understanding more about how birth trauma presents in partners can lead to better assessment for birth trauma.

Lastly, the perspectives of Black men who have named barriers to accessing mental health services after experiencing trauma have the potential to translate into tangible direction and framework for future equitable service delivery and professional clinical practice. The researcher argues that utilising service user participation (i.e., Black men) in developing services will be key in reviewing how services are marketed to those who have been deemed

'hard to reach' (Matsuda et al., 2016). Raising awareness of services and access pathways will help those understand how and where they can seek support should they need it.

Legislation and policy. There is the potential to prevent birth trauma in fathers by making changes to maternity care to reduce the number of men who experience birth as traumatic. A number of guidelines recommend for healthcare providers to offer fathers support and information with adjusting to their role and responsibilities within the family unit (NHS England, 2015; NICE, 2006). The findings from the present study suggest that this is not routinely being done and exposes the gap that exists between the recommendations from NICE and NHS guidelines and the actual experiences of parents.

NICE guidelines recommend for healthcare professionals to offer mothers psychological interventions if they experience birth trauma, however, asks for "partners to be encouraged to accept support from family and friends" (NICE 2014 guidelines, p.1.9.4). From the present findings, it is evident that some fathers do not feel as though they can receive support from their community due to cultural reasons or those around expectations of men and would benefit from being offered support. It is suggested that the NICE guidelines could be reconsidered to include a recommendation for fathers to seek and be offered psychological support. It is hoped that by reviewing the NICE guidelines, both clinicians and fathers may feel that the psychological support is intended for them.

The findings from the present study add to the on-going discussions in the DOH and Public Health England to develop the next phase of efforts to promote mental well-being among BME populations and address racial/ethnic inequality throughout the mental health system. I believe that the findings of this study would be relevant and inform the development of such efforts.

Further research. The mortality rate of Black women in the UK has been clearly identified, however there remains a significant lack of research into the experiences of these

women. Research into their experiences of a traumatic birth is warranted to begin to fully understand the experiences of Black women. Further, the researcher believes the exploration of Black couples' experiences of labour is important.

In the present study, only a limited number of participants explicitly identified the ethnicity of the treating healthcare professionals. Future research may benefit from including questions around the ethnicity of professionals to compare with that of participants (i.e. cross-ethnic or same-ethnic dyads), in order to explore the possible relationship between the ethnicity of the professional and the perceived quality of care given. Further, the findings from the present study indicated that trauma is not temporal and that the length of time since the traumatic event may not be significant in the experience of trauma symptoms in the present day. As participants in the present study had experienced a childbirth within the last 10 years, future research could explore the experiences of Black fathers who had children within any time frame.

Feedback and reflexivity

Feedback from participants. The literature on qualitative research highlights the importance of credibility (Lincoln et al., 2011). To check for credibility and ensure trustworthiness (Lorelli et al., 2017), all participants were approached to gain their feedback on the study findings. Four participants provided consent, however only one participant responded to a follow-up request sent via email. Following the analysis of the transcribed interviews, the participant was sent a copy of the findings, with the identified themes and subthemes and was invited to review and comment. The participant agreed with all of the themes and expressed a feeling of solidarity that although a very traumatic experience, he was not alone in what he had been through. The participant made no suggestions to the wording of the themes or the descriptions given.

Reflexivity. The process of undertaking this research study started with a general interest in subjugated voices. In the field of perinatal mental health, it is long recognised that the experiences of fathers are not held in the same esteem as the mother (Paulson & Bazemore, 2010). I found this quite interesting as fathers are involved in the baby's life from the point of conception through to childbirth and raising of the child. After doing research into the experiences of fathers who have had difficult births, it became apparent to me that most of the research only looked at White fathers and there was a great lack of existing academic research into Black fathers.

Reflexivity and self-reflection enhances the rigour of the research by identifying how the researchers' positions and interests affect the phases of the research process (Jootun et al., 2009; Ortlipp, 2008) and for this reason, during the process of undertaking the present study, I created a reflective journal and a memo log. This research occurred during a time of great unrest in the world for Black people during 2020. The Black Lives Matter (BLM) movement[4] (BBC News, 2020), which was exacerbated by the killing of unarmed Black men in America; COVID-19 disproportionately affecting people from minority ethnic backgrounds (Kirby, 2020), amongst others.

The overarching theme in my reflective logs was of feeling the need to highlight the voices of these men, who had long been suppressed, and to protect them. After conducting the interviews, I reflected on the feelings that I was left holding. I noted that each participant had commented to me about feeling pleased that someone was finally considering Black men in research and expressed greater pleasure that it was being done by a professional Black woman. At first, I felt a sense of pride that I was conducting research that would be of benefit to my community (i.e., the Black community), however after reviewing my reflective logs, I

[4] Black Lives Matter (BLM) is a decentralized political and social movement protesting against incidents of police brutality and all racially motivated violence against Black people.

noticed a recurrent theme. I demonstrated a tendency to consistently question if I had done these mens' experiences justice. I felt an incredible weight of wanting to do a good job and not wanting to let the participants down by failing to capture their stories effectively. This also encouraged me to reflect on my position as a Black trainee clinical psychologist who will soon qualify into a career where I am in the very small minority (Health and Social Care Information Centre, 2013; NHS, 2015) and whether this will be a weight that I feel I will always carry.

At the end of the research process, I noted that I experienced a feeling of sadness that I had not explored the experiences of Black women first. I was highly aware whilst writing this paper that my justification for the focus on Black men for the present research was because of their partnership with Black women who are five times more likely to die in childbirth here in the UK. There is a narrative in the Black community about the "strong Black woman" who is the backbone of the community supporting Black men who have been consistently oppressed by society, sometimes at a detriment to their own wellbeing. This research process occurred during the height of the BLM movement in the UK, with a focus on highlighting the value of the life and experiences of Black men, and I believe that this was the main contributory factor for the chosen topic area for this thesis. More importantly, exploring the experiences of Black women, as a woman of child-bearing age felt too close to home. Black women matter too, and their voices need to be heard equally.

As a researcher, I acknowledge that my perspective, background, history and context have all been brought to the research and will have influenced the lens through which I have made sense of participants' stories. My position as a Black woman in a professional role that holds privilege, was something I repeatedly reflected on and held in mind whilst conducting this research. I considered the transference and countertransference in the interview space. As participants shared their experiences, as a mid-twenties young woman, I wondered if my age

and gender impacted on how much they felt able to share with me in how they experienced a traumatic birth. I considered if the participants were protecting me from the full extent of what they experienced similar to how they reported that they did to their partners or were possibly protecting their masculinity by minimising the true impact of the traumatic birth on their wellbeing. Positioning Theory (Harré et al., 2009) draws upon this and explains that one's position influences what is shared and how it is interpreted by the researcher. In line with this, I reflected on how the participants possibly viewed me as the interview progressed: a researcher; a psychologist; or a young woman, and how my positionality may have influenced their answers.

Also considering my position as a young woman, I further reflected on my status as a woman who had not yet given birth and how this may have impacted on the research. I was aware that the experience of childbirth and delivery was something that I had little experience of and knowledge about, outside of the reading that I had done to prepare to conduct this study. I am aware of the gap in my experience and knowledge about what one would consider a normal experience and what one would consider to be out of the ordinary, or traumatic, when it came to childbirth. Having discussed this informally with female friends who had given birth to gain a better insight, some of the women reported that their partners had found it difficult to witness the delivery but did not believe that it was anything more than would be expected. Considering the findings from my research, which found that men often hid their distress from their partners, these conversations proved to be a helpful reminder of asking fathers directly about their experiences and not relying on their partner's interpretations. Further, reflecting on the clinical work that I undertake in my capacity as a trainee clinical psychologist, I recognised that I do not need to have experienced something myself to understand and validate another's experience. Ones' own experience of a distressing event does not provide a benchmark to compare how other people may experience the same event.

The implicit nature of how conversations happened during the interview was only made apparent to me after I had transcribed and analysed the interviews. Towards the latter end of the interviews, I realised that I had not probed participants to elaborate on certain concepts that dominated the themes of the interview or challenged their assumption, such as that of "the angry Black man". Upon reflection, I believe this was because as a Black woman, I am aware of what this stereotype, and other shared colloquial terms mean, and I believe that my participants presumed so too. This speaks to the nuances of engaging with someone from the same ethnic background as you, which is another theme that was highlighted in the data; Black men seeking support from those that they did not have to explicitly explain their race-related issues to, those who inherently understood the experience of being Black. In hindsight, I could have elaborated more by asking participants what their understanding of the stereotype meant for them, or how they believe it presented during their traumatic experience. This overfamiliarity has been mentioned in the literature on insider researcher (Brannick & Coghlan, 2007).

The interviews were dominated by themes of racism and not feeling involved in the birth or being offered support. I felt particularly uncomfortable and sad when I heard the experiences of the fathers who were essentially having to navigate two parallel processes: being a new father and being a Black man. Both appeared to be identities that were not considered during the childbirth process, but the latter identity appeared to be met with more negative reception. This reaffirmed to me the importance of researching the experiences of Black men specifically, as there are nuances in their experience that will not be found in White fathers or fathers from other ethnic minority backgrounds.

Gender versus Racial lens. Throughout the process of undertaking this research, I was repeatedly asked – "why Black men specifically? Is it not the same for all fathers?". Through conducting this research, I realised the importance of considering the use of multiple

lenses in approaching and reviewing the data, rather than an ‘either or’ approach when exploring the experiences of the participants. As a trainee psychologist who has worked with a large number of clients in different contexts, I am aware that one cannot begin to understand the experiences of others without holding in mind the multiple ways that their various identities intersect. In using a singular lens (e.g., racial or gender), there also runs a risk of negating the experiences of these men in an attempt to disentangle their identities. I hope that the findings from the present study encourage more reflections on intersectionality and using an intersectional lens and the different identities that can be located within a person. I aim to publish this research to widen the exposure of the experience of Black men to encourage both reflection and change within services.

The definition and measurement of birth trauma. As a psychologist, I reflected on the big (T) versus little (t) trauma debate (Shapiro, 2001) on what one would consider major trauma versus life events that have negative impacts on the mind (Cvetek, 2008). This is evidenced by the differing definitions of what birth trauma is conceptualised as, from ongoing emotional distress resulting from the delivery (Elmir et al., 2010), perception or actual injury to mother or baby (Beck & Watson, 2010), to obstetric complications resulting in physical injury sustained by an infant in the process of birth (Dumpa & Kamity, 2020). By undertaking this research and reviewing research articles utilising different definitions, it is clear that the perception of trauma lies in the “eye of the beholder” (Beck et al., 2013; Beck, 2004, p.35). As a psychologist, I would encourage for responsibility of defining trauma to lie with the client to prevent possible misidentification by professionals who may view a potentially traumatic birth as ‘routine’ (Beck et al., 2004; Delicate et al., 2020b). This has implications for clinical services in determining the criterion needed to be met and diagnostic measures used to be permitted access to perinatal services.

The participants in the present study also shared that they experienced a layer of difficulty that fathers from other studies did not - racism. Many of the fathers described racism as something that they experienced daily, which was replicated in the quality of care and interactions they had within maternity services.

Process of data analysis. The process of using thematic analysis was a non-linear one. I found that several codes fit into more than one theme. I also found myself going back and forth on the names I had given to themes, questioning if they could be named something else that would better contextualise and capture the phenomena of the interviews.

As a researcher I grappled with deciding what excerpts to include in the thematic analysis. This required me to determine the dominant and subjugated voices. I was torn between what voices would add strength to this research and what voice(s) may dilute it, due to the context and focus on wider societal issues. I believed it was important to ensure the stories of prejudice were told, but also equally important to highlight the experiences where race was not a factor and actually contributed to a more positive experience for some participants.

Conclusion. The present study adds to the growing literature on the experiences of fathers who have found childbirth traumatic. This is the first study of its nature to explore the experience of birth trauma from the perspective of Black men. The findings suggest that Black fathers experience race-related stressors because of their interactions with healthcare staff, that contribute to the experience of a birth as traumatic. From these findings, it is suggested that improvements can be made to maternity services to be more inclusive of fathers during the delivery to prevent the likelihood of developing birth trauma. Additionally, as is being done with women from minority backgrounds, maternity services should consider the intersectionality of experiences based on ethnicity and gender and improve the cultural

competencies of healthcare professions who engaging with Black fathers who experience stigma and stereotyping in society that can be replicated within maternity services.

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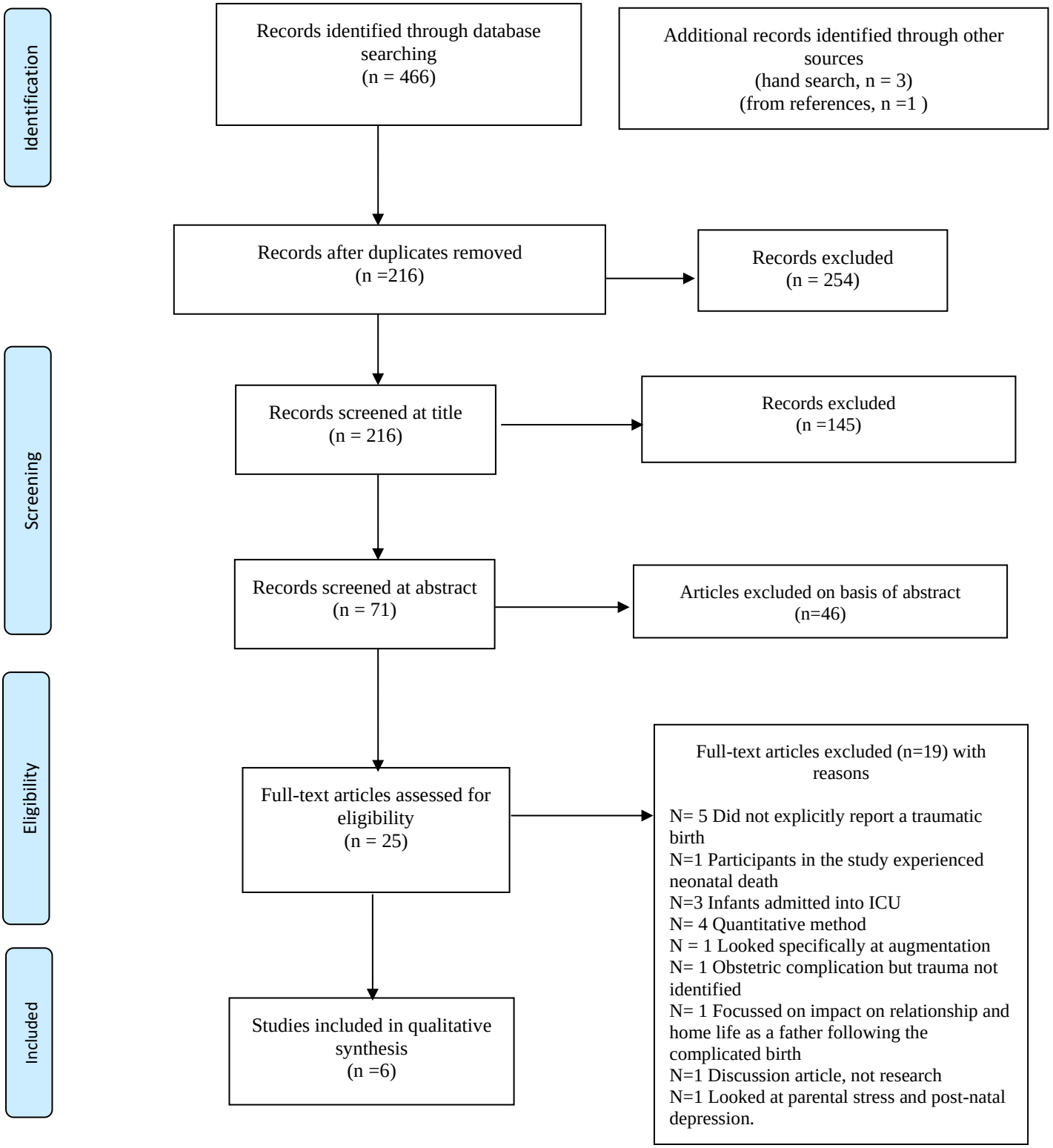
APPENDICES

Appendix A
PRISMA Flow diagram of literature search process



Appendix B

Summary Characteristics of articles included in the thematic synthesis

Author/Title/Location	Aim	Definition of birth trauma	Sample size	Methodology/Method	Ethnicity of participants	Inclusion criteria
Daniels et al. (2020) Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma United Kingdom	To explore fathers' experiences of witnessing a traumatic birth, how these experiences impacted their wellbeing and what support they received during and following the traumatic birth.	Physical and emotional suffering during birth that resulted from either complications, physical injury, or negative reactions during the birthing experience	61	Online qualitative questionnaire Thematic analysis	Not stated	UK-based father 18 years old < Witnessed their partner's traumatic birth
Elmir & Schmied (2021) A qualitative study of the impact of adverse birth experiences on fathers. Australia	To explore the immediate and longer-term impact of witnessed a complicated or adverse birth experiences on men in heterosexual relationships and their role as a father.	Not stated	17	Face to face (n=4) telephone (n=11) and email interviews (n=2) Thematic analysis	(n = 3) represented culturally and linguistically diverse backgrounds	Men who had witnessed a complicated birth or birth with an unexpected adverse outcome.
Etheridge & Slade (2017) Nothing's actually happened to me: the experiences of fathers who found childbirth traumatic United Kingdom	To investigate how men coped with a traumatic childbirth; the impact on their lives; and their views on what may have helped to reduce distress	Described a trauma response to the birth of "fear, helplessness or horror"	11	Semi-structured interviews Template analysis	Not stated	UK resident 16 years old < Present at the birth Answered 'yes' to feeling fear, helplessness or horror at a point during the birth
Inglis et al. (2016) Paternal mental health following perceived traumatic childbirth. Australia	To explore the experiences and perceptions of fathers after childbirth trauma	The actual or threat of harm to the mother or infant, including injury or death	69	Online qualitative survey (n=62) Semi-structured interviews (n=7) Thematic analysis	White n=65 Unknown n= 2 Black n=2	Fluent in English Trauma occurred at any phase during childbearing

Nicholls & Ayers (2007) Childbirth-related post-traumatic stress disorder in couples: a qualitative study. United Kingdom	To explore the experience and impact of childbirth-related PTSD in women and their partners	DSM I-V diagnostic PTSD criteria for childbirth-related PTSD in the first year after birth.	12 couples (6 men)	Semi-structured interviews Thematic analysis	White European n=12 White Australian n=1	18 years old < Fluent in English Trauma birth occurred over 3 months prior Both partners willing to be interviewed One member of the couple to have fulfilled DSM-IV PTSD diagnostic criteria
White (2007) You cope by breaking down in private: Fathers and PTSD following childbirth New Zealand	To explore the experiences of fathers who witnessed a traumatic birth	Actual or threatened death or serious injury to others, in this case, a loved one (their partner and/or their baby). Father's perception of the situation was essential	21	Verbal (direct to researcher or submitted on tape) or written (letter or email) Qualitative content analysis	White n=18 Minority (Maori) n=3	Not stated

Appendix C

CASP Qualitative Research Checklist of articles included in the thematic synthesis

Paper	Aim	Method	Design	Recruitment	Data collection	Researcher/participant r'ship considered?	Ethics	Analysis	Findings	Value	Outcome
Elmir & Schmied (2021)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Daniels et al. (2020)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	Included
Etheridge et al. (2017)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	Included
Inglis et al. (2016)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	Included
White (2007)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	Included
Nicholls & Ayers (2007)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	Included

Appendix D

Study recruitment poster

ARE YOU A BLACK FATHER?

Have you become a father for the first time, or again, within the last 10 years?
Did the birth of your child not go as expected, or was more difficult than you had imagined?
Did the birth leave a lasting negative impact on you?
Did you experience flashbacks, anxiety, nightmares, or feel low about what happened?
Or have you found it difficult transitioning to fatherhood?

My name is Lola Olukotun and I am a Trainee Clinical Psychologist at the University of Essex. For my research project, I am exploring the experiences of Black fathers who have experienced a birth that they felt was traumatic for them. There is a lot of research into the experiences of mothers who found birth very stressful and difficult, but a lack of research into how fathers experience birth trauma (i.e., a birth that was very difficult), and even less research and understanding of the experiences of Black fathers – I would like to uncover this. More understanding about Black fathers' experiences may lead to finding more effective ways of supporting them to speak to someone about what happened, and to seek treatment that is tailored to their needs.

Your participation would involve attending a short interview via Skype or Zoom. The interview will last for approximately 60 minutes, where you would be asked a series of questions tailored to help you to share your experiences. I will be able to send you the questions in advance, if you would like to know what to anticipate, and for us to think about anything you may prefer not to answer. This research project has been reviewed by and gained ethical approval from the University of Essex ethics committee.

<u>Unfortunately, if you meet any one of the below criteria, it may not be suitable for you to participate in this study:</u>

- Being a Black father who is under the age of 18, or was at the time of the birth
- If the birth experience led to the loss of the baby and/or mother, due to the sensitive nature of such a traumatic event
- If you experienced psychological difficulties for any other reason than a perceived traumatic birth
- If you were not present in the building where the childbirth happened during childbirth process

If you would like to participate in this study or you would like to know more about the study, please do not hesitate to contact me at oo18384@essex.ac.uk

Omolola Olukotun, Trainee Clinical Psychologist
University of Essex

Thank you.

University of Essex

Appendix E

Participant Information Sheet

Title of the Study: An exploration of the experience of Black fathers who have experienced the traumatic birth of their baby

My name is Lola Olukotun and I am a trainee clinical psychologist at the University of Essex. I would like to invite you to take part in a research study. Before you decide to participate, it is important for you to understand the purpose of the research, and what it will involve. Please take the time to read the following information carefully.

My research project is exploring the experiences of Black fathers who have experienced a birth that they felt was traumatic for them. There is a lot of research into the experiences of mothers who found birth very stressful and difficult, but a lack of research from the perspective of the father, and even less research and understanding of the experiences of Black fathers. This is something that I am looking to uncover. More understanding about Black fathers' experiences may lead to finding more effective ways of supporting them to speak to someone about what happened, and to seek treatment that is tailored to their needs.

What are the aims and objectives of this study?

This research study aims

- To explore the experiences of Black fathers who have experienced a traumatic birth of their baby. There is no specific definition of 'traumatic birth' for this study. For this study, traumatic birth is viewed as any birth that was experienced as very difficult, which could range anywhere from very minor changes in the birth plan to serious obstetric complications.

The objectives of this research study are

- To contribute to the knowledge base of birth trauma and in particular the experience of Black fathers
- To provide a space for fathers in order for their experiences to be heard and their needs considered.
- To provide healthcare practitioners with a nuanced understanding of this particular group in order for them to develop effective interventions for Black fathers and to reduce the restrictions of barriers identified which may be preventing them from accessing help.

Why have I been invited to participate?

You will have been invited to participate in this research if you identified yourself as a Black man who has experienced a birth of his baby that he felt was difficult or traumatic. I hope to interview 15 Black fathers.

What does taking part involve?

You will be required to sign an electronic consent form after reading this information sheet, prior to participating in the study. Your participation will involve attending an interview with me at a date and time convenient for you. This can be done via Zoom or Skype, two different types of video calling programs. Unfortunately, due to the current pandemic, we will not be able to meet face to face. Prior to taking part in the interview, I will ask you to complete a short questionnaire which will measure symptoms of stress regarding the birth of your baby. This questionnaire is not used to diagnose, but to help me to think about the different scores by participants and how they answer the interview questions. The interview will last for approximately 60 minutes and will be audio recorded. You will be asked questions about the birth in question, as well as how you coped with the aftermath and if or how, you sought help.

Do you have to take part?

There is no obligation to take part in this study because it is entirely voluntary. If you do wish to participate in this research study, you will be required to sign a consent form. After signing the consent form, if you change your mind about participating in the research, you are free to withdraw at any time without giving a reason. You data will then be immediately destroyed.

Who may not be suitable for the study?

- Fathers who are under the age of 18, or who were under 18 at the time of the birth
- Fathers whom the birth experience lead to the loss of the baby and/or mother, due to the sensitive nature of such a traumatic event
- Fathers who experienced psychological difficulties for any other reason than a perceived traumatic birth
- Fathers who were not present in the building where the childbirth occurred, at the time of the childbirth process

What are the possible disadvantages and risks of taking part in this study?

This study covers a topic that may evoke painful or very emotional memories, which may cause you some distress when reflecting on, and talking about such memories. In order to reduce the likelihood of feeling as though you are re-living what happened, you will only be asked fact-based questions about

the birth and will be given more space to talk about how the experience made you feel, and the lasting effects of it. The list of questions that I will ask, can also be sent to you in advance, so we can think about if there are any difficult questions that you may not want to answer. You will be able to take short breaks during the interview should you wish to do so, and you are free to decline to answer any questions that you do not feel like answering. If at the end of the interview you have any concerns, you will be given time to discuss with me any concerns you may have.

Should you experience any discomfort or distress as a result of participating in this study, you will be offered post-interview support by the Make Birth Better network, who are a collective of parents and professionals who are dedicated to reduce the life-changing impact of birth trauma. Information for the Make Birth Better network and other relevant support organisations are listed at the bottom of this document.

Costs
There are no costs expected for participating in this study.

What if there is a problem?
If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator of the project, myself - Lola Olukotun, using the contact details at the end of this document. Alternatively, please get in touch with my research supervisor, Dr Frances Blumenfeld (fblume@essex.ac.uk).
If are still concerned, and think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal investigator, please contact the departmental Director of Research in the department responsible for this project, Dr Ewen Speed (esspeed@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager , Sarah Manning-Press (e-mail sarahm@essex.ac.uk).

Will my participation be kept confidential?
The information that you provide will be kept confidential unless there appears to be a risk of harm to yourself or to others. If it is deemed that there is a risk of harm to yourself or to others, the appropriate services and organisations will be notified of the situation. However, I will inform you of my concerns before doing so. Overall, all the information that you provide for this study will be securely stored, and all identifiable information will be removed or altered. For instance, pseudonyms (i.e., a fake name) will be given to all the participants in order to protect their anonymity. Only the researcher will be able to identify the participants. Once the number has been assigned, participants will only be referred to (on written documents) by their pseudonym. Names of people, healthcare spaces (e.g., hospitals, midwifery clinics) and any other identifiable information will be removed and replaced with alternative names or

removed completely, if changing the name will impact on how the sentence or phrase uttered by the participant is understood. All information regarding the participants' identity such as their names and demographics will be kept in a locked filing cabinet in the Health and Social Care building on the Colchester Campus at the University of Essex.

The interviews will be audio recorded using a dictaphone, however this will be for the explicit purpose of the present research study, to aid transcribing. Once the interview has been recorded, it will be stored within a password-protected secure drive at the researcher's university, before being transcribed. Only the researcher and the research supervisor will have access to the recorded data. The researcher will then delete the original file from the recording device used.

Throughout the research process, you will be given the opportunity to discuss with the researcher any concerns you may have regarding the recording of the interview, confidentiality and or other aspects of the study.

For the purpose of journal publication, the interview material will be retained for five years after the completion of the study, and all the data will be processed in accordance with the Data Protection Act (2018). If you wish to withdraw from the study at any point, your data will be destroyed immediately.

What is the legal basis for using the data and who is the Data Controller?

The legal basis for processing your data is informed consent, as obtained by completing an informed consent form.

The Data Controller for this study will be Sara Stock, University Information Assurance Manager (dpo@essex.ac.uk).

What should I do if I want to take part?

If you would like to participate in the interview, please email me at: oo18384@essex.ac.uk where I will send you a consent form to complete and return, before we arrange an interview.

What will happen to the results of the research study?

The results of this research project will be published as a journal article in the public domain. The research project will also use the results from the study in the researcher's doctoral thesis which will be deposited in the University of Essex online Theses and Dissertations repository as an online document. As stated earlier in this document, the results of the research will be anonymised and that participants will not be identifiable.

If you would like a copy of the findings of the study, this will be made available to you once the information has been collated. The researcher will ask you if would like a copy at the end of the interview.

Who is funding the research?

This research project has received no funding.

Who has reviewed the study?

This research project has been reviewed and approved by the Science and Health Ethics Sub-Committee at the University of Essex.

Your contribution to this study

Your contribution to this study will be immensely valuable in that it will provide NHS services and the clinical practitioners who work within them, with a nuanced understanding of how Black fathers who experience traumatic births make sense of their experiences and how it may impact on them. This will allow practitioners to develop tailored interventions, service promotion and outreach work to address Black fathers' needs more effectively.

How do I get involved?

If you would like more information about this study, please contact me using the contact details provided below.

Researcher: Lola Olukotun
E-mail: oo18384@essex.ac.uk
Research Supervisor*:* Dr Frances Blumenfeld
E-mail: fblume@essex.ac.uk

For further support please contact:

Make Birth Better
https://www.makebirthbetter.org/supportforparents.

NHS
https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

University of Essex

Appendix F

Consent Form

Title of the Project: An exploration of the experience of Black fathers who have experienced the traumatic birth of their baby

Research Team: School of Health and Social Care

Please initial box

1. **I confirm that I** have read and understand the Information Sheet dated 12/06/20 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal e.g., will be destroyed; cannot be withdrawn because it cannot be identified. ☐

3. I understand that, due to the sensitive nature of what will be talked about in the interview, this research may not be suitable for participants who are have been bereaved as a result of a traumatic birth; were under the age of 18 at the time of the birth; or suffering from other psychological difficulties not related to a difficult birth. I confirm that I do not meet any of the above criteria. ☐

4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. ☐

5. I understand that my fully anonymised data will be used for publishing a journal article and as part of a doctoral thesis. ☐

6. I understand that the data collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

7. I give permission for the de-identified (anonymised) transcripts and audio recordings that I provide to be deposited in University of Essex online Theses and Dissertations repository so that they will be available for future research and learning activities by other individuals. ☐

8. I agree to take part in the above study. ☐

Participant Name	Date	Participant Signature
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix G

Interview Topic Guide

1. Can you tell me about yourself?
    - Prompts: age, family and relationships, occupation hobbies/interests
2. Can you tell me about your current relationship situation with your partner?
3. Where was your baby born?
4. I understand things did not go as planned for the birth of your new baby. Do you mind telling me a bit more about what happened?
    - To explore; how the birth felt, what was your experience of the birth, what the birth complication was
5. What has been your experience of childbirth before this (difficult/insert participant's adjective used to describe) one?
6. How did you feel following the birth?
7. What (if anything) was most difficult about the experience?
8. Did you feel as though your race, ethnicity or culture had an impact on how you experienced the traumatic birth?
9. Have you tried anything to help cope with (insert difficulty mentioned here)?
    - Prompt: what have they tried
10. Did you seek help for what happened?
    - Prompts: professional, spiritual or cultural help
11. How has your relationship with your child been since the birth?
12. Is there anything that could have helped your experience after the birth?

13. Is there anything that would change your experience now?

    - Do you think that would be helpful for other people in a similar situation?

Clarifying and prompting questions –

- Can you tell me a bit more about that?
- Can you share an example of that?

The researcher will reflect on participants' responses and will feedback throughout to summarise and check back about their understanding of what each participant has said.

Appendix H

University of Essex Ethical Approval

22/06/2020

Miss Omolola Olukotun

Health and Social Care

University of Essex

Dear Omolola,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Black fathers experience of birth trauma" has been reviewed by the Science and Health Ethics Sub Committee.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Louise Vincent

Appendix I

Impact of Events Scale-Revised

IMPACT OF EVENTS SCALE-Revised (IES-R) INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ _ _____ (event) that occurred on _____ (date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1.Any reminder brought back feelings	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3.Other things kept making me think about it	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4

16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Appendix J

Emotional Continuum