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**Childbirth-related post-traumatic stress disorder in couples:  
a qualitative study**

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## ABSTRACT

**OBJECTIVES:** Previous research has established that women can develop childbirth-related post-traumatic stress disorder (PTSD) but the effect of this on a couple's relationship has not been examined. This study aimed to look at the experience and impact of childbirth-related PTSD in women and their partners. **DESIGN:** This was a qualitative interview study of six couples, where at least one partner had clinically significant symptoms of childbirth-related PTSD. **METHODS:** Semi-structured interviews were conducted separately with each partner and interview transcripts subjected to thematic analysis. **RESULTS:** Analysis identified four themes with 18 subthemes as follows: (1) birth factors (pain, negative emotions in labour, perceived lack of control, lack of choice or lack of involvement in decision-making, restricted movement or physical restraint, and expectations not being met); (2) quality of care (information provision, staff factors, continuity of care, and environment); (3) effects on relationship with partner (impact on physical relationship, communication within the relationship, negative emotions within the relationship, receiving or giving support from partner, coping together as a couple, and overall effect on the relationship); and (4) effects on relationship with child (perceptions of the child, and attachment styles). **CONCLUSIONS:** This study suggests that PTSD may have a negative impact on the couple's relationship and the parent-baby bond.

## INTRODUCTION

In 1995 four case studies were published of women with post-traumatic stress disorder (PTSD) after childbirth (Ballard, Stanley, & Brockington, 1995). Since then, evidence from cross-sectional and prospective studies carried out in various countries has established that up to 9% of women have severe symptoms of PTSD in the first few weeks after birth, and up to 2% of women are likely to develop diagnostic PTSD that continues six months to a year after birth (Ayers & Pickering, 2001; Creedy, Shochet & Horsfall, 2000; Czarnocka & Slade, 2000; Soderquist, Wijma & Wijma, 2002; Soet, Brack & Dilorio, 2003; Wijma, Soderquist & Wijma, 1997).

The aetiology of postnatal PTSD is not yet properly understood but appears to have similar vulnerability factors and determinants to PTSD following other events, such as a history of psychiatric problems or previous trauma. In common with PTSD following other events, research to date indicates there is not a simple dose-response effect of traumatic events during birth on postnatal stress responses. For example, whilst emergency caesarean section is associated with postnatal PTSD, the majority of women who develop postnatal PTSD have normal vaginal deliveries. It is more likely there is a complex interaction between individual vulnerability factors and events during birth that determine whether women develop postnatal PTSD or not (Ayers, 2004).

The effects of postnatal PTSD on women and their relationship with their partner have not been widely examined but are subject to speculation (e.g. Bailham & Joseph, 2003). Case studies and qualitative research indicates there are good reasons to expect that postnatal PTSD has implications for women's ability to maintain and develop meaningful relationships. For example, qualitative studies of postnatal PTSD find that women report it affects their sense of self, that they have less patience, have

feelings of anger, anxiety, depression, find it hard to sympathise with others' problems, feel isolated from their infant, fear future pregnancy, and report that it affects social relationships (Allen, 1998; Beck, 2004b). However, none of these qualitative studies assessed PTSD using diagnostic criteria. Case studies, in which women do fulfil diagnostic criteria, suggest postnatal PTSD may be associated with sexual avoidance (O'Driscoll, 1994), secondary tocophobia (Hofberg and Brockington, 2000), and disordered mother-infant attachment (Ballard et al, 1995; Lyons, 1998). It has been speculated that symptoms of avoidance may lead to the mother not bonding with the infant or, conversely, that hyperarousal and vigilance may lead to an over-anxious or protective attachment style (Bailham & Joseph, 2003)

The impact of traumatic birth experiences on male partners has been largely overlooked to date. Again, there are case studies that suggest men can be affected by birth trauma and develop subsequent postnatal anxiety (Stewart, 1982). Given that DSM-IV stressor criterion recognises that *witnessing* a traumatic event is sufficient for PTSD, coupled with the increased number of men attending births, it seems logical to also consider partners' postnatal traumatic stress responses. A number of studies have suggested that postnatal co-morbidity in couples exists (Goodman, 2004). For example, research by Ballard, Davis, Cullen, Mohan and Dean (1994) found that whilst mothers had a significantly higher prevalence of psychiatric cases of depression than fathers, fathers were significantly more likely to be cases if their partners were.

Only two quantitative studies have been published to date that examine these issues in relation to postnatal PTSD. A prospective study in Norway looked at postnatal psychological responses in 127 mothers and 122 fathers and found no evidence of co-morbidity of postnatal PTSD in couples (Skari et al, 2002). A second

study in the UK looked at the effect of postnatal PTSD symptoms on a couple's relationship and the parent baby bond and found that, although 5% of men and women had severe symptoms of postnatal PTSD, there was no association between symptoms of PTSD and the couple's relationship or the parent baby bond (current authors, in press). This discrepancy between case studies and qualitative research, on the one hand, and quantitative studies, on the other hand, is difficult to explain. One possibility is the inconsistent findings could be explained by differences in focus and perhaps severity of PTSD. For example, qualitative studies tend to focus only on traumatic births, whereas quantitative studies include all women with a range of childbirth experiences, including positive experiences. Thus quantitative studies may be identifying factors associated with general stress responses and adaptation to birth, whereas qualitative studies may be identifying the repercussions of traumatic births that are more likely to fulfil DSM-IV criterion A.

There is therefore considerable scope to extend knowledge regarding the aetiology of postnatal PTSD, the effect on women, their partners, and parent-infant attachment. Moreover partners' experiences of traumatic birth have not been purposively explored in any study and further research is needed to ascertain whether men might also develop clinically relevant PTSD. The effects of childbirth-related PTSD on the family have not been explored and no research has looked at the impact of childbirth-related PTSD from both partner's perspective. Additionally, little research has explored the effects of clinically significant postnatal PTSD on parent-infant attachment and preliminary evidence for such effects comes predominantly from case studies.

This study is therefore a qualitative investigation of the experience and perceived impact of a traumatic birth and postnatal PTSD on couples where at least

one person had clinically significant symptoms of PTSD in the year after birth. Participants were interviewed about their experience of the birth, the perceived effect of birth on their relationship with each other, and their relationship with the baby.

## **METHOD**

### **Design**

This was a qualitative study using semi-structured interviews to explore the experience of postnatal PTSD in couples and the perceived impact of postnatal PTSD on the couple's relationship and their relationship with the baby.

### **Participants**

Individuals were eligible to participate in the study if they were over 18 years of age, able to read and speak English fluently, if they or their partner had experienced a traumatic birth over three months ago, and both partners were willing to be interviewed. One member of the couple had to have fulfilled DSM-IV diagnostic PTSD criteria for childbirth-related PTSD in the first year after birth.

Nine women volunteered to participate in the study. Three were excluded because their partners did not agree to take part. The final sample therefore comprised of six couples (6 men and 6 women). All couples were married. Five couples reported a traumatic birth for their first child; one couple reported a traumatic birth for their second child. Ages ranged from 26-50 (mean = 37 years, SD = 6.31). Eleven participants were white European and one participant was white Australian. Eighty-three percent of the sample had degrees or professional qualifications.

Of the 12 participants, five women and three men fulfilled diagnostic criteria for PTSD in the year after birth. Three couples reported PTSD in the female but not

male partner (couples A, B and C), two couples reported PTSD in both partners (couples D & E), and one couple reported PTSD in the male but not female partner (couple F). However, the female partner of couple F only lacked one hyperarousal symptom to qualify for a diagnosis of PTSD. Of the eight participants who had PTSD, seven reported immediate onset of PTSD symptoms and one woman reported delayed onset. Similarly, PTSD symptoms were chronic for seven participants and acute for one man. Time since the traumatic birth was less than 2 years for two couples (9 months & 22 months respectively), 5 years for one couple, and between 8 and 10 years for three couples. Four women and three men reported a previous trauma history including serious accidents, natural disaster, assault, sexual assault, imprisonment and life-threatening illness. Only women reported a history of sexual assault and sexual abuse. Only men reported a history of assault or serious accident.

At the time of interview, of those participants with PTSD, three participants reported still having clinically significant symptoms of PTSD (both of couple D and the woman from couple C). Three participants reported residual symptoms (both of couple E and woman from couple A); and two participants had recovered (woman from couple B, man from couple F).

## **Materials**

An interview schedule was designed consisting of 14 open-ended questions exploring participants' experience of their or their partner's childbirth, what aspects they found traumatic, how the experience had affected their personal life, their relationship with their partner, and their relationship with their child (see Appendix).

Questionnaires were used to obtain demographic details and to measure childbirth-related PTSD. Childbirth-related PTSD was measured using an adapted

version of the PTSD Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1997), a self-report questionnaire that provides a categorical diagnosis of PTSD and/or a continuous measure of symptom severity. The PDS has 17 items corresponding to the 17 PTSD symptoms listed in the DSM-IV (American Psychiatric Association, 1994) and further items measuring impairment of functioning, perceived threat to life, symptom duration, time of onset of symptoms, and a checklist of prior trauma history. The PDS has established reliability and when used as a diagnostic measure it has a specificity of .75, a sensitivity of .89, and an 82% agreement with structured clinical interviews (Foa et al., 1997).

For this study the PDS was adapted to refer specifically to childbirth-related symptoms of PTSD in the first year after birth. The trauma history checklist was placed at the end of the questionnaire. To qualify for a PTSD diagnosis responses had to meet the following criteria: presence of physical injury or perceived threat to life; feeling helpless or terrified during the event; scoring at least one or higher on a minimum of one intrusion item, three avoidance items and two arousal items for at least one month post trauma; and impaired functioning in at least one area (Foa et al., 1997).

## **Procedure**

Ethical approval was obtained from Sussex University prior to commencing the study. Participants were recruited via (1) advertisements on internet discussion boards (<http://www.mumsnet.com/> and <http://www.ivillage.co.uk>) set up by women to discuss traumatic birth experiences and (2) via the members mailing lists of relevant self-help organisations (the Birth Trauma Association <http://www.birthtraumaassociation.org.uk> and the Association for Improvements in

Maternity Services <http://www.aims.org.uk/>). Invitations to participate in the study were sent via email to these members. Women expressing interest in the study contacted the researcher and were sent an information leaflet and asked to discuss the study with their partner. Thus, male participants were recruited through their partners.

Interviews took approximately 50 minutes, were done in participant's homes and were conducted separately with male and female partners alone (i.e., no partners/children present). Prior to the interview, participants were given an information leaflet, given the opportunity to ask questions about the study, and fully informed written consent was obtained.

All data collected in the study was stored anonymously with identifying details removed. For the purpose of reporting findings, couples have been labeled A to F.

### **Analysis**

Transcripts were analysed for each individual rather than by couple, gender, or PTSD status. This is because we were primarily interested in the perceived impact of PTSD by men and women (as individuals) on their relationships with each other and with the baby. Qualitative analysis of interview transcripts was performed using inductive thematic analysis where dominant themes were identified through careful examination of the data. All transcripts were read repeatedly in order to identify emergent themes before assigning codes to text using WinMAX computer software. Codes and themes were identified and agreed by the authors. In addition, transcripts were independently coded by a third researcher and percentage agreement was 89% (Boyatzis, 1999).

## RESULTS

Thematic analysis of interview transcripts yielded four major themes which included 18 subthemes. The major themes were (1) birth factors, (2) quality of care, (3) perceived effects on relationship with partner, and (4) perceived effects on relationship with child. The content of each of the major themes and subthemes are described below and illustrated using quotes from participants. The majority of quotes used to illustrate themes assume a link between the factors being discussed and traumatic birth or postnatal PTSD, because this link was explicit in many of the questions asked e.g. “Was there one particular aspect that made your birth traumatic?” (see appendix).

### Birth Factors

Birth factors most commonly mentioned were pain and pain relief, negative emotions in labour, perceived lack of control, lack of choice or lack of involvement in decision-making, restricted movement or physical restraint, and expectations not being met.

Pain and pain relief was the most frequently commented on birth factor and was mentioned by nearly all participants. For example “*All I remember is disappearing into this spiralling, black abyss of pain. All I knew was the pain, I didn’t know anything else, that was it. The fact that there was going to be a baby at the end of all this had become completely and utterly irrelevant.*” (Couple B, woman)

Associated to this were comments on inadequate analgesia. One woman had an emergency caesarean section without effective anaesthetic and another was denied analgesia throughout her labour. For example “*So I started saying ‘I can feel the knife, I can feel the knife’, and they were very slow to react. They just sort of went*

*‘well, you should feel some form of tugging or pulling’ but I was just getting more hysterical saying, ‘I can feel the knife, I can feel the knife’ and one of them said / obviously the surgeon could see that I could feel it and that it was obvious that something had gone wrong.” (Couple F, woman)*

Negative emotions in labour were another frequently commented on birth factor. Common negative emotions experienced by the sample were *feelings of helplessness, fear, shock, feeling violated, confusion, feeling humiliated, and feeling dehumanised.*

Men reported helplessness more often than women did. For example, the man from Couple C said he had *“a massive feeling of helplessness. I mean, I could do absolutely nothing to help [my wife]”*. Women more often reported fear or feeling violated. For example the woman from Couple B said *“I was absolutely terrified. I remember thinking, I might die, I really might die and I don’t know what’s going to happen”*. The women from Couple A reported *“She [the midwife] just had no respect for what I wanted for my body. I just felt that I had no body integrity...It was just like being raped by these people.”* Women also reported feeling humiliated or dehumanised using phrases like *“I was just a sack of meat on the table.”* (Couple A, woman). Finally, half of women commented on experiencing *dissociation* during the birth. The woman from couple B said, for example, *“in the end I managed to tune her out and I don’t know what happened, I have no memory of what happened next.”*

Perceived lack of control was another common birth factor. Men’s comments were related to their perceived lack of control over events, such as emergency caesareans, for example *“When [my wife] was in there having the operation, it was like, this is not the way it should be...suddenly you’ve got no real control of what is*

*happening... and you're just completely overwhelmed. You have no control, no input."* (Couple C, man)

Women's comments tended to relate to a perceived lack of control over events and/or their own or others' behaviour, i.e., not being able to control their own pain, a sense of "losing it", or of staff being over controlling. For example *"It was all out of my hands, I was afraid for me, I was afraid for my baby. I was just afraid that everything was just completely out of control. It didn't feel like a birth, it felt like an emergency operation."* (Couple E, woman)

Similarly, lack of choice or lack of involvement in decision-making was mentioned. For example, one woman said *"Nobody said to me, 'Is this alright? do you mind five or six complete strangers having a look at the most intimate parts of your body, sitting there with your legs in the air and the whole thing on display?'"* (Couple B, woman)

Related to this was restricted movement or physical restraint during the labour, for example *"They told [my husband] to come in and then got [my husband] to pull me upright, [midwife] on one arm and [my husband] on the other... which I think was actually a terrible thing to do because it sort of brought an element of violence and restraint into our relationship which had not obviously been there before. And I was just fighting to get down."* (Couple A, woman)

*"And literally they went through the skin and as they were getting to the muscle [my wife] was pulling her legs up and ended up with a midwife on each leg holding her down."* (Couple F, man)

Finally, nearly all participants mentioned expectations not being met. For example *"I had a birth plan, it was just like a joke really, it was like you have the*

*birth plan and then you have what actually happens... I mean, how far away from your birth plan can you actually get?!"* (Couple E, woman)

### **Quality of Care**

Without exception, participants commented on some aspect of quality of care affecting their experience. The emergence of quality of care as a major theme is of particular importance given that these comments were unprompted in the interview, as questions were not asked specifically about quality of care (see Appendix). Aspects of care that were most frequently mentioned were information provision, staff factors, continuity of care, and the environment, which are described in turn below.

Information provision covered aspects such as *not being informed about what was happening during the birth, not been given/offered information, receiving inaccurate information, inadequate information, or the need for more information prior to birth*. Not being informed about what was happening during birth seemed to be particularly important for men. For example the man from Couple F said it was *"so chaotic, I'm walking around the room... and there is [my wife's] uterus on her stomach and nobody is telling me what is going on, I think she's having an emergency hysterectomy, honestly... I'm going 'what is going on?'"* Women's comments were spread across other aspects of poor information, for example *"I don't know to this day whether I had an episiotomy or a tear. I haven't been told."* (Couple D, woman)

Staff factors included comments about *staff attitudes, competence, or conflict with/between staff*, which were made by both men and women. In addition, women mentioned *poor communication skills*.

Staff attitudes were reported as disparaging, disdainful, impersonal, or disregarding. For example *“She [the doctor] was cold, she seemed very resentful that she was called out of her bed at six o’clock in the morning to do the job. She didn’t say anything personal to me. Nothing, just ‘right, lets stitch this’ and examined me.”* (Couple A, woman). Women talked about the difference a positive staff attitude can make, for example *“And they’ve got to start, I think, understanding just how profound an effect on the woman their mental attitude has, and how much good they can do with the right mental attitude.”* (Couple B, woman). This woman went on to say *“The people who are there to help you should be making it better not worse...the attitude of the people, the way they treat you, and pain relief. I think, you know, if those two things had been handled differently I would have had a totally different experience...if they’d been handled differently... I don’t think I would have ended up with PTSD”*.

Competence of staff was mentioned by the majority of participants and consisted primarily of comments about the *overall competence of staff*. To a lesser extent comments were made about *staff error* and *loss of faith in staff*. For example the man from Couple F said *“And the anaesthetist was just virtually like crying at the top trying to stroke [my wife’s] hair, and I was like ‘Jeeze, what is going on!’ So they are so unorganised... the incompetence and all the rest of it was just shocking”*. Similarly, the woman from Couple A said *“I just felt really abandoned and alone... I felt really unsafe with those midwives, because I knew if I had a haemorrhage in that bed and I pressed the emergency buzzer they would ignore me.”*

Conflict with or between staff included direct conflict such as *“I asked her twice to leave and shut up and in the end I said ‘I need SILENCE!’ and I just roared it out.”* (Couple A, woman) and indirect conflict such as staff ignoring requests to

stop procedures, for example *“It was a male doctor, um, I have a history of depression and anxiety and I don’t like being touched. I have very clear personal boundaries, and a male doctor came in, and I was like ‘I can cope, It’s only a doctor, It’s only an examination, I can cope’, and I just lay down on the bed, I just, melt down, started to cry, couldn’t cope. [My husband] said to the guy ‘stop’ and he was like, ‘well I’ve started it now’...then it continued.”* (Couple B, woman)

Finally, poor communication skills were mentioned primarily by women, for example *“nobody said anything - at all. I think the consultant said, good morning, and that was it. The rest of the time he talked to the other doctors, no one talked to me. I wasn’t there.”* (Couple B, woman)

Continuity of care seemed to be primarily around the *lack of continuity of staff*. Other aspects were an *overall lack of continuity of care* and a *need for follow-up care* in the postnatal period. For example the woman from Couple D said *“Every person that came in, I had to give them my medical history because they didn’t know, there didn’t seem to be any hand over happening.”* The man from Couple F attributed the traumatic birth experience to the lack of continuity of care saying *“The critical thing is I think that if [my wife] had continuity of care from the midwives from the start she would never have got in this situation.”*

Environment was also mentioned, particularly the overall physical *environment being unpleasant, the lack of privacy and poor hygiene*. For example *“The room looked like one of those places where after you kill your cows, you take them to be cut up. That is what it looked like. I really honestly believe that. I don’t know how people birth in rooms like that.”* (Couple A, woman). In addition, one woman and one man made comments on the *operating theatre being traumatic*. This serves as a reminder that unfamiliar environments can be stressful and traumatising to

some people. For example “*the thing with a caesarean is that you’re taken into the operating theatre awake, and they put you on the operating table awake, and an operating table is made of cold, hard metal, and you lie there and you look up and you see the circle of light, like in all the films.*”(Couple B, woman). Similarly, the man from couple E said “*Suddenly being surrounded by people in masks [was traumatic] and all the paraphernalia of an operating room.*”

### **Perceived Effects on Relationship with Partner**

All participants mentioned the perceived effects of the birth on some aspect of their relationship either spontaneously or in response to questions asking about the effects of the birth on their relationship with their partner. The main perceived effects on relationship with partner that were mentioned were on the physical relationship, communication within the relationship, conflict, emotions within the relationship, support from partner, coping together as a couple, and overall effects on the relationship.

Effects on the physical relationship were most frequently mentioned. The most commonly cited difficulty was *avoidance of sex*. Women mentioned avoiding sex either because (1) it served as a reminder of the event, triggering flashbacks or traumatic memories, (2) from an instinctive need to protect a “battered and bashed” body or (3) through fear of becoming pregnant. For example “*I had flashbacks whenever I went into the bedroom, I could smell the blood and stuff, it was just awful. Because we were trying to make love in the same place as the birth, you need to put it in its context.*” (Couple A, woman)

*“I think when you’ve been violated to that extent, you just don’t want to be touched by anybody ever again, these are the most intimate parts of your body, your most intimate parts of yourself.”* (Couple B, woman).

*“Sex, no, because I had a pathological fear of becoming pregnant. I was on the pill, it wasn’t going to happen, oh no, but it was in my head that it could happen. We had always been quite close physically, sort of touching and cuddling, but no, no, I didn’t want to know... I had a huge variety of excuses, but basically, no, no.”* (Couple C, woman).

Men also commented on their partner’s avoidance of sex and linked this with events of birth, for example *“Everything was focused on this visit [gynaecological examination], like that was the cause of everything that came afterwards, the stress, not wanting to be touched, you know, say the general reaction.”* (Couple B, man).

One man mentioned his own avoidance through fear of his wife becoming pregnant again. Related to this were comments made by women and men on the female partner’s *difficulty in being touched* and the *loss of intimacy* in their relationship as a result of this. For example *“And again, without thinking about having full sex, or whatever, but, caressing or touching, you know, it’s part of normal behaviour in a couple. [My wife] didn’t really like it. I mean she was really, really bad with it... certainly there was this problem that she obviously didn’t want to be touched, at all.”* (Couple B, man). Women also recognised this, for example *“a lot of the time I can’t bear for [my husband] to touch me and he’s quite a touchy person...he finds that very difficult.”* (Couple D, woman).

Men and women perceived this difficulty with intimacy to be due to events of birth or PTSD. For example, the man from Couple D said *“She’s a lot more standoffish now of me. At times when as a couple you want to be kind of closer, and*

*then that closeness seems to have something stopping it, there's a barrier to being closer that shouldn't be there. So I think she's experienced something that has made her feel that way and kind of can't get past her feelings and the whole experience."* (Couple D, man). The woman from Couple B described how PTSD interfered with all aspects of their lives: *"When I was suffering with PTSD it dominated my life and therefore by extension, our lives totally. ... You're so worn out by it all, after such a short time if your getting three to four flashbacks a day and it was totally undermining my belief in myself and my ability to cope with life and get on with life. There isn't room for anything else in a relationship when you are going through that... It destroys any intimacy you have in your relationship, you can't think about anything else except what is, what is this that's happening to me? Why am I like this, you know, and that's all there is."* (Couple B, woman)

Communication within the relationship primarily concerned *avoiding talking about the birth and associated difficulties*. For example *"I would get desperately upset if we tried to talk about it, talking about it was painful and awful"* (Couple B, woman).

*"There are probably quite a few things we haven't discussed. She keeps her bits to herself, and I keep mine to myself."* (Couple C, man)

Where couples had talked about the birth experience and associated difficulties this had helped create understanding but not necessarily solved the problem, for example *"Talking to each other has helped too, you kind of know how each other feels about it, but it hasn't helped to resolve things."* (Couple D, man)

In addition, participants commented on the importance of *empathy and/or understanding* within the relationship. Conflict within the relationship was also mentioned in the form of *arguing* and *conflict avoidance*. For example *"We would*

*end up having quite dreadful rows... Oh, dreadful, for... I would say a couple of years.” (Couple B, woman)*

*“I think with [my wife] I was a lot more careful of what I might say and what I might do. It was a bit like walking on eggshells all the time. You put one foot wrong and you’re likely to cop a serve. Yes I guess I avoided the position which could lead into an argument for a long time” (Couple A, man)*

Some men acknowledged how their own *lack of empathy and/or understanding* negatively affected the relationship and one couple talked about blaming one another. *“When it didn’t get any better we just started to take it out on each other really, and blaming each other for it.” (Couple E, man)*

Negative emotions within the relationship were mentioned by men and women. Women commented on *feeling abandoned by their partner* when men went back to work, and men commented on *feeling rejected by their partner* as a result of lack of sexual contact and subsequent loss of intimacy. For example *“It can make you feel quite unsure if you’re kind of wanted or needed in the relationship.” (Couple D, man)*. Men also mentioned *feelings of helplessness* within the relationship through not being able to help their partner or solve the problem, for example *“I have the warrior that comes out and wants to sort the problem, and therefore for me it was like, I want to do something about it, only you don’t have the tools to do it... we had arguments in which she says that she has a problem, I try to say, well, let’s talk about it right now, and [my wife] refusing... and therefore, for me, frustration because I cannot solve the problem, I cannot help.” (Couple B, man)*

Comments were also made regarding receiving or giving support from partner. Women mentioned receiving practical and emotional support from their partners, and men reported providing support. For example *“At no point did he ever*

*say to me, pull yourself together. God forbid! He took it totally seriously right from the word go, I mean very open minded and very understanding about mental health problems... he was completely supportive.” (Couple B, woman)*

Comments about coping together as a couple were also made. Women talked about barriers to coping together as a *lack of time together as a couple* resulting from childcare demands, balancing work and home life, and/or having little social support, meaning that couples had little time to talk to one another or take time out. The remaining comments related to adaptive coping as a couple and included comments about *partners helping them to cope* with their experience, *sharing the responsibility for coping*, and *positive appraisals of the relationship* as instrumental in helping them cope. For example “*Had he not been there, how would I have explained what had happened to me? I think that would have been more upsetting, that this thing had happened...how can you describe that to someone. So it has been very good for us in a way that he was there. You just can’t explain the horror of that unless you were there. I mean, what would I have said. I would have sounded as if I was completely exaggerating.*” (Couple F, woman)

“*For me it was almost natural to think that it’s our problem, not your problem... one attitude is, it’s your problem, solve it, and another one is, the problem is yours, but we have to sort it together, we have to be together in the process.*” (Couple B, man)

The overall effect on the relationship was commented on, primarily in terms of the relationship being *negatively affected*, for example “*We lost a lot of light hearted stuff like we used to have, we got a lot more serious with the responsibility and when [my baby] was crying it really pulled us down, and basically we did change quite substantially, I think it was a very dark period of our lives really.*” (Couple E, man).

However, one couple commented that their relationship had been *positively affected*, bringing them closer together. For example “*But, you know, what did it do to our relationship, it strengthened it if anything, not that it needed it, it was like we came through this thing.*” (Couple F, man)

### **Perceived Effects on Relationship with Child**

All participants mentioned perceived effects of the traumatic birth on some aspect of their or their partner’s relationship with the child. The two themes that arose were the perceived effect of the birth experience on perceptions of the child, and on parent-infant attachment. Comments in these themes were typically split between positive and negative effects. For example, the perceived effect of the birth experience on perceptions of the child were split between ascribing *negative attributes to the child* as a result of the birth experience or ascribing *positive attributes to the child* which compensated for the effect of the birth experience. For example “*She wasn’t ready to come out, she didn’t want to, it wasn’t her time and she was being forced out and it just made me think she is really angry...I just think the whole thing was so unnatural that it created an unnatural child.*” (Couple E, woman)

“*And because she was such a lovely and loving baby, she was very easy to love back.*” (Couple B, woman)

Comments on the perceived effect of the birth experience on parent-infant attachment were primarily around *poor attachment, attempts to compensate for poor attachment, and different attachment styles*. For example “*I was aware that I didn’t have the feelings and I put on an act with [the baby]...I used to coo to her and all that sort of stuff but I didn’t actually mean it... it was all fake, I honestly just did it because that’s*

*just what mothers are supposed to do...*” (Couple A, woman). Men recognised this and tried to compensate for it. For example “*I know I did try to direct a lot of attention and love to [the baby] because I felt maybe [my wife] wasn’t providing that so I was trying to bridge a bit of a gap.*” (Couple A, man).

Different attachment styles were apparent and seemed split between overprotective/anxious attachment styles and avoidant/rejecting attachment styles. For example, both women and men reported emotions and behaviour consistent with an *overprotective/anxious attachment style*. Women who reported this attachment style also commented on excluding their partners from childcare. For example “*I think it’s made me so overprotective of her. I don’t let her out of my sight. I don’t like other people touching her...I mean my mum ...obviously I trust her with her, but I’d go out to the pub with my sister and after half an hour later I’d have to go home again because I was so frightened about what would happen to [the baby]... I had to go back. I just can’t bear it, it’s just really frightening.*” (Couple D, female)

The remaining women reported emotions and behaviour consistent with an *avoidant/rejecting attachment style*. Some of these women reported acting out the mothering role (as above) until experiencing a delayed onset of emotional attachment. For example “*I still remember sitting one evening, watching something on television and there was a threat to a child... and I didn’t realise it, but I was reacting as if it was my own child, and I looked down and my hands had curled into claws, and I suddenly thought, oh my heavens, I love [my baby] to bits! And it’s like being hit by a tidal wave. It totally hit me how much I cared about [my baby]*” (Couple B, woman)

The remaining women who initially reported an avoidant/rejecting attachment style either subsequently developed behaviour and emotions consistent with an overprotective/anxious attachment style or persisted in an avoidant-anxious

attachment style up to five years after the birth. For example *“I hate the bond word, I think it is one of the worst words you can ever use, but I didn’t bond with her, I didn’t particularly want to go near her. I’d go near her, but I wouldn’t touch her.”* (Couple C, woman)

## DISCUSSION

This study aimed to explore the experience and perceived impact of childbirth-related PTSD on couples. The results showed that many birth factors and care factors are perceived as determining the experience of a traumatic birth by both men and women. There were a few differences between men and women in emotional responses during labour and in aspects of labour over which they felt a loss of control. The results also showed that childbirth-related PTSD was reported to affect the couple’s relationship and the parent-infant relationship in varying ways. Rather than reiterate these results, this discussion will focus on a few interesting points in relation to (1) the experience of a traumatic birth, (2) the perceived effects of a traumatic birth, and (3) study limitations and conclusions that can be drawn.

### **The experience of a traumatic birth**

This study demonstrates that clinically relevant childbirth-related PTSD can occur in women and men, which is consistent with research outlined in the introduction. Birth factors that were mentioned as important in the traumatic experience of childbirth are broadly consistent with previous research. For example, the emergence of perceived lack of control as important in a traumatic birth experience is consistent with both qualitative and quantitative research (e.g. Allen, 1998; Czarnocka & Slade, 2000; Lyons, 1998; Soet et al., 2003; Stewart, 1982). It is interesting, however, that men placed importance only on external control, whereas

women placed importance on perceived lack of external *and* internal control. This is consistent with Green and Baston's (2003) conceptual distinction between external control during birth (e.g., perceived control of what staff are doing, involvement in decision-making) and internal control during delivery (e.g., perceived control of own behaviour, control during contractions).

A second area where men and women differed was emotions during birth. Men reported more feelings of helplessness and shock than women, and women reported more fear, confusion, feelings of violation, humiliation, dehumanization and anger. This warrants further research as it may have implications for the development of PTSD or other pathology and treatment. For example, it has been argued that PTSD involving primary emotions, such as fear, should be treated differently than PTSD involving secondary emotions, such as anger and shame (Brewin, Dalgleish & Joseph, 1996).

The emergence of quality of care as a major theme is of particular importance because it was not asked about specifically, yet was perceived to be important by every participant. Previous research has also identified aspects of care as important (e.g. Czarnocka & Slade, 2000; Beck, 2004a) but quality of care and continuity of care have not yet been looked at systematically or in detail. This study suggests it is an area that future research should address, and the themes highlighted here could usefully inform the development of a questionnaire to examine this in more detail.

Finally, it must be acknowledged that the birth factors highlighted in this study are likely to be highly inter-related and that these factors are based on retrospective reports of participants so might be affected by subsequent mood and experience. For example, peritraumatic dissociation has been found in other samples to be predicted by prior perceived lack of control over emotions (Engelhard, van den

Hout, Kindt, Arntz, & Schouten, 2003) and previous research has shown that women who did not perceive healthcare professionals as considerate felt less in control during labour than those who did (Green & Baston, 2003). In addition, the design of this study does not enable us to examine the possibility that participant's pre-existing psychological state affected both their experience of birth and subsequent development of PTSD.

### **Perceived effects of a traumatic birth**

This study suggests childbirth-related PTSD has perceived negative consequences for both the marital relationship and the parent-baby relationship. The emergence of the perceived negative impact of postnatal PTSD on the physical relationship within couples is consistent with some of the research outlined in the introduction (Allen, 1998; O'Driscoll, 1994; Stewart, 1982). The loss of intimacy and difficulty being touched that were reported by the sample echo the effects on tactile relationships in adult survivors of sexual abuse (Noble, 1995). The feelings of rejection and helplessness reported by men, and feelings of abandonment reported by women as well as conflict and blame within relationships are of importance. Vetere comments that "systemically speaking, relationships within families affect other relationships" (2004, p.323). Thus, the systemic effects of postnatal PTSD in the relationship dyad may be substantial. However, in this sample all couples had remained together and five of the six couples appeared to function well. The remaining couple had continued conflict and had considered divorce. Thus the perceived long-term consequences of postnatal PTSD on the relationship vary between couples.

The perceived effects of postnatal PTSD may also differ depending on whether one or both partners suffer from PTSD. Balcom defines "dual couples" as

“couples in which both partners have experienced a trauma, or multiple traumas, which continue to impact their individual and relationship functioning” (1996, p.432). The fact that both of the male partners in the present study who expressed difficulty in understanding their partner’s experience did not report clinically relevant PTSD supports Nelson, Wangsgaard, Yorgason, Kessler, and Carter-Vassol’s view that “the nontraumatized partner may have limited empathy and understanding for his or her partner” (2002, p. 62). Where both partners are suffering from PTSD there may be understanding and empathy but this may not necessarily help resolve PTSD symptomatology as there may be “a mutual impact of the partners’ individual symptoms on one another” (Nelson et al 2002, p. 60). Thus the dynamics of single and dual trauma couples may be different, requiring different treatment approaches. Also, further research is needed to ascertain the processes underlying the development of paternal postnatal PTSD in order to determine if this is a direct sequela of witnessing the birth or secondary trauma through living with a partner with PTSD.

The study findings also support case studies that suggest postnatal PTSD may have an adverse effect on parent-infant attachment (Ballard et al, 1995; Reynolds 1997). However, it is important to note that the women in this study who reported emotional detachment from their infant also reported “acting out the mother role” so subsequent consequences for the infant are unclear. Additionally, male partners played a role in facilitating attachment or compensating for their partner’s initial emotional detachment. Thus, it is not clear whether there is likely to be any impact of postnatal PTSD on child development.

### **Limitations and conclusions**

Three main points need to be considered in relation to this study and interpretation of the findings. First, this was a qualitative study and, as such, does not attempt to generalize results to other samples; rather it highlights points of interest in the experience and perceived impact of postnatal PTSD that may warrant further research and exploration. Because of this, study limitations are perhaps less relevant but it should be acknowledged that this study was based on a small sample of self-selected couples in enduring marriages who were not broadly representative of the population. Thus participants may not be representative of couples that experience postnatal PTSD. It is therefore unlikely that all the key themes have been identified and explored. For example, couples who were excluded from the study because the male partner declined to participate may have been experiencing greater interpersonal difficulties.

Second, it is important to also note that qualitative studies do not enable us to determine causality. The themes reported here are those that came from men and women's retrospective perceptions of their experiences during birth, postnatal PTSD, and their understanding and interpretation of the impact of birth and PTSD on their relationships. This is useful for understanding the experience of these factors, but does not allow us to conclude that they play a causal role in the development of postnatal PTSD. As previously mentioned, factors such as pre-existing psychological state are also likely to play a role in both the experience of birth and the development of PTSD and this must be borne in mind when interpreting these results.

Finally, the results of this study need to be placed in the context of the impact of birth on couples without PTSD or other mental health problems. A substantial amount of literature examining the transition to parenthood shows the majority of couples report a decline in their marital relationship and sexual function during the

postnatal period (Cowan & Cowan, 2000) and that these are associated with mental well-being. However, this varies according to many factors such as the quality of marital relationship before birth and the presence of additional stressors. The transition to parenthood is therefore seen as having a range of consequences that require various adjustments and adaptations, which can both strengthen and test couples' relationships (Huston & Vangelisti, 1995). In relation to the current study, it is therefore possible that couples without PTSD would report similar problems and difficulties to those reported by our sample. Further research is therefore needed to compare the impact of birth on the marital relationship and parent-baby bond in couples with and without postnatal PTSD. For example, qualitative research could compare themes arising from interviews with couples with and without postnatal PTSD. Quantitative studies could use questionnaire measures to examine the effect of PTSD on couples' relationships, the parent-baby bond and daily functioning either cross-sectionally, if using samples with clinical PTSD, or prospectively if using a range of PTSD symptoms.

However, this study provides an interesting first step towards examining the man's perspective in postnatal PTSD, and the perceived impact of this on couples. If results are replicated in quantitative research there are a number of implications for clinical practice. Firstly, study findings indicate healthcare professionals have the potential to impact significantly on both a woman's and her partner's experience of childbirth. There is therefore a need for (i) greater awareness in healthcare professionals of postnatal PTSD and practices which may contribute to childbirth related trauma; (ii) for healthcare professionals to include and acknowledge partners in the management of traumatic births; and (iii) to recognise that individuals exhibiting peritraumatic dissociation may be in need of particular support. Secondly,

this study indicates it is important to include partners in postnatal screening for mental health, particularly if the woman has postnatal PTSD.

In conclusion, this study provides an interesting overview of the experience and perceived impact of a traumatic birth and postnatal PTSD on men and women. Results confirm that postnatal PTSD does occur in men and women and that this is attributed to birth and care factors by couples. The study suggests that PTSD may have a negative impact on the marital and parent-baby relationships but the significance of this for the couple or child in the long term is unclear. Finally, this study suggests there is a need to consider both the individual and systemic effects on families when considering assessment and treatment of postnatal PTSD.

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## **Appendix**

### **Interview Schedule**

#### **Introduction**

Thank you for agreeing to talk to me about your experience of childbirth. I am going to ask you some questions about your experience of birth, how it has affected your life, and your family.

If you don't feel comfortable answering any of the questions, just say so. We can leave them out or come back to them later. You are also free to stop the interview at any time.

#### **General background**

- How many children do you have?
- Have you had any other pregnancies?
- If more than one child, which of these births did you find traumatic or difficult?
- How long ago did you have this experience?
- How long have you and your partner been married/living together/living separately?

#### **Experience of childbirth**

First of all, I'd like to know something about your birth experience and what made it traumatic.

- Can you think back to when your labour first started and talk me through what happened from there onwards?
- Was there one particular aspect that made your birth traumatic?
- Could you tell me what things made that event particularly traumatic for you?

#### **Affects of traumatic birth on personal life**

- How did your experience make you feel afterwards?
- Has your experience changed how you feel about yourself?
- Do you think your behaviour changed after your experience? (If yes- can you tell me more about this?)
- Has your experience affected the way you live your life? (e.g. socialising, employment, future plans)?

#### **Affects of traumatic birth on relationship with partner**

- Do you think your experience affected your partner in any way? (If yes - Can you tell me more about this? How do you think your experience affected your relationship with your partner?)

#### **Affects of traumatic birth on the mother-baby bond**

- Do you think your experience affected the way you felt about your baby?
- Do you think you behaved differently with your baby because of your experiences in birth?

#### **Recovery & change**

- Do you feel you/your partner have recovered from the experience now?

- What [helped you/your partner / didn't help you/your partner] get over the experience?
- What changes would you like to see to stop this happening to other people and their partners?
- Is there anything we haven't covered that you would like to mention?