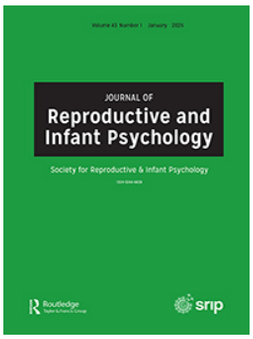

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One birth, two experiences: why is the prevalence of childbirth-related posttraumatic stress disorder four times lower in fathers than in mothers?

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EDITORIAL

One birth, two experiences: why is the prevalence of childbirth-related posttraumatic stress disorder four times lower in fathers than in mothers?

Childbirth-related posttraumatic stress disorder (CB-PTSD) is a mental health disorder with well-documented negative consequences for the whole family. Its prevalence is four times lower in fathers than in mothers (1.2% vs. 4.7%) (Heyne et al., 2022) – where these rates respectively refer to cisgender non-birthing and birthing parents. This difference in prevalence echoes the wider PTSD literature (Boyd et al., 2015), and it also seems obvious that it reflects a radically different stress exposure during childbirth: fathers* do not physically experience birth in their bodies, nor are their lives or physical integrity threatened. However, this may only partially explain the observed differences.

An important meta-analysis by Ayers and colleagues showed maternal CB-PTSD resulted from 1. vulnerability factors in pregnancy, 2. risk factors during childbirth, and 3. postpartum onset and maintenance factors (Ayers et al., 2016). Although focused on mothers, their model can shed light on the difference in prevalence between maternal and paternal CB-PTSD. More specifically, it encourages us to reflect on this issue of traumatic births beyond what may be different for mothers and fathers in the delivery room.

During pregnancy, the main factors Ayers and colleagues found to be associated with CB-PTSD were: a. depression during pregnancy, b. history of PTSD or psychological problems, c. fear of childbirth, and d. complications in pregnancy. These four factors all apply differently to expectant fathers and mothers. The first two, i.e., depression and PTSD, have consistently been shown to affect fewer men than women, both in the prenatal period and in general (Boyd et al., 2015). Fear of childbirth is also half as common in men as in women (e.g. Eriksson et al., 2005). As for pregnancy complications, they affect both parents with the same frequency insofar as they concern the developing baby. However, men's exposure is less direct than that of pregnant women, who experience the complications in their own body (e.g., bleeding, pain, and emesis) and cannot avoid repeated stressful reminders (e.g., close medical follow-up, bed rest, and hospitalisation). Thus, while fathers are less directly exposed to trauma during childbirth, it seems plausible that they enter the delivery room with less trauma-related vulnerabilities.

As for the postpartum period, the two main CB-PTSD onset and maintenance factors identified by Ayers and her colleagues were a. depression and other co-morbid symptoms (anxiety, general psychological health, physical health), and b. stress and poor coping (Ayers et al., 2016). Postpartum depression affects fathers half as often as mothers (Paulson & Bazemore, 2010). More generally, the postpartum context may be very different for the two parents. Fathers do not experience the same drastic hormonal changes as mothers, nor do they need extensive physical recovery. They may have easier access to a wider range of coping strategies, such as physical activity or going outdoors. Becoming a parent also involves different gender norms: although the paternal role is undergoing profound change in many

societies, women are typically still expected to be the baby's primary caregiver, which can be highly stressful (Henderson et al., 2016). Furthermore, men tend to return to work much more quickly than women. After a traumatic birth, this can facilitate distraction, increase social support, and reduce exposure to triggers (e.g., baby crying, postpartum appointments). Overall, CB-PTSD symptoms may therefore be less likely to arise and persist in fathers.

Importantly, the lower prevalence of paternal CB-PTSD should not obscure the fact that childbirth remains a potentially traumatic experience for fathers. The model developed by Ayers and colleagues, which was based on research into maternal CB-PTSD, only partially captures the risk and maintenance factors for paternal CB-PTSD: the pre-, peri-, and postpartum experiences of fathers have their own challenges and singularities. For example, work-related factors such as a high job burden during pregnancy have been identified as a risk factor for CB-PTSD in fathers, but not in mothers (Kress et al., 2021). Since they are not the ones giving birth, fathers may also have a heightened sense of powerlessness and receive less information from healthcare professionals. Moreover, it cannot be ruled out that paternal CB-PTSD prevalence may be underestimated: during the perinatal period, fathers tend not to feel legitimate in expressing their distress or asking for support (Darwin et al., 2017), which echoes a wider taboo surrounding men's mental health. Consequently, not only may the fathers who agree to take part in studies of perinatal mental health be particularly unrepresentative, but they may also tend to under-report their symptoms.

Overall, the finding that fathers are four times less likely to develop CB-PTSD than mothers is not only linked to a different traumatic exposure during childbirth. Compared to mothers, they may arrive less vulnerable in the delivery room and benefit from a postpartum environment that is more conducive to recovery. While this more favourable context does not prevent them from experiencing the birth as traumatic, it may protect them from developing CB-PTSD. However, there are factors specific to paternal CB-PTSD, as well as unique challenges in recruiting fathers and measuring their symptoms. For all these reasons, sex- and gender-sensitive research could provide new insights into understanding and preventing both paternal and maternal CB-PTSD.

Acknowledgment

We recognise the diversity of family models and gender identities. In this editorial, we use the words "mothers" and "maternal" to refer to parents who have given birth and the words "fathers" and "paternal" to refer to parents who have not given birth. However, we recognise that not all birthing parents are women and not all non-birthing parents are men. We make this choice because the text refers to factors linked to gender socialisation and, furthermore, there is very little data on prevalence in LGBTQ+ parents. The authors thank Dr. Zoe Darwin for helpful comments on an earlier draft.

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