Bliss Briefings

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for babies born too soon, too small, too sick

Discussion paper on the research findings of the lived experiences of first time fathers with a preterm infant in a neonatal intensive care unit.

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Introduction

Transition to parenthood on a neonatal unit is a challenge and research studies report that both parents find the postnatal period stressful and that neonatal healthcare practitioners have an important role in supporting parents to make that transition less traumatic [1,2]. Historically, there has been a gendered focus within parenting research on mothers' experiences of having a preterm infant [3,4]. Yet, other researchers have recognised the need to understand parenting from the father's perspective and the importance of establishing a loving father/child relationship from birth in both the home and neonatal environment [5,6,7].

Rationale

A comprehensive literature review revealed a paucity of UK studies into the experiences of men who become fathers of preterm infants and confirmed the need for further inquiry [8,9]. Previous parenting research in neonatal care has only managed to superficially address what is a life changing transition for men. This means that inferences on the specific needs of new fathers in a neonatal intensive care unit (NICU) may have been drawn from studies that do not adequately represent fathers' experiences.

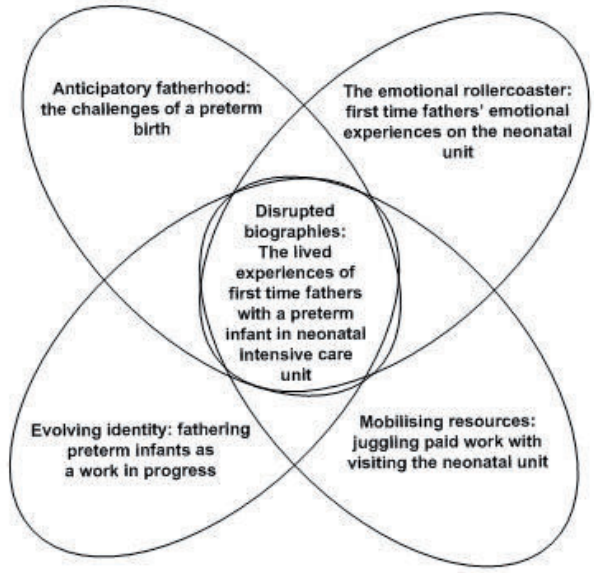
Methodology, method and sample

The study adopted a qualitative phenomenological methodology. The research question, "what does it mean to be the first time father of a preterm infant in a neonatal intensive care unit?" focused on a desire to understand what it means to become the father of a preterm infant from the father's perspective. Tape recorded interviews were conducted with eight first-time fathers of preterm singletons (27 – 35 weeks gestational age) shortly after admission of their infant to neonatal intensive care (NIC). Six of the eight fathers were interviewed again before discharge of their infant from the unit. A Heideggerian interpretive framework underpinned the method for collection, interpretation and analysis of data and provided an enriched and deeper understanding of the men's lived experience.

Findings

All interview transcripts were treated as meaningful text and analysis resulted in the identification of four themes that captured the fathers' lived experiences in NIC. A key theoretical concept that emerged from the data was biographical disruption (see figure 1).

Figure 1: The fathers' lived experiences in NIC



Service user representation

As a service user representative, Brett Jacobs was a key member of the research advisory group. As the father of two preterm daughters his role was invaluable. He provided feedback on the research proposal, both the design and content of parent information, and on the data analysis as it emerged. His commitment extended over six years and he co-presented his experiences of his involvement with parenting research at an international nursing research conference [10].

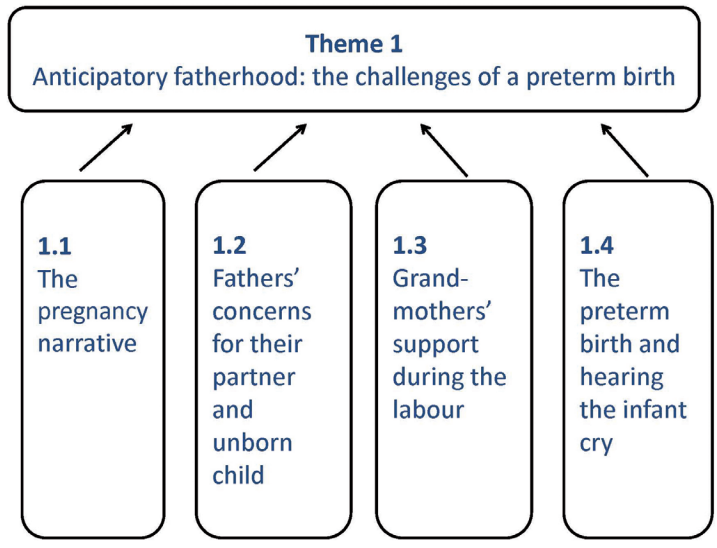
The study environment – a tertiary neonatal intensive care unit (on two sites)

The care of infants was divided into three categories: neonatal intensive care (NIC), high dependency (HD) and the home nursery (special care). It was standard practice for premature infants to be admitted to either NIC or HD and this was dependent upon the infant's condition at birth. The level of intensity, in terms of both technology and the number of staff to support the infant's care, decreased as infants progressed towards the home nursery. Each unit was busy during consultant ward rounds and staff handovers but there were quiet periods in the afternoons and evenings. Parents had unrestricted visiting, with the exception of the ward rounds on one site.

The findings

The four inter-related themes and sub themes are briefly discussed below:

Figure 2



"We didn't know how quick it would all happen."

Albert, father of Jack, born at 30 weeks gestation

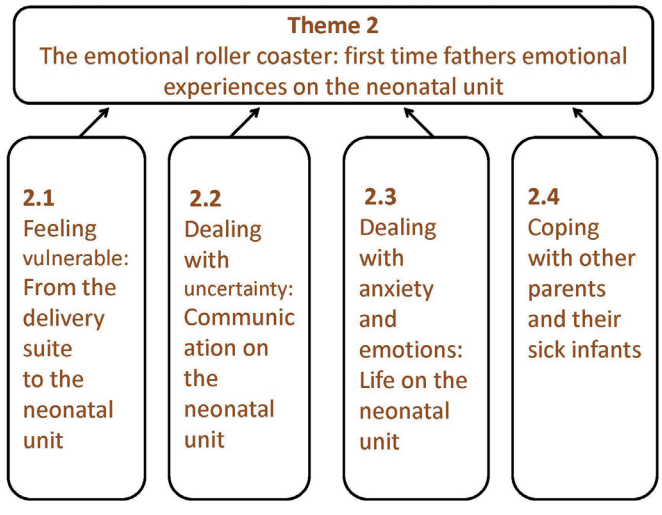
Pregnancy was no longer an enjoyable experience to share with their partner. Some of the men expressed feelings of guilt because of their overriding fear for their partner's wellbeing during the labour that superseded any concerns for the unborn child at that time, and this challenged all of the men's prior anticipations of fatherhood.

Consequently, the birth process was an emotional time, during which grandmothers provided emotional support to the fathers. Hearing their infant cry evoked a range of responses amongst the men, including the acknowledgement, however transient, that they were fathers. Some fathers felt less well supported by the midwifery and neonatal staff during the labour process and transfer to NIC (see figure 2).

"From our best day to worst day in hours."

Jack, father of Henry, born at 35 weeks gestation

Figure 3



The men felt unprepared for their experiences in the delivery suite, making them vulnerable to anxiety and fear of loss as they tried to cope with the unexpected situation of a preterm birth. As their infants' health improved, feelings of uncertainty and anxiety were less obvious but re-emerged in times of stress, such as when their infants' condition deteriorated or when preparing for discharge home.

The men's life on the neonatal unit could be likened to an emotional rollercoaster in that it was beset with emotional highs and lows. Some of the men tried to control their emotions by not daring to hope too much, keeping their emotions hidden from their partners.

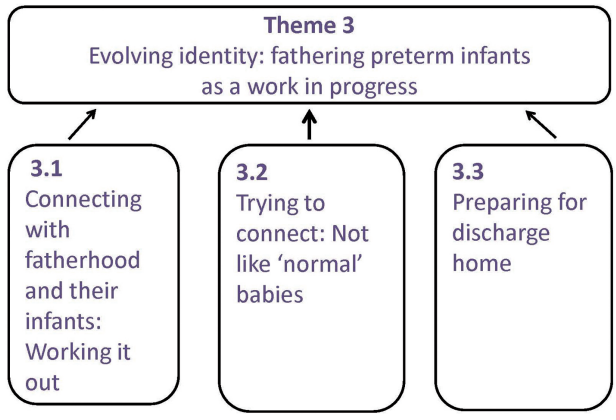
During interviews, all of the men revealed their emotional concerns as they tried to cope with the impact of seeing their infant in NIC for the first time, without their partner. Being sent home on the first evening after the birth of their infant was very traumatic. They felt isolated, afraid and unable to support their partner. Sometimes, seeing other preterm infants sicker than their own gave them hope and although sad for other parents, they felt better about their own situation. When communication with staff worked well the fathers felt informed and this helped them deal with some of the anxiety and uncertainty they were experiencing. At times, the men's lack of familiarity in dealing with healthcare practitioners in a hospital environment impacted on

their ability to make demands on the staff. Fathers expressed a need to have space, time and privacy to talk to a member of staff alone, particularly in the first few days following admission of their infant to NIC (see figure 3).

"I said 'it is Hugh here, I am Connie's daddy' and I just burst into tears."

Hugh, father of Connie, born at 27 weeks gestation

Figure 4



During the initial phase in NIC, when trying to navigate around the equipment, the men revealed that they were unsure of what they could do for their infant and this uncertainty negatively impacted on their evolving identity as a father. Being a father was defined by how they felt, but it was also dynamic and changing and continually redefined by what they could and couldn't do.

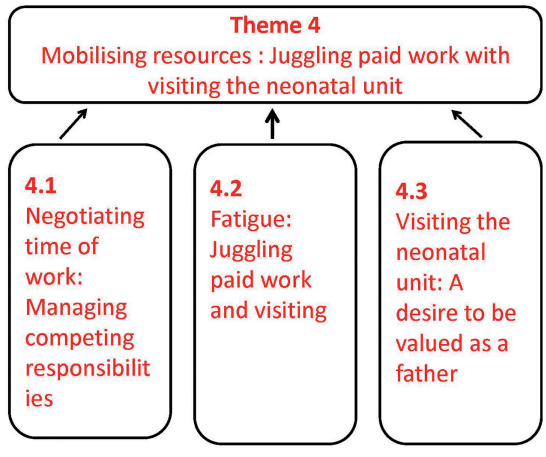
Most of the men recollected identifying with fatherhood immediately after the birth, but for some men these initial feelings were fleeting, as they watched their infants being whisked away to NIC. Working out how to get involved 'hands on' with their infants was an important process in enabling the men to connect with their infants in a physical way, not least because parenting tasks symbolised something more meaningful than the physical act they represented. They became a route into connecting with their infants; identifying with the practical aspects of being a new father, and a way to get to know their infants better.

However, some men felt that they would really only begin to feel like a father once they took their baby home. For some of the men, fatherhood on a neonatal unit was unreal, not "like being a real dad". All of the men very quickly learnt the unit culture - that progression through rooms on the unit had significance, not only in terms of the stability of their infants' condition, but also in terms of the opportunity for increased emotional and physical connection with their infants. Such progression symbolised hope, but was tenuous and could be undermined when the infant did not cope and had to be 'demoted' back a room (see figure 4).

"I think I have been on autopilot at work, whenever I come here I am falling asleep."

Ahmed, father of Sam, born at 32 weeks gestation

Figure 5



The mobilisation of physical, emotional and social resources was both a practical and an emotional response to the men's situations. It was clear that all of the men offered some insights into the challenges of negotiating time off work and how they tried to juggle the sudden demands of being a new father with those associated with their responsibilities at work.

In reality, once the men were back at work, their shift patterns restricted the time available to visit their infants and support their partners. These tensions eased over time once the men had settled into a routine that combined visits to the neonatal unit with paid work. All of the men achieved this to some degree, though some felt they had been more successful than others. In general, the men felt more supported by the staff in the home nursery. Although some fathers felt ignored at times by the neonatal staff, they also acknowledged that sometimes they were too exhausted on an evening, after working all day, to engage fully with the staff. Most importantly they desired staff to engage with them directly and value them as the father of their infant (see figure 5).

Brief introduction to the concept of disrupted biographies as an explanatory framework

It is argued that life is shaped by key moments which can leave permanent marks [12]. When someone makes the decision to share their biographical account at a point in time, they make the decision where to begin [12,13]. The men chose to begin their stories early on in the pregnancy experience, facilitated by a very broad opening question at the start of the first interview.

> ***"The present stood out as a time when things changed, ceased to be what they once were and became something different"***
> **11 (Mackey 2005:183).**

Having an opportunity to conduct a follow up interview revealed that the gravity of the initial biographical disruption was tempered over time by the men's continuing reappraisal and revision of their disrupted lives. Reconstructing, refining or accepting a new biography may be one way of dealing with this tension [14,15]. For example, the men had to come to terms with being the father of a preterm infant and reconstruct their biography to accommodate this unanticipated change. Importantly, Todres argues that we know ourselves through our experiences with others; for the men in this study that involved relationships with their partners, the ward staff, other fathers in NIC and fathers of healthy term infants that they had encountered [15].

Over time the men weaved work and visiting in such a way that it became natural to work all day and visit in the evenings, keeping this up until the infant was discharged from the unit to home. Recasting and repairing their biographies took time because it required a sense of control and predictability over the situation. Sometimes the unpredictable occurred, such as demotion back to HD or NIC that served to disrupt the men's biographical transition again.

Conclusion

A key finding was the pregnancy narrative, not explored in other neonatal studies [1,2 , 13,16,17] The opportunity for the men to discuss their experiences during their partner's pregnancy revealed a lack of preparation for the preterm birth, a disruption to anticipated fatherhood, overwhelming concern for their partner and not knowing what was happening, exacerbated by inconsistency in communication with the fathers once on the delivery suite.

The concept of disruptive biographies was another key finding and helped to contextualise the experiences of becoming a father on a neonatal unit. Interviewing the fathers twice revealed that identity as a father was continually evolving and was aided by hearing their infant cry on delivery suite, getting the first hold and being involved with the practical tasks of parenting. Initially, the men were afraid to touch their infant but, as the acuity of care improved, so too did the fathers' ability to provide care for their infants. Juggling paid work with visits to the neonatal unit was emotionally and physically tiring.

Much of the parentcraft teaching and discussions with neonatal consultants occurred during the day when the men were at work. Consequently the men felt ignored at times and undervalued.

However, when the fathers spoke of staff meeting their needs they emphasised the importance of being taught by nurses how to navigate the equipment to care for their infants, of how some doctors talked to them in a way they could understand and of how the home nursery staff had more time to teach them and build up a rapport with them. These strategies helped them to increase their confidence as the parent of a preterm infant.

Implications for policy, practice, education and research

Findings from this research both supports and advances earlier work on this topic [2,13,16,17,18] (see figure 6) and has implications for service users, service providers, educators, commissioners and policy makers in both midwifery and neonatal care.

There is a paucity of research within the UK on this topic and it is hoped this study will encourage others to do similar work and expand neonatal knowledge even further. Williams argues that the broader use of biographical disruption as an explanatory framework adds to a wider critique of its use in helping to "map new terrains" for its use in healthcare [17]. A number of specific recommendations are presented in the table on the following page (see figure 7).

Figure 6

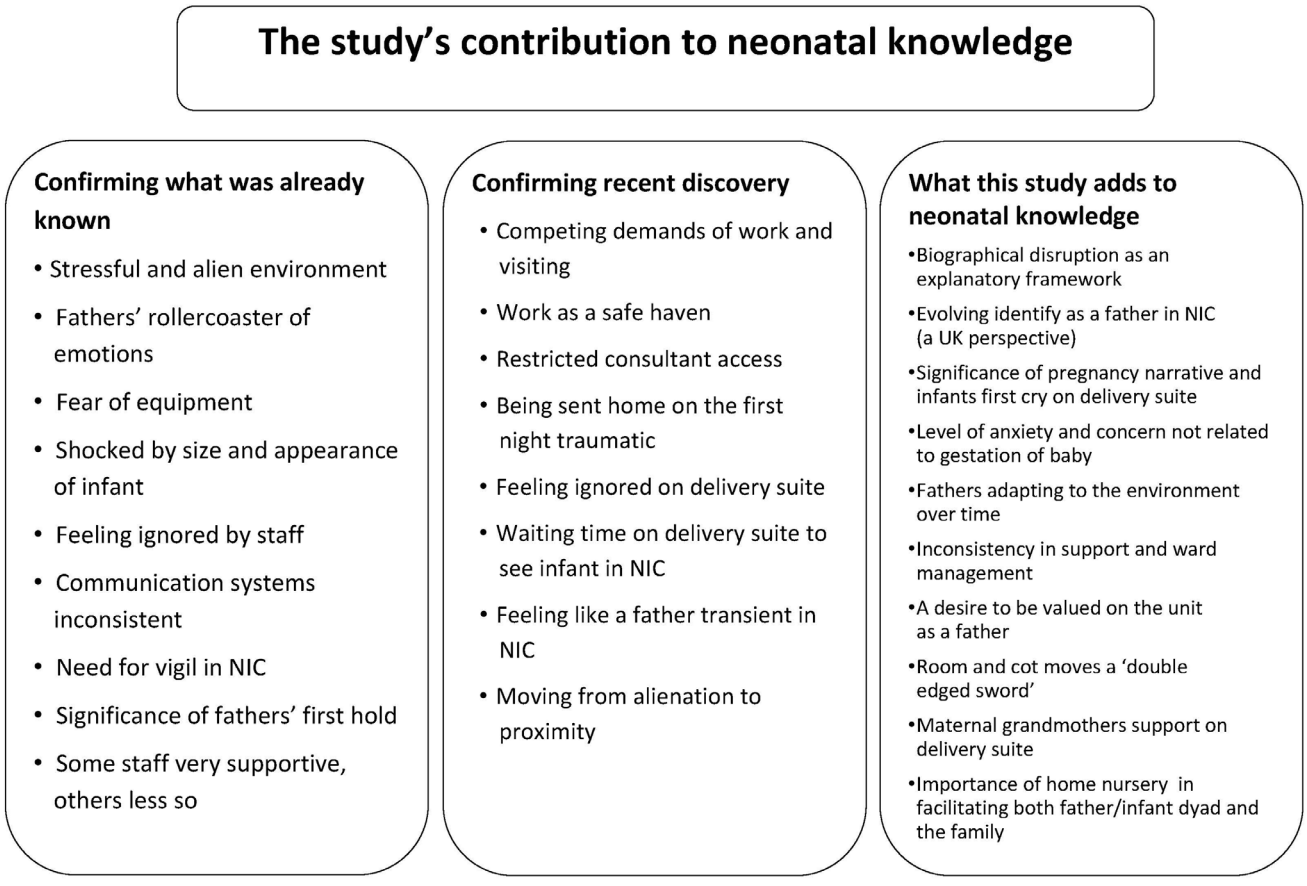
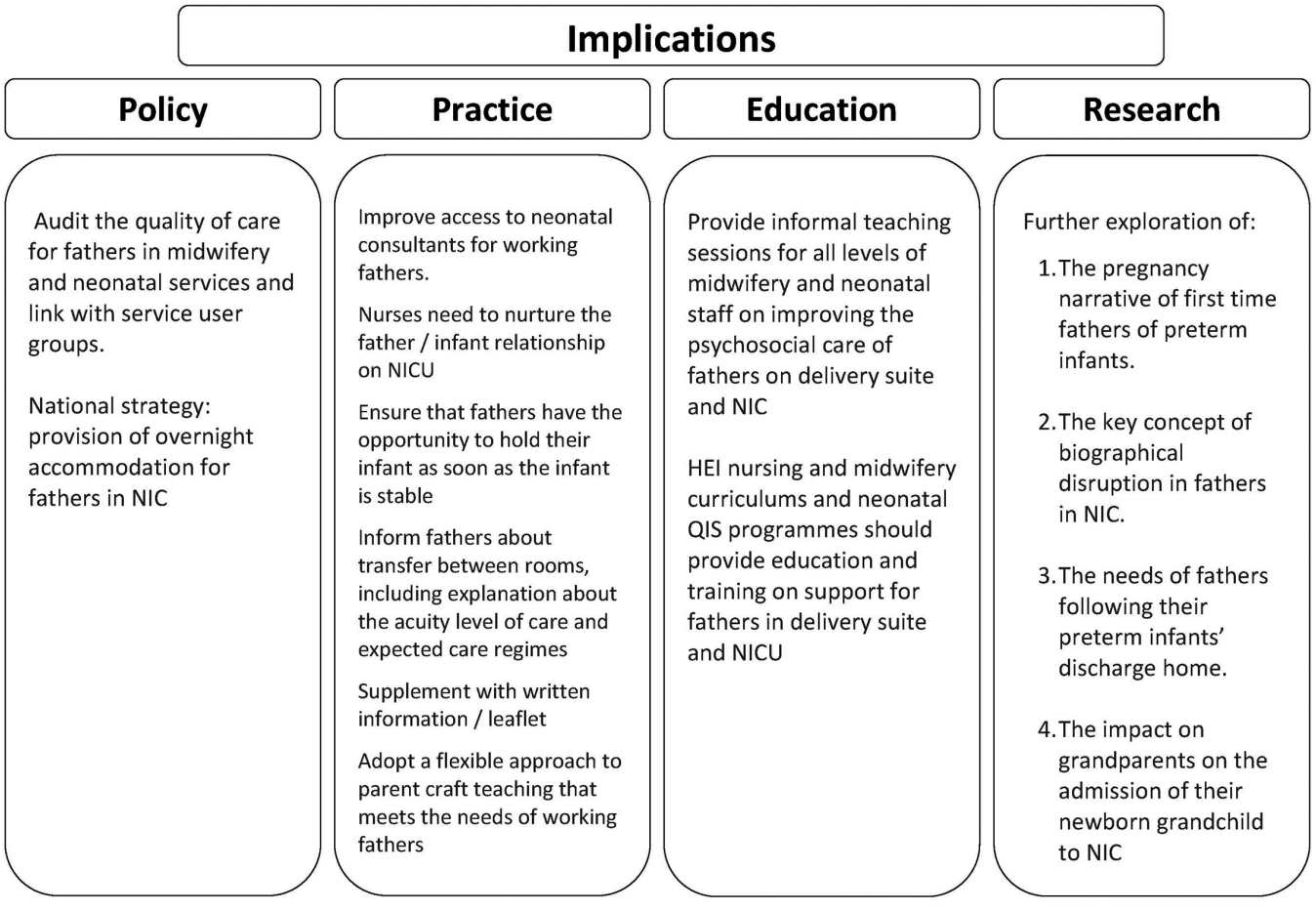


Figure 7



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