A qualitative study of new fathers’ experiences of care in relation to complicated childbirth

Inger Lindberg *,1, Åsa Engström

Division of Nursing, Department of Health Science, Luleå University of Technology, SE-971 87 Luleå, Sweden

Article info

Article history:
Received 12 October 2012
Revised 30 September 2013
Accepted 2 October 2013

Keywords:
Complicated childbirth
Fathers’ experiences
Intensive care nursing
Qualitative research

Abstract

Objectives: The objective of the study was to describe new fathers’ experiences with care related to complicated childbirth.

Methods: A qualitative approach consisting of individual interviews using a semi-structured interview guide with open-ended questions was applied. A purposive sample of eight fathers participated. The interview text was subjected to qualitative thematic content analysis.

Results: Analysis revealed the following three categories: (1) feeling scared and uncared for during acute situations; (2) appreciating the opportunity to participate in care and becoming a family; and (3) needing continued care. Based on these three categories, a recurring theme was identified: struggling to be recognized by care staff as a partner in the family was revealed.

Conclusion: Although fathers lack support and understanding from care staff, they strive to fulfill their roles as fathers by guarding their families and keeping them together. Caregivers involved in the childbirth process should realize that by acknowledging and encouraging fathers in these roles, they in turn support the entire family unit. Interventions developed for fathers and family care requires further development. Additional research concerning how midwives and critical care nurses (CCNs) view the presence of fathers in the emergency situations that may accompany childbirth is also needed.

© 2013 Elsevier B.V. All rights reserved.

Introduction

When childbirth does not progress as expected or when pregnant women experience an acute or serious delivery-related complication and thus require care in an intensive care unit (ICU), the father-partner is also affected by being placed him in an unexpected and overwhelming situation concerning not only the newborn but also the critical situation of his partner. In a review study, Rahmqvist Linnarsson et al. [31], findings show that partners of critically ill or injured persons face situations that can be overwhelming and emotionally challenging, which results in their felt need to be heard and seen.

Complications that can occur before, during, or after childbirth and that can lead to the mother's needing treatment in an ICU or postoperative unit include preeclampsia, infections, bleeding, hemolysis elevated liver enzymes, low platelets count (HELLP syndrome), disseminated intravascular coagulation (DIC syndrome), emboli, acute respiratory distress syndrome (ARDS), pulmonary oedema, trauma, and cardiovascular diseases [24]. Reasons for an emergency caesarean section include prolonged labour, abnormal presentations (e.g., face or breech presentation), asphyxia, cephalo-pelvic disproportion, preeclampsia, and placental abruption [18]. According to statistics from The National Board of Health and Welfare [37] 8.1% of childbirths in Sweden during 2011 concluded with an emergency caesarean section, while 8.8% required instrumental delivery, such as by vacuum extraction or forceps.

In Western culture, it is common for men to be present at the births of their children [8], especially their first children. Becoming a father entails significant life changes, leading some researchers [1,26,35] to describe the transition to fatherhood as a balancing act between the demands of their roles as providers and the demands that they engage in their new roles as fathers. In general, men experience great satisfaction when they first become fathers and find being present at their child’s birth rewarding and enjoyable [4,30].

Despite the desire to attend their children’s birth [13], men often find seeing their partner in pain very stressful and worry about being unable to support her emotionally [30]. Furthermore, though it is well known that the father is the most important person for the mother after childbirth [23,9,15], some fathers can develop depression or posttraumatic stress disorder (PTSD), either of which can affect both parent–child bonding [27,28] and the father's relationship with his partner [27,39]. Internationally, the incidence of
depression in men during the postnatal period ranges from 4% to 25% [25]. Studies [4,11,27,40,41] have also shown that negative emotional experiences affect men to a greater degree when labour must conclude with an emergency caesarean section or instrumental delivery due to the health status of the child or mother.

Though fathers, in addition to health care staff, are often very willing to provide support for their partners and newborns following complicated births, fathers as well as mothers need support. Studies [22,33] report that new fathers of prematurely born babies prioritized the needs of the mother and child, while putting their own feelings and needs second. Nevertheless, a study by Johansson et al. [16] has reported that although fathers enjoyed being involved during the birth process and made efforts to actively support their partners, they also expressed needing support from health care professionals.

Kynoch et al. [20] have demonstrated that CCNs lack confidence and competence in meeting and supporting the needs of critically ill obstetric women, which indicates a clear need for greater assistance and education of intensive care nurses. In order to develop a care model that integrates practices to support fathers after complicated childbirth, this study seeks to add to previous research—much of which has been performed respecting the mother's needs after a complicated childbirth. By focusing on new fathers' experiences of care in relation to complicated childbirth, this study thus complements research focusing on the experiences of fathers after elective caesarean section, which has concluded that the transition to fatherhood requires both presence and time [10].

Methods

Objective

The objective of the study was to describe new fathers' experiences of care in relation to complicated childbirth.

Setting

During 2009 and 2010 managers of an ICU and a maternity ward in northern Sweden were informed about and approved this study. A midwife in the maternity ward orally informed families about the purposes of the study and distributed information letters to prospective participants. From these prospects, fourteen fathers staying at the maternity ward were invited to participate (cf. [29]). Invitations were based on prospects' answers to the inclusion criteria: having experienced their partner's complicated childbirth, which involved a postoperative stay at an ICU, as well as the ability to speak and understand Swedish. From the fourteen prospects, eight fathers consented to participate and were contacted by telephone to schedule appointments to be interviewed at their convenience.

Ethical approval

Informed consent was collected after participants were informed orally and in writing about the study's purposes. Participants were assured that they could excuse themselves from participating at any time during the study, that findings would not be linked to individuals, and that all study events and materials would maintain confidentiality. Since this study examined sensitive and traumatic events, the authors—one an ICU nurse, the other a midwife, and both with extended clinical experience—were prepared to handle strong emotional responses. In addition, a medical social worker at the maternity ward was asked to be on call for participants. The study was conducted according to the Ethical Review Act [36] and approved by the Regional Ethics Board (Dnr 09-098M).

Participants

Participants' ages ranged from 24 to 44 (M = 36, 3 years), and their wives or partners had received intensive care lasting from 6 to 72 h. Seven participants had experience with the postoperative part of the ICU, while one had experience with the ICU. Each participant had experienced his partner's emergency caesarean section, three of which were due to prolonged labour, another to prolonged labour and unsuccessful vacuum extraction, two to foetal asphyxia, another to abnormal presentation, and another to placental abruption. Interviews occurred one-and-a-half to 3 months after childbirth and stay at the ICU. All participants currently lived with their child's mother. For four participants, the child of complicated birth was their first child; for another, his second child; and for the three others, their third child.

Data collection

A qualitative approach was used to explore the behaviours, feelings, and experiences of participants and their lives [14]. During 2009 and 2010, a semi-structured interview was used to collect data in order to reveal the new fathers' experiences with care following complicated childbirth. The authors created the interview guide and conducted the interviews. Participants first responded to the prompt, "Tell me what happened during the childbirth." Subsequent questions included: "How did you experience care at the ICU?"; "How were your needs met?"; "How did you experience relationships with the staff?"; "What was good or not so good in the care of your partner?"; and "How did you experience hospitality from the staff toward yourself and your family?" Questions of clarification included: "Please describe more about what you said"; "How did you feel then?"; "Can you please give an example?"; and "How do you mean?"

The first interview was conducted as a pilot interview to confirm its inclusion in data collection only if both the interview guide and interview were found satisfactory. The interviews, which ranged from 30 to 45 min, were recorded and completed at participants' homes or at the authors' workplace, depending on the participants' wishes. The interviews were transcribed verbatim, and were reviewed by the authors to ensure accuracy (cf. [19]).

Data analysis

The eight interview transcriptions were analyzed by qualitative content analysis as described by Downe-Wamboldt [7]. Each transcription was initially read to gain a sense of the whole and then followed by a closer reading to identify textual units that pertained to the study's objectives. Textual units were then condensed and sorted into broader but fewer categories during a four-step process based on similarities and differences in content, which resulted in three categories [7]. Once the final categories were determined, the textual units were reread and checked for the appropriateness of their categorization. A recurring theme forming a thread of meaning was revealed from a comparison of the categories (cf. [2]). The authors independently checked the analysis independently, and finally, their findings were discussed to reach consensus.

Results

An overview of the analysis with a main theme and three categories is presented in Table 1. Here follows a detailed description of the result including quotations from the fathers' labelled 'Father 1' to 'Father 8'.
Struggling to be recognised by the care staff as a partner in the family

Analysis categorised the main findings of fathers’ experiences into one theme and three categories. Findings show that fathers tried to be close to both their partner and newborn child, despite finding the acute situation very trying and frightening, as well as sometimes experiencing the feeling of being neglected by the care staff. When fathers were invited by the staff to participate in child-birth process, they felt that they were being treated as part of the family by the staff. Fathers struggled to stay informed and support partners before, during, and after childbirth; but in order to be that partner they requested continued care after being discharged in order to resolve remaining questions.

Being scared and uncared for in the acute situation

Fathers expressed awareness that childbirth could be complicated. While the expressions varying among fathers were one thing, actually being or feeling prepared for an acute situation, to say nothing of being caught in the middle of that situation. Fathers did not realize the acuteness of the situation and expressed either feeling absent when it was decided to interfere in the childbirth or not feeling informed about the situation by delivery room staff.

It changed so fast. [...] The umbilical cord was there, and it changed so fast, and then the midwife said that if we can have the baby out so—so it will be good, and they started to phone [...] the obstetrician and they disconnected her [his partner from the machines], and I think they changed beds and started to run in the room, and I just sat there and watched and thought is it—is it like this when things go wrong? (Father 3)

Expressions of fear, frustration, and helplessness related to not being able to do anything for the mother and the prospective child was central to fathers’ responses. Fathers’ fear escalated when they realized that delivery room staff was frustrated. One father described, with tears in his eyes, that he had felt that he was possibly seeing his wife alive for the last time. Fathers described the term “catastrophic caesarean section,” which staff used in the delivery room to alert the surgical and anaesthetic staff, as very dramatic. The term increased fathers’ stress as well as underscored their understanding that situations were becoming desperate. Fathers also reported that the atmosphere of the delivery ward and its organization of care were chaotic, though most admitted that their sense of disorder could derive from their feelings of being poorly informed about acute situations.

Fear, frustration, helplessness, not being able to do something by myself [...] just keep on trying [...] and then they just rolled away. (Father 1)

Fathers also expressed feeling abandoned, since they were not invited into the operating room by delivery room staff when their partners were taken away to undergo an emergency or catastrophic caesarean section. They reported experiencing being uncared for upon being excluded and separated from their partners. One father said that his role as a partner and father was lost as the staff ignored him and left him behind.

It was traumatic; you started to think that it was an emergency situation when everyone started to run around in the room, but then everyone disappeared. [...] It was just me and an auxiliary nurse left; well, I lost my role there. I didn’t know if I should stay or go to the operating room. (Father 3)

At the same time, fathers who were prepared for an acute situation during childbirth accepted the staff’s decision because delivery room staff had orally justified their operation decision to these fathers. The decision was thus often experienced as a relief, since fathers thought that, given the circumstances they now realized, the operation was the best decision for the mother and child. These fathers also mentioned being able to spend time with their partners prior to operation. Altogether, fathers reported experiencing less stress when they knew that their partners were in good hands and being treated well by staff.

Fathers described waiting on operation results as a very trying, apprehensive period that made them lose track of time. They reported that their thoughts were preoccupied with their partners and prospective child the entire time. While waiting, though fathers reported being either outside the operating room or in the delivery ward, they expressed needing better or more frequent communication with the staff about the conditions of their partners and prospective children.

I would have liked to sit there; I can change clothes [to sterile clothes], it doesn’t matter, so when she wakes up she can feel that I am beside her; I can hold her hand and say some words. (Father 6)

Appreciating the opportunity to participate in care and becoming a family

Although fathers reported experiencing the operating room as an uncomfortable, scary environment, fathers who were present during preparation and the operation expressed appreciation for not being excluded. They also expressed wanting the staff in the operating room to recognize them both as an active participant and as the father during the acute situation. These same fathers reported being treated well by staff and appreciated the continuous communication during the operation. Being present during the caesarean section was described to include family togetherness, during which time fathers could continue in their roles as partners’ caregivers and supporters. At the same time, other fathers reported not asking to be informed because they preferred that staff focus on the mother and child.

I mean to be participating, not just sitting in a room. (Father 4)

On the one hand, fathers reported experiencing great relief when their children’s healthy conditions were initially announced. Those fathers whose infants had to be treated by paediatrics and were referred to the neonatal ward, on the other hand, expressed great worry. Being presented with two care situations—one of the partner, the other of the child—made fathers feel torn between being a partner to the woman and being a father to the infant.

Fathers also reported appreciating and feeling rewarded by being together with the midwife after the caesarean section and caring for the new baby. They also appreciated the opportunity to have their own room at the maternity ward and having one-on-one time with their babies while their partners were in the postoperative unit. Such an intimate opportunity was considered by fathers to be highly important for getting to know the baby and becoming a father of a family. Nevertheless, fathers also reported feeling insecure while caring for the baby by themselves and expressed wanting staff to be more supportive and ask about their needs. In general, however, fathers expressed feeling satisfied.
during interactions with the maternity ward staff and described the environment as very supportive.

They [ ] were very professional, and they were very focussed on the situation and were able to stop the bleeding, so I was not expecting any warmer reception, but in the maternity ward, they were taking care very respectfully and [were] very warm to my daughter and myself. But in the ICU there is some business, like you see. (Father 8)

Fathers described themselves at the maternity ward as they waited for their partners, who were receiving postoperative care. They worried about their partners’ health and wanted to see their partners as soon as possible, but when they asked for information, no maternity ward staff could answer their questions. Fathers experienced this lack of information as frustrating and evocative of dramatic scenarios concerning their partner’s condition.

Maybe [...] you [ ] could have some information [...] that she [his partner] was all right because I asked and [...] they couldn’t say [...] if it was all right [... ]. As a father, you are worried. (Father 2)

Except fathers whose infants were in the neonatal ward, all fathers visited their partners in the postoperative unit and carried their babies with them. They stressed the importance of seeing their partners and knowing that their conditions were good. Fathers also thought that it was important for the woman to see and hold the baby. Altogether, these visits were expressed as being important for family bonding.

There was some waiting and I was thinking we must be together there [the postoperative unit] [...]. It was frustrating; you wanted to be together, but of course she needed to have surgery and that takes some time. (Father 5)

Fathers reported that they experienced both the environment and staff of the postoperative unit as unsupportive. They expressed not being spoken to or approached as a family member. Some staff members were perceived to be insecure and ignorant about how to care for the woman, the new baby, and the family, since they could not help with breastfeeding or answer questions. Moreover, the postoperative care environment was reported to feel sterile. One father described not having a chair to sit on next to his partner’s bed. Fathers also expressed feeling a lack of privacy in the postoperative care environment and that they were disturbing other patients when their babies were crying.

Though negative comments about the postoperative care environment were prevalent, fathers also expressed experiencing the environment as calm, peaceful, and well equipped to monitor patients’ health. They accepted the care environment and organisation as part of an effective emergency ward. Though the time spent in the postoperative unit was described as brief, men expressed satisfaction when returning to the maternity ward with their partners and babies. In general, fathers described the maternity ward as the more comfortable environment and its staff as more supportive of the family.

They didn’t say anything there in [the] postoperative unit; you couldn’t see anyone—not a surgeon, anyhow; there was someone new in the unit who didn’t know what to do. (Father 7)

Needing continued care

Lacking information regarding why partners’ acute situations arose or whether the baby had suffered lasting injuries was common to interview results. Fathers stressed the importance of being offered the opportunity of continued care during a follow-up talk with a professional, as opposed to having to ask for such an opportunity. Fathers expressed interest in reviewing the pertinent medical records and reported thinking that it was important to have a follow-up meeting after being discharged from the maternity ward. They also expressed that they would have liked to have a telephone number—at least—for someone who could answer their questions. Some fathers wanted to speak with the obstetricians who had performed the operation. Specifically, one father had questions about his partner’s incision, because there had been postoperative complications at home; without knowing where to turn, however, he sought information from the Internet. Moreover, fathers also reported that their partners had lingering questions concerning the delivery.

Fathers who had learned from their midwives and obstetricians expressed satisfaction with the care and had no remaining questions or need for follow-up visits; these fathers simply wanted to go home. They received this information as a sign that there would not be any problems during future births.

Yes, the obstetrician or someone could have said that this was the problem with this muscle [...]. It wasn’t until the next day [that we could ask what had happened]. Then we met a nurse or a midwife who found out information [...] and then we knew what had happened, and that it was a total—well, the muscle had retrieved. [...] They [care staff] have still not said what kind of problem there could be or what could happen in the future. (Father 7)

Fathers reported thinking that unexpected events affected their relationships with their partner to some extent, though the majority expressed that it had nonetheless strengthened their relationship. Nevertheless, these fathers were still concerned about the lack of support from the care staff.

Fathers also stressed the importance of communicating with their partners about their feelings and experiences. At the same time, fathers expressed that they did not want to burden their partners with their thoughts, because they believed that their partners had enough to deal with, such as nursing their children and recovering from childbirth. Fathers also expressed feeling worried about their partners, since they thought that their partners had had more severe experiences during the acute situation as well as disappointment over the birth not being natural. Fathers also expressed feeling guilty for thinking that, as observers, they had had an easier time during all the events surrounding the birth. In particular, one father stated that the most important thing was that the baby was healthy. In general, fathers expressed needing continued contact regarding care and opportunities to discuss their personal experiences.

We [the father and his partner] have a good relationship, and we can discuss most of the things [...]. Things can be up and down, but we have good communication, and that is very important. (Father 8)

Discussion

Given this study’s objective—to describe new fathers’ experiences with care in relation to a complicated childbirth—our main finding is that fathers struggled to be recognized by the care staff as partners in their families. Men’s transition to fatherhood has been characterized by Draper [8] as the product of the three phases: separation, liminality, and incorporation. Separation starts with the confirmation of the pregnancy, which signals the transition toward the new role of father. During the liminality phase, the prospective father falls between social statuses. Finally, during incorporation, he adjusts to his new role as father. Draper [8] describes labour and birth as particularly ambiguous times for men, who experience placelessness, powerlessness, and uncertainty...
regarding how to help their partners. They therefore often feel vulnerable. Though men are encouraged to participate in the pregnancy and birth, they receive mixed messages; that is, they feel welcome to participate physically but not emotionally [32]. Thus, the theme of this study’s findings is that while the presence of fathers during labour was acceptable, when childbirth evolved into an emergency situation, fathers felt the need to fight and assume responsibility for their families. According to Premberg et al. [30] midwives have the opportunity to acknowledge fathers as valuable participants and support them in their future role.

Findings also show that fathers were afraid and unprepared for acute situations; they expressed great concern about the health of their partners and babies. Furthermore, some fathers of our sample reported feeling abandoned and excluded by staff when their partners were transferred to the operating room. Studies [4,5,6,11] have shown, however, that fathers who attended a delivery experienced the event of childbirth as more traumatic and less rewarding. Nevertheless, fathers’ feelings of rejection from their baby’s deliveries were exacerbated if an emergency caesarean section became necessary. In this situation, fathers reported feeling unsure about their roles and not knowing what was happening to their partners and prospective babies [5,12]. According to White [40], prospective fathers have still reported feelings of being marginalized in a space dominated by women. Although many midwives strive to teach fathers vital information, there is evidence to suggest that the same midwives may inadvertently give mixed messages concerning the fathers’ role [10,35,40]. This study’s fathers described feelings of marginalization, which along with feeling out of touch, lacking knowledge, and generally fearing labour according, is characteristic of the liminal phase that peaks during labour [8]. Singh and Newburn [34] suggest that when the father’s presence is nurtured by his inclusion in discussions and he is provided with information, everyone benefits and distress is reduced.

Our findings also show that fathers appreciated staff efforts to keep them apprised of the status of their partners and babies, as well as efforts to invite them to the caesarean section, whether in or outside the operating room, because it validates their role as fathers who desire to keep families together. According to a review study [31], partners of critically ill or injured persons strive to be close in order to protect and guard the loved one. Thus, to be present during labour and childbirth is important for men’s transition to fatherhood [8]; Vehveiläinen-Julkonen and Liukkonen, [39]. According to Draper [8], the degree to which fathers feel involved in the childbirth process depends on the willingness of midwives and obstetricians to acknowledge them as fathers. Our findings generally reveal that when fathers were invited to participate, the caregivers acknowledged and facilitated their roles as fathers.

Our findings also show that fathers very much need information and explanations related to emergency situations, as well as follow-up visits. Although research regarding postnatal depressive symptoms in fathers requires more studies, it does suggest that experiencing postnatal depressive symptoms affects the interactions between the father and the mother and can impact the amount of practical support they can possibly give to their partners and babies, which may later affect the child’s behaviour [3]. Since fathers can experience posttraumatic stress syndrome (PTSD) after birth, studies [25,40] have suggested that appropriate antenatal guidance exclusively for fathers needs to be developed, as well as effective follow-up sessions for fathers still seeking a resolution [40]. Though depression falls outside of this study’s aims, it is important to respect the father’s need for information and follow-up visits because these gestures of inclusion can solve problems and resolve concerns that remain after childbirth.

Lastly, our findings show that fathers experienced unexpected events as somewhat influential to their subsequent relationships with their partners. The majority reported that such events had strengthened their relationships. Fathers also stressed the importance of communicating with their partners about feelings and experiences. In some studies [4], Vehveiläinen-Julkonen and Liukkonen (1998), men reported that being present during childbirth had deepened their relationships with their partners. Interestingly, fathers who found the experience unrewarding and felt that their relationship had worsened were those fathers who felt unprepared and unwilling to stay during the actual childbirth. In order to consider the importance of enhancing the parental relationship, it must be acknowledged that the child’s father is viewed as the most important person for the mother’s well-being during childbirth [17,23] and postnatal care [23,38]. Lavender [21] has reported that if society strives for equality, it is then unrealistic to expect men to automatically cope in an alien environment. Furthermore, Lavender [21] emphasizes that decisions concerning pregnancy and childbirth should be made by the mother, the father, and the midwife, and must also be acceptable to everyone involved.

This study’s acknowledges that it may be limited by having selected a group of fathers who had the opportunity to verbally express their feelings, while the fathers not participating were those that perhaps needed to talk the most. The experience of nonparticipants may have significantly influenced the findings. However, our findings accord with present research. Interviews were rich in content and were considered to answer the aim of the study. In order to enhance the trustworthiness of the study, during the analysis the authors compared their views regarding the textual units and categories until consensus was reached. Quotations were also used to ensure trustworthiness.

Conclusion and clinical implication

Although fathers generally lack the support and understanding of care staff, they strive to fulfill their roles as fathers guiding their families and keeping them together. Caregivers involved in the childbirth process should realize that by acknowledging and encouraging fathers in their roles, they also support the entire family unit. Interventions developed specifically for fathers and family care requires further development. Furthermore, there is a need for additional research concerning how midwives and CCNs view the presence of fathers in emergency situations that occur during childbirth.

Conflict of interest

We the authors, declare that there are no financial or personal relationships to people or organisations that would compromise the ethicality of our work.

Role of funding source

The research received grants from the County Council of Norrbotten, Sweden, which was not involved in this study.

References