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Fathers' experience of starting family life with an infant born prematurely due to mothers' severe illness

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ABSTRACT

Introduction

Becoming a father is often a happy event: the moment of birth can be exhilarating and might be accompanied by a deepened sense of connection to the newborn infant and partner [1]. However, occasionally, severe illness can force a premature birth. Severe preeclampsia is one condition that often necessitates premature birth, being a major cause of serious illness, long-term disability, and death of both the mother and infant [2,3]. Severe preeclampsia is characterized by high systolic pressure, pulmonary edema, and/or new-onset cerebral or visual disturbances. HELLP syndrome (hemolysis, elevated liver enzymes, and low platelet count) is the most serious related condition [3]. Because early onset preeclampsia that develops before gestational week 35 tends to progress more rapidly, hospitalization along with the necessary resources for maternal and neonatal intensive care is necessary. The mothers should then be given corticosteroids to increase fetal lung maturity, and birth should be delayed by 48 hours, if possible [4].

Fathers of a premature infant often experience a range of feelings, such as anxiety and fear [5,6], although many are reluctant to admit these feelings [7]. Deeney et al. [8] reported that fathers often believed it important to appear strong and stoic in such situations. However, Mackley et al. [9] reported that the emotional needs of fathers in the neonatal intensive care unit (NICU) might be neglected.

Studies have shown that maternal health has an impact on how the period after the birth of a premature infant is experienced. Some fathers have reported being afraid of losing both their partner and child [10], and often continue to worry about this possibility after the birth [7,11]. Furthermore, fathers might find it difficult to choose whether to stay with the infant or partner when the infant transferred to the NICU [12].

The first hours and days after birth are important for establishing the bond between parents and infant [13]. Fathers tended to first focus on the mother [10], and shifted their focus to the infant after the partner had stabilized. These fathers were often the first person to bond with the newborns [11]. Studies have shown that mothers' health might influence fathers' involvement with the infant. If the mothers had poor health after birth, fathers often spent more time with the infant in the NICU, which deepened their involvement with the child [14]. Fathers' pattern of involvement with the child in the NICU can be divided into three groups: those whose involvement is equal to mothers', those who considered the mother more important than the father, and those who were reluctant to become involved. A characteristic of the first group was that the mother was unwell after birth. These fathers spent much of their time in the NICU, when the mothers were unable to do so [15].

Provenzi and Santoro [16] found that fathers who were involved with their child in the NICU used two major coping strategies: hiding from their own feelings and returning to work. Pohlman [17] similarly found that the fathers of preterm infants tended to prioritize work and acted as observers in infant care rather than as active participants. According to Feeley et al. [14] fathers' various other life responsibilities—such as housework, caring for older children, work, and supporting their partners—hindered their involvement in the care of the newborn in the NICU. The factors that promoted their involvement in this care were physical contact and a desire to bond with the infant. Wigert et al. [18] also found that the need to care for other children at home could hinder fathers' involvement with the preterm infant in the NICU. However, in further support of the findings mentioned previously, mothers' poor postpartum health caused fathers to be more present in the NICU.

Serious preeclampsia often forces a premature birth to save the mother's and infant's lives. In these cases, the beginning of family

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life is characterized by the mother's severe preeclampsia and the infant's prematurity. Although there have been studies focusing on fathers' experiences in the NICU, including after a premature birth, few studies have included mothers' health in the puerperium as an additional contextual factor. Thus, the aim of this study is to describe fathers' experience of starting family life with an infant born prematurely out of necessity to save the mother's and infant's lives due to mothers' severe preeclampsia.

Method

We used a descriptive, qualitative design, and explored the phenomenon of interest using Dahlberg et al.'s reflective lifeworld research (RLR) [19]. RLR focuses on individuals' "lifeworld"—nam ely, the world that we experience through our bodies. It is based on phenomenology, in particular the philosophies of Edmund Husserl and Maurice Merleau-Ponty. The goal of RLR is to reveal the study phenomenon and thereafter describe it in a clear and understandable way. Here, the "phenomenon" refers to the fathers' experiences. Phenomenology's concept of "bracketing" is called "bridling" in RLR. More specifically, the researcher must be open, respectful, and sensitive, as well as attentive to the material of interest. While it is impossible to set aside all presumptions, the researcher must be as critical and reflective as possible. The purpose of "bridling" is to slow down the analysis process to permit the appearance of the phenomenon during the researcher's search for meaning [20].

Sample/data collection

Participants comprised a convenience sample [21] of six fathers whose partners had preeclampsia resulting in premature birth. The aim of a phenomenological study is to achieve deep knowledge of the research question, and thus the number of informants is unimportant so long as deep knowledge is achieved [22]. A rich variation in data will lead to a comprehensive understanding of the phenomenon and is as important as the number of informants [19]. Inclusion criteria were as follows: being the partner of a woman suffering from severe preeclampsia that led to delivery before gestational week 34, living together with the woman, and understanding and speaking Norwegian. Exclusion criteria were the death of the infant and having a partner with a chronic illness. The fathers were recruited from three university hospitals and one regional hospital in different areas of Norway (Table 1). They were recruited by midwives or nurses at the maternity wards or in the NICUs. To obtain a comprehensive description of the experience, including the infant's stay in the NICU, all informants were interviewed twice. Some informants expressed a variety of experiences in the two interviews; others more or less confirmed the first interview. The first interviews were performed between 6 and 24 days after delivery, while the last interviews were conducted around discharge from the NICU (4–22 weeks post-partum). The differences in interview time were due to differences in the conditions of the mother and/or infant. The first author conducted the interviews, recorded, and transcribed verbatim. The data collection was performed from July 2013 to March 2014.

The interview guide had a very open initial question: "Please describe, in as much detail as possible, how you have experienced becoming a father to premature infant, while your partner was seriously ill". Some examples of follow up questions included: "Do you think that the mother's illness has influenced the experience of having a premature infant?", "How has this experience influenced you in becoming a father?" "How have you experienced the time in the NICU?" The following themes were also of interest: "To become a family", "Experiences with mother and the infant", "To become acquainted with the infant". All of the fathers could initially be together with the mother and infant on a daily basis after birth. They had taken parental leave from work for a period ranging from several days to several months. The Norwegian social security policy [23] entitles fathers' to have parental leave from work depending on the infant's condition. In this case, the fathers' leave lasted as long as the infant needed respiratory support. Three of the fathers were staying with the mother at the hospital or at a hotel connected to the hospital, while the remaining three were staying at home. When mother and / or infant were stable, two of them had to leave mother and child in order to go to work. All of them practiced skin-to-skin care.

Data analysis

The analysis was conducted according to Dahlberg et al. [19]. Initially, to obtain an overview of the data all of the interview transcripts were examined carefully. Both interviews for each informant were read together. Then, so-called meaning units were differentiated. The emerging meanings and thoughts related to these meanings were noted alongside the interview text. Meanings that appeared to be related were placed into contemporary clusters. Patterns of meaning were then searched for by examining how the clusters were associated with each other. The constant shifting of attention between the clusters and specific details led to the emergence of the phenomenon of interest. "Bridling" was used to keep the clusters flexible and avoid defining meanings too quickly. In this way, the phenomenon gradually emerged. The findings will first be presented as an essential structure of meanings; afterwards the various constituents of this structure will be described in order to elucidate the variations and nuances of the phenomenon (Table 2).

Ethical considerations

The Regional Committee for Medical and Health Research Ethics West, Norway approved the study. The study followed the principles of the Declaration of Helsinki [24]. The informants received a written explanation of the study purpose, after which they gave their written informed consent. They were also informed of the opportunity to use the existing follow-up services, like consulting psychologist or priest at their hospitals.

Table 1
Characteristics of sample.

Informant	Age	Children	Education	Infant's gestational age	Health status of infant
1	46	1	Secondary school	31.6	Healthy
2	33	3	Secondary school, Bachelor's student	24	Ventilator, CPAP
3	33	2	Secondary school	27	Ventilator, CPAP
4	44	4	Two-year high school	31.5	CPAP
5	33	2	Three-year high school	31	CPAP
6	28	1	Secondary school, high school student	31.1	CPAP

Abbreviations: CPAP, continuous positive airway pressure.