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Original Article

Healthcare professionals in a Neonatal Intensive Care Unit: Source of social support to fathers

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ABSTRACT

The aim of this study is to show the ways in which healthcare professionals are a source of social support to fathers of premature infants in the Neonatal Intensive Care Unit (NICU) of the Toulouse University Hospital, France. Mixed methods are used for data collection: A qualitative approach with a semi-structured interview as well as the Family Support Scale. The emerging themes are sources of satisfaction, importance of shared information and identification as a source of social support. The survey analysis reinforces the perceived helpfulness of the healthcare team. Finally, the importance of the NICU's staff is pointed out.

Introduction

Healthcare professionals have a demanding role to fill in a Neonatal Intensive Care Unit (NICU). Not only do they develop a caregiving relationship with the hospitalized infant, they also develop a relationship with the parents. Moreover, they encourage the parent-premature infant relationship, by helping parents to adapt to the specificities of the parental role in a particular context such as that of premature birth.

Parents and professionals are connected in a caregiving process which may last for weeks or even months. Thereby, a close relationship is established on both a physical and an emotional level (Dowling, 2006; Espezel and Canam, 2003; McAllister and Dionne, 2006). The establishment of a satisfactory and mutual relationship is needed in order to facilitate the caregiving process (Fegran et al., 2008; Fegran and Helseth, 2009). When this closeness is achieved, parents have the sense of being entirely involved. Fegran's et al. (2008) qualitative study conducted on parents and healthcare professionals identified three stages in this relationship. The critical phase, during which parents are mostly in an observatory position of the caregiving process; however, if the communication with the physicians is satisfactory and if parents are invited and encouraged to participate as caregivers they will not feel excluded. In the beginning of the hospitalization, the premature infant is very fragile and needs highly specialized medical care, so its survival depends on the healthcare team, which is perceived as highly competent by parents (Borghini and Müller-Nix, 2008). During the stabilization phase, parents handle the caregiving of their child on their own with the help and supervision of the healthcare professionals. The parent-nurse relationship evolves from parental involvement to parental participation (Hutchfield, 1999). The healthcare team encourages parents in becoming independent and autonomous regarding the caregiving. From the moment the premature infant's condition improves, parents take over and play an even more central and active role. They feel directly responsible for their child's well-being and health (Borghini and Müller-Nix, 2008). During the final phase, before discharge, parents are the principal caregivers of their child and the healthcare professionals are present to support and reinforce the therapeutic alliance (Hutchfield, 1999). Even if parents are usually stressed and frightened by their infant being discharged and taking care of their infant on their own, they remain optimistic and work with the team in order to organize the discharge (Fegran et al., 2008).

A positive relationship with the healthcare team may help to increase the parents' adaptability (Borghini and Müller-Nix, 2008; Tombeur et al., 2007) as it creates a positive social environment for infants and parental engagement (Borghini and Müller-Nix,

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2008; Fraser et al., 2007). Consequently, the healthcare team represents an important source of social support during the hospitalization of the infant (Blanch D'Souza et al., 2009), due to their protective role towards parents (Lasiuk et al., 2013). On the other hand, negative relations can increase the parents' stress levels (Blanch D'Souza et al., 2009). Thus, physicians and nurses contribute to helping the parents in their role attainment and reducing their stress levels by participating in the caregiving process of the premature infant and transmitting information about baby's health (Lee et al., 2013). However, many parents may be hyper cautious/attentive to the words that the medical staff use, trying to sometimes over interpret the information received. Fathers in particular, evaluate the transmitted information as very important; this information has an impact on their well-being and their sense of control of the situation (Ignell-Modé, Mard, Nyqvist & Blomqvist, 2014). Receiving clear, comprehensible and transparent information about the unit, staff and technical equipment surrounding their baby is appreciated by fathers and improves paternal involvement. On the contrary, research shows that an overload of information may be as harmful as the lack of it, causing parents to feel stress, panic and confusion (Svensson et al., 2006; Wilkins, 2006).

Parents experience the vulnerability of the first bond and they feel the need to establish a relationship with their infant which is not always easy hence the importance of the social support in the NICU. O'Brien and Warren (2014) conducted a study on paternal perceptions towards the healthcare team and fathers evaluate it as an important source of support. In particular, 86% of fathers say they received an important informational support, 69% emotional support and 77% of fathers think that physicians and nurses were giving them sufficient feedback on their participation in the caregiving process. Nearly every father (98%) valued the very high level of caregiver support, meaning that the team was available to give the right information about the infant's condition and facilitate the caregiving process (O'Brien and Warren, 2014; Santiago-Delefosse, 2002; Blanch D'Souza et al., 2009).

Recently, Mahon et al. (2015) created a tool for identifying the techniques employed by the healthcare team to assess the fathers' stressors and to decide their reactions in order to provide support; nonetheless further investigation is yet to be carried out. A recent review of literature held by Walmsley and Jones (2016) suggests that specific father-centred care plans could be beneficial for fathers. In particular, fathers appreciate the nurses' positive feedback on their caregiving attitudes which helps them increase their confidence.

The aim of this study is to explore the relationship that is created between fathers and the healthcare team (nurses, physicians) in the NICU in France, during the hospitalization of the premature infant.

Methods and measures

Sampling and participants

Purposeful theoretical-based sampling is used in this study. This type of sampling is based on the study purpose and investigator judgments about which people and settings will provide the best and most comprehensive information for the research questions (Palinkas et al., 2015; Patton, 2015; Tuckett, 2004; Wu et al., 2016). The inclusion criteria were: 1) French speaking fathers, 2) infant gestational age (26–35 weeks), 3) the time spent in the NICU being more than one week. Fathers whose infants were born with congenital problems affecting development (such as Down syndrome) or whose partner abused drugs and/or illegal substances were excluded. Severely ill infants were also excluded.

Only fathers who were present on a regular basis (more than 3–4 times per week) in the NICU were interviewed; those who came very infrequently (due to geographical distance, work constraints or having other children at home to take care of) were not interviewed.

The sample of this study is composed by 48 fathers of premature infants. All fathers approached, participated in the study. The prematurity level is quite severe, with half of the infants born between 26 and 28 gestational weeks and the other half between 29 and 32.

The mean age of the fathers is 33.5 (SD = 3.5). All of the participants are married, in a relationship or in a civil union with their partner. There is no deviation in terms of ethnic group as all of the fathers are French. As far as the level of education is concerned, 51.1% of fathers have obtained degrees equivalent to a bachelors or master's degree. 13.3% have finished high school and 33.3% have completed a technical degree.[1] However, this is not correlated with the rest of our variables.

Sociodemographic data

The data was obtained via a self-report questionnaire. Elements such as the age of the participants, marital status, nationality,[2] level of education, occupation and severity of infants' prematurity are taken into consideration. All fathers signed a written informed consent. The study obtained local ethics approval.

Qualitative aspect

A semi-structured interview was conducted for the purposes of the study, based on the *Clinical Interview for Parents of High-Risk Infants* CLIP interview (Meyer et al., 1993). This tool has both affective and cognitive aspects; on the one hand, parents talk about their infant's condition trying to understand why this has happened to them while on the other hand they recount their experience during this difficult period. In other words, through open questions, parents describe their experience (Meyer et al., 1993). There was no pre-established limit and interviews lasted from 15 min to 1h30.

In order to ensure dependability, we used the same protocol of questions as presented in the CLIP (*eg.* "*I wonder if you could tell me which are the strong points of the unit and which the weak ones? "Which were your fist reactions when entering the unit?"*). Parents are asked about their first impressions of the unit and the staff and their first reactions. Parents are encouraged to talk about negative and positive experiences, even though they may be hesitant to discuss the negative points given their dependency on the healthcare professionals.

In order to strengthen credibility, detailed field notes about the interviews are kept as well as an additional questionnaire, the Family Support Scale is used.

Family Support Scale

This questionnaire measures parents' satisfaction with the perceived helpfulness of support (Dunst et al., 1984). The 17 items version was used. Participants are asked to answer on a 5-point Likert scale (0 = not helpful at all to 5 = extremely helpful) in order to identify their sources of support in informal kinship, social

[1] It should be noted that higher education in France is not the same. A technical degree is equivalent to a vocational certificate obtained 2 years after the 8th or 9th grade.

[2] In France, participants are questioned as to their nationality as nationality overrules ethnicity.

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