

THE EXPERIENCES AND PERCEPTIONS OF FATHERS ATTENDING THE BIRTH  
AND IMMEDIATE CARE OF THEIR BABY

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Doctor of Philosophy

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January 2010

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# THESIS SUMMARY

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The experiences and perceptions of fathers attending the birth and immediate care of their baby

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Fathers in the United Kingdom (UK) usually attend the birth and immediate care of their baby. They also have an increasing presence during complicated and preterm childbirth, newborn resuscitation and early neonatal unit (NNU) care. However, there is limited evidence about the effect of these experiences on them. The aim of this study was to gain an understanding of the experiences of fathers encountering these situations.

The study consisted of three phases and was undertaken in one National Health Service trust in the UK. Qualitative semi-structured interviews using a phenomenological approach were undertaken with 20 first-time fathers present at the delivery, resuscitation and/or admission of their baby to the NNU. Direct observations were made of 22 normal and complicated deliveries and initial newborn care and qualitative semi-structured interviews using the critical incident approach were undertaken with 37 health care professionals (HCPs). The study generated qualitative and quantitative data that were analysed accordingly.

The findings show that most fathers were involved for at least some of the time and often spontaneously initiated their involvement. Their most important need was for information. They were usually more concerned about their partner, irrespective of the baby's need for resuscitation and NNU care. To facilitate their involvement, fathers needed guidance and support from HCPs, particularly delivery suite midwives. Most HCPs recognised the needs of fathers and ways in which they could be helped to connect with their experience. However, these needs were not always met, usually because of inadequate staffing levels, a lack of resources or a mother-centred philosophy of care. The findings suggest the service often determines the extent to which fathers are involved. It is anticipated that these findings will inform HCP education and training and the development of both policy and health education thereby enhancing the quality of care provision for fathers.

## Key words / Phrases

Fatherhood / Complicated childbirth / Preterm childbirth / Neonatal resuscitation / Neonatal unit

## **ACKNOWLEDGEMENTS**

Much of this study was undertaken during a half-time secondment to the Bliss Neonatal Nurse Research Fellow post hosted by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford. The secondment was funded by the newborn charity Bliss and I am therefore indebted to Bliss for providing me with the opportunity to explore my area of interest. I am particularly grateful to Bonnie Green and Jane Abbott at Bliss and Maggie Redshaw at NPEU for their ongoing support.

The nature of this study made it imperative that someone with a wide knowledge of the subject area provided supervision. Helen Pattison undertook this role and I am grateful for her advice, guidance and support. I am also appreciative of the assistance and encouragement I have received from staff and students within the School of Life and Health Sciences at Aston University and in particular from members of the Health and Human Development Research Group.

Most of all, I am grateful to the participants: parents, midwives, neonatal nurses and doctors for giving me their time. In addition, I would like to thank health care professionals at the study site who, although directly not involved in the study were nevertheless welcoming, encouraging and interested in this research. I would also like to acknowledge the help, support and encouragement I received from Jenny Bansal, Geoff Durbin, Michele Emery, Mo Harris, Sayeed Haque, Sue Hodgson, Justine Jeffery, Sandra Levers, Jane Owen and Martin Whittle. Finally, I would like to thank family, friends and work colleagues at both Birmingham City University and the NPEU for their support and encouragement.

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# Chapter 1 – Introduction

## 1.0 General introduction

For many men, the birth of their child is a landmark event. Whilst the actual delivery can provoke a range of emotions, childbirth marks a new phase that brings additional roles and responsibilities. Transition to fatherhood begins during pregnancy. However, the birth is an important event in the ongoing process of adaptation to parenthood. Indeed some fathers have described it as being life-changing. Whilst for the majority of men childbirth is normal and straightforward, for others it is not. The incidence of complicated childbirth and preterm birth (before 37 completed weeks gestation) is increasing primarily because of developments in reproductive technology and obstetric care (Slattery, Morrison 2002; Murphy, Pope, Frost, Liebling 2003; Langhoff-Roos, Kesmodel, Jacobsson, Rasmussen, Vogel 2006). Families often encounter these types of delivery with little warning, sometimes in emergency situations. There may also be uncertainty regarding the survival and long-term wellbeing of the mother and/or baby. Whilst there is an established body of knowledge regarding mothers' experiences of normal, complicated and preterm birth (Kirkham 1989; Oakley, Richards 1990; Simkin 1992; Fleissig 1993; Ryding, Wijma, Wijma 2000; Lawler, Sinclair 2003) there is limited evidence regarding the impact of these events on fathers (Chandler, Field 1997; Vehviläinen-Julkunen, Liukkonen 1998; Chan, Paterson-Brown 2002; Johnson 2002; Parfitt, Ayers 2009). Whilst some studies have explored men's experiences, they have mostly involved fathers of healthy babies born at term by normal delivery (Hallgren, Kihlgren, Forslin, Norberg 1999; Morse, Buist, Durkin 2000; Bradley, Mackenzie, Boath 2004; Condon, Boyce, Corkindale 2004; Montigny, Lacharité 2004). This is particularly noteworthy given that during complicated childbirth men often encounter more than one significant life event; the birth of their baby and their partner undergoing an obstetric procedure that may involve emergency surgery (Taylor, Bullough, van Hamel, Campbell 2002).

Evidence from the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), indicates a correlation between the incidence of preterm birth and neonatal resuscitation (CESDI, 2003). Consequently it is likely that both the increasing survival of extremely low birthweight (ELBW) infants (birthweight less than 1Kg) (CESDI, 2003; Murphy, Fowlie, McGuire 2004) and the rising incidence of complicated childbirth (Murphy et al 2003) has impacted upon the number of babies resuscitated at birth. Given that most fathers in the United Kingdom (UK) attend the birth of their baby (Kiernan, Smith 2003) it can be surmised over recent years an increasing number will have been present during the resuscitation of their baby. Whilst 'witnessed resuscitation' has been the focus of research in accident and emergency, adult and paediatric intensive care settings in recent years (Jarvis 1998; Woning van der 1999; Weslien, Nilstun, Lundqvist, Fridlund 2005), no work has been identified that specifically explores fathers' experiences of the resuscitation of their baby at birth.

The increased incidence of preterm births also correlates with an increase in the number of newborn babies requiring admission to the neonatal unit (NNU) (Redshaw, Hamilton 2005; Redshaw, Hamilton 2006; Bliss 2007). Whilst the majority of babies requiring this level of care are preterm and/or low birthweight (LBW) (less than 2.5Kg) (Redshaw, Hamilton 2006), term babies may also require NNU admission following complicated childbirth and/or resuscitation at delivery. Following the birth, some fathers accompany their baby to the NNU. However, most visit on their own or with their partner some time after the delivery. Although there is a growing body of evidence regarding fathers' overall experience of neonatal care (Rimmerman, Sheran 2001; Montigny, Lacharité 2004; Arockiasamy, Holsti, Albersheim 2008; Deeney, Lohan, Parkes, Spence 2009), little is known about their experiences of the first visit.

The overall purpose of this study was therefore to explore the experiences of fathers of complicated and preterm birth, newborn resuscitation and their first NNU visit. In so doing, it is important to clarify the definition of a 'father.' Traditionally this has been regarded as the male biological parent who is head of the family. However, the situation has become more complex in recent times with the reconfiguration of families, greater

awareness of the incidence of concealed fatherhood and paternity fraud and assisted reproduction techniques (Mander 2004). For the purpose of this work, a father is deemed to be a man who is assumed to be the biological father and/or is assigned paternal responsibilities.

In this chapter, current evidence will be explored regarding the experiences of fathers of events occurring around the time of the birth of their baby. The literature regarding fatherhood and fathers' experiences of normal childbirth and healthy babies born at term will be reviewed. However, more detailed consideration will be given to the literature regarding fathers' experiences of complicated and preterm birth and their first NNU visit. The literature regarding witnessed resuscitation will also be scrutinised in order to explore issues identified in other settings that may apply to fathers present during the resuscitation of their baby at delivery.

### **1.1 The literature search**

An electronic search of databases including MEDLINE, CINAHL and INTERNURSE was undertaken in order to identify relevant literature. Keywords used included: fathers; fatherhood; birth; preterm; premature; resuscitation; neonatal care and witnessed resuscitation. Literature selected for this review was drawn from scientific peer reviewed specialist and generalist journals from a range of disciplines including nursing, midwifery, medicine, psychology, education and sociology. Frameworks for critical appraisal were used to facilitate judgments about which studies to include (Booth 2006; Parahoo 2006). The literature search also yielded a number of personal accounts. Whilst not peer reviewed or substantiated by supporting evidence these anecdotal descriptions provide a valuable insight into fathers' experiences and were therefore included. Relevant Government documents and material produced by professional bodies and user groups were also used.



The following review uses research and other literature from the UK, Europe, North America and Australia. Consideration must therefore be given to differences in the organisation and delivery of care. With the exception of seminal work, material prior to 1990 has not been used because of significant changes in care since that time. Some of the childbirth and neonatal care studies involved fathers whilst others included fathers and mothers. For clarity therefore, the term 'parents' will be used when referring to literature that alludes to the experiences of both parents.

## **1.2 Fatherhood**

The focus on fathers and fatherhood is becoming stronger (Friedewald, Fletcher, Fairbairn 2005). They are an increasingly topical subject for researchers and policy makers (Department of Health, Department for Education and Skills 2004; Mander 2004; World Health Organization 2007). Until recently parenting research focused exclusively on mothers. As a consequence fathers are underrepresented in the literature (Lewis, O'Brien 1987; Burghes, Clarke, Cronin 1997; Pruett 1998; Barclay, Lupton 1999; Draper 2002a; Greening 2006). Many studies purporting to investigate parenting issues did not include fathers (Condon, Corkindale 1998; Levy-Shiff, Dimitrovsky, Shulman, Har-Even 1998; Hess, Teti, Hussey-Gardner 2004). Indeed Pruett (1998) has suggested that in the context of research and other related literature the word 'parent' means 'mother' 75% of the time, although no evidence is provided to support this view. Whilst this anomaly may relate to conventions of language, it nevertheless risks the possibly unintentional perception that parenting is the exclusive domain of mothers.

Within the following sections issues pertaining to fatherhood in the UK will be explored. This will include an historical perspective of the role of fathers from the 19<sup>th</sup> century onwards and the reconfiguration of parenting roles in recent years. An overview of the current evidence regarding transition to fatherhood will be explored. A key aspect of this will be a review of father-infant bonding. The current drive to engage and involve fathers in the lives of their children will also be described.

### **1.2.1 Fatherhood – historical perspective**

During the 19<sup>th</sup> and early 20<sup>th</sup> century, men and women in the UK adopted clearly defined parenting roles. The father as the head of the family and breadwinner was the disciplinarian and decision-maker. The industrial revolution led to more fathers working away from home, and as a consequence they became emotionally and physically distant (Lewis, O'Brien 1987; Shulman, Seiffge-Krenke 1997; Draper 2003). A good father was regarded as being one who provided for his family (Pleck 1987). A key aspect of his role during this period was to ensure the child, whether male or female was trained for adulthood and subsequent responsibilities (Burghes et al 1997). This more distant stance enabled fathers to make objective decisions about their children (Lewis, O'Brien 1987). Detachment was apparent throughout the child's early years and was particularly evident during pregnancy and childbirth (see Section 1.3.1) (Burgess 1997; Mander 2004). By contrast, mothers as homemakers were generally more nurturing towards their children. They were often directly involved in their care, particularly during infancy (Lewis, O'Brien 1987; Shulman, Seiffge-Krenke 1997; Draper 2003). Although the increasing absence of working fathers led to a gradual diminution of their influence within the home, they continued to have overall decision-making authority (Pleck 1987).

This however, may be an over-simplification that does not take into account individual differences amongst families. Social constraints may have restricted some fathers who given the opportunity, would have been more involved in their child's life (Burgess 1997; Burghes et al 1997). Working class women also often undertook paid employment leaving their children to the care of others (Mander 2004). In upper class families both parents were often equally remote and young children were usually cared for by a nanny in a mother-substitute role. Evidence also suggests that during this period some fathers were an integral part of their child's daily life leading to deep long-standing father-child attachment (Burgess 1997; Lewis, Warin 2001). Historically, the exact situation is unknown because fathers were generally less accessible to researchers (Jackson 1983; Lewis, O'Brien 1987).

In more recent times the role of men has evolved in all aspects of life (Burghes et al 1997). A range of societal and economic changes, particularly since the Second World War has prompted this evolution. These include: changes in cultural and social expectations, reconfiguration of the nature and organisation of work, the increasing participation of women in further education and the workforce, the drive towards gender equality, changes in family dynamics and changes in economic trends (Lewis, O'Brien 1987; Bedford, Johnson 1988; Chalmers, Meyer 1996; Shulman, Seiffge-Krenke 1997; Pruett 1998; Sullivan-Lyons 1998; Torr 2003; Mander 2004; World Health Organization 2007; Bainbridge 2009a). These factors also had an impact on the father's role, which was first apparent amongst the middle-classes (Jackson 1983). However, a longitudinal study undertaken during the period of time covering these societal changes has identified that a number of other factors influenced the nature of father-involvement (Flouri, Buchanan 2003). A study of 17,000 children born in 1958 in England, Wales and Scotland showed that fathers were more involved with their children if they were boys, they were achieving academically and they had fewer behavioural and/or emotional problems. Parental factors were also noted; a father's educational background, employment status and health and the level of maternal involvement influenced paternal involvement (Flouri, Buchanan 2003). More educated fathers were more likely to be involved along with fathers who were unemployed, retired or disabled. Maternal and paternal involvement also correlated.

In the 1980s the 'new father' was first described. This father portrayed more explicit nurturing behaviours and was actively involved in his child's care and upbringing (Lewis, O'Brien 1987). Whilst the overall amount of time spent with their children did not in most cases change, fathers began to use the time more effectively interacting with their children in a more direct way (Lewis, Warin 2001). Fathers are now expected to undertake a broader range of responsibilities that encompass aspects of the former mother and father role in ways that differ from their own father (Tiller 1995; Barclay, Lupton 1999; Fåggerskiöld 2008). Separate, clearly defined maternal and paternal roles therefore no longer exist (Tiller 1995). The increased involvement of fathers is evident in relation to childbirth whereby their presence and participation is usually expected

(Section 1.3.1) (Burghes et al 1997; Shulman, Seiffge-Krenke 1997). Men are now more involved in the care of their children (Fatherhood Institute 2007) and an increasing number are their child's primary carer (Beardshaw 2001). This increased involvement has become regarded as the 'gold-standard' and much attention amongst recent research, government policy and the media relates to aspects of 'good' and 'bad' fathering with a strong emphasis on the impact of absent or negligent fathers (Jackson 1983; Burghes et al 1997; Sullivan-Lyons 1998; Torr 2003; Mander 2004). However, classification of fathers in this way has been criticised as being too polarising because most fathers adopt the middle ground (Lewis, Warin 2001). Whilst many men welcome being more involved in their child's life (Barclay, Lupton 1999; Henwood, Procter 2003; Torr 2003; St John, Cameron, McVeigh 2005) this presents challenges. The lack of effective fatherhood role models has been particularly noted (Condon et al 2004). A man's perception of the father role is therefore usually shaped by his culture, age, experiences, beliefs and the expectations of family and friends (Peterson 2008). Consequently the more traditional aspects of the father's role continue in some families (Lewis, O'Brien 1987; Burgess 1997; Lupton, Barclay 1997).

### **1.2.2 Fatherhood – transition to fatherhood**

Transition to fatherhood is an important milestone in a man's life. It is often more challenging than anticipated (Barclay, Lupton 1999; Crathern 2009). The more limited social preparation and support experienced by fathers in comparison to mothers may impact on this challenge. Transition to fatherhood can be considered in relation to two key issues: taking on new roles and the development of an emotional connection or bond with the baby (Section 1.2.3). The challenges associated with the roles and responsibilities of fatherhood include trying to maintain a work / life balance, financial pressures, role uncertainty, changes in relationships and feelings of powerlessness (McVeigh, Baafi, Williamson 2002; Deave, Johnson 2008; Bateman, Bharj 2009). The impact on fathers is encompassed in the phrase often used in the literature: 'life-changing' (Deave, Johnson 2008; Fägerskiöld 2008). Transition to fatherhood can be

stressful and for some it is a time of crisis (Tiller 1995; Henwood, Procter 2003; Crathern 2009). However, for many men transition to fatherhood is associated with more positive feelings about themselves that are manifested in greater self-confidence and self-worth and increased empathy with others. Fatherhood also brings a purpose and structure to their lives (Jackson 1983; Dartnell, Ganguly, Batterham 2005; St John et al 2005; World Health Organization 2007). Many men enjoy the level of responsibility that fatherhood brings and recognition of this role by others (Dartnell et al 2005; St John et al 2005). For some men fatherhood prompts changes to their lifestyle and attitudes that were not stimulated to the same extent by other family members (St John et al 2005). A study by Foster (2004) provides a more extreme example of this whereby men living in violent and impoverished communities felt fatherhood made them more aware of their mortality.

### **1.2.3 Fatherhood – development of an emotional connection**

Developing an emotional connection with the baby is generally regarded as an important aspect of 'good' parenting (Barclay, Lupton 1999). The ways in which mothers do this and implications associated with this process have been explored extensively over the last 60 years (Richards 1983; Mercer, Ferketich 1990; Goldberg 2000). These processes are referred to as bonding or the formation of an attachment. However, there is a lack of consensus regarding the definitions of these processes and they are often used interchangeably. For the purpose of this review the formation of an emotional connection will be explored in relation to the process by which a father bonds with their child (Goldberg 2000).

Klaus and Kennell described the concept of bonding in the 1970s (Richards 1983). Although the initial emphasis was on the impact of events surrounding childbirth, it is now regarded as being a lifelong process (Goldberg 2000). However, in line with the parameters of this study, the review will focus on events occurring around the time of the birth and will highlight differences between mothers and fathers. Whilst a number of hypotheses regarding bonding theory have been put forward, this review will focus on

events during pregnancy, the importance of physical contact and the sensitive period after birth.

As is the case in other aspects of parenting, fathers are under-represented in the bonding literature (Mercer, Ferketich 1990; Condon, Corkindale, Boyce 2008). Studies suggest a mother's bond with her child begins during pregnancy and is enhanced when she feels her baby move and sees him/her during an ultrasound scan (Klaus, Kennell 1982; Roeber 1987; Mercer, Ferketich 1990; Smith 1998; Condon et al 2008). Hormonal changes experienced by mothers may also be influential (Meadows 1986; Smith 1998). It has therefore been argued that mothers are genetically and endocrinologically programmed to bond with their babies (Boulton 1983). Surrogacy research provides further insight. Some surrogate mothers detach themselves emotionally from the fetus during their pregnancy, whilst others find it difficult or impossible to part with the baby (Smith 1998; van den Akker 2003; Edelmann 2004). It appears therefore that biological factors enable mothers to form a bond with their baby, but can be overcome to some extent.

Fathers experience pregnancy secondhand although they can feel fetal movements and listen to the fetal heart. Seeing the fetus during the ultrasound scan is also an important stage in the bonding process when the baby seems real for the first time (Bondas-Salonen 1998; Draper 2003). Draper (2002a, 2002b) explored the experiences of fathers of pregnancy confirmation and the ultrasound scan. A positive impact of these events on their feelings for their baby was reported but fathers generally felt detached during the pregnancy and experienced conflict between their anticipated and actual feelings. However, the fathers' background and previous experiences may have affected the findings. Draper's (2002a, 2002b) sample consisted of first-time and experienced white, middle class fathers who were recruited from parentcraft classes run by the National Childbirth Trust.

Fathers' feelings for their children appear to strengthen as the pregnancy continues. This was demonstrated in a longitudinal study of 90 fathers. Feelings for the baby

increased as the pregnancy progressed and this was not affected by their marital satisfaction, educational level or age (Hjelmstedt, Widström, Collins 2007). When preterm birth occurs, fathers may therefore experience disruption to the bonding process similar to that shown in mothers who have shortened pregnancies (Richards 1983; McFadyen 1994).

Studies of fathers who experienced miscarriages and stillbirths indicate that they had formed a bond with their baby during the pregnancy (Puddifoot, Johnson 1999; McCreight 2004; Turton, Badenhorst, Hughes, Ward, Riches, White 2006). Problems during pregnancy may also impact upon parent-infant bonding. A longitudinal study compared the impact of high and low-risk pregnancies (Mercer, Ferketich 1990). Whilst there was imbalance between the two groups (303 mothers, 178 fathers), the findings showed at one week post-delivery there was no difference in the scores of fathers of high and low-risk pregnancies. Whilst this appears to suggest that risk status did not influence paternal-infant bonding, more of the high-risk fathers had other children. This may have influenced their bond with the current child. Prior experiences of high-risk pregnancies may also have been influential. High-risk pregnancy mothers had significantly higher scores than their partners. These mothers may have been more alert to the level of risk because of the way in which the pregnancy was managed. However, the opposite effect has been reported in another study whereby fathers had higher scores than their partners (White, Wilson, Elander, Persson 1999). Underlying paternal anxiety may have been influential, but this was not measured. Men with a tendency to anxiety were found in another study to have higher scores at 26 weeks in comparison to other men (Hjelmstedt et al 2007).

Immediately after birth, animal studies have shown that physical contact between parents and their offspring enhances bonding. Whilst the extent to which these findings apply to other populations must be questioned, similar conclusions have been reported in studies with humans (Palkovitz 1985; Harrison, Leeper, Yoon 1990). Allied to this is the notion of a sensitive period of time during which physical contact should be made. Again, the origins of this theory are based in animal studies, but subsequently endorsed

by research with humans (Klaus, Jerauld, Kreger, McAlpine, Steffa, Kennell 1972). Although this was a small-scale (28 mothers), insufficiently validated study (Richards 1983; Mercer, Ferketich 1990; Billings 1995), the claim that contact with the baby during the first few hours enhanced bonding, led to the implementation of 'rooming-in' in maternity units during the 1970s (Klaus, Kennell 1982; Roebar 1987). The notion of a sensitive period appears to be supported by the literature exploring the long-term negative impact of separation (Bowlby 1988; Field 2007). Alternatively, failure to bond after separation may be a self-fulfilling prophecy (Billings 1995). It is also questionable whether anxiety about the cause of the separation, rather than the separation itself inhibits bonding (Meadows 1986).

Bonding is a complex process involving physiological, sociological and psychological factors (Boulton 1983). There is a lack of consensus in the literature regarding the process. However, external factors appear influential in some instances. Many studies exploring parent-infant bonding rely on self-report data which participants may be tempted to manipulate to be regarded 'good' parents. For most bonding theories there is a counter-argument. Evidence to support these counter-arguments is provided by fathers, adoptive parents, parents who have a child through surrogacy and parents of babies requiring hospital care in the era of restricted visiting who successfully bond with their baby.

#### **1.2.4 Fatherhood – the current drive to engage and involve fathers**

It is becoming increasingly reported that fathers have an important role to play in their child's development (Burghes et al 1997). It is claimed that their involvement has long-term social and economic benefit not only for fathers but also for children and mothers (Beardshaw 2001; Friedewald et al 2005; Fatherhood Institute 2007; Shribman 2007; World Health Organization 2007). It is also suggested that involvement of the father promotes a child's emotional wellbeing and social development and that in turn this is associated with a reduced incidence of criminality and substance abuse, better



educational achievement, improved interaction and empathy with others and self-esteem (Vandenberg 2000; Lewis, Warin 2001; Schoppe-Sullivan, Brown, Cannon, Mangelsdorf, Sokolowski 2008). However, the literature rarely provides statistical evidence to support claims of an association between the involvement of a child's father and these factors.

One way of determining the impact of father-involvement is to compare children of fathers with and without depression; the assumption being that fathers with depression would be less directly involved. In a population study of childhood, Ramchandani and colleagues found paternal depression influenced a child's behaviour. Boys aged 3.5 years showed more conduct and hyperactivity problems than boys of fathers without depression (Ramchandani, Stein, Evans, O'Connor and the ALSPAC study team 2005). However, the assumption that paternal depression equates with less involvement maybe incorrect. Gender differences were also noted; this finding was less apparent in girls.

Many initiatives to engage and involve fathers focus on opportunities arising during pregnancy, childbirth and early parenthood. These are appropriate time-points because fathers who are involved during pregnancy are more likely to maintain their involvement after the birth (Burgess 2008). Fathers are also usually the main source of support for mothers around this time, providing the opportunity to capture and promote their involvement (Diemer 1997; Pruett 1998; McVeigh et al 2002). A number of initiatives over recent years demonstrate the drive to include fathers more readily and emphasise their responsibilities. The Department of Health and Department for Education and Skills (DH, DES) (2004) National Service Framework (NSF) for Children, Young People and Maternity Services specifies the need for greater involvement of fathers at all stages of a child's life (DH, DES 2004). Although specific reference is made to fathers, the NSF also emphasises that the word 'parent' includes both the mother and the father. With particular relevance to the current study, the NSF states that birth environments should be welcoming to fathers and identifies their need for support when problems develop during pregnancy and/or when a newborn baby is ill (DH, DES 2004). Another initiative is the National Institute for Health and Clinical Excellence (NICE) guidelines for

postnatal care that specifies the need to enable both mothers and fathers to nurture their baby (NICE 2006). A range of other initiatives also emphasises the need to involve fathers (DH 2004; DH 2007; Shribman 2007; Department for Children, Schools and Families, DH 2009). However, some may regard other strategies as being more punitive. The Child Support Act 1991 highlights the financial responsibilities of fathers and The Criminal Justice Act 1991 outlines the responsibility of both parents for a child's behaviour (Burghes et al 1997). The current drive towards increasing paternal responsibility and involvement by documenting their name on a child's birth registration (Department for Work and Pensions 2008) may also be regarded by some fathers as being punitive. Although the Fatherhood Institute (2008) attests that most fathers support this move, this organisation may not be representative of all fathers.

User groups have also taken the opportunity to drive forward recognition of the need for change. Particular attention has been given to the provision of maternity and neonatal services (Fatherhood Institute 2008; Bliss 2009). Recommendations include the provision of facilities so fathers can stay with their partner after the birth, more inclusive parentcraft classes and the adoption of a truly family-centred philosophy of care (Fatherhood Institute 2008; Bliss 2009). However, some of these suggestions have stimulated debate, particularly amongst midwives (Fisher 2008; Fyle 2008) who feel proposed strategies could compromise care and in some instances put mothers and babies at risk (Fyle 2008). It would appear therefore, that there is sometimes dissonance between the perceived needs of service users and those responsible for service delivery. Despite this contention, the drive to involving fathers more readily is evident. From the industrial revolution onwards the roles and responsibilities of fathers have fluctuated. In more recent times, the balance has changed again and they are now being encouraged to play a more active role. As will be outlined in the following section, this is particularly evident in relation to childbirth.

## **1.3 Childbirth**

For many centuries, childbirth was the domain of women and fathers were rarely directly involved (Draper 1997). Over the last forty years however, the situation has gradually changed (Draper 2003; Kiernan, Smith 2003; World Health Organization 2007). Despite this, the literature regarding fathers' experiences of childbirth remains limited. Early research often relied on proxy accounts of fathers' experiences given by mothers or health care professionals (HCPs) (Bondas-Salonen 1998) and/or focused upon his role rather than the impact of the birth (Chalmers, Meyer 1996; Sullivan-Lyons 1998; Johnson, 2002). More recent research regarding men's experiences generally relates to the normal delivery of a healthy term baby (Chandler, Field 1997; Vehviläinen-Julkunen, Liukkonen 1998; Hallgren et al 1999). Within this section an historical overview will be provided of fathers' involvement during childbirth and the current situation regarding fathers' birth attendance in the UK. Evidence regarding fathers' experiences and the impact of their presence will also be explored. The rising incidence of preterm and complicated childbirth will be reviewed and the limited evidence regarding the impact these types of births have on fathers will also be explored.

### **1.3.1 Childbirth – United Kingdom historical perspective**

In the 1950s a third of all births in the UK took place at home (Shribman 2007) but it is not known how many fathers were present at the delivery (Burgess 1997). When births took place in hospitals or nursing homes during this period, most men were barred from the delivery room (Bedford, Johnson 1988; Bartels 1999; Draper 2003; Kunjappy-Clifton 2007). During the 1960s and 1970s there was a move away from birth under the auspices of the midwife at home to a more medicalised event in hospital under the control of obstetricians (Draper 1997). This trend accelerated in the 1980s with the view that all mothers should give birth in hospital (Shribman 2007). Mothers became increasingly aware that they needed an advocate during childbirth in hospital and fathers took on this role (Odent 1999). Consequently an increasing number of men attended the

birth of their baby (World Health Organization 2007). However, conditions were often imposed. Fathers were usually required to attend parentcraft classes prior to the birth (Cronenwett, Newmark 1974) and the sole reason for his attendance was deemed to be to support his partner (Burgess 1997).

Support for the presence of fathers during childbirth was not unanimous (Draper 1997). The medical profession expressed concern that fathers would be distracting and disruptive and that this would impact on an HCP's ability to undertake their role, increasing the risk of litigation (Brown 1982; Chapman 1992). It was also believed fathers would increase the incidence of infection and compromise the couple's future relationship (Cronenwett, Newmark 1974; Bedford, Johnson 1988; Chapman 1992; Mander 2004). Nevertheless by the 1980s, most fathers attended childbirth (Jacoby 1987). Today they are expected not only to be present but also to participate in their partner's care (Chan, Paterson-Brown 2002; Longworth 2006; Castle, Slade, Barranco-Wadlow, Rogers 2008; Kunjappy-Clifton 2008). The exact proportion of fathers attending childbirth is unclear. In some cases data regarding presence during labour and birth are combined (Singh, Newburn 2003). In other reports the definition of 'birth partner' is not clarified and therefore may include other relatives or friends (Redshaw, Rowe, Hockley, Brocklehurst 2007). Taking these factors into consideration evidence suggests 87 to 96% of fathers currently attend the birth of their baby in the UK (Kiernan, Smith 2003; TNS System Three 2005).

### **1.3.2 Childbirth – impact of the father's presence**

When the literature regarding the impact of a father's presence during childbirth is reviewed, three issues can be identified: the impact on him, his role and the impact on others. Many fathers see their presence during childbirth as being a rite of passage and the most important aspect of their transition to fatherhood (Jackson 1983; Bedford, Johnson 1988; Burgess 1997; Draper 1997; Hollins Martin 2008). Witnessing the birth may also be an important factor in father-infant bonding (Klaus, Kennell 1982; Bowen,

Miller 1980). Fathers derive satisfaction from feeling they have been helpful to their partner (Berry 1988; Vehviläinen-Julkunen, Liukkonen 1998; Somers-Smith 1999; Rosich-Medina, Shetty 2007) and often describe attending the birth as being a turning point in their life (Burgess 1997).

Fathers experience a number of negative affects when present during normal childbirth. Some feel pressurised into taking on an active role (Chapman 1992). They also feel helpless, useless and find it difficult seeing their partner in pain (Nicols 1993; Somers-Smith 1999; Kunjappy-Clifton 2008). Fathers become more anxious as labour progresses with the birth being the most stressful point (Berry 1988, Johnson 2002). This has been described as the father's "*personal Everest*" (Jackson 1983: 69). As the delivery approaches their focus of concern changes from their partner to the baby (Chandler, Field 1997). Fathers dread the actual delivery fearing the baby will not survive (Eriksson, Westman, Hamberg 2006). These issues were endorsed by a survey of 137 fathers about their childbirth experiences (Vehviläinen-Julkunen, Liukkonen 1998). Whilst all felt being present was important, just under two thirds (62%) worried about their partner and only slightly fewer (55%) worried about the baby. The most difficult aspect for them was seeing their partner in pain and being unable to do anything about it.

Fathers experience difficulty coping with the uncertainty of childbirth even when labour and birth are straightforward (Mander 2004; Davies, Iredale 2006; Kunjappy-Clifton 2008). They often feel marginalised, excluded and abandoned (Chandler, Field 1997; Draper 2003; Finnbogadóttir, Svalenius, Persson 2003; Kunjappy-Clifton 2008). The authors of a qualitative study involving eight fathers described them as a "*shocked bystander*" (Dartnell et al 2005: 58). In many instances this isolation is associated with feeling they have no control over what happens (Draper 2003; Rosich-Medina, Shetty 2007). For many men this could be an unusual situation if they have control over other aspects of their life.

Fathers who experience negative emotions often endeavour to control these feelings in order to protect their partner (Chandler, Field 1997; Somers-Smith 1999). This response may be compounded by their perception that to display negative emotions would be a sign of weakness (Sullivan-Lyons 1998). Consequently, some fathers find it difficult to support their partner when trying to cope with their own emotions (Berry 1988; Enkin, Keirse, Neilson, Crowther, Duley, Hodnett, Hofmeyr 2000; Kunjappy-Clifton 2008). In a few more extreme cases, fathers are traumatised by normal birth and some require support afterwards (Burgess 1997; White 2007; Kunjappy-Clifton 2008). However, a number of factors such as a father's underlying fear of hospitals could impinge upon their experience in this setting (Burgess 1997).

Despite these negative responses, birth can also be a positive experience for fathers (Nicols 1993; Chalmers, Meyer 1996; Vehviläinen-Julkunen, Liukkonen 1998; Somers-Smith 1999; Kunjappy-Clifton 2008), but the precise reasons for this are not established (Mander 2004). Nevertheless, fathers have described childbirth as being an enriching, joyous, life-affirming experience (Chandler, Field 1997; Vehviläinen-Julkunen, Liukkonen 1998). Relief that the baby and their partner are well enhances their joy (Nicols 1993; Chandler, Field 1997). Fathers are also often in awe of their partner's endurance and capacity to cope with the pain of childbirth (Ferketich, Mercer 1989; Fägerskiöld 2008). Although fathers report positive experiences of childbirth, the literature generally indicates a rather negative view. However, this could be the result of methodological limitations. For example studies sometimes involve small samples (Chapman 1992), have limited variability within the sample (Kunjappy-Clifton 2008), and / or involve only self-selecting participants (Draper 2003).

In relation to normal childbirth, the most commonly cited role fathers undertake is to support their partner (Klein, Gist, Nicholson, Standley 1981; Berry 1988; Enkin et al 2000; Morse et al 2000; Torr 2003; Kunjappy-Clifton 2008). More specifically fathers provide emotional support, physical contact and direct care. They also advocate for their partner and liaise with HCPs (Klein et al 1981; Bondas-Salonen 1998; Gungor, Beji 2007; Kunjappy-Clifton 2007). In some cases they fill in gaps in her care (Enkin et al

2000). These sorts of activity are endorsed by the findings of an ethnographic study involving eight couples. Fathers focused on practical support during their partner's labour such as providing drinks and massaging her (Somers-Smith 1999). Fathers are best placed to support their partner in these ways because they are often the only constant person throughout a mother's labour and delivery (Bondas-Salonen 1998). Fathers also usually know the mother better than any other person present (Longworth 2006). However, many fathers retrospectively report uncertainty regarding their role during childbirth (Sullivan-Lyons 1998; Kunjappy-Clifton 2008). Indeed their role is sometimes more clearly defined by what they cannot rather than what they can do (Draper 1997). This uncertainty and dissonance regarding their role may impact on a father's experiences of childbirth in a negative way.

The expectation that fathers will undertake supportive activities is reflected in the content of parentcraft classes; the main focus of which in relation to fathers is how they can best support their partner (Hildingsson, Häggström 1999; Mander 2004; Bainbridge 2009b). This may be a deliberate strategy to reinforce their responsibilities (World Health Organization 2007). Although many fathers in the UK do not attend parentcraft classes (Redshaw et al 2007; Mottram 2008), those that do will be made aware of the expectation that they will support their partner.

Frameworks have been developed to describe the different roles fathers adopt during childbirth (Berry 1988; Chapman 1992). In a study involving 20 couples, three possible roles were described: the 'coach' who leads and directs, the 'team-mate' who assists and supports and the 'witness' who takes on a distant and passive role (Chapman 1992). Two decades ago, the most commonly identified role was that of witness (Chapman 1992), which relates to the era in which the study was undertaken. Despite the small number of participants and the date of this study, this model has been used in other research (Johnson 2002; Gungor, Beji 2007; Kunjappy-Clifton 2008). More recent studies identified that fathers usually now adopt the more active roles of coach or team-mate (Johnson 2002; Gungor, Beji 2007).

Whilst claims have been made about the positive impact on others when fathers are present during childbirth, benefits have not been conclusively shown. It is often reported that the presence of a father shortens labour, reduces the need for operative delivery, reduces the mother's need for analgesia and has a positive impact on a mother's perception of the birth (Berry 1988; Somers-Smith 1999; Gungor, Beji 2007). However, supporting evidence for these claims is rarely provided. Furthermore, a systematic review of 14 trials identified that the continuous presence of a support person (HCP or lay-person) had a positive impact on these factors (Hodnatt 2002). Thus it appears the continuous support of someone rather than the father specifically is beneficial. Indeed, some have questioned whether a father's presence is advantageous. It is claimed a father may influence the progress of labour in a negative way and damage the couple's long-term relationship, but no evidence for these claims is provided (Odent 1999; Longworth 2006; O'Malley 2009). Although Odent (2008) argues that the father's presence induces the release of maternal adrenaline, which slows oxytocin activity, this claim is not substantiated and has been challenged by others (O'Malley 2009). However, the risks associated with the presence of fathers previously cited by opponents such as the increased incidence of infection are unfounded (Bedford, Johnson 1988; Chapman 1992; Mander 2004). It would appear that there is scope for further research in this area in relation to both normal and complicated childbirth.

### **1.3.3 Childbirth – the rising incidence of preterm and complicated childbirth**

Advances in maternity and neonatal care have led to an increased incidence of complicated and preterm birth both within the UK and internationally (Murphy et al 2003; Murphy et al 2004; Shennan, Bewley 2006). In this context, complicated childbirth includes forceps and ventouse deliveries and lower segment caesarean sections (LSCS). The LSCS rate in the UK increased from 3% in the 1950s to 24% by 2007. There was also a gradual increase in the number of forceps and ventouse deliveries from around 10% in the 1990s, to just over 15% by 2007. These changes have led to differences in the HCP conducting the delivery with an increase in deliveries conducted



by doctors (23.7% 1989-1990, 35.5% 2005-6) and a fall in midwife-conducted deliveries (75.6% 1989-1990, 64% 2005-6) (Healthcare Commission 2008). As a consequence, for many families childbirth has become a medical event (Shribman 2007).

There has been an increased incidence of preterm and LBW births in the last few decades in the UK and internationally (Slattery, Morrison 2002; CESDI, 2003; Murphy et al 2004; Langhoff-Roos et al 2006). This upward trend is most noticeable in babies born at less than 28 weeks gestation (Slattery, Morrison 2002; Langhoff-Roos et al 2006; Nuffield Council on Bioethics 2006). This increase has occurred despite interventions such as tocolytics, prophylactic antibiotics and cervical cerclage (Murphy et al 2004; Shennan, Bewley 2006). The increased incidence of complicated childbirth and preterm births coincides with an increase in the number of fathers attending childbirth (Kiernan, Smith 2003). It is therefore assumed that more fathers have attended these types of birth over recent years.

A number of factors may explain the rise in complicated and preterm births. These include: an increase in the number of assisted conceptions, the increased incidence of multiple births, delayed motherhood, developments in antenatal screening which have led to earlier referral and intervention and an increase in the number of women with complex health problems who are now able to conceive (Slattery, Morrison 2002; Murphy et al 2004; Langhoff-Roos et al 2006; Nuffield Council on Bioethics 2006; Shennan, Bewley 2006). Obstetricians are also more willing to deliver babies early because of developments in neonatal care and outcomes (Costeloe, Hennessy, Gibson, Marlow, Wilkinson 2000; Costeloe 2006; Shennan, Bewley 2006; National Audit Office 2007). It might be anticipated that an increase in preterm births would correlate with a decrease in the stillbirth rate. However, this does not appear to be the case (Confidential Enquiry into Maternal and Child Health 2009). Indeed the stillbirth rate increased in the UK 2002-2007. Whilst the increase in the stillbirth rate is unexplained (Confidential Enquiry into Maternal and Child Health 2009), it appears that developments in antenatal screening and obstetric care have not reduced the incidence.

### **1.3.4 Childbirth – the impact of complicated and preterm birth**

Complicated childbirth often involves emergency intervention (White 2007). Preterm birth can also involve intervention and may occur rapidly, with little prior warning (Calam, Lambrenos, Cox, Weindling 1999). Fathers who are present during these types of birth find themselves in an unusual situation because relatives do not usually attend the surgery of family members. Complicated and preterm birth involves a high level of uncertainty. The mother may require high dependency care before and/or after the delivery (Bharj, Nolan 1999; Goebel 2004). In addition, the baby will almost certainly require ongoing care if born prematurely and/or is compromised at birth. There may therefore be concern about the mother's and/or baby's recovery and wellbeing (Jackson, Ternestedt, Schollin 2003; Bakewell-Sachs, Gennaro 2004; White 2007). Consequently some fathers encounter events, the outcome of which is unknown at the time (White 2007). Indeed, Peterson (2008: 242) described fathers experiencing these sorts of situations as *"being catapulted into fatherhood."*

In order to gain insight into fathers' experiences of these types of birth, a literature search was undertaken but it was difficult to identify relevant sources. Many studies only considered the experiences of mothers and these were excluded. Several studies purporting to explore fathers' experiences of preterm birth (indicated by the title) did not investigate aspects of the delivery. Instead they focused on fathers' more general experiences of having a preterm baby. These studies were excluded along with other studies that provided insufficient information about the research process.

Having reviewed the literature the following were utilised: two literature reviews (Bakewell-Sachs, Gennaro 2004; Crathern 2009), four anecdotal accounts (Wildman 1995; Casimir 1999; Jenni 2000; Welch 2001), all but one of which were published in health care journals (Casimir 1999) and three case studies (Nolan 1996; Long, Smyth 1998; Strange 2002). In addition, 19 research papers published in English were used and Table 1.1 provides background information about these studies.

<i>AUTHORS</i>	<i>METHOD</i>	<i>FOCUS</i>	<i>SAMPLE</i>	<i>COUNTRY</i>	<i>1<sup>st</sup></i>
McCain, Deatrick 1994	Qualitative - Interviews	Birth & NNU	21 Parents	United States	No
Chandler, Field 1997	Qualitative - Interviews & diaries	Birth	8 Fathers	Canada	Yes
Greenhalgh, Slade, Spiby 2000	Quantitative - Questionnaires	Birth	78 Fathers	UK	Yes
Koppel, Kaiser 2001	Qualitative - Interviews	Birth & NNU	18 Fathers	Germany	NS*
Chan, Paterson-Brown 2002	Quantitative - Questionnaires	Birth	174 Parents	UK	No
Skari, Skreden, Malt, Dalhot, Ostensen, Egeland, Emblem 2002	Quantitative - Questionnaires	Birth	149 Parents	Norway	No
Taylor, Bullough, van Hamel, Campbell 2002	Quantitative - Questionnaires	Birth	91 Birth partners	UK	No
Cescutti-Butler, Galvin 2003	Qualitative - Interviews	Birth & NNU	6 Parents	UK	NS*
Jackson, Ternestedt, Schollin 2003	Qualitative - Interviews	Birth & NNU	14 Parents	Sweden	No
Lundqvist, Jakobsson 2003	Qualitative - Interviews	Birth & NNU	8 Fathers	Sweden	No
Keogh, Hughes, Ellery, Daniel, Holdcroft 2005	Quantitative - Questionnaires	Birth	130 Parents	UK	No
Eriksson, Westman, Hamberg 2006	Quantitative Questionnaires	Birth	739 Parents	Sweden	No
Alderson, Hawthorne, Killen 2006	Qualitative - Interviews & observations	Birth & NNU	Parents 80 babies	UK	No
Lindberg, Axelsson, Öhring 2007	Qualitative - Interviews	Birth & NNU	8 Fathers	Sweden	No
Rosich-Medina, Shetty 2007	Quantitative - Questionnaires	Birth	142 Fathers	UK	Yes
Wöckel, Schäfer, Beggel, Abou-Dakn 2007	Quantitative - Questionnaires	Birth & NNU	223 Fathers	Germany	Yes
Sloan, Rowe, Jones 2008	Mixed - Interviews & questionnaires	Birth & NNU	21 Fathers	Australia	No
Parfitt, Ayers 2009	Quantitative – Questionnaires	Birth	152 Parents	UK	No
Lee, Lin, Huang, Hsu, Bartlett 2009	Qualitative - Interviews	Birth & NNU	12 Fathers	Taiwan	Yes

NS\* Not stated

Table 1.1 Information regarding complicated and preterm childbirth research studies

Just over half the studies involved qualitative methods (Table 1.1). Nine focused on the impact of the birth (complicated and/or preterm). The remainder covered a broader range of issues including having a baby requiring neonatal care (Birth & NNU). Some of the papers did not state the number of participants so the number was calculated from the information provided. Of the nine studies involving parents, three had an equal number of mothers and fathers (Chan, Paterson-Brown 2002; Jackson et al 2003; Keogh et al 2005). One study did not provide this information but did include fathers (Cescutti-Butler, Galvin 2003). The remaining studies involved a higher number of mothers, providing further evidence of the under-representation of fathers. One study (Taylor et al 2002) involved birth partners (5 of whom were female). Twelve studies involved a mix of first-time and experienced parents, whilst two studies did not provide this information: 'not stated' (NS). Findings of studies involving experienced parents must be viewed with some caution. It is not possible to determine the extent to which their experiences were affected in either a positive or negative way by previous events. Eleven studies were undertaken outside the UK. Consideration must therefore be given to differences in the organisation and delivery of care. The dates of the studies reveal increased interest in the experiences of fathers in recent years. There has also been a greater emphasis in involving only fathers in such studies. However, few studies involved just first-time parents. The review of the literature revealed four themes relating to fathers' experiences: 'being unprepared', 'emotional impact', 'the father's needs' and 'long-term impact.' These will now be discussed.

### **Being unprepared**

Some fathers encountering complicated and preterm childbirth will have had prior warning about the delivery. However, in many cases problems arise spontaneously and unexpectedly leaving little time for preparation (Lundqvist, Jakobsson 2003). One father described in an anecdotal account his initial feelings of complacency. However, an incident during the latter stage of pregnancy made him realise the birth would not be straightforward. He described this as "*a rude awakening*" (Wildman 1995: 5). Parents feel unprepared for the suddenness and speed with which events occur (Jackson et al

2003; Lundqvist, Jakobsson 2003; Sloan et al 2008). Preterm birth in particular shortens a father's opportunity to prepare for his transition to fatherhood (Lindberg et al 2007; Sloan et al 2008; Lee et al 2009). In a phenomenological study, fathers described feeling overwhelmed and helpless when they realised their baby would be born early (Lee et al 2009).

Antenatal preparation may influence whether a father feels prepared for preterm and/or complicated childbirth. Whilst few studies make reference to this, one study investigated the impact of an additional fathers-only session. This included information about complicated childbirth during a course of parentcraft classes. Fathers attending the classes were randomised into two groups. Those who accessed the intervention (52) and subsequently encountered complicated childbirth (number not stated) felt they were better prepared and more able to support their partner than the control group of fathers (48) who did not access the intervention but encountered similar types of delivery (Wöckel et al 2007).

### **Emotional impact**

Many parents describe preterm birth as unreal and frightening (Long, Smyth 1998; Jackson et al 2003; Alderson et al 2006; Lindberg et al 2007). They also report feelings of denial, anxiety, fear and uncertainty, as the delivery got closer (McCain, Deatruck 1994; Lundqvist, Jakobsson 2003). This is not dissimilar to fathers' experiences of normal birth as discussed in Section 1.3.2. Whilst fathers have described being afraid of losing their partner and/or baby (Lee et al 2009), both qualitative and quantitative studies identify that most men were more concerned about their partner (Koppel, Kaiser 2001; Taylor et al 2002).

Parents are often shocked at the size of their preterm baby (McCain, Deatruck 1994; Long, Smyth 1998) and feel a lack of control (Jenni 2000; Cescutti-Butler, Galvin 2003; Lundqvist, Jakobsson 2003). One father described how the birth of his son brought uncertainty, anxiety and the immediate need to reappraise his plans for the future

(Strange 2002). In a few extreme cases families have to contend with additional pressures caused by media attention because of the circumstances of the birth (Long, Smyth 1998).

Sometimes problems occur during normal labour that result in complicated childbirth. Several fathers recalled being frightened when changes in the fetal heart rate were noted (Chandler, Field 1997; Jenni 2000). One father who was also a doctor described his distress. *“My own heart seemed to have stopped beating for a moment. I was emotionally distressed as (as) never before”* (Jenni 2000: 139). Another father described a partial placental abruption during labour. He recalled using all his strength to control his emotions in an effort to remain calm (Welch 2001). However, despite these negative experiences some fathers describe preterm and complicated birth as a joyful experience albeit shaded by anxiety and uncertainty (Nolan 1996; Strange 2002; Lundqvist, Jakobsson 2003).

Several studies have compared fathers' experiences of different types of delivery. One survey found that fathers were more anxious during LSCSs than other types of delivery and that complicated childbirth was less rewarding because they felt less helpful (Chan, Paterson-Brown 2002). Fathers attending LSCS deliveries have also described their baby in less positive ways than those attending normal births (Greenhalgh et al 2000). Rosich-Medina and Shetty (2007) reported that fathers attending emergency complicated deliveries felt frustrated and helpless and more anxious (though this did not reach statistical significance), than fathers who were present during normal deliveries. However, elective complicated childbirth also appears to cause paternal anxiety. In a survey of 91 birth partners nearly half (42%) had attended a previous LSCS but were just as anxious as first-time birth partners. (Taylor et al 2002). The authors suggest an anxious partner may be less able to support the mother (Taylor et al 2002). Keogh et al (2005) endorse this view by stating that high paternal anxiety was correlated with mothers' negative experiences of LSCS. However, the reverse situation may be the case whereby a mothers' negative perception may have increased paternal anxiety.

By contrast, some studies have identified more positive factors associated with complicated childbirth. Skari et al (2002) found the mode of delivery (normal versus complicated) did not have an impact on the stress response of parents. Whilst Eriksson et al (2006) reported that fathers were reassured by the involvement of technology. Fathers attending elective LSCSs also felt most able to help their partner when compared to fathers attending normal and complicated emergency deliveries (Rosich-Medina, Shetty 2007). No explanation of this finding is given. However, this may be because parents felt better prepared for the planned delivery. Mothers would also have been awake and pain-free during the birth and therefore able to interact with their partner.

### **The father's needs**

There is limited discussion in the literature about fathers' needs during complicated and preterm childbirth, but three can be identified. Parents need to understand what has happened and why (McCain, Deatrck 1994). The way in which this information is given is also important. Parents identified this when they said HCPs were sometimes abrupt and tactless. Whilst this was not identified in observations undertaken as part of the same study, the researchers acknowledge they did not observe formal discussions between HCPs and parents (Alderson et al 2006). Another need a father has is to be present at the delivery because this confirms he is now a father (Jackson, et al 2003; Lundqvist, Jakobsson 2003). This notion relates to bonding theories previously discussed (Sections 1.2.3; 1.3.2). A further need fathers have is to share their feelings after the event with someone who has insight into their experiences (Koppel, Kaiser 2001; Lundqvist, Jakobsson 2003; Lindberg et al 2007). Beyond these, fathers feel their needs are unimportant in comparison to those of their partner and/or baby (Jenni 2000; Koppel, Kaiser 2001; Lindberg et al 2007).

## **Long-term impact**

Events surrounding preterm and complicated childbirth are often recalled with clarity regardless of the intervening period of time (Casimir 1999; Jackson et al 2003; Crathern 2009). There is however, limited evidence regarding the long-term impact of these events on fathers. Traumatic childbirth (which may involve a complicated delivery) can have a negative impact on a father's relationship with his partner and/or child (White 2007). These harmful effects may be apparent years later and symptoms are synonymous with post-traumatic stress disorder (PTSD) (Chan, Paterson-Brown 2002). One father described experiencing flashbacks of the birth (Casimir 1999) and the study undertaken by Parfitt and Ayers (2009) provides further insight. Parents had a generally negative perception of the birth with most reporting it had been a worse experience than anticipated. However, this study specifically recruited parents who had experienced traumatic deliveries. Nevertheless, a higher incidence of PTSD was found in relation to emergency LSCS delivery in comparison to normal birth ( $p < 0.01$ ) (Parfitt, Ayers 2009).

There is limited evidence regarding fathers' experiences of complicated and preterm childbirth. The majority of studies exploring fathers' experiences have excluded these types of birth (Johnson 2002). There is therefore a need to explore these specific situations. The difficulty in extrapolating differences between having a preterm baby and the birth per se also highlights a need for research focusing on the latter. In the following section the literature regarding newborn and witnessed resuscitation will be explored.

### **1.4 Newborn resuscitation**

It is likely that the increasing incidence of preterm and complicated childbirth (CESDI, 2003; Murphy et al 2004; Langhoff-Roos et al 2006; Shennan, Bewley 2006) will have had an impact on the number of babies resuscitated at birth. The increased potential for ELBW babies to survive, means more babies are now resuscitated at birth (Nuffield Council on Bioethics 2006). However, it is important to note that 'resuscitation' has a



variety of definitions. The term can encompass fluid replacement, attending to trauma, and/or cardiopulmonary support (Royal College of Nursing 2002). For the purpose of this study, the definition is taken from the CESDI report (2003: 61): *“the process of artificially maintaining the airway, breathing and circulation in a patient when the respiratory or cardiovascular system fails.”* Resuscitation therefore includes a range of interventions such as intubation, bag and mask ventilation and chest compressions, the administration of facemask oxygen, suction, drugs and/or volume expanders.

The concept of witnessed resuscitation (WR) has been explored in the literature over the last two decades in the context of accident and emergency (A&E), adult intensive care unit (AICU) and paediatric intensive care unit (PICU) settings (Jarvis 1998; Woning van der 1999; Weslien et al 2005). However, no work has been identified that specifically explores fathers' experiences of the resuscitation of their baby at birth. Within the following section literature relating to WR in other settings will be explored to determine issues of relevance when fathers are present during the resuscitation of their baby at birth. The content of neonatal life support training programmes will also be reviewed. Firstly however, the incidence of newborn resuscitation in the UK will be explored.

#### **1.4.1 Newborn resuscitation – incidence in the United Kingdom**

It is unclear exactly how many babies in the UK require resuscitation at birth (Resuscitation Council 2006). Rennie and Robertson (2002) state that 0.5 to 1% of babies require intubation at birth, whilst the European Resuscitation Council (2006) reports that 5 – 10% of babies need some form of support. However, no supporting evidence is provided to substantiate either statement. A recent attempt to record the number of babies requiring intubation at delivery was abandoned because data were poorly reported (Health Care Commission 2008). This problem was also reported in a large national study where the decision was made not to collect data regarding newborn resuscitation because of concerns regarding data validity (Costeloe et al 2000). Nevertheless, it is likely that whilst the number of babies requiring resuscitation at birth

in the UK is small, it is increasing. It can therefore be assumed over recent years an increasing number of fathers have attended the resuscitation of their baby at birth.

#### **1.4.2 Newborn resuscitation – witnessed resuscitation**

The phenomenon of WR began to be discussed in the literature in the 1990s and has been the focus of much debate since then. Two papers described the implementation of WR programmes in A&E departments in North America and led to wider consideration of this care strategy (Doyle, Post, Burney, Maino, Keefe, Rhee 1987; Hanson, Strawser 1992). In the following review of the subsequent WR literature the term ‘relative’ refers to the person attending the resuscitation and ‘family member’ refers to the adult or child being resuscitated.

Having reviewed the literature the following have been used: course documentation, guidelines and recommendations (Royal College of Nursing 2002; European Resuscitation Council 2006; Baskett, Steen, Bossaert 2005; Resuscitation Council 2006; Lynch, Fulbrook, Latour, Albarran, de Graaf, Devictor, Norekvål 2008), literature reviews (Offord 1998; Boyd 2000; Boudreaux, Francis, Loyacano, 2002; McGahey 2002; Walker 2006, Moore 2009) and editorials, opinion articles, letters and anecdotal accounts (Adams, Whitlock, Higgs, Bloomfield, Baskett 1994; Schilling 1994; Goldstein, Berry, Callaghan 1997; Stewart, Bowker 1997; Hartley 2001; Tsai 2002; Mason 2003). However, very little of this work directly relates to fathers’ or parental experiences of newborn resuscitation. In addition to this literature, 15 research papers published in English were used. Table 1.2 provides background information about these studies. Two other studies although primarily focusing on preterm childbirth briefly mention resuscitation of the baby at delivery. These studies and one father’s anecdotal account have therefore also been included (Jenni 2000; Lindberg et al 2007; Lee et al 2009).

AUTHORS	METHOD	CARE SETTING	SAMPLE	FAMILY MEMBER	COUNTRY
Redley, Hood 1996	Quantitative - Questionnaires	A&E	132 HCPs	NS*	Australia
Belanger, Reed 1997	Quantitative - Questionnaires	A&E	49 HCPs	Adult	United States
Meyers, Eichorn, Guzzetta 1998	Quantitative - Telephone interview	A&E	25 Relatives	Adult, Child	United States
Jarvis 1998	Quantitative - Questionnaires	PICU	56 HCPs	Child	UK
Robinson, Mackenzie-Ross, Campbell Hewson, Egleston, Prevost, 1998	Quantitative - Questionnaires	A&E	25 Relatives	NS*	UK
Boie, Moore, Brummett, Nelson 1999	Quantitative - Vignettes & questionnaires	A&E	400 Relatives	Child	United States
Woning van der 1999	Qualitative - Interviews	NS*	5 Relatives	NS*	UK
Sacchetti, Carraccio, Leva, Harris, Lichenstein 2000	Quantitative - Questionnaires	A&E	85 HCPs	Adult, Child	United States
Grice, Picton, Deakin 2003	Quantitative - Questionnaires	AICU	110 Patients & Relatives 100 HCPs	Adult	UK
MacLean, Guzzetta, White, Fontaine, Eichorn, Meyers, Désy, 2003	Quantitative - Questionnaires	A&E, AICU, PICU	984 HCPs	Adult, child	United States
Fulbrook, Albarran, Latour 2005	Quantitative - Questionnaires	A&E, AICU	124 HCPs	NS*	Europe
Weslien, Nilstun, Lundqvist, Fridlund 2005	Qualitative - Interviews	A&E	17 Relatives	Adult	Sweden
Fulbrook, Latour, Albarran 2007	Quantitative - Questionnaires	PICU, NNU	158 HCPs	Child	Europe
Maxton 2008	Qualitative - Interviews	PICU	14 Relatives	Child	UK
Perry 2009	Quantitative - Questionnaires	A&E, PICU, NNU	32 HCPs	Child	UK

\*NS Not stated

Table 1.2 Background information regarding witnessed resuscitation research studies

The majority of the studies involved quantitative methods (Table 1.2). The setting of A&E features in ten studies. This probably reflects the fact that relatives often accompany family members to A&E or arrive shortly afterwards. The question about whether they should stay may therefore occur more frequently in this setting. Two of the studies involved HCPs working in NNU settings. However, parental presence during resuscitation in the delivery room was not explored. Eight studies focused on HCP opinions and experiences of WR, whilst six considered the impact upon relatives. One study explored the experiences of HCPs, relatives and unusually patients (Grice et al 2003). Some of the papers did not state the number of participants so the number was calculated from the information provided. Three studies involving relatives included a high proportion of participants whose family member did not survive (Meyers et al 1998; Robinson et al 1998; Weslien et al 2005). Whilst this may reflect the ratio of unsuccessful to successful resuscitation attempts, extrapolation of the findings must take this imbalance into consideration. Four studies did not state if WR was explored in relation to the resuscitation of adults or children. In two of the three studies involving relatives where the resuscitation of children was explored, fathers were under-represented (Boie et al 1999; Maxton 2008). This may be because fathers were less likely to be present during the resuscitation. However, it also reflects the limited involvement of fathers in child health and childbirth studies (Sections 1.2, 1.3). Most WR research emanates from outside the UK. Two European surveys of critical care nurses involved some UK nurses. Fewer but more recent studies have been undertaken in the UK. This suggests that the UK is still in the process of exploring WR.

In most cases the data collection tools appear to have been designed specifically for that particular study. As a consequence of the less structured approach of qualitative research, the qualitative papers give an indication of the sorts of topics covered during the interviews (Woning van der 1999; Weslien et al 2005; Maxton 2008). However, only one of these studies provides underpinning evidence to explain the inclusion of these topics (Woning van der 1999). Only two of the quantitative studies used previously validated tools. Robinson et al (1998) used five different tools to measure the psychological impact of WR on participants, whilst Fulbrook et al (2007) used a

questionnaire that was developed by the same research team for a previous study (Fulbrook et al 2005). This lack of consistency in the use of data collection tools means there is limited opportunity to compare the studies' findings in a direct way. As a consequence, the current body of knowledge surrounding WR is somewhat fragmented. Nevertheless, the themes identified from this review of the literature will be explored. These themes include 'the experiences of relatives', 'the experiences of HCPs' and 'guidelines for good practice.'

### **The experiences of relatives**

Although studies exploring relatives' experiences have used both qualitative and quantitative methods involving a range of participants (5 to 400), consistency is found in the findings. There are a number of benefits for relatives when they are present during the resuscitation of a family member that may apply to fathers attending the resuscitation of their baby at birth. Being present helps relatives understand what happened, reassures them everything possible was done and enables them to advocate for their family member (Grice et al 2003; Baskett et al 2005; Maxton 2008). These factors may explain why there have been fewer legal cases involving resuscitation events when relatives were present (Royal College of Nursing 2002; Mason 2003). Being present also provides an opportunity to see, touch and speak to the family member. This is often important to relatives if the resuscitation is unsuccessful and can help the subsequent grieving process (Hanson, Strawser 1992; Royal College of Nursing 2002; Grice et al 2003; Baskett et al 2005).

The literature identifies several disadvantages for relatives associated with WR. They sometimes find the experience distressing and overwhelming (Grice et al 2003; Weslien et al 2005). However, Maxton (2008) identified in qualitative interviews with 14 parents that they were not distressed by the resuscitation per se rather than the fact that their child needed this level of support. As a consequence some parents did not watch what was happening (Maxton 2008). An anecdotal account from a father describes a similar response when his baby was resuscitated at birth (Jenni 2000). Whilst he could vividly

recall the sound of the bag and mask ventilation, he could not watch when his son was intubated and had to leave the room whilst an intravenous line was sited. This response is striking because he was a doctor working in a PICU (Jenni 2000). This notion is further endorsed by Lee et al's (2009) study of fathers' experiences of preterm birth. One father identified that although he did not want to watch the resuscitation, he did so because he thought he might not see his baby alive again.

Other negative issues occur when HCPs over-use medical jargon and terminology and/or underplay what is happening so relatives' understanding is compromised (Weslien et al 2005; Maxton 2008). This may be a deliberate strategy by HCPs to reduce anxiety or exclude relatives. It may also indicate a lack of confidence amongst HCPs about breaking bad news or uncertainty regarding their role and responsibilities. Although relatives feel frustrated by a lack of information they would rather HCPs focused their attention on the resuscitation (Maxton 2008). Whilst HCPs have expressed anxiety about relatives interfering with the resuscitation or distracting the team, few accounts of this have been reported (Schilling 1994; Grice et al 2003). By contrast, relatives often worry about being in the way (Meyers et al 1998) and some try to help (Weslien et al 2005). This may help them overcome the powerlessness that some feel (Woning van der 1999).

Most relatives want to be with their family member during the resuscitation and those who were, felt in retrospect they were right to do this (Belanger, Reed 1997; Meyers et al 1998; Robinson et al 1998; Boie et al 1999; Maxton 2008). However, they also value being able to leave and return to the room during the resuscitation (Goldstein et al 1997; Maxton 2008). This raises a question about what fathers would choose if given the opportunity. Most fathers who attend a birth will be present during the resuscitation because babies are usually resuscitated in the same room. Although Jenni (2000) describes leaving the room and returning, it is not known if fathers generally do this. Some relatives do not want to be present during the resuscitation at all (Woning van der 1999; Grice et al 2003). For example a prospective survey of 55 relatives whose family member was about to undergo cardiac surgery identified that just over half (53%) did not

want to attend (Grice et al 2003). It is not stated how many relatives were present during subsequent resuscitation episodes.

The long-term impact on relatives has not been explored extensively although the possibility that they may experience PTSD has been raised (Woning van der 1999). A small-scale study followed-up relatives six months after WR using a range of previously validated tools to assess morbidity and found no evidence of psychological distress (Robinson et al 1998). However, relatives of family members who survived were not followed up. Whilst it might be assumed these relatives would be less adversely affected, the impact on them remains unknown. The general lack of research pertaining to long-term impact may be indicative of the potential ethical issues surrounding research of this nature and logistical problems associated with longitudinal studies.

### **The experiences of health care professionals**

Studies exploring HCPs' experiences have usually involved a large number of participants (32 – 984). Quantitative questionnaires have been used and this may have limited opportunities to explore their perceptions and feelings in a detailed way. Early studies identified a negative view of WR amongst many HCPs (McGahey 2002). In addition to the potential harmful affects to relatives previously identified, HCPs felt they should not attend resuscitation events because of a lack of sufficient staff to support them and potential hazards arising from equipment used and a lack of space. It was also felt the presence of relatives would increase the risk of litigation and have a negative affect on the HCPs (Hanson, Strawser 1992; Schilling 1994; Jarvis 1998; Grice et al 2003; MacLean et al 2003). Similar arguments were used against fathers attending the birth of their baby (Section 1.3.1). HCPs acknowledge that they would want to be with a member of their family during resuscitation (MacLean et al 2003). Whilst this may indicate 'double-standards', HCPs may feel their prior knowledge and awareness of events renders their presence more appropriate.

This generally negative view reflects the stance that is often adopted when a change in practice is proposed (Parkin 2009) and probably explains the initial opposition to WR (Meyers et al 1998). The notion of HCP control is prevalent in the literature. Many authors use terms such as 'allow' or 'prohibit' when discussing the presence of relatives (Adams et al 1994; Grice et al 2003; MacLean et al 2003; Fulbrook et al 2005). This suggests HCPs feel relatives are crossing into their territory or they are perhaps taking a paternalistic view of the best interests of those involved.

Despite early opposition, WR is now more common. This is probably because over time HCPs have been exposed to WR and found ways to accommodate it in their practice. In much the same way, HCPs have become accustomed to fathers attending childbirth (Chan, Paterson-Brown 2002; Castle et al 2008; Kunjappy-Clifton 2008). Nevertheless HCPs are more likely to support parental presence during paediatric resuscitation (Stewart, Bowker 1997; Boyd 2000; McGahey 2002; Fulbrook et al 2007). This probably relates to duty of care issues and the general trend towards family-centred care (Stewart, Bowker 1997; American Academy of Pediatrics 2003). Some studies report that nurses are more in favour of WR than doctors (Jarvis 1998; Boudreaux et al 2002; MacLean et al 2003; Mason 2003). However, this finding is not consistently reported and may reflect variances in the configuration and experiences of HCPs participating in a particular study (Goldstein et al 1997; Sacchetti et al 2000).

### **Guidelines for good practice**

Factors to be addressed regarding WR are often encompassed within protocols, guidelines and recommendations (Royal College of Nursing 2002; European Resuscitation Council 2006; Lynch et al 2008) and these could be applied to fathers attending newborn resuscitation. However, evidence underpinning proposed aspects of practice is not always stated or is sometimes dated. Whilst specific consideration has recently been given to neonatal resuscitation, it is unclear whether recommendations apply to the delivery room (Lynch et al 2008).



If WR is to be implemented, HCPs require education and ongoing professional development about crisis management, breaking bad news, the grieving process, bereavement counselling, preparation for the chaperone role and communication skills (Jarvis 1998; Royal College of Nursing 2002; Grice et al 2003; Baskett et al 2005; Perry 2009). The need for HCP support and debriefing after the event has also been identified (Royal College of Nursing 2002; Baskett et al 2005). It is yet to be established the extent to which any of these recommendations are addressed in relation to HCPs involved in situations where fathers are present during neonatal resuscitation at delivery.

Relatives should be briefed prior to going into the resuscitation area and should receive follow-up support afterwards (McGahey 2002; Baskett et al 2005; Weslien et al 2005). They should not however, be pressurised to attend (Royal College of Nursing 2002; Baskett et al 2005; Walker 2006). It is therefore important to determine their views about attending in advance if at all possible (Grice et al 2003; European Resuscitation Council 2006). It is not possible to determine the extent to which any of these recommendations are addressed in relation to fathers attending newborn resuscitation at delivery.

When relatives are present the healthcare team should be open and welcoming and the individual needs of relatives should be addressed (Baskett et al 2005; Lynch et al 2008). Although not all HCPs are in support of the chaperone role (Fulbrook et al 2007) it is mostly regarded as essential. Their role is to explain what is happening and to support, reassure, and de-brief the relative. They can also intervene if the relative's behaviour becomes distracting (Goldstein et al 1997; European Resuscitation Council 2006; Baskett et al 2005). This role should be undertaken by a senior HCP, usually a nurse, who can provide adequate information (Goldstein et al 1997). Parents endorsed this view by stating that chaplains and/or social workers should not undertake this role because they were unable to answer their questions (Maxton 2008). However, it is not stated how many of the 14 parents experienced support from these personnel (Maxton 2008). It has been suggested that it is not always possible to provide a chaperone during neonatal resuscitation (Lynch et al 2008). However, it is not clear whether the authors are referring to resuscitation in the delivery room (Lynch et al 2008). Whilst no

explanation is given why a chaperone cannot be provided, an alternative is proposed whereby a designated HCP is allocated to support the parents (Lynch et al 2008). It is not stated how this role differs from that of a chaperone.

### **Neonatal resuscitation training programmes**

Although the literature regarding WR does not directly relate to newborn resuscitation in the delivery suite, an opportunity for HCPs to consider ways in which to address the needs of parents is presented in newborn and paediatric life support training programmes (European Resuscitation Council 2006; Resuscitation Council 2006). Many HCPs involved in newborn resuscitation undertake these programmes. However, within course documentation limited reference is made to the parents and this is mainly in relation to the need to communicate with them before and after the event (European Resuscitation Council 2006; Resuscitation Council 2006). No guidance is given about ways in which to support parents generally and the father in particular during the resuscitation. It is identified that parental needs should be respected and that they should be encouraged to see, touch or hold the baby afterwards if appropriate. An inconsistency in the documentation is noted whereby reference is either made to the parents or the mother (Resuscitation Council 2006). No specific reference is made to the father or birth partner.

The course providers would probably argue the main purpose of these programmes is to facilitate the physiological support of the baby (European Resuscitation Council 2006; Resuscitation Council 2006). The parent's perspective has however, been successfully incorporated into simulation-based training programmes and this is felt to enhance the learning experience of HCPs (Wayman, Yaeger, Sharek, Trotter, Wise, Flora, Halamek 2007). However, the involvement of parents requires adequate training, support and debriefing (Wayman 2008). Nevertheless, this strategy could be adopted in neonatal resuscitation simulation-based training programmes.

This review of the literature has revealed that support for WR is not unanimous (Boyd 2000; Sacchetti et al 2000; Walker 2006; Perry 2009). It has however, become accepted practice in many Western countries and this reflects a generally more open and inclusive approach to health care and acknowledgement of the need to deliver family-centred care (American Academy of Pediatrics 2003; Baskett et al 2005). However, the need for more research relating to this issue is evident (Royal College of Nursing 2002). The limited amount of literature pertaining to the experiences of relatives may be indicative of the potential ethical issues surrounding research of this nature. The emphasis on studies relating to the opinions and experiences of HCPs may also reflect the need to assess opposition to WR and garner support from this group. It has taken two decades for WR to become accepted practice in settings such as A&E, AICU and PICU. Within the context of childbirth most fathers attend the birth of their baby and a proportion will therefore witness the resuscitation of their baby. The potential impact of this on fathers or HCPs appears not to have been questioned.

### **1.5 First visit to the neonatal unit**

The admission of a baby to the NNU can be a stressful time for parents. The mother is often unwell following the delivery and this compounds anxiety about the baby (Alderson et al 2006). Some fathers accompany their baby to the NNU. However, most visit their baby on their own or with their partner some time after the delivery. Within this section issues pertaining to fathers' first visit will be explored. In order to do this, a literature search was undertaken. However, it was difficult to identify relevant sources. No studies were identified that focused solely on the first visit. Many studies only considered mothers' experiences of neonatal care and these were excluded. Other studies were excluded because insufficient information was provided about the research process. Most studies involving fathers explored their overall NNU experience and/or the long-term impact of having a baby requiring neonatal care. Therefore literature utilised in this section either involved data collection within a few days of the baby's NNU admission or when specific reference was made to first NNU visit. Having reviewed the literature two

anecdotal accounts (Casimir 1999; Jenni 2000) and one case study (Strange 2002) were used. In addition, 16 research papers published in English were used and Table 1.3 provides information about these studies.

AUTHORS	METHOD	LONGITUDINAL	SAMPLE	COUNTRY	1 <sup>st</sup> TIME
Perlman, Freedman, Abramovitch, Whyte, Kirpalani, Perlman 1991	Mixed - Questionnaires & interviews	No	61 Parents	Canada	NS*
Miles, Funk, Kasper 1992	Quantitative - Questionnaires	Yes	46 Parents	United States	NS*
Curran, Brighton, Murphy 1997	Quantitative - Questionnaires	No	60 Parents	UK	NS*
Griffin, Kavanaugh, Soto, White 1997	Qualitative - Interviews	Yes	13 Parents	United States	NS*
Sullivan 1999	Quantitative - Questionnaires	Yes	27 Fathers	Australia	NS*
Koppel, Kaiser 2001	Qualitative - Interviews	No	18 Fathers	Germany	NS*
Eriksson, Pehrsson 2002	Quantitative - Questionnaires	No	47 Parents	Sweden	No
Jackson, Ternestedt, Schollin 2003	Qualitative - Interviews	Yes	14 Parents	Sweden	No
Lau, Morse 2003	Quantitative - Questionnaires	Yes	119 Parents	Australia	NS*
Lundqvist, Jakobsson 2003	Qualitative - Interviews	No	8 Fathers	Sweden	No
Alderson, Hawthorne, Killen 2006	Qualitative - Interviews & observations	No	Parents of 80 babies	UK	No
Gavey 2007	Qualitative - Interviews	No	16 Parents	UK	No
Lindberg, Axelsson, Öhring 2007	Qualitative - Interviews	No	8 Fathers	Sweden	No
Lundqvist, Hellström Westas, Hallström 2007	Qualitative - Interviews	Yes	13 Fathers	Sweden	No
Turner, Pinelli, Saigal, Wu, Cunningham, DiCenso 2007	Quantitative - Questionnaires	No	348 Parents	Canada	No
Lee, Lin, Huang, Hsu, Bartlett 2009	Qualitative - Interviews	Yes	12 Fathers	Taiwan	Yes

\*NS Not stated

Table 1.3 Background information for research studies relating to the first NNU visit

Just over half the studies involved qualitative methods. Seven were longitudinal in design. For seven other studies data collection took place on one occasion either during the baby's stay (Perlman et al 1991; Lundqvist, Jakobsson 2003; Turner et al 2007) or after discharge (Curran et al 1997; Eriksson, Pehrsson 2002; Gavey 2007; Lindberg et al 2007). One large study involved a combination of both strategies with different groups of participants (Alderson et al 2006) and one study did not state when the interviews took place (Koppel, Kaiser 2001). Six studies involved fathers only. Of the ten involving parents, three had an almost equal number of mothers and fathers (Lau, Morse 2003; Jackson et al 2003; Turner et al 2007), one involved more fathers (Perlman et al 1991), two involved fathers but did not state how many (Curran et al 1997; Eriksson, Pehrsson 2002) and the remainder involved more mothers. One study stated that only first-time parents were involved (fathers). Eight studies involved a mix of first-time and experienced parents, whilst another seven did not provide this type of information (NS). Findings of studies involving experienced parents must be viewed with some caution. It is not possible to determine the extent to which their experiences will have been affected by previous parenting experiences generally and neonatal care in particular. Thirteen studies were undertaken outside the UK. Consideration must therefore be given to differences in the organisation and delivery of care. The dates of the studies reveal increased interest in the experiences of fathers, particularly over the last decade. The review of the literature revealed four themes relating to father's experiences around the time of their first NNU visit: 'emotional impact', 'his needs', 'interaction with the baby', and 'his role' which will now be discussed.

### **Emotional impact**

Parents usually have limited opportunity to see and touch their sick / preterm baby in the delivery room. Most parents therefore meet their baby in a meaningful way during their first NNU visit (Eriksson, Pehrsson 2002; Alderson et al 2006). The impact of this is powerful and often negative. Most parents are able to recall their first visit in detail (Casimir 1999; Jenni 2000; Gavey 2007). Fathers are shocked by the size, appearance and vulnerability of the baby (Strange 2002; Lee et al 2009). As a consequence they

worry about their baby's wellbeing (Casimir 1999; Jackson et al 2003; Lundqvist et al 2007). There are few reports of fathers crying on seeing their baby (Jenni 2000). Indeed Lee et al (2009) identified that fathers, although distressed generally tried to remain calm during the first visit. Nevertheless, parents describe feeling distressed, frightened, anxious, stressed, terrified and guilty during this visit (Miles et al 1992; Curran et al 1997; Casimir 1999; Jenni 2000; Lau, Morse 2003; Gavey 2007). One longitudinal study also found fathers felt disappointed at this time but this feeling significantly decreased by one and five months post-delivery (Sullivan 1999). This change may have been due to the stabilisation of the baby and the establishment of paternal-infant bonding.

Some fathers feel emotionally distant and have difficulty adjusting to the NNU environment (Lundqvist, Jakobsson 2003; Lundqvist et al 2007). The equipment used to support the baby can also cause anxiety. They are shocked and distressed by the amount and intensive nature and reports of these feelings have persisted over time (Miles et al 1992; Strange 2002; Lindberg et al 2007; Lee et al 2009). So whilst equipment used to support babies may have changed, the parents' negative perception of this persists. However, one small-scale qualitative study reports that fathers found focusing on the equipment and technology was helpful (Lundqvist, Jakobsson 2003). It would appear they were adopting an emotion-focused coping strategy in order to regulate their response (Lazarus 1999) (Section 1.7).

One way of helping parents to adjust to the NNU environment is by enabling them to have a pre-admission visit (Wilkinson, Ahluwalia, Cole, Crawford, Fyle, Gordon, Moorcraft, Pollard, Roberts 2009). Parents who have the opportunity to do this find it reassuring and informative (Curran et al 1997; Lundqvist, Jakobsson 2003). Parents who are acquainted with the NNU in this way, feel they know what to expect and this decreases their level of fear when they come to see their baby for the first time (Griffin et al 1997; Jackson et al 2003).

A father's first encounter with his baby in the NNU is not always a completely negative experience. Some recall their happiness and joy on seeing their child (Jenni 2000;

Lindberg et al 2007). Others are reassured that the HCPs are competent in caring for such babies (Lundqvist, Jakobsson 2003). Longitudinal studies have also identified that parental stress and anxiety experienced around the time of the first visit diminishes over time as they become more used to the NNU environment and they develop a bond with their baby (Miles et al 1992; Lau, Morse 2003).

### **His needs**

Some fathers feel their needs are unimportant in comparison to those of their partner and/or baby (Jenni 2000; Koppel, Kaiser 2001; Lundqvist et al 2007). For others their main need is to see their baby as soon as possible (Gavey 2007). Consequently they become distressed when delays occur (Gavey 2007). By contrast, some fathers prefer to wait so they can visit the baby with their partner (Gavey 2007; Lindberg et al 2007). They feel this is an important way of acknowledging they are now a family (Lindberg et al 2007).

There is conflicting evidence regarding the information parents need during their first visit. Some want honest, detailed and accurate information particularly about the care of the baby (Perlman et al 1991; Lindberg et al 2007). Others do not want to be given bad news or advised about potential problems that in the event, may not occur (Alderson et al 2006). Some of these differences maybe influenced by the length of time between the first visit and data collection. Whilst in one study data collection occurred within three days of admission (Perlman et al 1991) in another this took place during the baby's NNU stay or after discharge (Alderson et al 2006). Stated information needs may therefore have been influenced by the benefit of hindsight. Parental information needs may also relate to preferred coping strategies (Section 1.7). In the event, many parents are unable to recall exactly what they were told during their first visit (Casimir 1999; Turner et al 2007) and often do not ask questions (Jenni 2000; Lundqvist et al 2007). These findings are supported by more general studies of doctor-patient communication. Patients often cannot accurately recall what they were told and do not ask questions during the interaction (Sarafino 2006). Explicit and personalised information usually enhances



understanding (Sarafino 2006, Ogden 2007). Anxiety is one of the factors that can hinder information recall. This may explain why parents are unable to remember what they were told during the first NNU visit (Sarafino 2006, Ogden 2007).

### **Interaction with the baby**

Fathers have a limited amount of interaction with their baby during the first visit. Many determine this themselves because they are worried about passing on an infection and/or the size of the baby (Alderson et al 2006; Lee et al 2009). Other fathers say contact with the baby was restricted or prevented by the NNU environment and/or HCPs (Lindberg et al 2007; Lundqvist et al 2007).

Touching or holding the baby as soon as possible after the birth is widely reported by parents as a positive experience (Sullivan 1999; Jackson et al 2003; Lundqvist, Jakobsson 2003; Alderson et al 2006; Lundqvist et al 2007). For some it is only then that the baby becomes real (Lundqvist et al 2007). This in turn is felt to facilitate transition to fatherhood (Jackson et al 2003; Lundqvist, Jakobsson 2003; Lindberg et al 2007). Lundqvist and Jakobsson (2003) take this a step further by suggesting if appropriate, fathers should have skin-to-skin contact (kangaroo care) with their baby during the first visit. Many of these findings relate to bonding theories previously discussed (Section 1.2.3).

### **His role**

Fathers often feel confused about their role around the time of their baby's NNU admission. In the midst of this, they generally see themselves as a partner / husband rather than a father (Koppel, Kaiser 2001). Although the baby may be sick and there may be uncertainty regarding his/her survival, fathers are usually more concerned about their partner (Lindberg et al 2007; Lundqvist et al 2007). Fathers justify feeling this way in their belief that the baby is being well cared for (Lundqvist, Jakobsson 2003; Lindberg et al 2007). Fathers therefore feel their main role is to support their partner and help her

adjust to motherhood (Lundqvist, Jakobsson 2003; Lindberg et al 2007). However, studies reporting these findings involved a high proportion of fathers who encountered complicated childbirth. Their continued concern for their partner may therefore have been influenced by ongoing uncertainty about her wellbeing. One of the ways fathers support their partner is by providing information about the baby in situations where she is unable to visit the NNU. In this way, fathers become an intermediary between the NNU and his partner (Lindberg et al 2007; Lee et al 2009). Some fathers take this a step further and deliberately do not explain the extent of the baby's problems in order to protect her (Lee et al 2009).

There is a growing body of evidence about fathers' experiences of neonatal care and the long-term impact of having a baby requiring this level of support. Whilst it is important to understand these issues, further insight is required about the period of time immediately after the baby's NNU admission. This period of time is when, under more normal circumstances fathers get to know their baby and continue their transition to fatherhood. There is therefore a need for greater understanding of the experiences of fathers when these events take place in the NNU environment.

## **1.6 Key themes**

A number of common themes in relation to fathers can be identified within the literature regarding complicated and preterm birth, immediate neonatal care and witnessed resuscitation (WR). These themes focus upon 'his needs', 'his role', 'impact upon him', 'controlling his emotions' and 'coping strategies adopted' and they will be explored in the following sections.

### **1.6.1 Key themes – his needs**

It is important to fathers that they are present during the birth and they want to be able to see their baby on the NNU as soon as possible (Jackson et al 2003; Gavey 2007). Being present on these occasions confirms their status as fathers and assists transition to fatherhood (Lundqvist, Jakobsson 2003; Lindberg et al 2007). Relatives also generally wish to be with their family member during a resuscitation event, even if this is ultimately unsuccessful (Grice et al 2003; Baskett et al 2005). Fathers and relatives are altruistic in explaining this response by saying their primary concern is to support their partner / family member. However, being there is also important to them. Whilst some relatives do not wish to be present during all or part of a resuscitation attempt (Woning van der 1999; Maxton 2008), it is not clear if this is the case for fathers.

The need for information is evident. Fathers and relatives want to understand what has happened and why (McCain, Deatrack 1994; Basket et al 2005). However, giving information during emergency procedures can be a challenge for HCPs, outcomes are often uncertain and the situation can change rapidly (CESDI 2003). As a consequence the needs of fathers / relatives are not always met (Weslien et al 2005; Alderson et al 2006; Lindberg et al 2007). The type of information fathers require also varies (Perlman et al 1991; Alderson et al 2006) and this presents HCPs with further challenges. Fathers have identified that they often cannot recall exactly what they were told and did not ask questions during their first visit to see their baby (Miles et al 1992; Lundqvist et al 2007). This highlights further issues for HCPs in relation to information giving. This can be complex and challenging in situations where fathers are highly stressed (Fowlie, Jackson 2007).

Little mention is made in the literature of fathers and relatives needing support. Fathers report that they have few other needs during complicated and preterm birth and their first NNU visit (Lindberg et al 2007; Lundqvist et al 2007). Relatives who attended the resuscitation of a family member endorse this notion. Whilst fathers and relatives may feel under pressure to state this view in order to appear selfless, this finding is replicated

throughout the literature. The only context in which support is discussed is in relation to the need some fathers have following complex and preterm birth to talk about what has happened (Koppel, Kaiser 2001; Lindberg et al 2007). Debriefing relatives is explored in the WR literature and is regarded as being good practice (Royal College of Nursing 2002; Baskett et al 2005). Social support during or after stressful events can mediate or provide protection against the stressor (Sarafino 2006; Ogden 2007). For fathers present during complicated and preterm birth, neonatal resuscitation and NNU admission potential sources of support are their partner, HCPs and friends and family. The extent to which fathers receive support from these sources is worthy of investigation. The types of support these sources could provide include advice, companionship, practical help, information and emotional support (Schwarzer, Knoll, Rieckmann 2004; Ogden 2007). Support is less likely to be effective if the person providing the support is a stranger (Sarafino 2006). Whilst this does not appear to be an issue in the context of WR, this may be of relevance regarding fathers' experiences of events occurring around the time of the birth of their baby.

### **1.6.2 Key themes – his role**

The literature regarding complicated and preterm birth does not specifically explore the fathers' role, but evidence can be extrapolated. Fathers believe their most important responsibility is to support their partner. Although some feel a conflict of priorities, the focus of their attention and concern is usually their partner (Koppel, Kaiser 2001). However, the suddenness and speed with which events occur and the nature of the delivery has an impact. As a consequence, some fathers feel unable to support their partner in the way they would like (Rosich-Medina, Shetty 2007; Wöckel et al 2007).

Relatives who attend the resuscitation of a family member also feel support is a key aspect of their role. They describe advocating for their family member and providing comfort through touch and speech (Baskett et al 2005; Maxton 2008). They also often want to help HCPs in whatever way they can (Weslien et al 2005). Around the time of

their first visit to the NNU fathers feel uncertainty about their role, but usually feel supporting their partner is most important (Lundqvist, Jakobsson 2003; Lindberg et al 2007). One of the ways this is done is by retrieving information about the baby (Peterson 2008; Lee et al 2009). There is a need to explore this issue in more depth in order to determine the specific ways in which fathers access information and the ways in which fathers can be supported.

### **1.6.3 Key themes – impact on him**

Fathers and relatives are usually able to recall the effect of complicated and preterm birth, their first NNU visit and WR on them in detail some time after the event (Robinson et al 1998; Jackson et al 2003; Gavey 2007). The considerable impact these events have on them is apparent. When fathers and relatives describe their experiences, negative emotions are often reported (Lazarus 1991; 1999). They also report feeling a lack of control and that they were in the way (Lundqvist, Jakobsson 2003; Meyers et al 1998). For many fathers the environment in which events take place is unlike any they will have encountered previously (Sloan et al 2008). The impact of technology and the equipment varies. For some it adds to their anxiety (Rosich-Medina, Shetty 2007; Lee et al 2009), whilst for others it provides reassurance (Lundqvist, Jakobsson 2003; Eriksson et al 2006). The impact of physical contact with the baby or family member has been explored in a limited way. Fathers are generally reluctant to touch or hold their baby during their first NNU visit (Alderson et al 2006; Lee et al 2009) but when this happens it can be a positive experience (Sullivan 1999; Lundqvist et al 2007). Relatives who touch family members during resuscitation events also usually find this comforting (Baskett et al 2005; Maxton 2008).

Complicated and preterm birth, resuscitation and NNU admission can provoke positive emotions (Lazarus 1991; 1999). The birth and seeing their child for the first time is a joyous occasion for many fathers, even if the long-term outcome remains uncertain (Lundqvist, Jakobsson 2003). Relatives also take comfort in their belief that their

presence may have been beneficial even if the resuscitation attempt was unsuccessful (Grice et al 2003; Baskett et al 2005). There is limited evidence regarding the long-term impact on fathers and relatives. However, the possibility that they will be more susceptible to PTSD has been raised (Woning van der 1999; Parfitt, Ayers 2009).

#### **1.6.4 Key themes – controlling his emotions**

Fathers often report controlling their emotions. They may do this in order to protect their partner (Clark, Miles 1999; Crathern 2009) or use this as a coping strategy (Section 1.7). Expectations regarding a man's typical response may also explain why some fathers distance themselves, control their emotions and look only to the future (Shaw, Deblois, Ikuta, Ginzburg, Fleisher, Koopman 2006; Lee, Miles, Holditch-Davis 2006; Lee et al 2009). These expectations maybe expressed or implied by his partner, family and friends, HCPs, society in general or indeed himself. Although there is more recent acceptance of men expressing their emotions, traditional stereotypes prevail (Lupton 1998; Eriksson et al 2006). Attempting to remain in control for the benefit of their partner presents fathers with an additional challenge when they find themselves in a situation over which they have little or no control. The long-term implications of fathers not voicing their fears and anxieties have been identified. Their support needs may not be addressed, whilst the phenomenon of paternal perinatal depression is increasingly being recognised (Eriksson et al 2006; Crathern 2009).

#### **1.7 Theoretical framework for the study**

The literature provides evidence that suggests fathers adopt a range of coping strategies when they encounter adverse situations surrounding the birth and immediate care of their baby. These strategies are apparent in their actions and behaviour. Theories of coping therefore provide an appropriate theoretical framework for this study. Coping is what people do or think in order to manage a stressful episode either by

dealing with the stressor or its effects (Lazarus 1999; Levy-Shiff et al 1998; Ogden 2007). Individuals appraise the situation they find themselves in, determine what is at stake and which coping strategies are available to them (Van Der Molen 1999). Different models, styles and strategies of coping have been described (Ginzburg, Solomon, Bleichi 2002; Ogden 2007). Most however, encompass variations of the model of problem and emotion-focused coping originally described by Folkman and Lazarus (1980) that built upon work undertaken by Lazarus in the 1960s (Lazarus 1999). Problem-focused coping includes strategies that moderate or confront the stressor (Ludwick-Rosenthal, Neufeld 1993; Levy-Shiff et al 1998). These include seeking information, accessing help and/or support, taking direct action, stopping the stressor and/or accessing social support (Van Der Molen 1999; Pinelli 2000; Schwarzer et al 2004; Ogden 2007). Individuals adopting this strategy therefore attempt to deal with the stressor in a direct way in order to facilitate adjustment (Lazarus 1999; Shaw et al 2006) and it is associated with less distress and more effective adjustment in the long-term (Ludwick-Rosenthal, Neufeld 1993; Harnish, Aseltine, Gore 2000).

Emotion-focused coping includes strategies to regulate stressful emotions by changing their meaning (Lazarus 1999). These may involve avoidance, detachment, apportioning blame, distraction, minimising and/or consumption of alcohol or smoking (Ludwick-Rosenthal, Neufeld 1993; Levy-Shiff et al 1998; Van Der Molen 1999; Ogden 2007). Whilst possibly more effective in the short-term (Ginzburg et al 2002), suppressed emotional responses are associated with poorer long-term outcomes with a higher incidence of acute stress disorder and PTSD because the stressor is not dealt with effectively (Sutker, Davis, Uddo, Ditta 1995; Ginzburg et al 2002; Shaw et al 2006; Ogden 2007).

An individual's self-confidence, age, gender and/or personality can determine which strategy is used (Folkman 1984; Lazarus 1999; Recchia, Lemétayer 2005; Ogden 2007). During the course of a stressful event an individual may change strategy or use aspects of different strategies (Lazarus 1999). Therefore the strategy a father adopts will depend on the situation, resources available and the level of control they feel they have

at the time. Emotion–focused strategies are more commonly used in situations when individuals feel they have limited control (Ludwick-Rosenthal, Neufeld 1993; Lazarus 1999). By altering the meaning of a situation individuals can exert some level of control (Folkman 1984). Fathers often feel they have little or no control during the scenarios previously described (see Sections 1.3.4, 1.5). Shock and the speed of events can also lead to denial and the use of emotion-focused avoidance coping strategies in order to minimise the affect of their experiences (Calam et al 1999; Doering, Moser, Dracup 2000).

When potential coping strategies are reviewed it is apparent that they are closely linked with the level of control a person feels they have over a stressful situation. There are different models or theories of control and the relationship between stress and control can be complex (Folkman 1984). Attribution of the cause of the stressor, the meaning of the situation and the context in which the event occurs, influences appraisal of personal control (Folkman 1984; Ogden 2007). A person’s perception of their control whether believed or actual, also enables them to determine situations that are within or beyond their control (Ogden 2007). People who believe they have control over their situation can be described as having an internal locus of control. Those who believe factors outside themselves control their situation have an external locus of control (Myers, Newman, Enomoto 2004; Sarafino 2006). A person’s perception of their self-efficacy may also be an influential factor. This is the extent to which a person believes they can perform a desired activity or exert control (Bandura 1977; Sarafino 2006). The debate surrounding loci of control and self-efficacy is ongoing. The boundaries between these factors are not clearly defined (Ogden 2007). In addition, different types of control have been described and these include behavioural; taking action to minimise or avoid the effect of a stressor, cognitive; using thought processes or strategies; decisional; choosing between alternative courses of action and informational; acquiring knowledge about the stressor (Sarafino 2006; Ogden 2007). These different types of control are closely allied to the coping strategies previously described.



Regardless of the coping strategy adopted, pressure is often exerted on fathers to cope in whatever way he can in order to focus his attention on supporting his partner (Crathern 2009). As a consequence of this pressure, fathers sometimes feel obliged to conform to stereotypical expectations regarding a man's coping response (Clark, Miles 1999; Pinelli 2000; Shaw et al 2006).

## **1.8 The study**

The literature review has revealed a general lack of evidence regarding fathers' experiences of adverse events occurring around the time of the birth of their baby (Crathern 2009). From whatever perspective the current parenting literature is reviewed there is disparity, with a predominant focus on the experiences of mothers (Cleveland 2008). There continues to be a gap in the body of knowledge in relation to fathers' experiences of complicated and preterm childbirth and neonatal care. There is also little evidence in relation to fathers' experiences of the resuscitation of their baby at delivery. There is therefore a need for an investigation of the experiences of fathers encountering these situations. This provides the rationale for a father-specific study. Consequently the research to be described was undertaken, the overall aim of which was to gain an understanding of the experiences and perceptions of fathers attending the birth and immediate care of their baby. To achieve this aim, a mixed methods study consisting of three phases utilising the paradigm of pragmatism was undertaken.

The aim of phase one was to explore the experiences and perceptions of fathers of events surrounding the birth and immediate care of their baby. The objectives were:

1. To conduct interviews using a phenomenological approach with fathers who were present during complicated or preterm childbirth, the resuscitation and/or admission of their baby to the NNU.
2. To provide an account of the experiences and perceptions of fathers who were present during complicated or preterm childbirth, the resuscitation and/or admission of their baby to the NNU.

The aim of phase two was to gain insight into issues occurring around the time of the delivery of a baby when the father was present. The objectives were:

1. To utilise the paradigm of pragmatism in order to conduct observations of normal and complicated childbirth and the immediate care of the baby when the baby's father was present.
2. To describe and compare events occurring during normal and complicated childbirth and the immediate care of the baby when the baby's father was present.

The aim of phase three was to gain understanding of events encountered by health care professionals involving childbirth, newborn resuscitation and/or NNU admission when the baby's father was present. The objectives were:

1. To conduct interviews using the critical incident approach with HCPs who had experience of childbirth, newborn resuscitation and the admission of baby to the NNU when the baby's father was present.
2. To provide an account of the experiences of HCPs of childbirth, newborn resuscitation and the admission of baby to the NNU when the baby's father was present.

It was believed this study would add to the body of evidence relating to fatherhood in a way that reflects the increasing drive to gain an understanding of health care users' perception of care (Kemppainen 2000). It was also felt this study would generate new knowledge that would inform HCP education and training and the development of policy and health education. The quality of care provision would thereby be enhanced such that the needs of fathers will be more adequately addressed (DH, DES 2004, Department for Children, Schools and Families, DH 2009).

## **1.9 Structure of the thesis**

The following chapter describes the development of the research proposal and the rationale for the use of a mixed methods approach. Chapters three, four and five provide a description of the research process and an appraisal of the method adopted for

phases one, two and three respectively. In each of these chapters the findings for that particular phase are presented and are compared with those of other studies. A synthesis of the findings of all three phases is provided in Chapter six. The findings are also discussed in the context of other work and theories of coping. The thesis concludes with chapter seven which provides an evaluation of the study, recommendations for future practice and suggestions regarding future research.

## **Chapter 2 – Overview of Methods**

### **2.0 Introduction**

In this the chapter, development of the research proposal is described along with the rationale for the research approach. An outline of the three phases of the study is given. However, detail regarding each of these phases is addressed in subsequent chapters (Chapters 3, 4, 5). Potential ethical issues arising from the study and the possible impact of the researcher's prior knowledge and experience are acknowledged. Strategies undertaken to minimise the effect of these factors are therefore also described. The research skills training completed by the researcher and procedures undertaken to gain access to the study site and ethical approval are addressed. Strategies to prepare staff at the study-site are also described.

### **2.1 Development of the research proposal**

Having secured the post of Bliss Neonatal Nurse Research Fellow based at the National Perinatal Epidemiology Unit (NPEU), University of Oxford as a half-time secondment, the opportunity arose for the researcher to develop a small-scale study (Appendix 1) into a full research proposal. Factors influencing this evolution include discussions with key personnel. This included the researcher's supervisor, senior academics at the NPEU and senior post-holders at the proposed study site: the Head of Nursing and Midwifery, the Professor of Fetal Medicine and the Clinical Director of the NNU. Discussion with Bliss representatives also provided the opportunity for user involvement (Grant, Ramcharan 2006). The researcher also spent a day with a senior midwife who had undertaken research of a similar nature. This enabled the researcher to discuss specific aspects of the proposed study and to refine the data collection tools (Section 4.5.1). This period of consultation culminated in the finalised research aim (Section 2.2) and proposal.

## **2.2 Overall research aim**

The overall aim of this study was to gain an understanding of the experiences and perceptions of first-time fathers attending the birth and immediate care of their baby. For the purpose of this study 'birth' included both normal and complicated childbirth and 'immediate care' included routine care given to healthy newborn babies, newborn resuscitation and/or admission to the NNU.

## **2.3 The research paradigm**

In order to achieve the research aim, data describing the feelings and experiences of fathers were required. It was also felt that data regarding the perceptions and experiences of HCPs would explain the context in which these experiences occur. Predominantly qualitative data in the form of narratives and descriptions were required in order to gain insight into fathers' experiences in a format that was not influenced by the researcher's preconceived ideas or suppositions (Baker 2006; Parahoo 2006; Polit, Beck 2010). However, the overall organisation of the study required a structured approach (Polit, Beck 2010). The study was therefore undertaken within the paradigm of pragmatism (Creswell 2009; Creswell, Plano Clark 2007; Doyle, Brady, Byrne 2009). In the following sections, an overview will be provided of research paradigms along with justification for the use of pragmatism.

### **2.3.1 The research paradigm – background**

In the context of research, a paradigm is defined as being a school of thought or framework that encompasses a defined set of beliefs and values. The paradigm therefore provides a philosophical underpinning or general perspective that shapes the way in which research is undertaken (Dykes 2004; Weaver, Olson 2006; Polit, Beck 2010). Paradigms encompass ontological, epistemological and methodological beliefs about the nature of reality, theories of knowledge and how knowledge is created (Patton

2002; Denzin, Lincoln 2005). A person's beliefs and values therefore influence their paradigmatic stance (Dykes 2004). The paradigm with which a researcher aligns themselves influences the way phenomena are studied by determining the design and conduct of the research and the subsequent development of knowledge (Parahoo 2006; Weaver, Olson 2006; Morgan 2007).

It has been suggested that differences between research paradigms have sometimes been over-emphasised (Crossan 2003; Yardley, Bishop 2008; Bryman 2010) and that demarcations between paradigms, theoretical frameworks and research methods are not always clear (Patton 2002; Foss, Ellefsen 2002). It has also been argued that focusing on a particular paradigm constrains a person's understanding or acceptance of other perspectives (Patton 2002; Dykes 2004). An alternative view is that paradigms help researchers to select the most appropriate method for their research (Crossan 2003). Within the context of health care, the most influential research paradigms have been positivism and interpretivism (Weaver, Olson 2006).

With its foundation in the natural sciences, proponents of positivism include philosophers and scientists such as Locke, Comte and Newton (Crossan 2003; Polit, Beck 2010). Positivists believe facts and events do not occur haphazardly or randomly but instead have antecedent or underlying causes (Polit, Beck 2010). Positivists therefore argue that an objective reality exists which is independent of human behaviour (Crossan 2003). The epistemological assumption of positivism is that measurable, objective and generalisable data are required in the generation and dissemination of new knowledge (Doyle et al 2009). Positivists aim to be objective in their pursuit of knowledge and research undertaken within this paradigm utilises structured quantitative approaches (Weaver, Olson 2006). The key features of quantitative research include prediction, measurement and objectivity with the aim of explaining causal relationships (Ashworth 2008). In order to achieve this, a reductionist approach is usually adopted so that data become objective, measurable components (Crossan 2003; Topping 2006). To

facilitate objectivity the researcher adopts a position of neutrality or detachment during an investigation, 'outside' the research (Coyle 2007).

In any given era, one paradigm usually dominates (Parahoo 2006). Much health care research over the last century has involved medically orientated quantitative studies to determine the underlying causes of disease and/or the most effective forms of treatment. Those who led the drive for nursing to be accepted as a profession recognised the need for a body of knowledge that would be acknowledged by others (particularly medicine and academia). In the pursuit of this knowledge, early nursing research was almost exclusively undertaken within the then dominant paradigm of positivism (Weaver, Olson 2006). As a consequence, it has been suggested that the female profession of nursing had to comply with the male dominated medical ideology that quantitative 'scientific' research was the gold standard for clinical research (Rees 2003). This gender-argument is often used when nursing attempts to explain its history and relatively slow development as a profession. It may however, be an oversimplification. In the same way, whilst proponents of feminist research generally advocate the use of flexible, qualitative methods, this is not always the case (Robson 2002; Parahoo 2006).

In the latter half of the 20<sup>th</sup> century the use of quantitative methods to investigate human phenomena, particularly in relation to health care began to be questioned. The reductionist simplification was felt to be inappropriate in studies attempting to understand and interpret human behaviours and experiences (Mapp 2008). Positivism was criticised because it did not provide a way to investigate human behaviour in-depth (Crossan 2003). Consequently other paradigms began to be used in health care research (Topping 2006). The most frequently adopted alternative has been interpretivism. The ontology of interpretivism is based on the notion of relativist ontology; truth consists of multiple realities that are subjectively perceived by individuals (Denzin, Lincoln 2005). Interpretivist researchers argue that reality is established both inter and intra-subjectively through the meanings individuals generate from their world (Angen 2000). Humans are believed to have individual and often different interpretations about

their experiences that are socially constructed (Robson 2002; Polit, Beck 2010). Interpretivism therefore places emphasis on the meaning individuals give to their experiences and adopts a subjectivist epistemology (Denzin, Lincoln 2005; Weaver, Olson 2006). As a consequence there is no single interpretation, truth or meaning (Topping 2006) and interpretivists reject the view that truth can only be established by quantitative methods (Robson 2002). Knowledge is generated by obtaining an understanding of an individual's perspective and behaviours in naturalistic settings (Dykes 2004; Denzin, Lincoln 2005; Topping 2006). The paradigm of interpretivism is therefore particularly suited to research endeavouring to gain insight into the experiences of users of health care services in order to improve the quality of care (Van der Zalm, Bergum 2000; Foss, Ellefsen 2002; Kingdon 2004). It is especially useful when little is known about a particular phenomenon (Richards 2005; Parahoo 2006) because it provides a way of exploring human behaviour in-depth without the researcher superimposing preconceived ideas or becoming entrenched in conventional ways of thinking (Broom, Willis 2007). As a result, qualitative research has played an increasingly important role in the evaluation and development of health care in recent years (Polit, Beck 2010).

Interpretivists believe human behaviour can only be understood by exploring the context in which it occurs (Parahoo 2006). Phenomena are therefore explored through the eyes of individuals who have encountered the issue under investigation often via accounts of their experiences (Dykes 2004; Weaver, Olson 2006). Researchers work closely with participants and are therefore sometimes referred to as being 'inside' the research. By taking this approach, researchers endeavour to attain a relationship of mutual respect and minimise the impact of power relationships between themselves and participants (Weaver, Olson 2006; Birks, Chapman, Francis 2008). The research findings are the product of this interaction (Polit, Beck 2010). Interpretivists use interactive and flexible qualitative methods (Parahoo 2006). Rather than theory testing, theory emerges inductively (Weaver, Olson 2006). Whilst criticised for a lack of objectivity (Weaver, Olson 2006), the paradigm is congruent with the holistic approach to nursing care (Weaver, Olson 2006; Mapp 2008).



It has been argued that the research aim should determine the type of data required and the method of enquiry to be adopted (Patton 2002; Richards 2005; Topping 2006; Weaver, Olson 2006). Whilst the argument previously presented may suggest the paradigm of interpretivism was the most appropriate for this particular study, the flexible and evolving approach could have hindered the achievement of the research aim. It was felt therefore that a more structured strategy was required. Consequently, the paradigm of pragmatism was utilised.

### **2.3.2 The research paradigm – justification for the use of pragmatism**

Research undertaken within the paradigm of pragmatism aims to seek meaning and the context is also considered important. Researchers taking this approach believe a person's experience is primarily determined by the situation rather than any antecedent causes (Greenwood, Levin 2005; Creswell 2009). The paradigm of pragmatism has been described as being the third or middle way between the opposing forces of positivism and interpretivism (Doyle et al 2009). Whilst there are inherent differences between quantitative and qualitative methods (Bryman 2010), pragmatism enables the researcher to use aspects of both approaches in a mixed methods study because the outcome is more important than the process (Creswell, Plano Clark 2007; Doyle et al 2009). This paradigm has therefore been described as being eclectic, practical, logical, intuitive, dynamic and commonsense (Robson 2002; Doyle et al 2009). Within this paradigm the researcher selects the most appropriate approach in order to address the aims and objectives rather than being constrained by the restrictions of the defined epistemological and ontological suppositions of a particular paradigm (Patton 2002; Creswell 2009; Polit, Beck 2010). Pragmatism therefore overcomes the limitations of utilising an exclusively positivistic or interpretivist approach (Doyle et al 2009) and the mixed-methods approach yields a more complete picture of the phenomena under investigation (Yardley, Bishop 2008). This is achieved through the facility to collect both qualitative and quantitative data and the researcher's opportunity to adopt both structured and unstructured approaches (Bryman 2010). Combining qualitative and quantitative methods in this way enables the researcher to use different approaches to

measure the same or similar concepts. As a consequence the findings from these different approaches can be expanded, combined and compared. This triangulation has the potential to strengthen the overall study if the findings can be validated or corroborated (Creswell, Plano Clark 2007; Teddlie, Tashakkori 2009; Bryman 2010). Pragmatism is particularly suited to health care research because it enables the researcher to investigate complex issues in the most appropriate way. As a consequence it is rapidly becoming the dominant, yet often understated paradigm in health care research (Doyle et al 2009).

Pragmatism is not without its critics (Morgan 2007; Bryman 2010). It has been suggested that the epistemological differences between quantitative and qualitative approaches are irreconcilable and any integration is often superficial (Mason 1993; Yardley, Bishop 2008). In addition, researchers often do not have the skills to fulfil the requirements of both approaches (Bryman 2010). However, it has been argued that these approaches are compatible and the fundamental goals of both approaches, the rigorous, scientific and context-sensitive generation of knowledge, are the same (Yardley, Bishop 2008; Bryman 2010).

The notion that a person's experience is determined by the situation they find themselves in (Greenwood, Levin 2005; Creswell 2009) is allied to aim of this study. This is relevant given that first-time fathers are unlikely to have had any direct antecedent experiences relating to childbirth. The paradigm of pragmatism was also appropriate for this study because it enabled the researcher to draw on the strengths of interpretivism and positivism. Taking a predominantly qualitative approach facilitated the collection of qualitative data regarding fathers' experiences, a subject about which little was previously known (Richards 2005; Parahoo 2006). However, the facility to also adopt aspects of a quantitative methodology enabled a structured and systematic approach to be used. Consequently the research process was formulated and the data collection tools were devised before the start of data collection.

A number of different models or designs for mixed method studies have been described (Creswell, Plano Clark 2007; Yardley, Bishop 2008; Teddlie, Tashakkori 2009). These designs place varying emphasis on the sequence, timing and weight to be given to the qualitative and quantitative elements within a study. When selecting which design to use, the researcher must consider the purpose of the study, the priority to be given to the qualitative and quantitative approaches, the theoretical perspective, resources available, researcher expertise and whether the different elements could or should be undertaken simultaneously or concurrently (Creswell, Plano Clark 2007; Teddlie, Tashakkori 2009). Within this study, the purpose was to explore fathers' experiences and therefore a predominantly qualitative approach was required using a mixed methods multistrand design (Teddlie, Tashakkori 2009). The three phases of the study were undertaken sequentially in terms of the data collection largely as a consequence of the resources available (researcher availability). However, some aspects of the data analysis were undertaken concurrently (Section 2.5) (Creswell, Plano Clark 2007; Teddlie, Tashakkori 2009).

## **2.4 Qualitative methods**

Although undertaken within a structured framework, a generally qualitative approach was adopted (Section 2.3). Consequently within this section an overview will be presented of the key features, strengths and weaknesses of qualitative methods and strategies undertaken to enhance and evaluate trustworthiness. This discussion will underpin the appraisal of each phase of this study to be found in subsequent chapters (Chapters 3, 4, 5, 7).

### **2.4.1 Qualitative methods – an overview**

In the process of data collection, qualitative researchers utilise opportunities to interact with participants and in many cases the participant leads or influences the process (Yardley 2008). The most commonly used qualitative data collection methods are

interviews, focus groups, participant and non-participant observation, case studies and life histories (Endacott 2005; Baker 2006). Most qualitative methods use strategies that require data collection in a direct way in natural settings in order to attain rich, in-depth descriptions and narratives of the many facets of often-complicated phenomena (Polit, Beck 2010; Topping 2006). Whilst qualitative methods do not generally include a pilot phase (Richards 2005), strategies are often used to enhance the development of data collection tools. This may include utilising evidence from other similar studies, consulting experienced researchers and peer review. Initial data analysis often informs subsequent data collection because the two processes usually occur concurrently (Jacelon, O'Dell 2005; Polit, Beck 2010). Data collection continues until data saturation is reached and this can be assisted by efficient sampling and data management (Richards 2005). Details regarding the data collection processes used in the three phases will be described in subsequent chapters (Chapters 3, 4, 5).

In the determination of sample sizes, consideration has to be given to the purpose of the study, the timeframe available and the need for credibility. Qualitative methods usually involve small, purposive samples (Baker 2006; Mapp 2008). Decisions are generally made before the start of the study regarding participant inclusion and exclusion criteria (Endacott, Botti 2005). Participants are recruited because they have ongoing or prior experience of the phenomena under investigation (Mapp 2008). It can be difficult to predict the exact sample size because sampling usually continues until data saturation has been reached (Endacott, Botti, 2005; Parahoo 2006; Mapp 2008). Within a quantitative study the intention is to generalise the findings to the wider population. As a consequence the sample must be representative and of a sufficient size. Identification of universal truths and generalisation of the findings is not the aim of qualitative research. However, the findings can provide insight into the experiences of participants and the context in which they occur (Broom, Willis 2007). The extent to which findings are applicable to different people in other settings can therefore be considered (Parahoo 2006). Robson (2002: 177) describes this as being “*analytic or theoretical generalization.*” Consequently, it is important that the sample of a qualitative study includes sufficient variation in order to ensure a comprehensive range of experiences is

described (O’Leary 2004). Details regarding the samples and recruitment strategies will be described in subsequent chapters (Chapters 3, 4, 5).

The purpose of qualitative data analysis is to understand meanings and to provide an accurate portrayal of that meaning for others (Robson 2002; Todres, Holloway 2006). Qualitative researchers also endeavour to determine individual interpretations of phenomena and the impact of the context (Yardley 2008). A central feature of qualitative data analysis is the iterative nature of the process (Robson 2002; Lathlean 2006). The researcher engages in a ‘conversation’ with the data to facilitate interpretation. In order to do this, the researcher must be open and curious (Johnson 2000; Jacelon, O’Dell 2005). In their interpretation, the researcher will draw on their personal experiences whether intentionally or otherwise (Richards 2005; Birks et al 2008). Qualitative methods can therefore be referred to as being dialectical; whereby the researcher is affected by the phenomena they seek to understand and in turn affects the phenomena themselves (Coyle 2007, Birks et al 2008). Consequently the qualitative researcher must reflect throughout the study on their preconceived ideas and the impact of these on their interpretation of the findings (Parahoo 2006; Yardley 2008).

Although a number of frameworks for qualitative data analysis exist, it has been acknowledged that there is no definitive method for this process (Jacelon, O’Dell 2005; Braun, Clarke 2006). Some have been criticised for being too restrictive (Van der Zalm, Bergum 2000). Within this study, thematic analysis was undertaken; an approach that is flexible and widely used (Braun, Clarke 2006). Data, usually in the form of text are repeatedly returned to and understanding gradually evolves (Johnson 2000; Robson 2002). The text is coded into themes from which theory may develop (Parahoo 2006). It is often stated that themes ‘emerge’ from the data (Lathlean 2006; Polit, Beck 2010). However, this notion has been criticised by Richards (2005) who argues that the researcher plays an active part in the process of discovering and describing themes which are therefore both context and researcher related (Parahoo 2006). Within this study, themes were identified when the data appeared to capture something new. The generation of themes was not therefore determined by the number of times an issue

was found (Braun, Clarke 2006). Once themes have been identified it is important to acknowledge contradictory themes because this reassures others that the researcher has considered all of the data (Endacott 2005; Yardley 2008). A counter theme also indirectly supports the opposing theme. To facilitate effective thematic analysis, the checklist devised by Braun and Clarke (2006: 96) was utilised (Appendix 2).

Within this study a number of strategies facilitated the data analysis process. Discussion with the researcher's supervisor regarding coding and themes and the presentation of preliminary findings at conferences (Appendix 3) helped to refine the researcher's thinking (Plummer-D'Amato 2008; Yardley 2008). Whilst it has been suggested that this strategy may be problematic because others will not have had the same level of involvement as the researcher (Giorgi, Giorgi 2008) it provided the opportunity to determine whether she could defend her interpretation in a convincing and credible way (Angen 2000).

The process of transcription is an integral part of the data analysis process (Lapadat, Lindsay 1999; Bird 2005). It enables the researcher to become immersed in the data (Dearnley 2005; Kvale, Brinkmann 2009) and during transcription the researcher may begin to notice themes (Lapadat, Lindsay 1999; Richards 2005). Within this study, the researcher transcribed all of the qualitative data from phases one and two and most of the data from phase three (Sections 3.7.1, 4.7, 5.6). The use of memos helped the researcher to engage with and explore the data and assisted the development of a thematic structure (Birks et al 2008; Charmaz, 2008). A reflective diary also enabled the researcher to consider the influence she had on the process (Lathlean 2006). Although qualitative methods generally involve small samples, large quantities of detailed data are often generated. Qualitative analysis software packages can therefore facilitate the management and organisation of data in a way that can be difficult to replicate manually (Jacelon, O'Dell 2005; Plummer-D'Amato 2008). Within this study the software package 'NVivo 7' was used. This enhanced the process of coding, the development of themes and recognition of the relationship between them.

## **2.4.2 Qualitative methods – enhancing and evaluating trustworthiness**

Despite the advantages of qualitative methods previously identified, they have been criticised for being anecdotal and lacking ‘scientific’ rigour (Coyle 2007; Plummer-D’Amato 2008). The idiosyncratic nature of the research process has also been criticised. It is likely that two researchers conducting the same study, with the same participants, in the same setting at the same time would generate different findings (Polit, Beck 2010). However, rather than seeing this as a flaw, it can be argued this potential for individual interpretation is the strength of qualitative methods (Rolfe 2006). Nevertheless, there is little consensus about the key features of sound qualitative research. It has been argued this lack of consensus is inevitable because of the varied nature of qualitative methods (Coyle 2007; Yardley 2008). However, as a consequence of this lack of agreement, quantitative research has been able to continue its position of dominance (Angen 2000).

In order for their work to be universally accepted, some qualitative researchers use quantitative criteria to evaluate their research (Yardley 2008). This has been particularly apparent in nursing research, in its attempts to attain ‘scientific’ acceptance (Rolfe 2006). Others however, have discredited the use of the term ‘valid’ because of its close association with quantitative research (Silverman 2006). These differing views are determined by an individual’s beliefs and assumptions and the extent to which (if at all) they uphold the ontological and epistemological suppositions upon which positivistic (quantitative) research is based (Angen 2000). Determining validity, reliability and generalisability has become the definitive way in which to judge quantitative research (Angen 2000, Coyle 2007). Those rejecting the use of these criteria do not believe they should be applied to qualitative research (Angen 2000; Plummer-D’Amato 2008). The need for academic authenticity means qualitative researchers have had to find ways in which to legitimise their work (Angen 2000).

Lincoln and Guba introduced the concept of trustworthiness as a way of judging qualitative research in the 1980s (Plummer-D’Amato 2008). A number of strategies have

been suggested to enhance the trustworthiness qualitative research (Creswell 2009; Silverman 2006; Robson 2002; Endacott 2005; Tuckett 2005; Coyle 2007), some of which are identified in Table 2.1.

<b>STRATEGY</b>	<b>EXPLANATION</b>	<b>EXAMPLE OF A STUDY USING STRATEGY</b>
Purposive sampling	Non-probability strategy whereby participants are recruited according to pre-defined criteria (Polit, Beck 2010)	Lee et al 2009
Triangulation	Use of different methods, types of data, researchers and/or theoretical perspectives (Patton 2002)	Bondas-Salonen 1998
Thick description	The detailed description of the context of a study and the participants (Richards 2005)	Alderson et al 2006
Inductive analysis	Reasoning from a case or cases to a more general theory or conclusion (Parahoo 2006)	Jackson et al 2003

Table 2.1 Strategies that enhance the trustworthiness of qualitative research

Other strategies include standardisation of the transcription process, peer review of data analysis, acknowledgement of conflicting evidence, use of verbatim quotes in the research report, presentation of data from all participants, a detailed account of the research process and acknowledgement of potential researcher bias (Creswell 2009; Silverman 2006; Robson 2002; Endacott 2005; Tuckett 2005; Coyle 2007). If these strategies are adopted qualitative research can be both systematic and rigorous and it is therefore argued, a genuine form of science (Giorgi, Giorgi 2008). Evidence to support a study's trustworthiness can be drawn from the audit trail, supervision reports, the researcher's reflective diary and achievement of the research aim (Tuckett 2005; Plummer-D'Amato 2008). Yardley (2008) offers a framework against which a qualitative



study may be evaluated. The elements of this framework are: 'sensitivity to context', 'commitment and rigour', 'coherence and transparency' and 'impact and importance' (Yardley 2008: 243-244). This framework will be used in the overall evaluation of this study and will be presented in a subsequent chapter (Section 7.3).

The audit trail and the researcher's reflective diary recorded contemporaneously play an important role in the evaluation of trustworthiness. The audit trail should document all decisions made by the researcher during the research process. It also includes the raw data. The audit trail should enable others to track research activity and verify the researcher's final interpretation of the data (Richards 2005; Birks et al 2008; Plummer-D'Amato 2008; Yardley 2008). Within the reflective diary, researchers should consider each aspect of the research process, their decision-making and their interpretations (Topping 2006; Gardner 2008). The reflective diary also provides a means by which the researcher can consider the impact and repercussions of any sensitive or emotionally difficult issues (Rager 2005).

The findings of a qualitative study are not generalisable and causal relationships cannot be established. However, findings can be substantiated by similar studies and/or corroborated by people who have had similar experiences (Angen 2000; Yardley 2008). Whilst the findings are time and context bound, they should appear plausible and may resonate with other similar populations and/or settings (Angen 2000; Baker 2006; Yardley 2008). The written account of the research may therefore invoke in the reader a feeling of authenticity and realism (Angen 2000). This can be facilitated by the provision of information regarding the characteristics of participants and the setting (Plummer-D'Amato 2008). Whilst this information will be provided in subsequent chapters (Chapters 3, 4, 5) the researcher has noted that confidentiality should also be maintained (Section 2.6.3).

## **2.5 Outline of the three phases of the study**

In order to achieve the overall research aim (Section 2.3), and in accordance with factors previously described (Section 2.4) the paradigm of pragmatism was used with a qualitative emphasis within a defined structure. Having decided that the study would consist of three phases: qualitative interviews with fathers, direct observation of deliveries involving the collection both qualitative and quantitative data and qualitative interviews with fathers (Section 1.8) a decision had to be made about which mixed methods design to use (Section 2.3.2). It was decided that the three phases should be undertaken sequentially rather than concurrently. This was largely determined by practical and logistical factors such as the researcher's availability. Teddlie and Tashakkori (2009) also suggest that this approach is more manageable for the solo researcher. It could be argued that carrying out the direct observations first would reveal issues that could be further explored in the interviews with fathers and HCPs. However, the experiences of fathers had been the starting point for this study (Section 2.1) and the researcher and her supervisor felt it was important that the fathers' voices should underpin the other two phases. Consequently the three phases were undertaken chronologically as described in the following sections. Although the data analysis for all three phases occurred concurrently, synthesis or convergence of the findings was undertaken when all three phases were completed (Creswell, Plano Clark 2007). Specific justification and appraisal of the research process adopted and the aims and objectives of each phase will be addressed in subsequent chapters (Chapters 3, 4, 5).

### **2.5.1 Outline of the three phases of the study – Phase one**

This phase involved exploration of the experiences and perceptions of fathers who were present at the delivery, resuscitation and/or admission of their baby to the NNU. A purposive sample of 20 first-time fathers of singletons was recruited from the NNU of one NHS Trust in the UK. In order to capture the entirety of the fathers' experiences, semi-structured qualitative interviews using a phenomenological approach were

undertaken (Polit, Beck 2010). Fathers were asked to describe their experiences and feelings around the time of the birth of their baby. Their responses were analysed using thematic analysis.

### **2.5.2 Outline of the three phases of the study – Phase two**

In order to gain further insight into the experiences of fathers direct observation of 22 deliveries was undertaken in the maternity unit of one NHS Trust in the UK (as per phase one). Events occurring during normal and complicated childbirth were observed and the deliveries of both healthy babies and those requiring resuscitation and/or NNU admission were included. A purposive sample of first-time parents was recruited. Quantitative data were collected using a structured, predetermined schedule regarding activities and interventions. Recordings were made at two-minute intervals. Qualitative data were also collected regarding behaviours and actions. Both qualitative and quantitative data were collected because together they provide a more complete understanding of the phenomena under investigation (Kingdon 2004). Consequently data analysis involved the use of both quantitative and qualitative methods.

### **2.5.3 Outline of the three phases of the study – Phase three**

The final phase provides further insight into the experiences of fathers. Qualitative, semi-structured interviews were undertaken with HCPs involved in complicated childbirth and situations when a baby required resuscitation and/or NNU admission. A purposive sample of 37 HCPs including midwives, obstetricians, anaesthetists, paediatricians, neonatal nurse practitioners (NNPs) and neonatal nurses was recruited from one NHS Trust in the UK (as per phases one and two). Using a critical incident approach (Flanagan 1954; Holloway, Wheeler 2002; Silvester 2008), HCPs were asked to recall situations when fathers were present. Participant responses were analysed using thematic analysis.

## **2.6 Potential ethical issues**

Within this section, general ethical issues relating to a study such as this will be explored. Issues to be considered include the potential impact on the participant, informed consent, maintaining confidentiality and factors affecting the researcher. The ways in which these issues were addressed will be identified. Other specific ethical issues relating to the three phases will be addressed in subsequent chapters (Chapters 3, 4, 5).

### **2.6.1 Potential ethical issues – impact on the participant**

Researchers are responsible for the ethical, moral and legal integrity of their study (O’Leary 2004) and their obligation to protect participants should take precedence over everything else (Parahoo 2006). It is sometimes assumed that qualitative methods do not have the potential to cause harm (Baker 2006). However, when feelings and experiences are explored sensitive or difficult issues may be encountered (Baker 2006). The holistic nature of qualitative research also means that a wide-range of sometimes unexpected issues may be revealed. Whilst researchers are responsible for the welfare of participants it can be difficult to predict how they will respond (O’Leary 2004). The researcher must therefore be constantly vigilant for signs of a deleterious affect on participants. Researchers must sensitively deal with adverse incidents and in so doing may have to accept they could lose data (Baker 2006; Rogers 2008). The researcher’s responsibility to participants does not end with the completion of data collection. It may therefore be appropriate to advise participants about sources of ongoing support (Baker 2006; Rogers 2008).

An issue that should be considered in all research is the presence and potential impact of power relationships between the researcher and participants (Polit, Beck 2010). It might be assumed that qualitative research does not present difficulties relating to an imbalance of power. However, it has been suggested that this is an incorrect

assumption (Kvale, Brinkmann 2009). Consequently the potential risks associated with this issue will be addressed in a subsequent chapter (Section 3.5.1). Difficulties also sometimes arise when the researcher is a HCP (Lalor, Begley, Devane 2006; Parahoo 2006) whereby participants believe the researcher can intervene or act on their behalf. Nurses are particularly susceptible to this blurring of roles (Johnson, Macleod Clarke 2003). It was therefore important to ensure participants understood the researcher was not an employee of the NHS Trust and was therefore not involved in patient care. Despite these potential difficulties, it is believed the researcher's neonatal nursing background was beneficial in the recruitment of participants. During the course of this study the researcher had to adhere to the code of conduct in place at the time (Nursing and Midwifery Council 2004). There were a few occasions when the researcher experienced conflict over her primary role during data collection and these will be discussed in subsequent chapters (see Sections 3.5.2, 4.6.2).

### **2.6.2 Potential ethical issues – informed consent**

Given the potential impact on participants, researchers must ensure the principles of informed consent are followed (Mapp 2008). Before participants agree to take part in a study, researchers must ensure they fully understand the purpose of the research and what will be required of them. Participants must also be aware of any potential costs (financial and/or emotional) and benefits to themselves and/or others (Rogers 2008; Kvale, Brinkmann 2009). Benefits should always outweigh risks and all research should have a scientific purpose (Corbin, Morse 2003; Kvale 2007). It was acknowledged there would be no direct personal benefit to participants taking part in this study. However, the long-term benefits were anticipated to be improvement in the care and support of fathers in the future (Appendix 4, 5, 6). Many participants said this was their reason for taking part. This is not an uncommon response (Corbin, Morse 2003).

To help potential participants decide whether to take part, the researcher should provide comprehensible written and verbal information about the nature and purpose of the

research (Manning 2004). As part of the consent process, participants should also be informed of their right to withdraw at anytime without adverse consequences (O'Leary 2004; Rogers 2008; Kvale, Brinkmann 2009). The researcher should also be satisfied that a participant is capable of giving consent and they are doing so autonomously and voluntarily (O'Leary 2004; Manning 2004). However as previously identified, the flexible nature of qualitative research means that researchers may not always be able to predict the way in which the data collection process will evolve and thereby potential risks (Rogers 2008). Therefore informed consent should be regarded as being an ongoing process rather than a single event (Parahoo 2006). The consent process for each of the three phases will be addressed in subsequent chapters (Sections 3.3.2, 4.4.2, 5.3.2).

### **2.6.3 Potential ethical issues – maintaining confidentiality**

Within any research and subsequent publications, participant confidentiality and protection of participant identity should be maintained (O'Leary 2004; Mapp 2008). However, this can be problematic within qualitative research. Participants may be identifiable because of the small sample size, their biographical details and/or use of only one study site. There is therefore a risk of inadvertent disclosure of participant identity (Baker 2006) and avoiding breaches of confidentiality is a challenge for qualitative researchers (O'Leary 2004). The use of participant codes, non-identification of the study site and careful selection of verbatim excerpts to be used in publications and presentations should minimise the risk (Dearnley 2005; Baker 2006). These strategies have been adopted in this study.

Other situations where maintaining confidentiality may be problematic occur when participants reveal issues of concern and/or unsafe practice is observed or reported (Rogers 2008). Within this study the researcher was duty bound by her code of conduct (Nursing and Midwifery Council 2004) and the law. There may therefore have been situations where the researcher had a moral, professional or legal obligation to disclose information to others, for example the police or senior managers within the NHS Trust

(Manning 2004; O’Leary 2004). If such incidents had occurred the researcher would have sought guidance from her professional body, her point of contact within the Trust (Section 2.9) and her research supervisor. Discussion with the person concerned can also enable individuals to self-disclose or seek appropriate help and/or support (Rogers 2008). Fortunately, no such incidents occurred during this study.

#### **2.6.4 Potential ethical issues – impact on the researcher**

Research participants are generally well protected during a study. However, researchers are often not well supported even when they are involved in studies addressing sensitive or emotionally challenging topics (Rager 2005; Lalor et al, 2006). Given the focus of this study; issues involving complicated childbirth and newborn resuscitation, there was the potential for the researcher to be adversely affected (Johnson, Macleod Clarke 2003). Strategies were therefore put in place to support the researcher. These included keeping a reflective diary, periodically taking time-out and regular discussion with the researcher’s supervisor (Johnson, Macleod Clarke 2003; Rager 2005). Other potential sources of support were also identified at the start of the study and these included senior colleagues at the NPEU and the researcher’s professional organisation. However, in the event support from these other sources was not required.

There are a number of other factors that may concern researchers during the course of a study. They may encounter resistance to their research and/or have to deal with direct confrontation. Whilst the researcher encountered some ambivalence amongst a few HCPs at the study site (Section 2.11) this did not have a deleterious affect. Although some potential participants did not want to take part in the study (Sections 3.3.2, 4.4.2, 5.3.2) no outward hostility was experienced. It was important to reassure individuals they had a right to decline participation without recrimination (O’Leary 2004; Rogers 2008). The researcher’s professional manner on occasions such as this is believed to have diffused any potential difficulties.

Working in an unfamiliar setting can leave researchers feeling isolated, unsupported and in extreme situations concerned about their safety (Johnson, Macleod Clarke 2003). It is therefore important to ensure steps are taken to minimise these feelings. Within this study all data collection took place within an NHS Trust, a setting with which the researcher was familiar (Section 2.9). This meant the researcher often encountered individuals who were known to her. Whilst not directly involved in the study, contact with these individuals provided a valuable source of encouragement. Being known within the NHS Trust also appeared to raise the researcher's credibility amongst HCPs more directly involved in the study.

## **2.7 Potential impact of the researcher's prior knowledge and experience**

It has been acknowledged that qualitative researchers sometimes find it difficult to set aside their preconceived ideas about the topic under investigation (Jacelon, O'Dell 2005). This is particularly problematic when the researcher has a central role in the data collection and data analysis processes (Rager 2005). In order to minimise the risk that these presuppositions unduly influence the conduct of the research, researchers should acknowledge any influences they might have (Baker 2006). Therefore it is recommended that researchers write an account of their experiences and expectations in relation to the research topic before the study begins. Researchers should also use a diary to reflect on each aspect of the research process as the study progresses (Richards 2005). This process is not undertaken in order to eradicate preconceived ideas or remove bias. It is done so the researcher's preconceived ideas can be acknowledged through the promotion of ongoing self-awareness (Kingdon 2005; Richards 2005).

Consequently, prior to the start of the study the researcher wrote a reflective account drawing on her relevant clinical experiences and her involvement with the newborn charity Bliss. She also reflected on observations undertaken for her MSc study in which fathers played a central role and documented her thoughts and ideas about fatherhood.



The researcher has maintained a reflective journal throughout the study, elements of which have been discussed periodically with her research supervisor.

## **2.8 Researcher skills training**

In order to successfully undertake and complete the proposed study it was essential to ensure the researcher had the required skills (Baker 2006). The ultimate trustworthiness of a study is partly determined by the researcher's skill and competence (Angen 2000). The researcher had previous experience of conducting interviews with both parents of sick and/or premature babies and HCPs (Redshaw, Hart, Harvey, Harris 1999; Redshaw, Harvey 2001). She was therefore aware of the practical and logistical issues to be considered when using this method of data collection with these groups. The researcher also had prior experience of undertaking observation within maternity and NNU settings (Redshaw et al 1999; Redshaw, Harvey 2002) and consequently was aware of the challenges to be addressed when using this method of data collection in these types of settings.

It was important that the researcher availed herself of the research skills training and professional development opportunities available as part of her PhD registration and secondment to the research fellow post. Therefore workshops, conferences and short courses were attended on a variety of topics. Throughout the duration of the study, in line with the requirements of Aston University, the researcher's supervisor has monitored the researcher's competence and professional development.

## **2.9 Gaining access to the study site**

When selecting a study site it is essential to ensure it will provide access to participants who will fulfill the sample inclusion criteria (Endacott 2005; Polit, Beck 2010). Establishing contact with key players within the proposed site during the early

development of a study enhances their cooperation and support (Hunn 2006; Polit, Beck 2010). During this initial contact, key players often want to be convinced of the value of the research and any potential benefits to that particular setting (Robson 2002). The proposed study-site was a large NHS maternity hospital with a level three NNU (DH 2003) serving both the local and regional population. The key players were identified as being the Head of Nursing and Midwifery, the Professor of Fetal Medicine (who was also chair of the Trust R&D committee) and the Clinical Director of the NNU. It has been suggested that it can be more difficult to gain access for studies involving qualitative methods because of their emergent nature (Robson 2002). However, the key players at the proposed study site were all supportive of the study.

Using former contacts within an organisation can be useful in the process of gaining access (Robson 2002), although it is acknowledged that this could also be counterproductive. The researcher had previously been employed at the study-site and was a former colleague of both the Head of Nursing and Midwifery and the NNU Clinical Director. The researcher had subsequently maintained links with the Trust through her involvement in the delivery of post-registration neonatal nursing and pre-registration midwifery and child branch programmes at a local university. The researcher was therefore familiar with the study-site (Richards 2005).

Establishing one point of contact within the proposed study-site has been recommended (Robson 2002). For the purposes of this study this was the Head of Nursing and Midwifery. Meetings with the key players took place during 2005 to which the researcher was accompanied by her supervisor. Key players were sent an outline of the proposed study in advance and this facilitated discussion about the research (Robson 2002). Specific aspects of the research process were discussed including the proposed timescale and funding issues. Suggestions were made regarding the recruitment of participants, the consent process and potential methods of data collection. Confirmation was also obtained that this research would not overlap with any other studies at the site. All the key players were supportive of the study and felt the findings would be beneficial to both the Trust and the wider service.

The researcher required an honorary contract in order to collect data within the study-site. This necessitated occupational health and Criminal Record Bureau clearance, and confirmation of indemnity cover from the researcher's professional organisation. Having obtained access to the study site, ethics committee and Trust research and development (R&D) department approval was required before data collection could begin.

### **2.10 Ethics committee and Trust R&D department approval**

The Research Governance Framework 2004/5 details the process required for research undertaken within health and social care systems. Any such study requires approval from a research ethics committee (Parahoo 2006), the function of which is to protect and promote the rights of those involved in any aspect of the research. Ethics committees must be assured that the researcher is both trustworthy and competent (Rogers 2008) and is able to deal with adverse events. Ethics committees must also ensure researchers conduct their study in accordance with the requirements of the 1998 Data Protection Act (Carey 2004).

The required procedures for approval were followed and meetings attended to which the researcher was accompanied by her supervisor. Trust R&D approval was obtained 30<sup>th</sup> September 2005, subject to conformation of LREC approval. Apart from requiring some clarification regarding the destruction of interview tapes at the end of the study, the LREC was satisfied with the researcher's planned strategies for handling the data. Consequently for the duration of the study all data have been securely stored on the researcher's password-protected computer (O'Leary 2004). Access to the raw data has been strictly limited to those directly involved in the study and participants are identified on all documentation by an allocated code (O'Leary 2004). The only documents identifying the names of participants are the researcher's copies of the consent forms. These have been securely stored and on completion of the study will be destroyed in the manner outlined by the Data Protection Act (Carey 2004).

The LREC required minor amendment to some of the participant documentation. These were made and confirmation of LREC approval was obtained 1<sup>st</sup> March 2006. Confirmation of Aston University approval was obtained 3<sup>rd</sup> April 2006. In line with ongoing requirements, annual progress reports have been submitted to the LREC, the Trust R&D department and Aston University.

### **2.11 Preparation of staff**

It was important to prepare HCPs who may have come into contact with some aspect of the study. Consequently the researcher met with midwifery and nurse managers of the antenatal clinic, delivery suite and NNU in order to introduce herself and discuss the research process. Whilst they were already aware of the study, these informal meetings provided the opportunity to clarify more detailed aspects of the research and to establish a supportive working relationship (Robson 2002). The researcher also attended staff meetings and gave informal presentations about the study. This gave HCPs the opportunity to clarify their potential involvement and ask questions. Some HCPs also made helpful suggestions about ways in which the recruitment of participants could be enhanced. From these meetings the researcher was able to ascertain that whilst a few HCPs were ambivalent about the study, the majority were supportive. In the following chapter, the method and findings of phase one will be explored.

## **Chapter 3 – Phase One**

### **3.0 Introduction**

This chapter focuses on phase one (outlined in Section 2.5.1), which explored the experiences and perceptions of fathers regarding the delivery, resuscitation, and/or admission of their baby to the NNU. Semi-structured interviews adopting a phenomenological approach were undertaken with 20 fathers. Within this chapter, the aim and objectives are identified, the sample is described and the research process is appraised. Strategies undertaken to enhance trustworthiness are considered and ethical issues are explored. Key themes identified in the analysis of the data will be described using direct quotes to illustrate them. The findings will be compared with those of other studies.

### **3.1 Phase one - aim and objectives**

The aim of this phase of the study was to explore the experiences and perceptions of fathers of events surrounding the birth and immediate care of their baby. The objectives were:

3. To conduct interviews utilising a phenomenological approach with fathers who were present during complicated or preterm childbirth, the resuscitation and/or admission of their baby to the NNU.
4. To provide an account of the experiences and perceptions of fathers who were present during complicated or preterm childbirth, the resuscitation and/or admission of their baby to the NNU.

### **3.2 Phenomenological approach**

To gain insight into the experiences and perceptions of fathers, semi-structured interviews were undertaken using a phenomenological approach. This strategy has

been used in studies of fatherhood, parental experiences of witnessed resuscitation (WR) in the PICU and fathers' experiences of traumatic childbirth (Somers-Smith 2001; White 2007; Maxton 2008). Within this section justification and appraisal of this approach will be presented.

### **3.2.1 Phenomenological approach – justification for use**

A personal account of an individual's experiences helps others to understand that experience. Phenomenology facilitates this process by enabling participants to describe their lived experiences (Todres, Holloway 2006; Kvale, Brinkmann 2009). The most commonly used method of data collection is an interview during which participants are encouraged to reflect upon their experiences and feelings. The phenomenological interview can be regarded as being an engaged-conversation and narrative accounts are generated which provide as accurate a portrayal as possible of the participant's lived experience (Johnson 2000; Van der Zalm, Bergum 2000; Endacott 2005; Giorgi, Giorgi 2008). Consequently the researcher and participant are co-authors of the data (Robson 2002; O'Leary 2004).

The phenomenological approach has been increasingly used in nursing research (Van der Zalm, Bergum 2000; Robson 2002; Polit, Beck 2010) because its underpinning philosophy is congruent with that of nursing (Van der Zalm, Bergum 2000; Weaver, Olson 2006). Both are person-centred and holistic and require skills of communication, observation and interpersonal interaction (Koch 1995; Parahoo 2006). In order to effectively care for individuals, HCPs must understand their perspective (O'Leary 2004; Todres, Holloway 2006). The phenomenological approach provides a way of gaining this insight. Knowledge generated by a phenomenological study can therefore inform practice (Van der Zalm, Bergum 2000). Consequently this approach was appropriate for this phase (Somers-Smith 2001).

### **3.2.2 Phenomenological approach – an appraisal**

Phenomenology is derived from philosophy and follows the interpretive tradition (Parahoo 2006; Mapp 2008). The epistemology of phenomenology focuses on the belief that knowledge is revealed when meaning and understanding are established (Van der Zalm, Bergum 2000). Phenomenology is based on the assumption that individuals encounter their experiences with and through others and that they play an active role in shaping their experience (O'Leary 2004). A person's experiences and perceptions are therefore influenced by the context in which they occur. They are also embedded in and cannot be separated from their culture and personal history (Johnson 2000; Somers-Smith 2001; Robson 2002). Whilst phenomenology is closely associated with interpretivism, the paradigm of pragmatism enables the researcher to select the most appropriate approach to address the aims of a study (Patton 2002; Creswell 2009). The researcher was therefore able to use the phenomenological approach within this mixed methods study (Section 2.3.2).

There are two main approaches to phenomenology, descriptive and interpretive (Polit, Beck 2010). The differences between these approaches are determined by their theoretical underpinnings (Dykes 2004; O'Leary 2004). However, it has been argued that over-emphasis has been placed on these philosophical differences and the literature on phenomenology can be contradictory (O'Leary 2004; Silverman 2006). Descriptive phenomenology is grounded in Husserl's ideology (Johnson 2000; Dykes 2004; Polit, Beck 2010), which focuses on the concept of the 'life world' or 'lived experience' (Koch 1995; Todres, Holloway 2006). The aim is to describe an individual's perception or account of their experiences (Smith 1996; Somers-Smith 2001). Descriptive phenomenology does not require the researcher to have prior knowledge or experience of the phenomena under investigation. To many proponents this lack of prior knowledge is desirable (Mapp 2008).

In situations where the researcher is familiar with the phenomena under investigation Husserl advocated they set aside, suspend or 'bracket' prior knowledge, assumptions, beliefs and/or prejudices (Giorgi, Giorgi 2008; Johnson 2000; Parahoo 2006). This

process assists data analysis by increasing the likelihood that the reported findings describe the participants' experiences and perceptions and not those of the researcher (Johnson 2000; Parahoo 2006). Bracketing therefore enables the researcher to be receptive to participants' accounts (Somers-Smith 2001; Polit, Beck 2010; Kvale, Brinkmann 2009). Bracketing is not a way of eradicating the researcher's prior knowledge. It does however, enable the researcher to look anew at phenomena and if necessary question their prior assumptions (Todres, Holloway 2006).

Heidegger developed an alternative phenomenological approach known as interpretive phenomenology or hermeneutics (Johnson 2000; Mapp 2008). Whilst the underlying aim remains the same (Somers-Smith 2001) interpretive phenomenology rejects the notion of bracketing (Dykes 2004; Parahoo 2006; Todres, Holloway 2006). It is argued that a researcher's understanding of participants' accounts is grounded in their personal experiences. Researchers cannot therefore bracket their prior knowledge, assumptions and beliefs (Koch 1995; Johnson 2000). Within interpretive phenomenology the researcher's preconceptions are therefore an essential factor in the interpretation process (Somers-Smith 2001; Parahoo 2006; Todres, Holloway 2006). Interpretive phenomenology consequently requires the researcher to have prior knowledge of the phenomena (Polit, Beck 2010; Mapp 2008). The key difference therefore between descriptive and interpretive phenomenology is an ontological difference regarding the nature of reality (Koch 1995).

Whichever approach is adopted, phenomenological research requires purposive sampling in order to obtain narratives relevant to the phenomena (Endacott, Botti 2005; Todres, Holloway 2006). Participants must have encountered the events under investigation and data collection proceeds until data saturation is reached (Endacott 2005; Parahoo 2006; Polit, Beck 2010). For this phase, it was not possible for the researcher to adopt an entirely descriptive approach because it was difficult to bracket presuppositions about fathers' experiences. Indeed, the researcher's prior experience had been integral to the development of the overall study (Somers-Smith 2001) (Section 2.1). Therefore, a generally interpretive phenomenological approach was adopted.



However, strategies were undertaken to minimise undue influence of the researcher's prior knowledge and experience thus enabling others to judge the trustworthiness of the study (Angen 2000) (Sections 2.4.2, 7.2).

### **3.3 The sample**

Within this section the sampling framework will be described and the inclusion and exclusion criteria defined. The recruitment process will be outlined and the nature of the sample described.

#### **3.3.1 The sample – the sampling framework**

In accordance with the qualitative approach of phenomenology, a purposive sample was utilised (Baker 2006; Mapp 2008) (Section 2.4.1). Much of the literature regarding fathers' experiences of childbirth presents a negative view (Mander 2004; Davies, Iredale 2006; Kunjappy-Clifton 2008). There may be a number of reasons for this, one of which could be recruitment bias. Within this study, the intention was to explore the experiences of fathers in an unbiased way by ensuring appropriate variability within the sample (O'Leary 2004). Consequently the inclusion and exclusion criteria were defined (Tables 3.1, 3.2). It can be difficult to predict the exact sample size at the start of this type of study because recruitment continues until data saturation is reached (Endacott, Botti 2005, Richards 2005; Parahoo 2006). However, Kvale and Brinkmann (2009) suggest a sample of between five and 25 participants, 20 were ultimately recruited.

<b><i>INCLUSION CRITERIA</i></b>	<b><i>RATIONALE</i></b>
Present during delivery, resuscitation and/or admission of their baby to the NNU	Essential in order to address the objectives of this phase of the study
Singleton baby	Avoids the impact that a multiple birth might have on the father's perception and experience of events
First baby	Avoids the impact that previous childbirth experiences might have on the father's perception of events
Minimum of 18 years of age	Avoids issues relating to the need to obtain consent from a minor
Has a reasonable command of English	Essential requirement in order to obtain informed consent and in order for the interviews to be conducted
No known child protection issues	Avoids the researcher being party to confidential information and avoids the effect that any child protection issues might have on the father's perception of events
Is able to give informed consent	Avoids issues relating to the need to obtain consent from vulnerable groups
The baby has survived and is nearly ready for discharge home or transfer to the postnatal ward	Avoids causing the father further undue distress

Table 3.1 Phase one sample inclusion criteria

It could have been valuable to ascertain the experiences and perceptions of fathers who do not meet the inclusion criteria. For example: fathers under 18 years of age or fathers without reasonable command of English. However, these factors can present challenges with regard to consent and data collection (Corbin, Morse 2003). Consequently involving these groups was felt to be beyond the scope of this study.

<b><i>EXCLUSION CRITERIA</i></b>	<b><i>RATIONALE</i></b>
Multiple birth	A multiple birth is likely to alter the father's perception and experience
Second or subsequent baby	Previous childbirth experiences may alter the father's perception of events
Father is under 18 years of age	This may present difficulties regarding the need to obtain consent from a minor
Father does not have a reasonable command of English	This would present difficulties in obtaining informed consent and in the conduct of the interviews
Known child protection issues	This would mean the researcher would become party to confidential information and the child protection issues might have an impact on the father's perception of events
The father is unable to give informed consent	It is unacceptable to take consent from those who are unable to give it
The baby has not survived	It would be unethical to cause the father further undue distress

Table 3.2 Phase one sample exclusion criteria

### **3.3.2 The sample – the recruitment process**

Participant recruitment took place between April and October 2006. A senior nurse working in the NNU identified potential participants. The researcher met with them to discuss the study and gave them an information leaflet (Appendix 4). Assurances were given about strategies to maintain anonymity and confidentiality (Section 2.6.3). Fathers were given a minimum of 24 hours to decide and if they wanted to take part an interview date and time was negotiated. Most interviews took place in the evening or weekends to suit participant availability. Informed consent was taken immediately prior to the start of the interview (Section 3.4.2).

Not all fathers who met the inclusion criteria were approached about the study because data collection took place on a part-time basis. Time constraints and other priorities can sometimes place competing demands on researcher availability (Tuckett 2004).

Consequently some fathers were not recruited when it was identified that it would not be possible to carry out an interview before the baby's discharge. During the period of recruitment, one father approached about the study did not want to take part. It is acknowledged that the senior nurse may have acted as gatekeeper regarding the recruitment process (Tuckett 2004). However, there was no evidence to suggest this is the case. She was a former colleague of the researcher and supported the aim of the study. The researcher was therefore confident she would adhere to the study's inclusion and exclusion criteria.

### **3.3.3 The sample – the nature of the sample**

Table 3.3 identifies the biographical details of the 20 fathers. They were between 19 and 44 years of age (mean 28 years, 10 months). Eighteen were employed and the sample included fathers with a range of occupations. One father was a fulltime student and one was unemployed (fulltime carer for his disabled wife). Nineteen fathers were living with their partner (ten married, nine cohabiting) and one was living with his parents (fulltime student). The sample included fathers from a range of ethnic backgrounds that correspond with the main groups represented in the study-site's local population.

<b>NO</b>	<b>AGE</b>	<b>OCCUPATION</b>	<b>MARITAL STATUS</b>	<b>ETHNICITY*</b>
F10	23	Self-employed decorator	Single - cohabiting	White British
F11	25	Design engineer	Single - cohabiting	White English
F12	26	Postman	Married	White British
F13	32	Doctor	Married	Pakistani / British
F14	32	Management accountant	Married	Indian
F15	27	Warehouse manager	Single - cohabiting	White English
F16	36	Police officer	Married	White British
F17	44	Charity worker	Married	White British
F18	22	Electronic security engineer	Single - cohabiting	White British
F19	30	Engineer	Single – cohabiting	English
F20	35	Unemployed / fulltime carer	Married	English
F21	36	Legal Executive	Married	White British
F22	28	Commercial accountant	Married	Pakistani / British
F23	19	Deliveryman	Single – cohabiting	English
F24	19	Student	Single – not cohabiting	Black Caribbean
F25	31	Nurse	Married	Black African
F26	30	Asbestos remover	Single – cohabiting	White English
F27	25	Own marketing business	Single – cohabiting	White British
F28	23	Crane driver	Single – cohabiting	White English
F29	34	Lecturer	Married	Indian

\* As described by participants

Table 3.3 Phase one sample biographical details

Fathers were not recruited on the basis of their baby’s characteristics. However, these are outlined in Table 3.4. A range of deliveries, birthweights and gestational ages are represented. The babies were between 24<sup>+1</sup> and 41 weeks gestation and birthweights ranged between 604 grams and 3.9 Kilograms (Kg). At the time of the interview, babies were 3 – 119 days of age (mean 20.5 days). The sample includes variation such that the participants described a range of experiences (O’Leary 2004).

<b>CHARACTERISTICS</b>	<b>BOYS (10)</b>	<b>GIRLS (10)</b>
<i>Type of delivery:</i>		
Emergency LSCS	6	3
Normal vaginal delivery	3	5
Ventouse	1	0
Breech vaginal delivery	0	2
<i>Gestation:</i>		
32 completed weeks or fewer	4	6
33 completed weeks or more	6	4
<i>Birthweight:</i>		
1.5 Kg or below	6	7
Over 1.5 Kg	4	3

Table 3.4 Phase one characteristics of babies

### 3.4 Data collection

Interviews are the most commonly used qualitative method of data collection and they are closely associated with phenomenological research (Richards 2005; Kvale, Brinkmann 2009). Within this section, the development of the interview schedule will be described. The interview process will be discussed with particular reference to the practical and logistical challenges. The ways in which these issues were addressed will

be described and this will include an exploration of the required researcher skills. Reflection will also be presented on the data collection process.

### **3.4.1 Data collection – development of the interview schedule**

Questions posed within a phenomenological interview should enable participants to describe as comprehensively as possible their feelings, experiences and actions regarding the phenomena (Kvale, Brinkmann 2009). The starting point in the development of an interview schedule should be the researcher's consideration of what they want to know (Richards 2005). It is difficult to determine in advance the exact format of the questions because of the flexible nature of the interview process (Kvale 2007). Usually, therefore the researcher develops a loose set of open-ended questions and possible probes (Dearnley 2005; Todres, Holloway 2006; Kvale, Brinkmann 2009). The probing questions are used to further explore issues initially raised by the participant and should yield clearer, deeper and richer descriptions (Johnson 2000; Baker 2006). A flexible interview schedule also enables the participant to retain a level of control and reduce the power imbalance between themselves and the researcher (Rogers 2008). The participants should be able to tell their story without interruption. As is the case for all types of interview, questions should be brief and simple, avoiding the use of jargon and complicated terminology (Kvale 2007; Kvale, Brinkmann 2009).

A number of factors influenced the development of the interview schedule for this phase. This included discussion with the researcher's supervisor, senior academics and post-holders at the study-site (Section 2.1) and consideration of related research. An interview schedule was developed (Appendix 7) consisting of key questions to trigger the conversations. Possible follow-up questions, or probes, were identified in italics. The use of these probes was determined by the father's response to the initial question. The interview schedule also included biographical questions about the baby and themselves (Appendix 7).

### **3.4.2 Data collection – the interview process**

The interviews were conducted in a quiet, private, comfortable room within the NNU where it was anticipated fathers would feel safe and at ease (Kvale, Brinkmann 2009). In order to make the process as relaxed as possible refreshments were provided (Dearnley 2005). The researcher felt it was important not to wear her nursing uniform, therefore smart but comfortable attire was deemed appropriate (Dearnley 2005).

Immediately prior to the start of the interview the consent process was completed (Appendix 8) (Section 3.3.2) and the recording equipment checked (Dearnley 2005). The interviews were tape-recorded to facilitate verbatim transcription (Mapp 2008; Kvale, Brinkmann 2009). Fathers were reminded of their right not to answer specific questions if they wished and that they could temporarily pause or discontinue the interview at any time (Corbin, Morse 2003; Kvale, Brinkmann 2009). Fathers were also asked if there were any issues requiring clarification before the interview started. This approach set the tone of the interview and facilitated the development of trust (Corbin, Morse 2003). Once recording commenced, an opening statement was made to define the purpose of the study (Appendix 7).

The initial questions related to the baby's biographical details (Appendix 7) because it was felt fathers would feel comfortable answering these questions. This information also provided a context for subsequent questions. An open-ended question was then asked about the baby's birth (Appendix 7). Subsequent questions were determined by the response. As a consequence the overall format of each interview was slightly different. An attempt was made to proceed with the interview as if it were a natural conversation (Kvale, Brinkmann 2009). Probing questions were used judiciously because they can have benefits and limitations. They enable the researcher to explore issues in greater depth and can be used to draw the participant back to the phenomena under investigation (Price 2002). They also help the participant to understand the nature and depth of information the researcher is seeking. However probes may limit the boundaries of what is discussed by narrowing the focus (Johnson 2000). They may also disrupt the participant's narrative (Corbin, Morse 2003; Kvale 2007) and if



inappropriately applied, the participant can feel they are being interrogated (Price 2002; Manning 2004; Parahoo 2006). Where appropriate the researcher used closed questions to confirm her understanding (Kvale, Brinkmann 2009). In order to ensure all aspects of the fathers' experiences were covered, towards the end of the interview participants were asked if there were any other issues they wished to raise (Kvale 2007) (Appendix 7).

In order to determine when to use probing questions the researcher must be spontaneous, adaptable, respectful and responsive. Researchers must also maintain concentration, actively listen and be intuitive (Johnson 2000; Price 2002; Parahoo 2006). The researcher therefore adopted the approach of qualified naiveté (Kvale, Brinkmann 2009). This phase required fathers to tell their stories to a stranger so it was important to establish a level of trust (Parahoo 2006; Kvale 2007). In order to do this, the researcher tried to establish a good rapport and respond to the fathers' accounts (Somers-Smith 2001; Mapp 2008; Creswell 2009).

The researcher did not take notes during the interview because she felt this would be distracting (Kvale, Brinkmann 2009). Most fathers became more relaxed as the interview progressed and appeared comfortable describing their feelings and experiences (Johnson 2000; Corbin, Morse 2003). However, it was important not to end the interview with emotionally sensitive questions (Corbin, Morse 2003; Rogers 2008). Therefore the final questions related to the fathers' biographical details. At the end of the interview, fathers were thanked and once the recording was stopped they were given a debriefing sheet identifying potential sources of support (Appendix 9) (Baker 2006; Rogers 2008; Kvale, Brinkmann 2009). Many of the fathers asked the researcher if the information they had given was useful (Price 2002). They often appeared to think their story was unimportant or insignificant. All fathers were reassured that whatever their experience, their contribution to the study was invaluable. In accordance with Kvale and Brinkmann's (2009) recommendation, the researcher reflected on the interview as soon as possible in her reflective diary. Issues reflected on included the way in which the interview was

conducted, ways in which questions and probes could be refined and the presence of any power issues (Richards 2005; Kvale, Brinkmann 2009).

### **3.4.3 Data collection – reflection on the process**

The 20 interviews ranged between 22 and 77 minutes, 45 seconds (mean 48 minutes). Whilst the process was time consuming (Corbin, Morse 2003; Mapp 2008), the data provides detailed insight into a range of experiences and feelings. Some fathers were more articulate, gave more thorough accounts and/or remained more focused than others (Corbin, Morse 2003; Todres, Holloway 2006; Kvale, Brinkmann 2009). The researcher's use of probing questions was generally successful in her attempts to elicit more detailed information for example:

MEH: *Can you remember what you were feeling as your daughter was born?*

F29: *Well I was like, she was born, I was in the delivery suite as well. I was like calming my wife down basically, holding her hand as well, because they did give her that epidural for the pain, and like before that, I was like giving her the gas and all that as pain relief. Basically I was just comforting her, I don't know what she was saying, she was talking a lot of stuff as well.*

MEH: *So when that was happening and you were doing those things, what were you thinking and feeling?*

F29: *It was distressing seeing my wife at that point as well. It was emotional, so I was a bit, I did like have tears come to my eyes and everything so, and my wife as well. I felt so, I felt like it wasn't really happening to me.*

Some fathers gave more coherent accounts than others. Kvale and Brinkmann (2009) offer reassurance, suggesting this inconsistency may not be because of poor interview technique or a deliberate strategy used by the participant. It is more likely that these less articulate accounts reflect the complex nature of the phenomenon under investigation (Kvale, Brinkmann 2009). There is the possibility that fathers felt obliged to make positive comments about their experiences. Particularly since their baby continued to receive care within the NNU and in some cases, their partner was still an in-patient

(Price 2002; Giorgi, Giorgi 2008; Kvale, Brinkmann 2009). However, all fathers made negative comments at some point. This suggests they trusted the researcher and were reassured their comments would not detrimentally affect their family's care. Fathers were also aware their comments would be anonymised and not reported until after their baby's discharge.

Some participants may use an interview strategically to comment on other topics (Sandelowski 2002). Whilst most fathers focused their discussion around the specific aspects of their experience, some described seemingly unrelated issues. For example one father was critical of the physical care his partner received on the postnatal ward. However, these more peripheral issues were part of the fathers' overall experience and were important to them. In accordance with the holistic nature of the phenomenological approach (Parahoo 2006) fathers were not denied the opportunity to discuss these other issues. Sometimes participants reveal additional information once the tape-recording has ended. This presents the researcher with a dilemma regarding the management of such a situation (Kvale, Brinkmann 2009). In the event, this did not happen during this phase. This suggests fathers had the opportunity to tell their story in full and there was no information that they did not want to divulge during the recording.

### **3.5 Ethical issues**

General ethical issues pertaining to this study have been explored (Section 2.6) and the consent process and strategies to maintain confidentiality have been described (Sections 2.6.2, 3.3.2, 3.4.2). Within this section specific issues regarding the potential impact on the participant and the researcher will be explored.

### **3.5.1 Ethical issues – potential impact on the participants**

Within this phase, there was the possibility that participants would be adversely affected (Corbin, Morse 2003; Rogers 2008). Reflecting on feelings and experiences can provoke distress and the actual process of being interviewed can cause participant anxiety (Kvale, Brinkmann 2009). However, individuals who think they will be unduly upset or are uncomfortable about being interviewed usually decline participation (Corbin, Morse 2003). Nevertheless, the researcher constantly evaluated the apparent impact on participants (Rogers 2008). Three fathers became distressed during their interview, two wanted to continue without a break. The researcher briefly stopped the third interview, which was resumed shortly afterwards. It had been suggested that fathers might prefer to be interviewed by a male researcher. Whilst strategies to deal with this situation would have been put in place if necessary, in the event the fathers appeared to be comfortable being interviewed by a female.

Another situation the researcher should constantly monitor is the potential impact of an imbalance of power (Kvale, Brinkmann 2009). The phenomenological approach provides participants with a level of control over what they disclose. The potential for an imbalance of power is therefore reduced in comparison with many other research methods (Corbin, Morse 2003). However, regardless of the researcher's attempts to ensure participants felt comfortable and relaxed (Section 3.4.2); the interviews were professional encounters with the potential for power issues to develop (Price 2002; Kvale, Brinkmann 2009). Consequently there was a risk fathers revealed more than they intended (Corbin, Morse 2003; Kvale, Brinkmann 2009). The researcher therefore endeavoured to ensure she did not unduly coerce fathers during the interviews. In some instances, when probing questions revealed no further information the researcher assumed the father had disclosed all he intended. The fathers appeared to be comfortable during the interviews and none said afterwards that they wished to rescind information.

Rather than being adversely affected, most fathers seemed to find the interview a positive experience (Corbin, Morse 2003). Interviews exploring feelings and experiences can be cathartic and enhance participant wellbeing (Rager 2005). The fathers appeared to appreciate interest being taken in their experiences (Kvale, Brinkmann 2009). They also hoped participating in this study would help others in the future (Corbin, Morse 2003).

### **3.5.2 Ethical issues – potential impact on the researcher**

The researcher experienced some role conflict during data collection (Lalor et al, 2006; Parahoo 2006). There were a few occasions when fathers asked the researcher for information. In most cases they asked for an explanation of terminology or aspects of their baby's care. For example, one father asked the researcher to explain ABO incompatibility. On other occasions, there was the potential for the researcher to adopt a counselling role. In all situations, the researcher had to adhere to her code of conduct (Nursing and Midwifery Council 2004). Therefore when fathers asked questions about their baby's care brief general information was given. Fathers were then urged to refer to the HCPs caring for their baby for more specific information. The researcher is not a trained counsellor and it would have been inappropriate for her to counsel fathers. Therefore all participants were given a debriefing sheet at the end of the interview identifying sources of support (Appendix 9) (Baker 2006; Rogers 2008).

### **3.6. Data analysis**

An overview of the qualitative data analysis undertaken within this study has been given (Section 2.4.1). For this phase, thematic analysis was undertaken; an approach that is flexible and widely used (Braun, Clarke 2006). Interview transcripts were initially read to facilitate understanding (Johnson 2000; Robson 2002). Using the software package 'NVivo 7' the text was then coded into broad themes. A new theme was generated when the data appeared to capture something new. The creation of themes was not therefore

determined by the number of times an issue was found within the data (Braun, Clarke 2006). The themes were then reviewed and some were merged. The themes were then developed into hierarchies consisting of overall themes incorporating a number of sub-themes. These themes and sub-themes were added to, reviewed and amended until the final framework consisting of six overall themes was produced (Section 3.8). It was important that the researcher acknowledged ways in which her prior knowledge and experiences may have unduly influenced her interpretation of the data. As a consequence, the researcher documented her thoughts and experiences in her reflective journal. During the data analysis process, this journal was constantly referred to thereby ensuring the researcher's preconceived ideas were not imposed on the fathers' accounts.

### **3.7 Strategies to enhance trustworthiness**

General issues and strategies employed to enhance the trustworthiness of a qualitative study have been explored (Section 2.4.2). Therefore within this section specific issues regarding the transcription process and the use of participant checking will be explored.

#### **3.7.1 Strategies to enhance trustworthiness – the transcription process**

Transcription is an integral part of the data analysis process (Lapadat, Lindsay 1999; Bird 2005). There are no standard rules regarding transcription. However, there are practical issues to be addressed (Bird 2005; Kvale 2007). The researcher should decide before the process commences on conventions to be used (Bird 2005; Kvale, Brinkmann 2009) (Appendix 10). The interviews were transcribed verbatim in order to ensure an accurate account was presented (Lapadat, Lindsay 1999; Rogers 2008). Digressions and/or seemingly irrelevant data were therefore included (Richards 2005). Intonations and emotional expressions such as laughter were also included. The transcripts were reviewed several times in order to confirm accuracy (Tuckett 2005).

Verbatim quotes can appear incoherent and difficult to read when published. This may lead readers to make inappropriate judgments about participants (Kvale, Brinkmann 2009). Therefore for the purpose of this work, conference presentations and future publications quotes have been rendered readable:

F28

*“They spotted that on err, Wednesday night err, if I remember, umm, so to start with err, she was umm, normal, umm, I can’t remember the name for it now, umm, but she was head first, umm, but they err, was checking the err, baby’s heart beat every hour up until the Thursday dinner time.”*

F28

*“They spotted that on Wednesday night, if I remember, so to start with she was normal, I can’t remember the name for it now, but she was head first, but they was checking the baby’s heart beat every hour up until the Thursday dinner time.”*

It is essential however, that quotes remain faithful to the participant’s narrative (Braun, Clarke 2006). Overall meanings have therefore not been changed.

### **3.7.2 Strategies to enhance trustworthiness – participant checking**

Participant checking is the process by which analysed data are returned to participants to confirm accuracy (Angen 2000; Baker 2006; Rogers 2008). Whilst recommended by some (Polit, Beck 2010) its usefulness has been questioned (Tuckett 2005). Use of this strategy appears to support the notion of a fixed truth, yet this is counter to the underpinning philosophy of phenomenological research (Rolfe 2006). In addition, the accounts given by participants are context-bound (Angen 2000). They may also forget what they meant, change their point of view or feel obliged to agree with or contradict the analysis (Sandelowski 2002). Consequently, participant checking can lead to confusion rather than confirmation (Angen 2000). For this phase, participant checking was deemed to be neither logistically possible nor appropriate (Richards 2005; Yardley 2008). The findings presented in the following sections are therefore based on the researcher’s interpretation of the data as discussed with her supervisor (Baker 2006).

### **3.8 Findings**

Six key themes were identified in the analysis of the interviews: 'preparation', 'the delivery and resuscitation' 'the neonatal unit', 'his needs', 'role and responsibilities' and 'the whole experience' (Figure 3.1). These themes will now be described and direct quotes will be used to illustrate them.



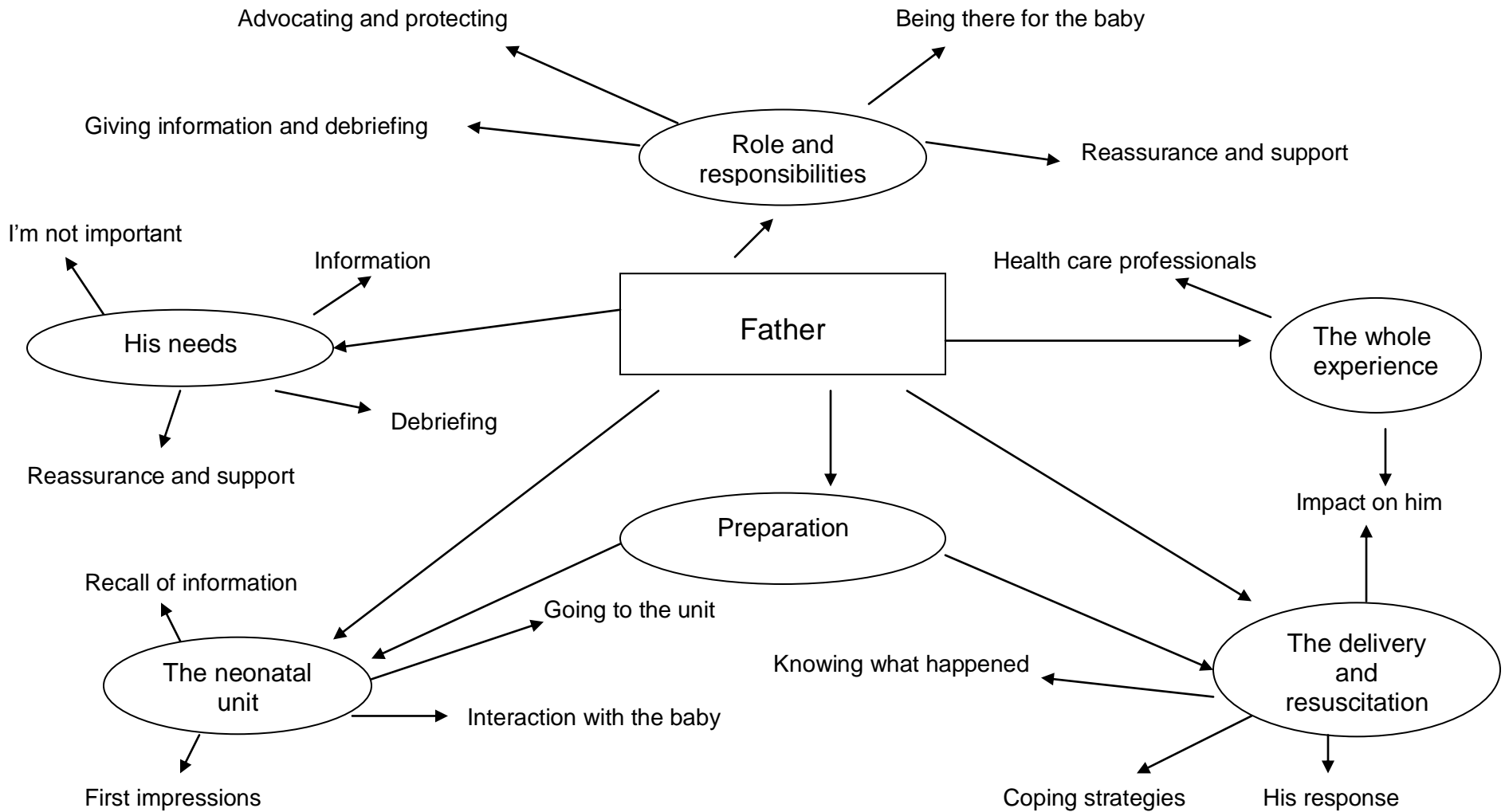


Figure 3.1 Phase one themes

### **3.9 'Preparation'**

This theme describes the preparation fathers undertook before their child's birth regardless of whether or not events occurring at the delivery were anticipated. Preparation included activities that the fathers initiated such as accessing literature and talking to family and friends. These sorts of activities are often undertaken by expectant fathers (Deave, Johnson 2008; Mottram 2008). This theme also includes preparation offered by HCPs such as a pre-admission visit to the NNU. Just over half the fathers (12) were aware antenatally that complicated childbirth, newborn resuscitation and/or NNU admission were likely. Most of the others (5) were advised during early labour that these events would occur. Consequently in a few cases (3), these events were not predicted.

#### **3.9.1 'Preparation' – parentcraft classes**

A few fathers attended parentcraft classes and found them helpful in a general way. At the time of attendance, adverse events occurring at the birth had not been predicted. These aspects were not addressed in the classes and fathers felt they would have been useful. They all however, acknowledged these topics are irrelevant for most parents and may alarm them unnecessarily. One useful aspect covered was events occurring during an LSCS delivery. Although addressed in relation to an elective LSCS at term, fathers found it beneficial to have information about the number of HCPs at the delivery and their different roles. They also recalled being told fathers had to wait in the recovery area whilst preparations were made in theatre and that the baby would be taken to a special cot or trolley (the resuscitaire) for ongoing care. However, resuscitation was not mentioned.

#### **F11**

*"I found that quite useful, they talked us through everything you know that we would expect and if it, you know, it wasn't so much, concentrated on if it was early, it was more, you know, if you*

*need a caesarean if there was any problems. What might, the kind of people might be in the room.”*

### F17

*“In the antenatal classes they’d actually done a role play of a caesarean, more from the perspective of the number of people that would appear so that if it happens, you’re not shocked by the number of people and the fact that the husband comes in at the end.....One of the reasons they did this the tutor said, well she’d known fathers that had sat outside waiting and thinking well there’s something seriously wrong. My baby’s died, my wife’s died and then to have this scene where you know, you might wait for 20 minutes and they’re just setting up.”*

Several fathers planned to attend parentcraft classes but their baby was born before they were able. They were disappointed about this particularly because most had been made aware antenatally of potential problems surrounding the birth.

### F21

*“Yea, again in the early days we sort of talked about this and where we would go for parentcraft classes and, even though there were problems, I thought we were going to have time to do this and again it all just caught me out, yea. So no, we never did anything like that.”*

Some fathers decided not to attend classes. Sometimes this was because they could not take time from work. A few said they wished they had attended because they underestimated what childbirth was like. Fathers often assume they will be able to cope (Dartnell et al 2005). One father, whose baby had known renal problems did not attend classes because he and his partner felt their needs would not be addressed. Thus identifying the need some parents have for parentcraft classes with a specific focus.

### F27

*“We never went and then, looking back, I wish we had have done now ((laughs)). So like yea, the breathing techniques and things. It’s just, I think they do all help yea, you know. Looking back you know to me was like a bit over the top, you know you have a baby and it’s all simple and easy and then looking back now, actually no, it ain’t that easy. We could have done with a*

*bit of training on it really and being told what's gonna happen. So I think that was our own ignorance that we didn't go to that really."*

#### F19

*"We didn't want to be stuck in this room, with all these smug people knowing that for us and our baby, it wasn't going to be like that."*

### **3.9.2 'Preparation' – reading literature**

Most fathers irrespective of anticipated problems accessed written material during their partner's pregnancy. They bought or borrowed books, a few accessed literature specifically relating to fatherhood. None recalled HCPs recommending books. Whilst HCPs may be reluctant to suggest specific texts, there may be scope for them to make general recommendations. In most cases fathers read material written by recognised authorities or authors recommended by friends and family. Most found these books helpful in a general way. However, those who had not anticipated problems acknowledged that whilst some books covered complicated and preterm birth, newborn resuscitation and NNU care, they rarely read those sections.

#### F28

*"No, we always glanced passed that bit. We thought, we won't need that, we won't need that either."*

When problems had been diagnosed antenatally some fathers adopted problem-focused coping strategies by accessing literature (Pinelli 2000; Ogden 2007) (Section 1.7). Others adopted avoidance coping strategies (Van Der Molen 1999; Ogden 2007) and deliberately did not access such information (Section 1.7).

## F20

*"In the 'Tommy's Guide' there's a really good section in there about neonatal units and SCBU ((special care baby unit)) beds and, and it was like a question and answer format. So all the sort of questions that you would normally ask, it was actually already laid down there. So again, it prepared you mentally for the outcome."*

## F16

*"I never felt the need to access the information; in fact we made a positive decision not to because it was bad news I think we just didn't want to find out about it."*

### **3.9.3 'Preparation' – accessing information via the Internet**

Several fathers accessed information via the Internet irrespective of anticipated problems. These fathers used the Internet for other purposes (work and/or leisure) and found this information more accessible. Several enjoyed monitoring normal fetal development week-by-week and comparing that with their own baby's progress. A few fathers, whose babies were almost certainly going to be born prematurely accessed relevant research studies, professional and charity websites. Whilst in most cases they found this information reassuring, it was sometimes difficult to avoid overtly negative or erroneous information. Guidance from HCPs regarding websites to access may therefore be useful.

## F21

*"I got on all these interesting medical websites and papers published and studies.... some of it, you know, you've got to trawl through an awful lot when you go on the Internet. Especially when you get on the American and different sites and European and British and, there's a British obstetricians site that did a bit on small babies, some of it was relevant and some of it wasn't, you know. But I looked at quite a lot of it and I spent a good few hours at different times looking at those sort of sites."*

## F29

*"There was like one story on the Internet that I was reading about a baby that was born. Basically it was a diary that somebody had kept on the Internet. So I was just reading through it. .... It did worry me slightly because at the beginning of the diary it weren't all positive stuff but*

*gradually it was getting a bit more positive.... So it was a good idea, keeping a diary for other people to read and it was easily available on the Internet.”*

### **3.9.4 ‘Preparation’ – talking to family and friends**

Several fathers talked to male relatives, work colleagues or friends about their childbirth experiences. Fathers felt this information was helpful but only in a general way because they had mostly been present at normal deliveries of healthy term babies. A friend told one father that childbirth was a ‘horrible’ experience. However, all others received positive comments and for most this reaffirmed their decision to be present at the birth.

#### F13

*“Yea, my sister had a child recently and her husband was in with her and I had a chat with him and quite a few of my friends have had children recently and, you know, we’d often talk about it.”*

#### MEH

*“And was that helpful to you do you think? In terms of what actually happened?”*

#### F13

*“I don’t think so, I think it’s fairly incidental. I don’t think it made much difference, because our situation was so different to what my friends have been through. So I don’t think it made much difference.”*

Some fathers did not speak to others about their childbirth experiences. In some cases they did not know other fathers or were not comfortable having that sort of conversation. In a few cases, fathers intended to discuss childbirth experiences but their baby was born before they had an opportunity. A few fathers deliberately avoided such a discussion because they knew their experience was likely to be different to those they would have otherwise asked.

### F11

*“No, boys don’t really, they just go to football, they don’t talk about it. Not like, I think it is different for girls because they obviously talk about it and their experiences but no, I never really spoke about it.”*

### F21

*“I don’t know that many dads. My brother doesn’t have any children. I know a friend of mine who yea, he was a dad, I don’t know if he was present or not. I didn’t discuss it with him, to be honest.”*

## **3.9.5 ‘Preparation’ – tour of the neonatal unit**

When it is identified that a baby may require NNU admission, parents sometimes visit the unit before the birth (Griffin et al 1997; Jackson et al 2003). However, only a few fathers did this. Several wanted to and made their wishes known to relevant HCPs but the opportunity was not forthcoming.

### F29

*“We were supposed to during that week ((when his partner was an in-patient)). We kept asking but then my wife did get discharged so we were, we were going to come down and have a look at how the neonatal unit works, but it never happened.”*

A few fathers were unaware of this option. Having subsequently seen other prospective parents visiting the NNU they were disappointed this opportunity had not been made available to them. None of the fathers were taken to view the NNU whilst their partner was being cared for on the delivery suite.

### F16

*“I’ve seen since, because I’ve been at the hospital quite some time, people having tours, but no, but I hadn’t been down here. I think it would have helped if I had.”*

Of the fathers who visited the NNU, some found it useful because it enabled them to meet NNU staff and prepared them for their baby's subsequent admission. Others felt it was inappropriate.

#### F12

*"To actually see the ward, which was good. It was really good, especially for me .... So to come down and actually see the ward, NN1 ((neonatal nurse)) I think her name is, she showed us around, and she, she was very good and just sort of showed us some monitors and the bleeping and stuff like that, just so we had a fair idea what to expect."*

#### F22

*"To be honest I wasn't really at that point interested in this place because I didn't ever expect and I dunno, it was probably giving, I don't know if it was giving false hope to my wife that she ((the baby)) was going to make it or not. And I didn't want to lead her that way."*

### **3.10 'The delivery and resuscitation'**

This theme covers the period of time immediately before their baby's birth until the baby was taken from the delivery room to the NNU. It therefore includes the delivery and the baby's resuscitation. The theme consists of four sub-themes; 'knowing what happened' which describes the fathers' understanding of events, 'his response' which encompasses their focus of concern, actions and behaviours, 'impact on him' and 'coping strategies' which identifies the ways in which they dealt with the situation.

#### **3.10.1 'The delivery and resuscitation' – knowing what happened**

Some fathers described what happened in detail whilst others gave brief and at times vague summaries. Some fathers described what they 'thought' happened. Most recounted HCPs 'drying', 'wrapping' and 'checking' their baby. However, several were unaware their baby had received some form of resuscitation. Others said they did not realise at the time that their baby was resuscitated. This was only discovered afterwards, often by chance. This raises questions about HCP information giving,



professional responsibility and non-compliance with practice guidelines (European Resuscitation Council 2006; Resuscitation Council 2006).

F17 (normal delivery, face mask oxygen)

*“The resuscitaire was at a slight angle so I could see that she ((paediatrician)) was rubbing. The baby was in a blanket or towel or something and she was rubbing, but that was all I could see. Oh then there was also, there was, they were holding an oxygen thing over her, just above her mouth, or face, but other than that, I couldn’t see.”*

F27 (normal delivery, face mask oxygen)

*“Immediately after they took her off, they had the trolley there. They obviously weighed her and cleaned her off and checked her over, wrapped her up, that’s all I think.”*

F20 (LSCS, manual breaths and face mask oxygen)

*“It was only about a week or so after that we actually found out that they had to bag him.”*

The understanding of some fathers was influenced by their position in the room. Others said they were focusing on their partner at the time. Recall and understanding of events was not affected by the length of time since the delivery. Most fathers did not have a clear understanding of what happened. This may be because many did not know what to expect (Section 3.9) and therefore could be described as being none-expert fathers. The findings may have been different if the sample included experienced fathers.

### **3.10.2 ‘The delivery and resuscitation’ – his response**

This sub-theme relates to the fathers’ focus of concern and whether they stayed with their partner or went to the baby on the resuscitaire. All fathers talked of their conflict about whom they should be most worried. Several said they thought their partner and/or baby would not survive. Reflecting on this conflict caused some fathers to become upset. One interview was stopped briefly at the researcher’s instigation but resumed when the father confirmed he wanted to continue. Other fathers who were distressed wanted to continue without a break.

Most fathers felt they were more concerned about their partner, which concurs with other studies (Lindberg et al 2007; Lundqvist et al 2007). Some felt uncomfortable admitting this, implying they should have been more concerned about their baby. Some felt the greater concern for their partner was influenced by the length of their relationship. A few fathers felt they did not have a bond with their baby and consequently were less concerned about him/her. Their more limited concern for their baby may also have been influenced by their lack of understanding of the immediate situation (Section 3.9.1) or anticipated negative outcomes.

#### F12

*"I was really, really worried for M12 but then I was so worried for the baby, Oh man, I think my worry was with M12 more at that point yea, I'd say with M12, it breaks my heart to say that really."*

Greater concern for their partner was not exclusive to complicated childbirth and babies nearer term. The fathers' concern related to both her physical and psychological wellbeing. They worried about the long-term effect of invasive procedures and complications associated with conditions such as pre-eclampsia. They were also worried about how his partner would cope if the baby died saying she would blame herself. They may also have been considering the subsequent impact of her grief and guilt on themselves.

#### F21

*"So I was worried about M21, I mean the effect it would have on her if things went wrong, I know she'd take it very badly; she'd take it terribly badly. So I was kind of worried about him but I think more for M21"*

## F22

*"I can't see my wife go through the pain of loss because I know; I don't see how she would have coped. I don't think she would cope at all because I know M22, she'd blame herself if something happened, she'd blame herself."*

By contrast, a few fathers felt they were more concerned about their baby. To some extent, this occurred if his partner was otherwise well.

## F29

*"My main concern was the baby. At that point, I mean my wife was all right; she wasn't in danger or anything. It was just my main concern was the baby. You see I didn't know if she ((the baby)) was gonna be OK or not. My main concern was the safety of our baby."*

## F13

*"Although I was worried about both of them, at that point actually the fear was more about B13."*

Conflict continued for fathers over whether to stay with their partner or go to the resuscitaire. Although most wanted to go to their baby, they felt they ought to stay with their partner. Several thought their partner would have felt abandoned if they went to the baby. They were also concerned about impeding the baby's care. Fathers felt they could do more for their partner by reassuring and supporting her than they could for their baby. None recalled being encouraged to go to their baby and assumed HCPs wanted him to stay where he was. Some felt this more strongly by saying they were not 'allowed' to go to the baby and this was generally the case when the baby was delivered in the operating theatre.

## F13

*"I didn't feel as if I was allowed to go across, although I would have liked to have done. I mean I would've liked to have gone across but I didn't feel as if I could."*

### F17

*"I wasn't, I wasn't quite sure what to do. I mean in some ways I didn't want to leave her ((partner)), she'd already lost the baby, well not lost the baby, but the baby had been taken. So for me to run off as well.....I think I didn't feel, although nothing was said, I didn't feel that it really was an option. There was a job being done over there and they wanted, they sort of wanted to get on with it, and I felt well if I approached I would sort of be in the way, I would be told to go away sort of thing, so, I think it was the unsaid."*

A few fathers spontaneously went to the resuscitaire but quickly returned to their partner. None had physical contact with their baby. There has been debate about relatives being present during resuscitation in other care settings (Section 1.4.2). Evidence suggests this enables them to understand what is happening and reassures them about care given (Grice et al 2003; Baskett et al 2005). Relatives also feel their physical presence, which can be further enhanced through touch is something positive they can do for the patient (Hanson, Strawser 1992; Grice et al 2003; Baskett et al 2005). Fathers may therefore have benefited from the opportunity to go to the resuscitaire and touch their baby.

### **3.10.3 'The delivery and resuscitation' – impact on him**

Fathers reflected on the impact of the delivery and resuscitation. Three issues appeared important: waiting on his own, the delivery itself and the baby's cry. Several fathers described waiting by themselves in the recovery area whilst preparations were made for delivery by LSCS. As a consequence of hospital policy, fathers were unable to accompany their partner. They estimated they waited 20 to 60 minutes before being able to join her. A few said this was the most distressing episode of their entire experience. The impact was felt to be worse because they were alone, often without information. Several fathers felt 'abandoned' and could not find anyone to ask what was happening. A few fathers received limited information, generally from the midwife. On a few occasions, other HCPs and parents were in the recovery area and fathers found this difficult. They felt 'in the way' and would have preferred to wait somewhere private. These fathers appeared to feel 'alone' in the presence of others.

## F12

*"That was the hardest time, because I was just, I've never felt so alone really, because I was completely on me own with no idea what was going on, and it was probably that time I had no control at all of what was going on, that was really difficult. Probably the longest hour of my life."*

## F20

*"I was pacing up and down and that and then that was getting, then I was winding myself up thinking, I shouldn't really be pacing up and down."*

## F21

*"I didn't really want to be in that big room with other people coming and going past me and I would have preferred somewhere a bit more quiet and private."*

The delivery appeared to impact upon fathers in a number of different ways. A few were fascinated, watched closely and described what happened in detail. More commonly however, and in almost all cases of complicated childbirth, fathers did not want to see what happened. They often felt 'too close for comfort.' Some fathers described the physical impact and were worried they would faint or vomit.

## F23

*"I weren't looking; I was just like that ((turns his head away)) I didn't want to look really, I didn't want to look down there really."*

## F26

*"I was a bit scared because I, well I was more scared that I'd be sick by seeing it, because of all the blood and etc, because it's not a thing I'd like to see, but they'd all said how much blood was there. That's why I was standing behind her"*

Fathers experienced a range of emotions about the delivery and these remained vivid. They had no difficulty recalling these emotions unlike other aspects of their experience. Joy and pride was often mixed with anxiety and fear. Some positive emotions were reported; a few fathers said they were 'chuffed' or 'over the moon.' These feelings were recalled when outcomes remained uncertain indicating that even in extreme situations birth can be a joyous occasion (Nolan 1996; Strange 2002; Lundqvist Jakobsson 2003). However, negative emotions were more commonly described. Fathers said they were 'worried', 'distressed', 'stressed', 'petrified', 'devastated', 'panic-stricken' or 'scared.' Several cried, sometimes due to joy and relief, not just because they were distressed. Other fathers said they felt 'bewildered', 'numb' and 'overwhelmed.' One father felt cheated because he had not attended a normal delivery as anticipated. He saw his partner's LSCS delivery as an operation rather than a delivery. Another father said his over-riding emotion was anger because the baby was born so prematurely.

#### F10

*"I was that scared, it was so frightening."*

#### F29

*"It was heart-shaking. I was just like holding my missus like that ((puts his arms out)). It was emotional, so I was a bit, I did like have tears come to my eyes."*

#### F22

*"I wasn't happy, I was angry. But I don't know who I was angry with, certainly not my wife. My wife was like a hero; she brought the baby to this level. But I was angry with someone; I think I was probably angry with god to be honest. Because my wife has never hurt anyone, never ..... I just thought it was so unfair, so unfair, for this to happen but you know, it was really unfair."*

Many studies have described the impact on relatives of being present during resuscitation events in other critical care settings (Section 1.4.2) and this was one of the motivators for this study (Section 2.1). However, the impact of the resuscitation on these fathers is more difficult to determine. Although none of the fathers left the room during the resuscitation, most described their response to the delivery and resuscitation as one

continuous event, which in effect it is. Many fathers were also unaware of their baby's specific resuscitation requirements (Section 3.10.1). In addition to the baby, fathers were also concerned about their partner and this is an important difference when comparisons are made with the literature regarding WR in other settings (Section 1.4.2). The impact the fathers described therefore relates as much to the delivery and a general awareness that the baby may be in jeopardy than the resuscitation per se.

Hearing the baby's first cry had a great impact on all fathers. They felt 'relieved' and 'reassured.' Joy was evident in their accounts. Several fathers cried themselves on hearing the cry and a few became emotional when they recalled the occasion.

#### F26

*"I was just chuffed when he started crying 'cos I knew that was the main thing he needed to do blaa ((makes crying sound)) and I thought lovely ((claps his hands)) everything's sound. As soon as he cried, yea, I was buzzing."*

#### F18

*"Hearing my baby's voice for the first time, it's just unbelievable. But the feeling, it was just immense, like. Absolutely immense. I'll remember that until the day I die. It was just unbelievable..... I was just in bits, I was just absolutely ecstatic, in bits like."*

Most fathers assumed the cry meant their baby was well. In some instances, the baby subsequently required resuscitation, which fathers found alarming. Some babies did not cry immediately or for some time afterwards. Fathers described their anxiety and the ominous silence whilst waiting for the cry. They assumed this meant their baby was not breathing which may not always have been the case. Issues raised regarding the baby's cry suggest that fathers need clearer guidance from HCPs about what the presence or absence of a cry indicates.

#### F17

*"I think in a sense it was a shock, because we'd heard her cry therefore the assumption was she's OK. But then she stopped, that was probably the point of greatest concern."*

#### F14

*"I think when he came out quietly as well it was, OK, your heart starts to flutter waiting for the baby noise."*

### **3.10.4 'The delivery and resuscitation' – coping strategies**

Fathers alluded to their coping style during the interviews and this was mostly in relation to the delivery and resuscitation. This suggests this was the 'crisis point' of their experience. Several talked about how they coped with other unrelated stressful situations and felt they used the same strategies. Although a range of approaches was described, fathers most commonly adopted emotion-focused coping strategies (Section 1.7). They tried not to think about what was happening and focused on reassuring themselves of a positive outcome. They also avoided watching what was happening and ignored what HCPs were telling them.

#### F11

*"So all the time I was just thinking in my mind, you know, to try and not think about what's happening if you know what I mean?"*

#### F22

*"I decided to ignore it, because they were being pessimistic. Anything that they were saying I decided I weren't gonna believe."*

#### F29

*"I think I was still in like denial. I thought no, it's not going on. You know, this isn't happening I thought even up to the point when we got to the delivery suite, I thought it's still not gonna happen."*



Some fathers adopted problem-focused approach coping strategies and described gathering as much information as they could, putting their trust in HCPs and endeavouring to stay out of their way.

### F13

*“Everyone’s different, but myself, I always prefer to know what’s going on. If you have some information about it, your anxiety levels decrease don’t they? I’d rather know, rather than to not know.”*

### F21

*“I’d certainly say, for me, you know, from my point of view, you know, I let them get on with it, they knew what they’re doing, you know.”*

Fathers who adopted emotion-focused strategies to control emotions felt they were generally successful.

### F12

*“It got to the point where we ended up playing eye-spy ((laughs)) just to try and take our mind off things, as silly as it sounds it was a bit of a saving grace really.”*

### F18

*“Her mum said to me after that, she thinks I held it in brilliant when I was in the room with her and I did think I was gonna be more emotional than I actually was like but I had a reason for that, ‘cos I had to keep myself calm.”*

## **3.11 ‘The neonatal unit’**

This theme consists of four sub-themes which together focus on the fathers’ experiences and perceptions of their first visit to the NNU. The sub-theme ‘going to the unit’ includes their decision to either stay with their partner or go with the baby, the timing of the visit, the impact of delays and whether or not they were accompanied. The

impact of the NNU environment, the equipment and other babies is encompassed in the sub-theme: 'first impressions.' 'Interaction with the baby' describes the nature and extent of their physical contact with their child and recollection of any information given by HCPs during the first visit is encompassed in: 'recall of information'.

### **3.11.1 'The neonatal unit' – going to the unit**

Fathers being given permission by HCPs to visit their baby are prevalent in this sub-theme. Many fathers were uncertain whether he should accompany his baby. A few wanted to go but only one did. Others tried to go but were stopped by the midwife or paediatrician. The remainder assumed they were not 'allowed' to accompany their baby because HCPs did not indicate they could.

#### F19

*"I did try to, I tried to but she ((midwife)) said I couldn't come down. She seemed cross, so I thought I'd better not argue ((laughs))."*

Most fathers felt they should stay with their partner. They thought they could do more for her than for their baby. Another factor influencing their decision was the strength and length of their relationship in comparison to that with the baby. Many fathers continued to be concerned about their partner's physical wellbeing. Most fathers felt their baby was in 'safe hands' and were worried about being 'in the way' in the NNU.

#### F11

*"I mean it's a weird feeling. 'Cos it's, you think that you can't wait for your baby to come, and when it comes all you wanna do is be with it but, I don't know it's, it seems like a daft comment but you know, you've known your partner longer and they take priority at that time for some reason. It's a weird feeling but I just felt like M11 needed, I could do more for M11 than I could for the baby 'cos I can reassure M11 and talk to her. Whereas the baby, you know if there's something wrong it's down to the doctors, I can't do anything for her really."*

## F20

*“Then my next thought was who do I be with? ((laughs)). Who needs my help more than the other? And as much as I wanted to be like with him, I knew my role was also to be, and I actually felt sort of very torn apart as to where my loyalties actually lied. When it actually came to it, basically what I decided was that my wife needed me a little bit more than him.”*

For most fathers thinking about whether to go with the baby was compounded by a conflict of loyalty. Several said it would have been helpful if the midwife had raised the issue before the birth, so they could have discussed what he should do.

## F16

*“A bit of forewarning that you’re gonna be confronted with that, if I’d known that beforehand, me and M16 could have discussed it and she’d have said well go with B16 because I want you to make sure that she’s OK and get back to me as soon as you can with what’s going on, or she might have said, well she’s in good care just stay with me for a bit ‘cos I might need you, but that enables you then to make that decision, doesn’t it, with the information beforehand.”*

Having remained with their partner, fathers had to wait varying lengths of time before they could visit the NNU. Unusually one father visited his baby within 30 minutes of the delivery. Having spoken to other fathers he felt ‘lucky’ to have had this opportunity so quickly. Most waited one to two hours. Some waited more than three hours and two fathers waited about ten hours. To some extent delays were caused by the father’s decision to visit with his partner. Several couples wanted to go to the NNU together so they could be with the baby as a family. In these cases, there was often considerable delay before their partner was ready. Usually they were waiting for her post-delivery care to be completed and several fathers felt this was compounded by staff shortages and unnecessary paperwork. The other cause of delay was when fathers or couples had to wait until the NNU was ready. Whilst fathers said their baby’s immediate care was the priority they nevertheless found the delay difficult. The impact was exacerbated by a lack of information and most fathers assumed there were problems they were not being told about. For a few fathers this was the most difficult part of their experience. Some parents received updates via the midwife, but this was usually non-specific. A few

fathers went uninvited to the NNU, but were turned away. Most did not receive an explanation for the delay either at the time or subsequently.

F23:

*“So they took him down to the clinic here ((NNU)), the baby clinic and they said oh, you can’t see him for an hour. I goes to M23 I’m going to go down to check on him. So I come down and I weren’t allowed to see him. They said oh, can you come back in twenty minutes. Oh I was, I was worried, really bad I was. I just wanted to go down there quickly and just see him, see if he was alright.”*

F27:

*“I think towards the end of it before we come down, we was getting a bit nervous, oh what’s going on then? You know, it’s been a long time, how long does it take to get her down there and set up or whatever it is they’re doing with her. Or is there a problem that they’re not telling us about so you know, there weren’t enough information there really.”*

F20:

*“I think that was sort of like, that was like a little bit painful and that’s the time when I sort of sat there thinking I hope everything’s alright. Oh, and why haven’t they, and that’s when your mind is sort of playing up. So I think that would be like the most agonising part of the complete thing, just that wait from when I saw him in the corridor to actually seeing him on the unit.”*

When they were able to go to the NNU, a few fathers went on their own because they wanted to focus their attention on the baby. They were also concerned about becoming emotional in the presence of others. In some cases the midwife caring for his partner offered to go with him. They appreciated this gesture, but most felt obliged to decline the offer because they felt the absence of the midwife would compromise their partner’s care. In retrospect some fathers felt it would have been helpful to have been accompanied.

F18

*“I wanted it to be like me and her ((the baby)) kind of thing, you know what I mean. So I was happy to come on me own.”*

F16:

*“They just pointed me in the right direction and I sort of found my way here in a sort of, a bit of a daze. I can remember being in a daze; it was like walking in a sort of trance, weird. I suppose in that sense it might not have been a bad idea to have somebody with you.”*

When fathers were accompanied they went with their partner, the midwife and/or family members. Fathers who were accompanied by the midwife valued this support. A few fathers who were accompanied by family members found this supportive (Ogden 2007), whilst others felt it intrusive.

F24:

*“My dad was with me as well and my dad wanted to come down with me. He didn’t ask me, he just came. I think I’d have rather be on my own.”*

F19:

*“I actually came down with one of the, the actual midwife who helped deliver him from the delivery unit. She actually came down with me which I actually thought was very supportive.”*

### **3.11.2 ‘The neonatal unit’ – first impressions**

All fathers described their first impressions of the NNU in detail and their recollections remained intense. They spoke about the NNU environment in general and the equipment in particular. They also spoke about other babies in the nursery. Most were overwhelmed by the heat and noise and said this was why they stayed for only a short time (usually no more than ten minutes). Several fathers felt claustrophobic even in the larger nurseries and others felt inhibited by the lack of privacy. Unusually, one father said he felt cold when he first went into the nursery and attributed this to emotional shock.

Most fathers felt overwhelmed by the equipment; several said they were more aware of this than the baby. They were shocked by the amount and complicated nature of the

technology. Some said this made the situation look worse than it actually was. Fathers often found the bleeps and alarms distracting and frightening. They became particularly anxious when alarms sounded.

#### F16

*“The incubator was a big shock, you know, all these beepers and buzzers going off. I know being confronted with the equipment was a shock.”*

#### F28

*“She was on the ventilator so you see all these wires and plastic tubes coming out of her, that’s a bit daunting as well.”*

#### F21

*“All the equipment, all the monitors and it was stiflingly hot. It’s kind of a small, stuffy, horrible room with a lot of stuff in. A small room and I remember that and a lot of equipment. He had everything on him then and I could only just see bits of him.”*

By contrast the amount of equipment reassured a few fathers. They felt this indicated everything possible was being done for their child. One father was grateful his baby had the last available ventilator. The type of equipment used also reassured some fathers; babies nursed in open-incubators or cots were felt to be less sick.

#### F17

*“Although she was kind of wired up, I don’t think there was a sense of being overly concerned because she wasn’t on an incubator so you know, that’s not as serious as you know, it might have been.”*

Most of the fathers said they used other babies as a point of reference when assessing their baby. Their level of anxiety reduced if their baby was bigger and/or had less equipment. They were also reassured if other babies appeared as sick as their child.

They felt this meant the HCPs were capable of caring for such babies and the NNU was well equipped. Fathers compared the monitor readings of theirs and other babies. However, they said they did not know at this stage what normal ranges were or if they were comparing like-for-like.

F15:

*“When I first went in, all the baby’s looked sick. They looked really small and withdrawn and with B15, she just looked tiny. She’s still got like chubby cheeks even though she was tiny and I thought well my baby looks a lot better, you know what I mean? She’s got colour in her and I think that calmed me down a bit.”*

F24

*“Yea, almost all the other babies were small, small, really, really small man. That made me feel good actually, yea he ain’t that sick then, he’s alright ((laughs)).”*

Some fathers however, were not reassured when they compared their baby with others because this emphasised how sick their baby was. These fathers often wished they had not looked at other babies.

F28

*“They were all a lot bigger than our baby so that’s daunting. You think well she’s the smallest kid in the class sort of thing. Fuck me, sorry, she’s got a long way to go.”*

Fathers used a range of emotions to describe the impact of the NNU. Most recalled positive and negative emotions and they often had difficulty reconciling the joy of fatherhood with the reality of the situation. Fathers felt ‘happy’, ‘pleased’, ‘reassured’ ‘relieved’ ‘overjoyed’ and ‘comforted’ to see their baby. Several also described an overwhelming feeling of protectiveness. For many, this visit confirmed he was now a father.

F18:

*“I was stood there for about five minutes and I was just taking it all in, that little girl there is mine like, and I had a little tear then with her ”*

F13:

*“I suppose mostly relief at that point and speaking to other dads that seems to be what we all felt. Just glad that he was alive and doing better than I feared, so mostly relief and happiness I suppose.”*

However, most fathers also experienced negative emotions which they felt were influenced by the ‘sights and sounds’ of the NNU. They felt ‘anxious’, ‘scared’, ‘shocked’ ‘angry’ and ‘frightened’ by what they saw. A few felt they were in a foreign or alien world and said they were in a daze. Some fathers said these feelings were exacerbated by their own mental and physical exhaustion and ongoing concern for their partner.

F22:

*“It was such an absolute shock to see her, what she was like. I wasn’t happy. She was just so tiny you could see her rib cage and you just thought to yourself; why? And I was just disappointed, angry and again like I said disappointed for my wife.”*

### **3.11.3 ‘The neonatal unit’ – interaction with the baby**

Most fathers had limited interaction with their baby during their first visit. This was influenced by the equipment used to support the baby (Section 3.11.2), the baby’s ongoing care and concern about the baby’s wellbeing. Only a few fathers held their baby, one of whom also bottle-fed his son. In many cases fathers were unable to hold their baby because he/she was too sick. However, those who were offered the opportunity generally declined. Several admitted they were afraid to hold their child. A few said they wanted their partner to be the first person to hold the baby, even if this meant the baby would not be held for several days. In a few cases fathers wanted to hold their baby but felt it inappropriate to ask because the HCPs were busy.



F25

*"Yea, I was able to hold him ((laughs)), tiny little thing."*

F18

*"I didn't wanna hold her without her mum holding and it was like three or four days before her mum was allowed down to see her because she was in a bad way after. So I mean I had the option, they did give me the option but I thought seeing her for the first time on me own and holding her was taking too much away from her mum like. Because I wanted her mum to hold her first."*

F26

*"No, I didn't want to, because of how small he was. I was a bit scared to hold him. I'd rather leave him in there and know that he's good in there, do you know what I mean."*

Several fathers stroked or touched their baby. This had a powerful impact, particularly when the grasp reflex was elicited. Fathers of extremely premature babies were amazed that such a small baby could hold their finger. They thought this meant their child had a good chance of survival. Of all the experiences fathers described, this appeared to be one that had a positive and lasting effect. This concurs with the findings of other studies (Arockiasamy et al 2008).

F12

*"They said I could touch her so I sort of put my hand in and sort of just touched her hand. It was very, very surreal."*

F15

*"... when she grabbed my finger, it was just unbelievable, I've never felt anything like it in my life."*

F20

*"I just sort of like put my finger in and he gripped hold. He sort of gripped hold of me hand and it were like, that's the first contact. Then I sort, and then my sort of feeling was I can imagine, when Neil Armstrong landed on the moon, having a similar same sort of feeling the, all your, all your good emotions sort of rose up and that and it was like wow, this is it, he's alive, he's fine, he's doing well from what I could see."*

### 3.11.4 'The neonatal unit' – recall of information

All fathers were certain they were given information about their baby during their visit. However, most could not recall in detail what they were told or who had spoken to them. This was not influenced by the length of time between the incident and the interview. Most fathers said they could not remember what they were told by the time they left the NNU. Whilst some found this amusing, others said it was frustrating and distressing when they attempted to relay information to others. Fathers felt they were unable to recall information primarily because of distractions within the NNU and the emotional impact of seeing the baby properly for the first time (Section 3.11.2). Information fathers could remember covered three aspects of care: respiratory support, feeding and thermoregulation. Several also remembered being told the next few hours were critical. One father was dissatisfied with the information given by junior staff and asked to see the consultant. This father was a doctor (unrelated speciality) and wanted more detailed information about his baby.

#### F21

*“NN3 ((neonatal nurse)) came up and said are you the dad? Yes, and she said I’m going to say a few things now and you won’t take it all in and by the time I got back to M21 that’s the only bit I remembered ((laughs)).”*

#### F28

*“I don’t think I really took in, I can’t remember if I actually listened to what she was saying to me anyway. I was just looking in to the incubator really, there was all these noises going on around you. You can’t concentrate that first time you go in there.”*

#### F13

*“I had to ask to see the consultant to tell me what was going on and what the plan was. Just to say he’s fine doesn’t really tell you very much, but that’s generally what was said.”*

Within this NNU parents were given leaflets and a booklet about the NNU around the time of their baby’s admission. However, there were inconsistencies when and to whom these were given (Section 5.9.1). Several fathers recalled being given these but said

they did not read them, lost them or deliberately did not give them to their partner. Most felt this information was ‘too much, too soon’ and some thought the content was inappropriate. One father who was concerned about both his partner and baby’s survival felt to have been given leaflets about breast-feeding was tactless and threw them away. Several fathers acknowledged whilst they did not read the information initially it was useful to refer to over the intervening days and weeks.

#### F19

*“I lost that. I had a pack about visiting and what the neonatal unit’s about which is all very good but I don’t know where it went to be honest. It got put somewhere and we lost it.”*

#### F29

*“I don’t think they gave me any literature. Or I can’t recall if they did, I’m not going to say that I didn’t, but I don’t recall that I did have.”*

### **3.12 ‘Role and responsibilities’**

This theme focuses on the fathers’ identification of their roles and responsibilities during the delivery, resuscitation and their first NNU visit. In most cases, these centred on their partner, but sometimes included the baby, family and friends and to a much lesser extent HCPs. Four sub-themes were identified, which describe their roles and responsibilities at this time: ‘reassurance and support’, ‘advocating and protecting’, ‘giving information and debriefing’ and ‘being there for the baby.’

#### **3.12.1 ‘Role and responsibilities’ – reassurance and support**

All fathers felt their most important role was to reassure and support their partner. This view concurs with that of fathers attending normal childbirth and/or the delivery of healthy infants (Section 1.3.2). However, in contrast to other studies (Chandler, Field

1997), these fathers felt their partner needed as much reassurance and support after the delivery as before or during the birth. Fathers described distracting, encouraging, motivating, calming and comforting their partner. They also participated in her care and maintained physical contact whenever possible. Several fathers talked about staying close to her, physically and emotionally. Whilst a few received guidance from the midwife, most felt it was left to them to find the most appropriate strategies to use. Some clearly relished the challenge and felt a sense of pride and achievement about what they had done. However, most felt useless at times. Fathers commonly felt frustrated that they could not relieve their partner's physical pain. For some trying to support and reassure their partner was overwhelming and for a few, a burden they found difficult to cope with.

#### F23

*"Then all the doctors then come in, she started, she knew something was wrong so she started getting upset and I just like, I said to her come on be strong, don't get upset, come on and then she was alright. So in the end I was standing right next to her, just holding her hand."*

#### F28

*"So I'm always the positive one in our relationship. I always look for the good side to it even in a bad situation and my partner; she tends, sometimes she buckles under the strain and can't deal with it. So it was quite hard for me, oh it was so hard for me, trying to keep her going."*

### **3.12.2 'Role and responsibilities' – advocating and protecting**

Another responsibility fathers described was advocating for and protecting his partner, which corresponds with other studies of fathers' childbirth experiences (Section 1.3.2). In doing this, fathers were also often advocating and protecting themselves and/or their baby in a less direct way. Undertaking these activities seemed to be particularly apparent immediately before the delivery. This included insisting the midwife remained with her, questioning who specific HCPs were, ensuring information was directed to her, asking questions when she had not understood and protecting her privacy and dignity.

Fathers also listened to conversations between HCPs, intervened in their discussions and on a few occasions, challenged their decisions.

### F13

*“The paediatric team weren’t in the room, and I could hear people asking, you know, well where are they? Somebody asked and there was no response. A couple of minutes later again, and then I piped up and said you know, if they’re not here then can somebody bloody well put a fast bleep out for them, because, they should be here.”*

### F20

*“When I saw her facial expressions and I sort of knew she hadn’t understood it completely, that’s when I would then sort of cut in and ask questions about well, what are you actually sort of saying and that? Can you make it in a little bit more English and that so that she can actually understand and that than rather using, medical terminology.”*

### F19

*“The good thing was that they spoke loud enough, so you know, I could hear what they were saying to each other you know, I made sure I kept my ears open just to make sure.”*

A few fathers had previously agreed with his partner that he would make the final decision regarding his partner and/or baby’s care in extreme circumstances. The legal situation may have in reality prevented this course of action. However, these couples were aware that the severity of their situation meant urgent decisions regarding ongoing care maybe required.

### F14

*“We spoke about that previously, our last resort would have been if it had to be, a caesarean. That was only a last resort. It depended on the complications. All decisions would be left to me to do. If the heart beat was dropping as well and if it was a drop, there’s no way I was going to hesitate, I’d say go straight to theatre for a section, get the caesarean done.”*

A few fathers described advocating for their partner after the delivery. Some did not hold the baby until after the mother had done so. Others prevented family members visiting the baby on the NNU because she had not seen him/her.

#### F12

*“People were wanting to visit, like the grandparents and I was saying no because I wanted M12 to be the first person to visit B12.”*

### **3.12.3 ‘Role and responsibilities’ – giving information and debriefing**

All fathers said giving information to others was an important aspect of their role. This involved passing information to his partner from others or describing events she could not see, for example during an LSCS delivery. Several explained to her afterwards what had happened at the delivery. This seemed to range from ‘filling in the gaps’ to informal debriefing.

#### F25

*“I was able to go and see the baby and I kept updating her on how the baby is and, that reassured her.”*

#### F10

*“I explained what had happened like and she couldn’t believe it.”*

#### F15

*“She can hardly remember anything. Actually things are coming back to her every now and again, she asks me questions like; did this happen? Did that happen?”*

Most fathers described informing family and friends about what was happening. Fathers knew others were relying on them for progress reports. Some viewed this in a positive way particularly when they had good news to report. Spending time making telephone

calls or sending text messages also gave them something to do during stressful situations. A few fathers felt it helped them face the reality of what was happening.

#### F20

*"It actually gave me a chance to then, actually speak to like her family and sort of say look this is the situation. She's actually gone into theatre and within the next hour or so you're gonna have your grandchild ((laughs)) and that. So in a way, it actually gave me that time to actually, I suppose prepare the rest of the families, what was actually happening. Because it was just as much, a sort of shock to them, as it was with me."*

For other fathers this responsibility caused additional pressure at an already stressful time. Some said they were a 'middleman' or 'go-between.' A few felt this was a chore and a distraction. Others became distressed when talking to family members and were worried they had caused loved ones additional anguish. Fathers also commented that there was nowhere they could speak privately. As a consequence some fathers delayed making telephone calls despite knowing family and friends were worried, this increased their distress. The fathers' experiences of informing others appeared to be influenced by the type of information they had to give at the time (Arockiasamy et al 2008).

#### F16

*"I had to make the 'phone calls 'cos M16 was still in the delivery unit, still hooked up to loads of drips, morphine, drugs etc, and I was doing the 'phoning around, I just had two contact points really, M16's parents and my parents, with the news obviously, because I broke down telling them."*

#### F21

*"I wanted to 'phone, to start making 'phone calls to my parents, to M21's parents, I didn't actually want to do it with this sort of audience because I thought I might get a bit emotional as well, so I didn't want to do it. So I kind of waited..... as soon as I was alone in the room, I started to make 'phone calls. I just wanted them to go."*

### 3.12.4 'Role and responsibilities' – being there for the baby

All fathers talked about their role and responsibilities to the baby. This included forming a bond, being at the delivery, and protecting the baby. Although several fathers said they bonded with their baby during the pregnancy they felt their bond deepened after the birth, largely because they could now see and touch their child. Fathers who said they had not formed a bond with their baby during the pregnancy felt they needed to be able to interact with the baby in a direct way before he/she felt real. Others felt the baby's premature birth rendered insufficient time for a bond to form. This factor has been identified in other studies of preterm birth (Lee et al 2009; Sloan et al 2008). By the time of the interview, most fathers felt they had a bond with their child. However, this was felt not to be as strong as that between his partner and the baby. It was felt to be more instinctive for mothers to form a bond because of their physical closeness during pregnancy. A few fathers said they had not yet bonded with their child and that he/she continued to feel unreal. They felt guilty about these feelings and under pressure to demonstrate stronger feelings towards their baby. The range of bonding experiences reported by fathers reflects the different theories regarding the bonding process (Section 1.2.3).

#### F24

*"I felt love for him before when he was in the womb. But now he's here and you can hold him and touch him and that. It's a lot, lot deeper."*

#### F21

*"He's just this little boy who I visit occasionally. It's a weird kind of way to be a parent, it's really is quite strange; I don't feel I'm being a proper parent at the moment."*

All fathers said they intended to be present at the birth, although some said given the choice they would not have attended. In retrospect, all were pleased they had been present. This was felt to be an important step in their transition to fatherhood; a view expressed by other fathers (Jackson et al 2003; Lundqvist, Jakobsson 2003). Whilst



most said the main reason for their presence was to support their partner (Section 3.12.1), they also felt it showed commitment to the baby. A few expressed this in a different way saying they had a duty to attend.

#### F19

*"I always said I wanted to be there, obviously watch her come in to the world. I think that's an important part of you know, being in a relationship and having a baby. I think it makes you part of the whole process of it."*

All fathers felt responsibility for their baby after the delivery. Several described an immediate feeling of protectiveness. Some felt this was exacerbated by concern about the baby's wellbeing. The depth of these feelings surprised many fathers and in some cases challenged their view of themselves and their general approach to life. Several described having to initially be both father and mother to their child in the temporary absence of their partner. They often talked about 'watching over' their baby. This included staying physically close and on occasions, advocating for their child. Many of the issues fathers talked about in relation to this sub-theme can be allied to the roles, responsibilities and feelings associated with transition to fatherhood (Sections 1.2.2; 1.2.3).

#### F16

*"I was the one who was doing the mother and the father bit."*

#### F27

*"You do get a weird sense of over-protectiveness as well, despite the fact that you know; to me it's a person that I've just met really. Somebody whose just entered our lives even though she's obviously been in the womb for the last seven months you know, she's just entered our lives and there's this unbelievable feeling of over-protectiveness comes to you, and you know, you just want to make sure everything's OK."*

## F28

*“You’re very protective of your children I suppose. I never thought I’d be like that because I was always a very selfish person looking after number one. I’ve always said, look after number one until she came along. So she’s my number one now.”*

### **3.13 ‘His needs’**

Fathers said they had three needs at this time. These were for: ‘information’, ‘reassurance and support’ and ‘debriefing.’ An additional sub-theme ‘I’m not important’ became apparent when some fathers said their needs were insignificant in comparison to those of their partner and/or baby.

#### **3.13.1 ‘His needs’ – information**

Almost all fathers said their overriding need was for information, which correlates with aspects of his role (Sections 3.12.1, 3.12.2, 3.12.3). They had differing views about ways in which this need was met. Fathers suggested what was said (the product) and the way it was said (the process) were both important. In many cases, aspects of either or both were not fulfilled. When fathers are given inadequate information and/or do not understand, their ability to pass on information diminishes (Section 3.12.3).

A number of issues were identified regarding the ‘process’ including the extent to which fathers were included, the style of information delivery and the seniority of HCPs. Several fathers gave examples of ways in which HCPs included them. They introduced themselves, talked to fathers with their partner and engaged eye contact. Although information was generally directed towards their partner, fathers felt included because HCPs acknowledged their presence. A few fathers were not concerned if information was directed solely to their partner. They felt included because they could hear what was being said. Some fathers however, felt differently in that situation and felt excluded.

## F27

*“If I’m looking back now, I think it was basically aimed at both of us. It wasn’t specifically at her obviously; I think it was specifically aimed at both of us. So I don’t think it was just targeting my partner as such.”*

## F22

*“They were mainly directly talking to my wife because obviously it’s such a, everything just happened so quick and to be honest I didn’t really care because for me it’s more important that they 100% focused on my wife, nothing’s happened to me.”*

## F25

*“I don’t know, they were not involving me and they were just, you know talking to her. The nurses ((midwives)), they were not involving me. They didn’t still, they just didn’t involve me even though I was there.”*

On other occasions, HCPs gave the mother important and sometimes distressing information when the father was temporarily absent. Fathers were concerned they had been unable to support her at this time and described the impact on her when she had to relay the news to him.

## F12

*“I found that tough, because I do think this is a thing, as, as a father and what a mother should be going through together, for M12 to be having to take in the information on her own and she burst into tears and I wasn’t there with her.”*

A few fathers described situations when the only way they could find out what was happening was by listening to conversations between HCPs (Section 3.12.2) and a few recalled reading their non-verbal communication. They found this particularly distressing because no information was given to clarify their understanding or interpretation of events.

### F13

*"...the decelerations were becoming quite pronounced and prolonged. The obstetric registrar's face was just dropping and her jaw was almost on the ground really. At one point I don't think she meant me to see, but she looked across at the anaesthetic consultant and shook her head as if to say it's either very bad or it's all over. But you know, I did see her and obviously that was not a pleasant thing to see."*

### F22

*"Then there were four of them and they were struggling and one of the paediatricians, she kept shaking her head, kept shaking her head, shaking her head."*

Professional issues were raised when several fathers said the seniority of the HCP giving information was important. They were often concerned when juniors gave information. They felt more reassured when this was done by senior HCPs, even if they were repeating information previously given.

### F17

*"I think in a sense there was a, we did have a feeling that the doctor who came was, seemed quite junior and inexperienced. Now whether that was true or not, I mean he was junior, but whether he was inexperienced, but he didn't inspire confidence. It was probably more his manner that didn't inspire confidence. He didn't seem sure about what he was saying."*

### F14

*"I think the surgeon who came in was very helpful, informative to me because I think he could probably see in my eyes, the worry and everything, but he said it's OK. I think, for me I felt he was senior, so I think when he says that it calms you, you know, everything's gonna be OK."*

Fathers had conflicting views about what they needed to know and whether this need was met. Some felt HCPs kept them fully informed. Detailed explanations were given about what was likely to happen, including the possibility of negative outcomes. Several found the use of statistics, graphs or charts helpful. Wherever possible HCPs answered questions or found someone who could. Fathers also appreciated honesty when HCPs said outcomes were uncertain.

## F28

*“They tell you all the bad things as well, that could happen. You know, this could also happen and you take a little bit of the good so yea, they was OK. It was good because it prepares you, you know for what could happen. So yea, it was definitely worth telling us that, I think, yea.”*

## F13

*“The paediatric registrar came across and she was fine, she was good, answered all the questions from the paediatric team, yea, the information was particularly good I think, I don’t think I could really fault that.”*

However, several fathers were critical of information they received. A few felt they were overwhelmed by too much information, which often included terminology they did not understand. Some did not want to know what was likely to happen. A few fathers described being given conflicting information, particularly within the obstetric team. They did not know therefore, who to believe and this sometimes led to an overall lack of confidence in the team.

## F12

*“So they ‘phoned the registrar, he come and had a look like and he said I think we’re gonna have to deliver you now. That was a bit of a confusing thing because then we were put to the high dependency unit and we saw another registrar and he was saying things like, well we’ll just see what happens and that, which was, it was a bit unfair to play with our emotions really.”*

## F11

*“The one doctor came in and said you’re gonna deliver soon, the baby will be early and that’s a problem and then the other doctor came in and said you’ve not started dilating so we’ll give you some tablets and send you home. It was a bit, so I wasn’t too impressed with the doctors to be honest.”*

More commonly fathers felt they were given inadequate information. They found this frustrating and had to repeatedly ask questions to clarify their understanding. None of the fathers could recall being given information about resuscitation their baby may require. A few recalled HCPs making general comments that the baby ‘may need some

help.’ The exact nature of ‘help’ was not explained so fathers usually assumed it would only involve drying and warming. Similarly most fathers received limited or no information about the resuscitation whilst it was happening. They appreciated that key personnel needed to focus on what they were doing but felt someone, possibly the midwife, should have told them what was happening. Most fathers felt more detailed information about their baby’s resuscitation requirements would have enabled them to cope better and more adequately support their partner.

#### F17

*“...but then the paediatrician said, send for the, send for the registrar. There was, and all this time, the paediatrician said nothing, wasn’t explaining anything of what was going on and we said well, we said well why? you know, well what’s happening? and just got, well she’s a bit, she’s a bit grunty, her breathing’s a bit grunty, but they didn’t say what that meant.”*

#### F19

*“There were also two midwives in the room who were obviously, I mean, but they were both focused on you know, the next stage with M19, or I suppose one of them, at least one of them was, the other one perhaps may have been able to have sort of been a bit of a go-between, in terms of what they were doing.”*

The contrasting views of fathers about their information needs highlight the challenges HCPs face when giving information (CESDI 2003; Alderson et al 2006). Some fathers valued aspects that were criticised by others. Most felt the information needs of fathers would vary and thought it would be difficult to meet the need of every father on every occasion. A father’s coping style will also influence the nature and extent of information he wants (Section 1.7). Nevertheless, some fathers felt HCPs were blasé about information suggesting they had forgotten or were unaware of the impact of inadequate information-giving.

#### F11

*“It’s difficult for the doctors and the midwives really ‘cos’ they don’t know, the level of people’s knowledge.”*

### F17

*"It's very easy you know, whatever role you're in, when you're familiar in whatever role you're in, because you as a professional have been through this many, many times before, not, maybe not to really appreciating the need for information from the patient, because just because the professional knows everything's going alright, that isn't automatically what the patient might be deducing from the same information or lack of information."*

Most fathers felt the other factor that impacted upon HCP provision of information, was staff shortages. They recalled occasions when HCPs were also responsible for the care of others. This meant limited time was available for information giving. Some fathers demonstrated an altruistic approach towards other families and felt sympathy for the HCPs. They were reluctant to ask too many questions because they did not want to delay the HCPs and compromise the care of others. Although they were concerned about their own situation they were aware that other families could have been in a similar or even worse situation.

### F17

*"Once we were delivered there were other people you know in delivery suite who had more pressing needs than telling us well how heavy she was or what's happening next. .... there can be a danger in what, you know is in the increasingly an individualistic society, that my needs are always paramount and, whoever the patient is there maybe somebody else whose needs are higher at that particular moment..... sometimes we have to just be patient and wait."*

### F20

*"There was quite a lot of activity going on outside and all and that. I wasn't really, and to tell you the truth I would rather like the midwives and that attend to someone else."*

### **3.13.2 'His needs' – reassurance and support**

Fathers identified their need for reassurance and support. However, none felt they received emotional support from HCPs. It may have been difficult for HCPs to do this because they did not know them. HCPs may also have felt their duty of care was to the mother. Fathers felt their main sources of reassurance and support were family and

friends. In some cases their partner's mother was present at the delivery. Whilst her role was primarily to support her daughter, most fathers were relieved not to be 'on their own.' They felt the presence of another person took the pressure off them and gave them someone to interact with. A few spent time with their own father who came to the hospital specifically to support them. They felt 'taking time out' both before and after the birth enabled them to cope and they appreciated this man-to-man attention. They also found comfort in being reassured by someone they trusted, even though they may not have fully understood what was happening.

### F23

*"She ((partner's mother)) kept telling me it's alright, don't worry or anything, he'll ((baby)) be alright."*

### F15

*"He ((his father)) calmed me down and told me everything's gonna be alright. He just kept on telling me everything was gonna be alright. She'll ((partner)) be fine, just reassuring me, basically. I think I just needed someone to tell me it was gonna be alright."*

### F12

*"Me dad was very good, especially while we were just waiting ((to go to theatre)) when my dad came, I went out with me dad and we had a cup of tea and I chatted to my dad, which was very, very vital."*

Other fathers had contact with family members by telephone. Whilst this was generally pre-empted by the need to pass on information, fathers spoke movingly about the support, encouragement and reassurance they received. They felt family members appreciated how difficult the situation was for them.

### F20

*"I'd sort of 'phoned them just prior and that and I actually spoke to my mum quite, for the majority of the time and she was sort of saying well, and she was quite reassuring and sort of saying well how are you coping and that and I was sort of saying I'm not doing too badly."*



## F16

*“She ((mother)) asked how I was, make sure you eat, make sure you look after yourself all that sort of stuff because again, you’re fending for yourself buying sandwiches.”*

### **3.13.3 ‘His needs’ – debriefing**

Several fathers identified a need to talk about their experiences with others; which is not an uncommon response (Koppel, Kaiser 2001; Lindberg et al 2007). Most had done this in a limited way. In most cases this was with family, friends or, on a few occasions, work colleagues. Although this was helpful to some extent, fathers found it difficult to identify someone who understood their experiences. One father’s sister previously had a premature baby and he found talking to her invaluable. Fathers said during conversations, their confidante often retold their own unrelated experience, which was unhelpful and distracting. Some felt the need to protect their confidante and did not give too much detail. Possibly as a consequence, some fathers reported people making unhelpful or inappropriate comments when they belittled or joked about their experiences. Some fathers deliberately did not discuss their experiences with family and friends because they wanted to keep their ‘hospital’ and ‘home’ lives separate. In addition, some fathers had not discussed their experiences with male friends and family because ‘men don’t talk about those sorts of things’.

## F26

*“Just about everything, because she’s been through it. She’s got five children but she had a premature one. So she knows more about it and she was like just, you know, just securing my mind for me you know. Making me feel better in myself kind of thing.”*

## F22

*“The first time I spoke about it was a couple of weeks ago and, I was having a one-to-one conversation with my manager about my future plans with my job. I had no idea that my manager actually went through the same thing and their baby was born at exactly the same time. .... I said to my manager it’s so good to speak to someone who actually knows.”*

Fathers had limited discussions with HCPs about their experiences. When this did happen it occurred either by chance or because they knew the HCP socially. One father joked that HCPs did not initiate these discussions because fathers are unimportant. Several felt they would be uncomfortable discussing their experience whilst the baby was being cared for within the hospital. They were concerned they or their family would be unfairly judged if they made criticisms about care. Several fathers felt an independent counsellor linked to the NNU would be advantageous.

### F17

*“There have been three people who worked here that we’ve known personally and therefore they’ve had conversations with me. But that was because they knew me, rather than they were doing it as part of their job.”*

### F25

*“No, not really ((laughs)), nobody asks me ((laughs)). They think I’m not involved ((laughs)).”*

Fathers rarely discussed their experiences with other NNU fathers. They were reluctant to reveal the extent of their feelings to someone they hardly knew. The design of the unit was also felt to limit the opportunity for this sort of conversation. Fathers said mothers often had conversations about their experiences whilst expressing milk in the breast-pump room. However, there was nowhere for fathers to have a similar conversation in private. It might be anticipated fathers would discuss what had happened to them with other fathers because of commonality in their experiences but they felt this would necessitate a reciprocal arrangement and said they were not ready to cope with the experiences of others. Arockiasamy et al (2008) confirms that fathers are generally reluctant to share their experiences with other fathers. On the rare occasion that fathers did discuss their experiences, this was with other NNU mothers. Fathers had rarely spoken to their own partner about their experiences and most said they did not intend to do so in the future. This finding is not supported by the literature about dealing with traumatic events (Ogden 2007; White 2007).

## F29

*“There’s one dad I say hello to and we have a general conversation. It’s mainly just saying hello, but I haven’t talked to any other dad. I think, it could be maybe because I wouldn’t like to, plus, I wouldn’t want to ask a lot of personal questions as well. I wouldn’t like to start the conversation off basically.”*

## F21

*“I’ve probably talked more to the mothers actually funnily enough than to the fathers you know, about what’s going on now and what had gone on.”*

At the time of data collection, the NNU had recently established a parent support group. Some fathers attended meetings and found them useful. Whilst discussing events occurring around the birth was not the sole purpose of the group, some fathers had been present when this had been done. A few found it helpful to discover other parents who had encountered similar situations. However, fathers were generally uncomfortable during these discussions.

## F12

*“It is good for knowing how other parents are going through, we were hearing other stories and stuff like that and that was quite good to hear those stories and hear we weren’t the only ones, who went through this.”*

## F28

*“It was, it was like sit in this hot room for an hour and listen to everybody’s horror stories .... I dunno if that could be a good thing because it did upset one of the ladies and I thought, how’s this helping anybody? You know, I’m looking on and I feel a bit cut up and I feel like I wanna cry, but I’m not gonna do it here, so I don’t really know how that’s supposed to help people.”*

Some fathers had not discussed their experiences with anyone. Some would have liked to, but had not identified an appropriate person. Others felt it was too soon to do this or said there had not been an opportunity. As a consequence some fathers felt participating in this study had helped them begin to understand and accept what they

had experienced. Some fathers did not intend to discuss their experiences with anyone. Although they agreed to take part in the interview and answered all questions without hesitation, they said they wanted to 'move on' from their experience and felt they would not personally benefit from revisiting the past. They saw participation in the study and discussion about their experiences in a more general way as being different activities.

#### F12

*"I mean there is obviously, like me dad I could speak to and there's my pastor and that but actually, getting a chance to see them, you know, it's very difficult at the moment."*

#### F29

*"No, not, no. No-one's actually been in that situation that I know of, that I could have had a chat to."*

### **3.13.4 'His needs' – I'm not important**

This sub-theme comes from fathers who said their needs were less important than those of their partner or baby. Some felt the needs of family members or other couples were also more important. Many said they did not think about their own needs during the delivery or afterwards and did not realise until some time later that they had not eaten or drunk for many hours. A few fathers found it difficult to identify their needs. They often said 'there was nothing wrong with me' or 'I was OK' and were surprised at the suggestion they might have had needs. Nevertheless, they were grateful when HCPs or family members spontaneously attended to their needs. Quite often this was something simple like making a drink or bringing food or fresh clothes from home. Fathers regarded these as genuine acts of kindness and concern. This generally selfless response is replicated in other similar studies (Koppel, Kaiser 2001; Lindberg et al 2007).

#### F29

*"I never thought about myself. I was always making sure that my partner was OK. I didn't give myself a second thought."*

## F16

*"I was stuck here and XX ((sister-in-law)) went back to my house and got me some change of clothing and a toothbrush. Without me even asking."*

Although most fathers said their needs were unimportant they felt fathers-to-be should think about their needs when preparing for the actual birth. They suggested he would need snacks, drinks, toiletries and clean clothes. The lack of parentcraft classes and limited discussion with family and friends before the birth appears to have left most fathers unprepared for the birth in a practical way (Sections 3.9.1, 3.9.4).

## F19

*"Bring an overnight bag. Genuinely, I joke about it but M19, we were all concerned about M19's overnight bag, I think it's important actually to think about that for a man especially if the unexpected does happen, you've gotta be prepared for it. Which usually I am but I just never, ever thought about it, an overnight bag for myself."*

Many fathers felt they would have benefited from practical advice on how to cope with the situation. Several thought a leaflet identifying resources and facilities available and suggestions about ways in which he could address his own needs would have been helpful. Some fathers were able to stay overnight after the birth if their partner required ongoing care within the delivery suite. Whilst concerned about their partner, they were grateful they could stay with her. This contrasts with the experiences of fathers whose partner was transferred to the postnatal ward after the birth. They had to go home and found it difficult to leave their partner and baby in the hospital. These fathers said facilities should be available for all fathers to stay overnight, particularly if the baby was extremely sick.

## F16

*"I think about advice how to handle family, like I say the points of contact, the mobile 'phone issues. I suppose a bit of practical advice, on how to basically make sure you're caring for your wife and your baby, and still look after yourself enough to be here."*

## F18

*“I think, basically the partner should be allowed with their partners anytime in the hospital as well. I didn’t wanna leave her that night when she was put up on that ward ((postnatal ward)).”*

### **3.14 ‘The whole experience’**

This theme focuses on the fathers’ reflections on their entire experience. Towards the end of the interview they were asked to consider the effect of these events (Appendix 7) and this is encompassed in the sub-theme: ‘impact on him.’ Many fathers also summarised their thoughts about the HCPs in the context of the whole experience and this is captured in the sub-theme ‘health care professionals.’

#### **3.14.1 ‘The whole experience’ – impact on him**

For all fathers this had been an unforgettable experience. For some it had been ‘horrible’ and ‘traumatic’ and they were unsure how they had coped. A few questioned what he and/or his partner had done to deserve such an experience. Several said they felt shattered both emotionally and physically. Going home, on their own after the event was particularly difficult. Several felt they had not yet recovered from events and one father had recurrent nightmares about the birth synonymous with symptoms of PTSD (Chan, Paterson-Brown 2002; Shaw et al 2006; Ogden 2007). A few fathers felt their experiences had an ongoing negative impact on his relationship with his partner and/or baby.

## F12

*“The only way of describing it, I was happily walking along and then suddenly this brick wall’s whacked me and I’ve been put under all of this pressure and I think, goodness me how did I get through that? I’m still not sure how I got through it.”*

## F21

*"It certainly caused a strain on my relationship with M21, she takes it all very hard, I tend not to and then she thinks maybe I'm not caring enough about it or not worried enough as I should be.... so it's caused a strain on us, for sure, it really has."*

Others said their experiences had not been completely negative. A few felt they had changed in a positive way. They thought they were more caring, protective and 'softer' having seen what their partner and/or baby had endured. As a consequence, some fathers felt their relationship with their partner had strengthened, 'having been through it together.' They were also amazed at their partner's resilience and capacity to cope with childbirth. In some cases, they appeared to be in awe of her (Ferketich, Mercer 1989; Fägerskiöld 2008).

## F15

*"I think, that the overall experience as a whole has changed me, yea. It's just, I don't know, it's like my maternal instincts have just kicked in."*

## F22

*"I know it wasn't down to me ((that the baby survived)), but I know it's down to my wife. The enormous courage that girl has. I think she could fight a war by herself. I think she's such an inspiration for every single person."*

### **3.14.2 'The whole experience' – health care professionals**

Comments about HCPs were mostly positive and some fathers gave heart-felt testimonies of named individuals. Many felt the prompt actions of specific HCPs were responsible for their partner and/or baby's survival. They said they would be eternally grateful to them. Many commented on their professionalism and expertise and felt they had been in 'the best place' and 'safe hands.' Whilst fathers may have made positive comments because their baby and/or partner had survived, for some babies the long-term outcome remained uncertain.

### F18

*"I mean, they were brilliant, everyone. The whole hospital was fantastic; I can't bad mouth any one of 'em, not one of 'em. They were just fantastic."*

### F24

*"Yea, it shows me that they care about people as well as doing their job. You know what I mean, it's not just getting paid, they do actually wanna help, you know what I mean. So it's good."*

However, some fathers gave contradictory statements. For example the following father had been critical of the information he received and the failure of HCPs to respond to a specific situation (Sections 3.11.4, 3.12.2) and yet he was positive about the overall care his family received.

### F13

*"Everyone was fantastic, you know, from, right from the delivery, from delivery on the labour ward. Right through to the unit here, everyone was fantastic."*

Most of the fathers' comments were about midwives and neonatal nurses. This is unsurprising because these are the HCPs with whom fathers had most direct and continuous contact. There are also proportionally more midwives and neonatal nurses working in these settings. They were generally felt to be caring, kind, competent, friendly, reassuring, supportive and encouraging. Fathers felt they were an intermediary and ally, particularly between themselves and the doctors. Most fathers completely trusted the midwives and neonatal nurses involved in their care.

### F11

*"The midwife seemed really caring and they see women go through this day in and day out and they were a lot more supportive and know how the woman's feeling and know what to say and when to say it."*



#### F14

*“The people down here, the neonatal have been excellent, excellent. I find it the best that I’ve had in the hospital so far. The nurses very helpful, talk to you with courtesy, address you professionally, out there all the time asking you questions. They say don’t be shy to ask us questions.”*

Amongst the medical personnel, anaesthetists were singled out for praise. Fathers were grateful for their support during LSCS deliveries. They felt their light-hearted banter was the anaesthetist’s way of relieving tension and lightening the mood. Fathers appreciated these strategies. They were also grateful for information given during the delivery and occasions when they advocated on their behalf.

#### F16

*“Then I remember it was the anaesthetist actually saying, come on, we’ve got two worried parents over here, what’s going on?”*

Whilst positive comments were also made about obstetricians and paediatricians, this was less common. This may be because fathers had less direct contact with these HCPs. Nevertheless, they were mostly felt to be supportive, reassuring and caring. Fathers particularly valued more senior clinicians being involved in their care. Although this emphasised the severity of the situation, they felt experts were taking their case seriously.

#### F23

*“So the doctor-man ((consultant obstetrician)) took over and he was alright. I shook his hand and everything, he was good.”*

### F11

*“She was a really, really nice girl. She just said you know I’m basically the baby doctor and as soon as your baby comes out I’ll just check it over to make sure everything’s OK for her and then I’ll pass her over to you, so she was very reassuring and very kind, she was very nice about it all.”*

Some negative comments were made about all HCP groups except anaesthetists. However, in most cases fathers emphasised these were minor criticisms and the exception to the rule. Negative comments generally related to HCPs giving inadequate information and excluding him. In some cases fathers felt obstetricians and paediatricians involved in their care lacked adequate expertise. A few fathers had the impression that specific midwives and neonatal nurses ‘didn’t like men.’ It is not clear whether fathers held this view just because these HCPs were female.

### F22

*“They ((neonatal nurses)) just don’t like men and at first I was shy but I, now I give as good as I get and when they say, oh so you have decided to come in, where have you been? I’d say the same thing oh, I haven’t seen you here for ages as well, where have you been? ((laughs)).”*

### F12

*“The doctors themselves ((junior obstetricians)) they seemed, I don’t know, they just didn’t, I won’t say this, it may sound wrong, but beneath them but it’s like, I don’t know, I just got the impression that they feel they shouldn’t be, you know, like it’s trivial or minor.”*

Some fathers made comments about the unprofessional manner of HCPs when information was given. They described HCPs making casual or flippant comments, showing a lack of courtesy or being over-familiar. HCPs may use these approaches to lighten the mood and relieve tension. However, some fathers felt this was inappropriate, particularly in highly stressful situations as this quote from a father with a professional background reveals:

## F14

*“The way she conducted herself, it was very unprofessional, you don’t address someone as mummy, professionally you address them as their name, because you create that professional atmosphere. If you’re gonna address us like babies we’re gonna take your information like babies. Address us as professionals so we should be addressed as professional people so we know what we need to do, we take it as a serious matter.”*

### **3.15 Discussion**

Whilst there has been an increasing number of studies exploring fathers’ experiences of childbirth and neonatal care in recent years (Sections 1.3.4, 1.5) this is the first known to explore fathers’ experiences of complicated childbirth, newborn resuscitation and/or their first NNU visit. The interviews bear witness to their experiences and cover two broad areas; their feelings about what happened and the practicalities of their experiences. Fathers were not asked their reason for participating but many felt a greater awareness was required of their experiences. Although describing their experiences with the benefit of hindsight, many said they participated in order to help others facing similar situations.

Fathers gave detailed and in some cases emotional descriptions of their experiences. Most aspects of their experience were recalled with clarity (Casimir 1999, Jackson et al 2003). Many had not spoken to anyone else in such detail and felt their participation helped them begin to understand and accept what had happened (White 2007; Crathern 2009). During the interviews fathers made positive and negative comments about the care they and their family had received. Whilst their comments were generally positive, fathers were reassured that negative comments would not compromise their family’s care and they felt comfortable doing this.

This phase raises several important issues for further consideration including lack of preparation, fathers’ level of control over their experience, coping strategies adopted, conflict of priorities, the importance of information and the role of family, friends and work colleagues (Sections 1.7, 3.9, 3.10.2, 3.10.3, 3.11.1, 3.13.1, 3.13.2, 3.13.3). Most fathers felt unprepared for what occurred (Sections 3.9, 3.13.4). Whilst some had taken

steps during the pregnancy to prepare themselves, this was generally done with the assumption that their baby would be born healthy, at term by normal delivery. When unexpected events happened they often felt overwhelmed or 'out of their depth' and their lack of understanding impacted on their experience in a negative way. In cases where problems were identified during the pregnancy, fathers responded in one of two ways. Some adopted problem-focused coping and attempted to deal with the stressor in a direct way (Lazarus 1999; Shaw et al 2006). One of the ways they did this was by accessing information about the problem(s) (Folkman, Lazarus 1980; Ogden 2007) (Section 3.9.2). This strategy is associated with less distress and more effective adjustment in the long-term (Ludwick-Rosenthal, Neufeld 1993; Harnish et al 2000). However, other fathers adopted emotion-focused coping strategies. Whilst possibly more effective in the short-term (Ginzburg et al 2002), suppressed emotional responses are associated with poorer long-term outcomes (Sutker et al 1995; Shaw et al 2006; Ogden 2007). Although the coping style adopted may have influenced the fathers' preparation for the birth all fathers felt unprepared to some extent. It may therefore be the case that nothing can completely prepare fathers for the reality of such situations.

Recently published principles of care and recommendations suggest all parents should have the opportunity to visit the NNU when admission is predicted (Bliss 2009; DH 2009; Wilkinson et al 2009). However, the experiences of these fathers suggest this is not always the case (Section 3.9.5). As a consequence many fathers felt overwhelmed by the NNU environment. HCPs have also raised issues regarding NNU tours (Section 5.9.1). It may therefore be advantageous to consider ways of facilitating such tours and ensuring they are meaningful.

The fathers' lack of control over their experience and the coping strategies they used featured consistently (Section 1.7). They spoke on a number occasions about things they were not 'allowed' to do such as be with their partner in theatre during insertion of spinal anaesthetic, going to the resuscitaire and/or accompanying their baby to the NNU (Sections 3.10.2, 3.10.3, 3.11.1). Many examples were given where HCPs controlled the fathers' experience and fathers identified the need to obtain permission before undertaking certain activities. This is not dissimilar to a father's role during normal

childbirth, which is sometimes more clearly defined by what he cannot rather than what he can do (Draper 1997). This uncertainty regarding their role may determine a father's experiences of childbirth. Sometimes HCPs controlled the fathers' experience in an indirect way by not guiding, encouraging or involving them. Some HCPs may not feel they have a duty of care to the father in the same way as for the mother and/or baby. However, this view does not embrace the concept of family-centred care (American Academy of Pediatrics 2003; Ryan 2009). Involving fathers for example when decisions need to be made not only provides the opportunity for some level of control but also reaffirms their responsibilities (Crathern 2009). However, fathers commonly reported that they felt powerless and useless. Not having an internal locus of control and feelings of low self-efficacy, particularly at crisis points in their experience, may have influenced which coping strategy they adopted (Section 1.7) (Folkman 1984; Ogden 2007). Feelings of low self-efficacy could also be unfamiliar territory for some men, particularly if they have control over other aspects of their personal and working life. It may therefore account for some of their discontent about their experiences.

One specific situation over which some fathers had no control was when they waited in the recovery area whilst their partner was prepared for theatre (Section 3.10.3). Practice at the study-site has now changed whereby fathers attending elective LSCS deliveries are able to remain with their partner for the entire procedure. These findings support this change in practice. Whilst fathers in this study would not have been affected by this change, it is hoped it has alerted HCPs to more adequately meet the needs of fathers in this situation.

One way fathers asserted some control over their experience was in relation to the use of coping strategies (Section 1.7). Whilst fathers could not correct or remove the problem themselves they sometimes exerted some control by using strategies to tolerate or diminish the effect of the situation. It can be argued however, that not doing something such as not watching what was happening still involves a voluntary action. Therefore these fathers were still asserting some level of control over their experience.

The role fathers undertook around the time of the birth of their baby gives further insight into their attempts to assert control over their experience. Fathers said their most important role was to support their partner (Section 3.12.1). Taking an active role in order to share the experience was important to them. Using Chapman's (1992) framework the behaviours fathers commonly described were most closely associated with the roles of 'team-mate' and 'coach' (Section 1.3.2). This concurs with the findings of other recent studies of normal childbirth (Johnson 2002; Gungor, Beji 2007). On some occasions, particularly at crisis points in their experience, fathers described behaviours reflecting the more passive role of 'witness.' However, it would appear that most of the time they played a more proactive part in proceedings, thereby exerting some, albeit minimal, control over their experience (Myers et al 2004; Sarafino 2006).

Another recurrent issue fathers described was the conflict they felt over who they were most concerned about, their partner or the baby (Sections 3.10.2, 3.11.1). This influenced to some extent whether or not they went to the baby on the resuscitaire and/or with the baby to the NNU. Many fathers experienced divided loyalty and some time after the event, felt guilty about their decisions and found it difficult to reconcile their feelings. For a few fathers the transfer of their concern was straightforward. After the delivery, if the mother's physical and emotional wellbeing was assured she ceased being 'the patient' and the fathers' concern transferred to the baby. However, for the majority of fathers their experience was more complex. After the delivery, many mothers remained unwell. Even if her physical health was assured, fathers worried about her psychological wellbeing (Section 3.10.2). In this situation, the fathers perceived both his partner and baby to be 'patients.' It would seem therefore that in comparison to more straightforward childbirth fathers encountering complicated and preterm birth have ongoing concern about their partner (Lundqvist, Jakobsson 2003; Lindberg et al 2007).

Fathers discussed many issues relating to information (Sections 3.10.1, 3.11.4, 3.13.1, 3.14.2). In some cases they were critical about how and what they were told. Lack of information may have been the HCP's deliberate intention to avoid causing alarm and distress. However, many fathers would have rather known what was happening. In

some instances the lack of information caused them to come to their own, often incorrect and exaggerated conclusions about what was happening. Guidelines regarding witnessed resuscitation in other care settings recommend that relatives should be briefed prior to going into the resuscitation area and should receive support afterwards (McGahey 2002; Baskett et al 2005; Weslien et al 2005). This study identifies a discrepancy in relation to fathers encountering the resuscitation of their baby in the delivery room. None of the fathers recalled receiving this sort of information or support either before or after the birth. In addition, several fathers were unaware at the time that their baby had received some form of resuscitation (Section 3.10.1). Whilst they did not appear to be concerned about this during the interview, it would be interesting to know if they pursued this information afterwards.

Most, but not all fathers wanted HCPs be honest with them, even if the truth was uncomfortable or difficult (Section 3.13.1). HCPs therefore require skill and time to make accurate assessments about an individual's information needs. One of the easiest ways to do this is to ask the father himself, yet none recalled being asked what he would prefer. Many fathers could not remember specifically what they were told at key time-points (3.11.4). This finding concurs with other studies which demonstrate that patients / relatives often do not remember what they have been told, particularly in stressful situations (Sarafino 2006; Ogden 2007). The need for information in a variety of formats may be worthy of consideration (Watkinson 1995; Dartnell et al 2005; Bliss 2009). Whilst not all fathers found written information useful, this seemed to be because the information was generic and was given at inappropriate times. Careful selection of relevant written information may overcome the problem.

The importance of family, friends and work colleagues 'behind the scenes' should not be underestimated (Sarafino 2006; Ogden 2007; Deave, Johnson, Ingram 2008). They appear to play an important, but often-unseen role supporting both the psychological and physical needs of fathers (Sections 3.9.4, 3.13.2, 3.13.3). One of the surprising aspects of this study was the key role the father's own father played and this is in contrast to another recent study of fathers' childbirth experiences (Deave, Johnson

2008). It is possible that support provided by the father's own father in this study occurred because of the more extreme situations encountered. Their own father may also have been more accessible at the time. It is possible in the scenarios described, that HCPs were unaware of this occurrence. Absence of the extended family and the increasing numbers of fractured families may limit opportunities for support of this nature for fathers in the future.

A number of key findings can be determined from this phase. Fathers generally felt unprepared for the birth, resuscitation and/or admission of their baby to the NNU. They felt they had limited control over what happened and the nature and extent of their role during these events was determined both directly and indirectly by the HCPs involved in the family's care. They therefore expressed feelings of low self-efficacy and felt they had an external locus of control (Section 1.7). Fathers also most commonly described adopting emotion-focused coping strategies (Section 1.7). Most fathers felt a conflict of loyalty about their focus of concern, but on balance were usually more worried about their partner. As a consequence they often felt guilty admitting they were less concerned about the baby. Family, friends and work colleagues play an important role supporting fathers and are usually their only source of emotional support on these occasions. One of the reasons fathers experiences of childbirth are generally so poorly understood could be because they control their outward display of emotions so successfully (Sections 1.3.2, 3.10.4).

The ways in which fathers, family members and HCPs respond and interact were further investigated in phase two of this study. Direct observations were carried out of deliveries, resuscitation events and NNU admissions when the baby's father was present. Whilst the data collection tools for phase two were developed at the start of the overall study (Section 2.3.1), the findings from phase one informed both the data collection and data analysis processes for phase two. In the following chapter, phase two will be presented and discussed.



## **Chapter 4 – Phase Two**

### **4.0 Introduction**

This chapter describes phase two (outlined in Section 2.5.2) which involved the direct observation of 22 deliveries. Within this chapter, the aim and objectives are identified, the sample is described and the research process is appraised. Strategies undertaken to enhance trustworthiness are considered and ethical issues are also explored. This phase generated quantitative and qualitative data that were analysed accordingly. The quantitative data regarding physical contact, communication and activities will be presented in relation to the type of delivery and the care of the baby. Key themes identified from the qualitative data analysis will be described and excerpts from the researcher's field notes will be used as illustrations. The findings will be compared with those of other studies.

### **4.1 Phase two – aim and objectives**

The aim of this phase was to gain insight into issues occurring around the time of the delivery of a baby when the father was present. The objectives were:

3. To utilise the paradigm of pragmatism in order to conduct observations of normal and complicated childbirth and the immediate care of the baby when the baby's father was present.
4. To describe and compare events occurring during normal and complicated childbirth and the immediate care of the baby when the baby's father was present.

## **4.2 The setting**

The observations were carried out in the delivery suite and birthcentre of a maternity unit within an NHS Trust in the UK. At the time of data collection, the maternity unit had 6,800 deliveries per year (Hospital Trust 2007). The delivery suite consisted of a triage area with three admission rooms, ten delivery rooms, two operating theatres and two bedrooms for bereaved parents. It also had the capacity to care for three mothers requiring high dependency care. During the period of data collection, 400 mothers per year required this level of care (Hospital Trust 2007). The birthcentre, adjacent to the delivery suite consisted of five bedrooms. Couples were able to request delivery in this setting providing they fulfilled predefined criteria (Appendix 11). However, in the event of complications, mothers were transferred to the delivery suite for ongoing care. The birthcentre had a delivery rate of 700 deliveries per year (Hospital Trust 2007).

## **4.3 Observations**

Direct observations were undertaken of 22 deliveries. This strategy has been used in other studies of childbirth (Standley, Nicholson 1980; Kirkham 1989; Garcia, Garforth 1990; Bondas-Salonen 1998; Walsh, Baker 2004; Price, Johnson 2006) though not in relation to fathers' experiences of preterm and complicated childbirth and newborn resuscitation. Within this section justification and appraisal will be presented for the use of observation.

### **4.3.1 Observations – justification**

The purpose of human observational research is to facilitate comprehension of how people behave in particular situations and how they interact with others. This approach is based on anthropological methods whereby people are studied in the environment in which events occur (Silverman 2006; Watson, Whyte 2006). Observation is increasingly

used in nursing research and is regarded by some as one of the most important means of collecting data (Parahoo 2006; Watson, Whyte 2006).

One of the main advantages of observational research is that it facilitates the direct collection of data regarding behaviours, interactions and events occurring in a natural setting (Watson, Whyte 2006; Creswell 2009; Polit, Beck 2010). A first-hand account of what happened is therefore generated avoiding inaccurate recollection. Direct observations undertaken in real-time also provide essential information about the context (Patton 2002). The selection of observation as a means of collecting data should be determined by the research aim. In this study the aim relates to the experiences and perceptions of fathers of the birth and immediate care of their baby (Section 2.2). Observational research was therefore considered an appropriate way of collecting accurate and detailed information about events and the context.

Whilst interviews can offer an insight into the experiences and feelings of individuals, they provide a retrospective account (Silverman 2006). Participants may also be selective in their description of events (Patton 2002). Direct real-time observations therefore complement interviews (Richards 2005). Together they provide a more complete picture of events. Findings can be substantiated and the overall credibility of a study enhanced (Robson 2002; Tuckett 2005). Consequently, the use of observation adds strength to the overall study (Section 2.3.2). The observations were undertaken with a different group of fathers to those involved in phase one (Chapter 3). However, the observations provide another dimension that adds depth to the study. It is therefore argued that this triangulation of methods strengthens the overall trustworthiness of the study (Section 2.3.2) (Patton 2002; Walsh, Baker 2004).

#### **4.3.2 Observations – appraisal**

There are a variety of ways in which the different approaches to observational research have been classified. Most commonly participant and non-participant observation are described (Patton 2002; O'Leary 2004; Creswell 2009). These approaches can be

undertaken covertly or overtly (Walsh, Baker 2004). The recording of data may be structured (systematic) or unstructured (unsystematic) and both qualitative and quantitative data can be collected. The purpose of the research and the particular environment will determine the selection of observational mode and method of data recording (Punch 2005).

Participant observation attempts to “get back-stage” (Polit, Beck 2010: 353) whereby the researcher partakes totally in the activities and interactions being studied. In this way, the researcher endeavours to develop an understanding of the behaviours and experiences of participants. It is the appropriate means by which to carry out unstructured observation in ethnographic research (Parahoo 2006). A potential problem however, is that the researcher becomes too familiar with the participants, risking a loss of perspective (Parahoo 2006).

During non-participant observation, the researcher adopts a passive role and does not participate in activities and interactions. However, it has been argued that the overt non-participant researcher, by the very nature of their presence does impact upon the group (Robson 2002). Within this phase it was not possible for the researcher to participate within the different groups being observed. Neither would it have been possible to undertake covert non-participant observation, as it was the researcher’s intention to accompany the fathers to a variety of settings. Therefore overt non-participant observation was the most appropriate approach to use.

Observational research has advantages and disadvantages, some of which have been discussed. Strategies for minimising potential problems have been recommended (Robson 2002; Parahoo 2006; Watson, Whyte 2006) and these will be reviewed in the context of the current study. The researcher who has an understanding of the language and practices of the participants has some leverage, whereby little time is required to become accustomed to the environment and incidents that occur (O’Leary 2004). It has also been suggested that observation requires skills allied to those of nursing (Caldwell, Atwal 2005). A researcher with experiential understanding and skills may also be more

acceptable to the participants than a researcher without relevant knowledge or experience. Within this study, the researcher was familiar with the setting (Section 2.9) and was able to adapt to the different environments and understand activities and interactions. However, a researcher who is familiar with the setting can be at risk of making assumptions about what is occurring. Davies (1995: 225) suggests the “*comfortable sense of being at home*” should alert the researcher to the risk of jeopardising the research. The researcher therefore made every effort not to make hasty judgments about what was occurring.

The researcher should endeavour to have minimal effect on events (Watson, Whyte 2006) particularly when those being observed are undertaking psychomotor activities, for example HCPs delivering or resuscitating a baby (Feher Waltz, Strickland, Lenz 1991). Behaviour alteration in participants arising from the presence of an observer is known as participant reactivity (Polit, Beck 2010). This phenomenon sometimes referred to as the ‘Hawthorne effect’ (Caldwell, Atwal 2005), was first described in a study at the Hawthorne plant of the Western Electric Company in the 1920s. The researchers concluded that production levels changed when workers were observed (Roethlisberger, Dickson, Wright 1939). Initially those being observed may change their behaviour. Alternatively they may feel uncomfortable such that their behaviour alters in a negative way (Patton 2002; Rogers 2008). However, there is no reason to assume one person will respond to being observed any differently to another. Participants soon forget they are being observed and therefore do not maintain a deliberate alteration in their behaviour (Walsh, Baker 2004; Parahoo 2006). Standley and Nicholson (1980) offer particular reassurance regarding the observation of childbirth. They suggested that the effect of the observer’s presence rapidly diminishes (Standley, Nicholson 1980). In time therefore, the researcher becomes “*part of the furniture*” (Parahoo 2006: 351). However, it is acknowledged that a researcher cannot know how participants would have behaved had they not been present (Robson 2002).

The justification usually given by researchers for covert observation is that this approach minimises participant reactivity (Watson, Whyte 2006; Polit, Beck 2010). However this

strategy brings a range of ethical problems because observations are carried out without the knowledge of participants (Patton 2002; Walsh, Baker 2004). Deceitful, covert observation is therefore generally deemed ethically, morally and legally unacceptable (Johnson 1992; Patton 2002).

To reduce the effects of observer presence it has been recommended that the researcher spends a period of time with the participants, before data recording commences. This helps the development of understanding between the parties concerned (Walsh, Baker 2004). The length of time required for this settling in period can be as little as ten minutes (Feher Waltz et al 1991). However, it must be questioned whether the development of a rapport in this way could lead to researcher bias arising from preconceived ideas about the likely behaviour of participants. Within this phase, with the exception of the consent process, time was not spent with the parents or HCPs before the observation commenced. Over time, the researcher became known to many of the HCPs (O'Leary 2004). However, there were also situations when observations involved HCPs who met the researcher for the first time on that occasion.

An alternative strategy for minimising participant reactivity is for researchers to restrict observations whereby they spend intervals of time looking away, so participants do not feel they are being constantly monitored (Feher Waltz et al 1991). However, this strategy risks the researcher missing important activities or becoming distracted by other events. The researcher therefore tried wherever possible to maintain a discreet distance, so as not to interfere with events or make those being observed feel they were under the microscope (O'Leary 2004). The researcher endeavoured to adopt a position that provided a good view but was out of the line of vision of those present (Robson 2002; Silverman 2006).

A common concern of the researcher is that they will miss something (Punch 2005), particularly if several activities are occurring at the same time or when elaborate activities are occurring at a rapid pace. The researcher can also be distracted by activities involving those not being observed, or environmental factors such as heat and

noise (Parahoo 2006; Polit, Beck 2010). Observation can also be time-consuming (Walsh, Baker 2004; Condon et al 2008). Practice-effects as the researcher becomes more experienced reduce the risk of this problem occurring. Within this study the researcher ensured her concentration was maintained, in order to minimise the effects of distractions. The risk of recording errors was also minimised by adherence to the observation schedule (Appendix 12). The researcher also had experience of undertaking observations (Redshaw et al 1999; Redshaw, Harvey 2002) and was therefore aware of the practical and logistical issues to be addressed when using this method of data collection.

A strategy to overcome some of the previously highlighted problems is the use of a video camera whereby recordings capture events that can be analysed at a later date (Caldwell, Atwal 2005; Parahoo 2006). An additional benefit can be the involvement of others in the data analysis process, thereby reducing opportunities for researcher subjectivity. However, the use of video cameras can restrict flexibility, they can be expensive, cumbersome and intrusive and they are difficult to use effectively. It can also be complicated trying to film when events occur in more than one setting (Robson 2002; Caldwell, Atwal 2005; Parahoo 2006). Protecting the identity of participants is also problematic (Caldwell, Atwal 2005). In addition, many would-be participants decline the invitation to be filmed (O'Leary 2004). Consequently the use of a video camera was not considered feasible or appropriate within this study.

#### **4.4 The sample**

Within this section the sampling framework will be described and the inclusion and exclusion criteria defined. The recruitment process will be outlined and the sample described.

#### 4.4.1 The sample – the sampling framework

In accordance with the research method adopted, a purposive sample was used (Baker 2006; Mapp 2008) (Section 2.4) and the inclusion and exclusion criteria defined (Tables 4.1 and 4.2). It could have been valuable to ascertain the experiences of fathers who did not meet the inclusion criteria, for example: those under 18 years of age or those without a reasonable command of English. However, factors such as these can present challenges with regard to the consent process (Corbin, Morse 2003). Consequently involving these groups was felt to be beyond the scope of this study.

<b><i>INCLUSION CRITERIA</i></b>	<b><i>RATIONALE</i></b>
Parents received information regarding the study at the routine 20 week antenatal scan	Essential as part of the informed consent process
Father is present during the delivery	Essential in order to address the objectives of this phase of the study
Singleton baby	Avoids the impact that a multiple birth might have on events
First baby	Avoids the impact that previous childbirth experiences might have on parental behaviour and responses
Parents are minimum of 18 years of age	Avoids issues relating to the need to obtain consent from a minor
No known child protection issues	Avoids the researcher being party to confidential information
Is able to give informed consent	Avoids issues relating to the need to obtain consent from vulnerable groups.
The baby is either expected by parents / HCPs to require: resuscitation / admission to NNU or be a healthy infant	Essential in order to address the objectives of this phase of the study

Table 4.1 Phase two sample inclusion criteria



<b>EXCLUSION CRITERIA</b>	<b>RATIONALE</b>
Multiple birth	A multiple birth will alter events occurring at the delivery
Second or subsequent baby	Previous childbirth experiences are likely to alter parental behaviour and responses
Either or both parents are under 18 years of age	This would present difficulties regarding the need to obtain consent from a minor
Either or both parents do not have a reasonable command of English	This would present difficulties in obtaining informed consent and may have an impact on parental behaviour and responses
Known child protection issues	The researcher would become party to confidential information and these issues may influence parental behaviour
Parents are unable to give informed consent	It is unacceptable to take consent from those who are unable to give it
There are known life threatening fetal anomalies and a pre-delivery decision has been made that the baby will not be resuscitated	These circumstances are beyond the scope of this study.

Table 4.2 Phase two sample exclusion criteria

#### **4.4.2 The sample – the recruitment process**

Information leaflets were distributed between June and October 2006 to women at around 20 weeks of their pregnancy when they attended the antenatal clinic for a routine ultrasound scan (Appendix 5, 13). Data collection took place between October 2006 and March 2007. Following the admission of a mother to the delivery suite, the researcher spoke to potential participants. To facilitate this process, assistance was required from midwives to identify couples meeting the inclusion criteria (Section 4.4.1). Therefore at the start of each shift, the researcher made herself known to the midwives on duty. Some midwives may have acted as gatekeeper regarding the recruitment process (Tuckett 2004). However, there is no evidence to suggest this was the case.

The researcher discussed the study with the parents and a replacement information sheet was given if the original copy had not been retained. Assurances were given regarding strategies to maintain anonymity and confidentiality (Section 2.6.3). The parents were also advised that the observation could be terminated at their request at any point during the proceedings. Parents were given a minimum of an hour to decide if they wanted to take part. Written consent was obtained from both parents (Appendix 14, 15). Immediately prior to the observation commencing the consent forms were checked in the presence of both parents and the midwife.

The exact timing of the consent process was determined by each situation. Figure 4.1 identifies that there were 133 couples meeting the study inclusion criteria on occasions when the researcher was present. Data collection took place on a part-time basis; therefore ten couples were not approached about the study because it was evident that the mother would not deliver when the researcher was present. No attempt was made to obtain consent from a further 51 couples because the mother was in an advanced stage of labour. The study was initially discussed with 46 couples but consent was not obtained. The researcher decided not to follow-up one couple because the parents made a complaint about the midwife responsible for their care. The researcher felt it was inappropriate to risk further antagonising an already difficult situation. With regard to the remaining 45 couples; it was evident that nine mothers would not deliver when the researcher was present so it was agreed that the consent process would not be pursued and 36 couples decided they did not want to take part. Consequently, of the 133 couples, 26 consented to take part in the study. However, four deliveries were not observed. One couple decided immediately before the observations commenced that they did not want to take part, two deliveries took place when the researcher was not present and one occurred when the researcher was observing another delivery.

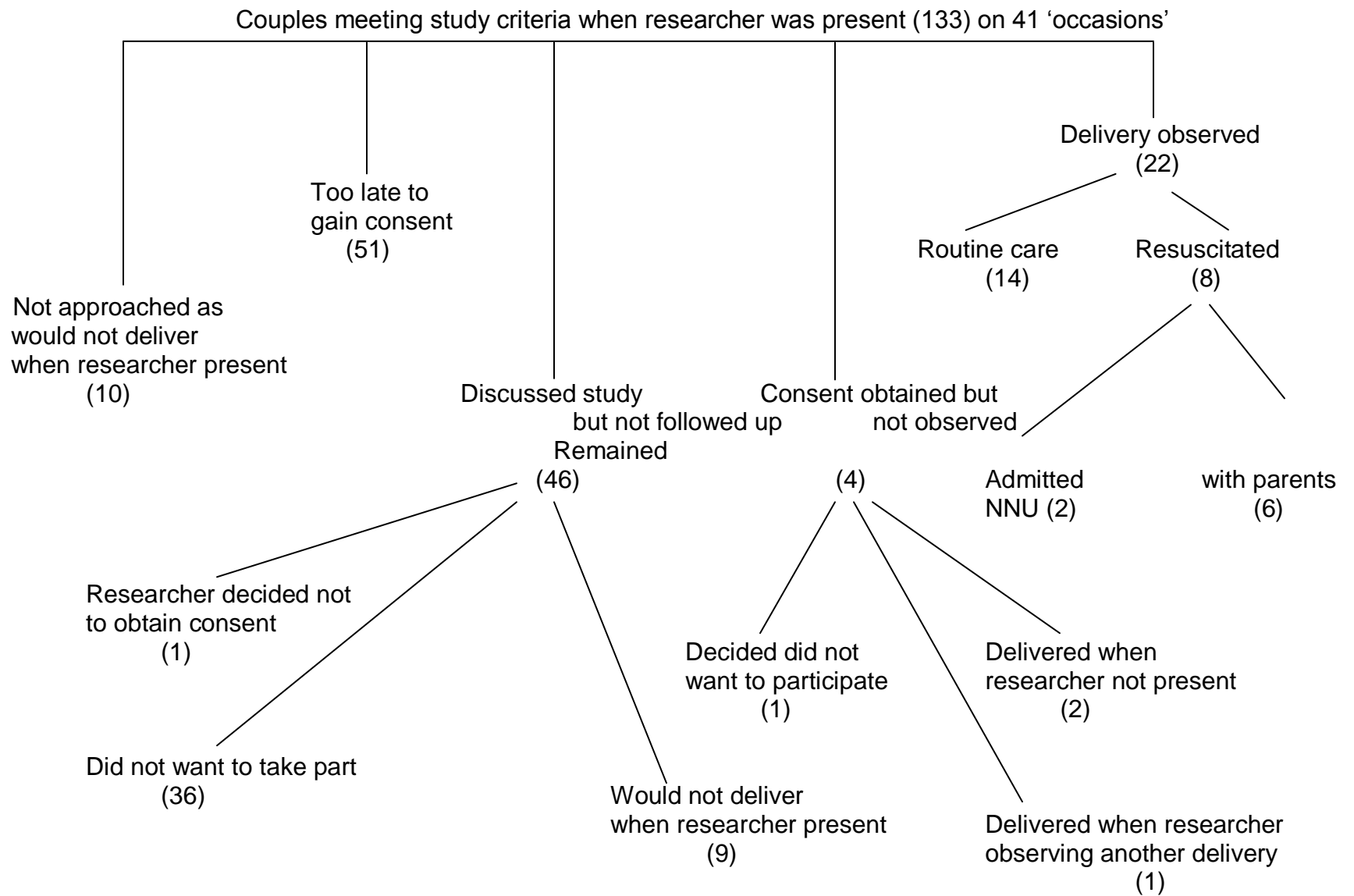


Figure 4.1 Parents meeting the study inclusion criteria on the occasions when the researcher was present

#### **4.4.3 The sample – the nature of the sample**

It was important to capture a range of situations within the data collection period. It was therefore difficult to predict the exact sample size at the start of this phase. When consent was taken some of the parents and HCPs were anticipating a normal delivery of a healthy baby born at term. In some of these cases complicated childbirth, newborn resuscitation and/or NNU admission occurred unexpectedly. It was also important to ensure the sample included parents who were aware when consent was taken that these events were likely to occur.

Tables 4.3 and 4.4 identify the sample biographical details. The fathers were between 19 and 43 years of age (mean 30 years, 10 months). Nineteen fathers were employed and the sample included fathers with a range of occupations, one was a fulltime student and two were unemployed. Twenty fathers were living with their partner (15 married, five cohabiting). The mothers ranged between 18 and 39 years of age (mean 28 years, 5 months). Fifteen mothers were employed with a range of occupations, one was a fulltime student, four described themselves as a housewife (all married) and two were unemployed. The sample included fathers and mothers from a range of ethnic backgrounds that correspond with the main groups represented in the study-site's local population.

<b>NO</b>	<b>AGE</b>	<b>OCCUPATION</b>	<b>ETHNICITY*</b>	<b>MARITAL STATUS</b>
F100	20	Unemployed	White English	Single – not cohabiting
F101	27	Mechanic	White British	Married
F102	32	Photographer	White British	Married
F104	25	Student	White British	Single - cohabiting
F105	33	Engineer	White British	Married
F106	41	Gardener	White British	Married
F107	19	Barman	White English	Single – not cohabiting
F110	29	Supervisor	Sri Lankan	Married
F111	25	Engineer	White British	Married
F112	31	Telecom engineer	White British	Married
F114	27	IT technician	Indian	Married
F115	38	Police officer	White British	Married
F116	36	IT technician	Indian	Married
F117	25	Sales assistant	White English	Married
F118	28	IT technician	Malaysian	Married
F119	38	Builder	Jamaican	Married
F120	35	Engineer	Spanish	Single – cohabiting
F121	26	Website designer	Pakistani	Married
F122	29	Unemployed	White English	Single – cohabiting
F123	37	Research scientist	German	Married
F124	43	Diving instructor	White English	Single – cohabiting
F125	35	Team leader	Afrocarribbean	Single – cohabiting

\* As described by participants

Table 4.3 Phase two fathers' biographical details

<b>NO</b>	<b>AGE</b>	<b>OCCUPATION</b>	<b>ETHNICITY*</b>	<b>MARITAL STATUS</b>
M100	20	Sales assistant	White English	Single – not cohabiting
M101	25	Teaching assistant	White British	Married
M102	32	Dance teacher	White British	Married
M104	25	Receptionist	White British	Single - cohabiting
M105	25	Housewife	White British	Married
M106	34	Care assistant	White English	Married
M107	18	Unemployed	White English	Single – not cohabiting
M110	29	Student	Sri Lankan	Married
M111	26	Nurse	White British	Married
M112	35	Teacher	White British	Married
M114	26	Doctor	Indian	Married
M115	30	Off-licence manager	White British	Married
M116	25	Housewife	Indian	Married
M117	25	Library assistant	White English	Married
M118	26	Office administrator	Malaysian	Married
M119	32	Civil servant	White British	Married
M120	39	Solicitor	White British	Single – cohabiting
M121	26	Housewife	Pakistani	Married
M122	22	Unemployed	White English	Single – cohabiting
M123	38	Housewife	Pakistani	Married
M124	32	Nursery nurse	White British	Single – cohabiting
M125	36	Social worker	White British	Single – cohabiting

\* As described by participants

Table 4.4 Phase two mothers' biographical details

Recruitment continued until a range of parents who encountered a variety of situations was recruited (Endacott, Botti 2005; Richards 2005; Parahoo 2006). The sample therefore includes parents who experienced a range of deliveries (Table 4.5). The parents were not recruited on the basis of their baby's characteristics or anticipated outcomes. However, a variety of birthweights and gestational ages are represented. This sample includes sufficient variation such that a comprehensive range of events can be described (O'Leary 2004).

<b>CHARACTERISTICS</b>	<b>BOYS (13)</b>	<b>GIRLS (9)</b>	<b>TOTAL (22)</b>
Gestation: Less than 37 completed weeks	2	0	2
38 to 41 completed weeks	10	9	19
More than 42 weeks	1	0	1
Birth weight: Less than 3Kg	3	2	5
3 – 4Kg	9	6	15
Over 4 Kg	1	1	2
Delivery: Normal	8*	4	12
Forceps	1	0	1
Ventouse	1	1	2
Elective LSCS	1	0	1
Urgent LSCS	2	2	4
Crash LSCS	0	2	2

\* Includes 1 water-birth

Table 4.5 Phase two characteristics of babies and type of delivery

## **4.5 Data collection**

Within this section the development of the observation schedule will be described. The data collection process will be discussed with reference to the practical and logistical challenges associated with the use of observation. The ways these issues were addressed will be described along with an exploration of the required researcher skills. Reflection will also be presented on the data collection process.

### **4.5.1 Data collection – development of the observation schedule**

Key issues for the researcher to consider before embarking upon observation include the tool to be used and the method of data recording. The researcher must also determine what will be observed, how the observations will be recorded and categories to be used. It is essential that the observation schedule is rigorous and can be used in a consistent way (O’Leary 2004).

With regard to recording data, unstructured and structured approaches in order to collect qualitative and quantitative data have been advocated and criticised (Parahoo 2006; Polit, Beck 2010). Unstructured qualitative data recording provides the researcher with flexibility and freedom, as there are no previously defined protocols. This facilitates the recording of data that are generally descriptive and have a greater depth and breadth than can be achieved when utilising a more structured approach (Feher Waltz et al 1991; Parahoo 2006; Polit, Beck 2010). Unstructured observation is particularly appropriate when little is known about the phenomena being studied (Parahoo 2006). When compared with the structured approach, the unstructured method is said to require greater skills because of the need to avoid becoming discriminating in the observation and recording (Feher Waltz et al 1991; Parahoo 2006).

Structured quantitative data collection is regarded as being less complex (Polit, Beck 2010). It is the most appropriate method of data collection when the aim is to record the nature, frequency, duration, context or outcomes of activities and behaviours (Parahoo



2006). In structured observational research, checklists and rating scales are commonly used and these tools must be devised and piloted before the study commences (Feher Waltz et al, 1991). The categories used in a structured schedule must be clearly defined and mutually exclusive (Feher Waltz et al, 1991). However, the structured approach can be too rigid and inflexible (Polit, Beck 2010). Whilst predetermined categories facilitate accurate and speedy recording, an extensive number can be difficult for the researcher to remember (Parahoo 2006). Therefore, the researcher may inadvertently allocate or record the wrong category (Parahoo 2006). This problem can be overcome by recording a brief comment or description in conjunction with the category. In this way, the appropriateness of the allocated categories can be checked at a later date.

Within this phase data were collected utilising a structured and unstructured approach, so maximising the advantages of both strategies as advocated by the paradigm of pragmatism. The observation schedule was developed from that previously used by the researcher (Redshaw et al 1999; Redshaw, Harvey 2002) and was refined through discussion with the researcher's supervisor, senior academics and senior post-holders at the study-site (Section 2.1). A two-minute time frame was adopted and to ensure accuracy, the researcher wore a discreet earpiece attached to a timing device that sounded at two-minute intervals. Observations were recorded in a structured way using predetermined categories (Appendix 12). To assist data analysis a brief commentary was recorded (Foss, Ellefsen 2002). In addition unstructured descriptions of behaviours and activities were also documented (Appendix 12). The quantitative data therefore provide a broad overview, whilst the qualitative data provide deeper multifaceted information (Foss, Ellefsen 2002). The father, mother and baby were the focus of each observation. Therefore the observation schedule was devised in such a way as to facilitate documentation regarding their behaviours and activities. The outcome measures were as follows:

- The nature and extent of physical contact between the father and others.
- The nature and extent of physical contact between the mother and others.
- The nature and extent of physical contact between the baby and others.
- The nature and extent of communication between the father and others.
- The nature and extent of communication between the mother and others.
- The nature and extent of father activity.
- The nature and extent of mother activity.
- The nature and extent of baby activity.

The observation schedule also facilitated the recording of biographical information about the baby and information regarding the delivery (Patton 2002) (Appendix 12). The researcher spent a day with a senior midwife who had undertaken a study using observation by recording deliveries using a video camera in a fixed position. The researcher was able to pilot her data collection tool by watching these videos (Section 2.1). This confirmed the pre-determined categories and abbreviations to be used (Appendix 12). This opportunity also validated the researcher's decision not to use a video camera because it was not always possible to determine who was in the room and some of the dialogue was inaudible.

#### **4.5.2 Data collection – the data collection process**

In most cases, the observation commenced at the start of the second stage of labour. In a few instances (6) when a LSCS was performed before the second stage of labour started, the observation commenced at the beginning of the LSCS. In situations when a baby unexpectedly required resuscitation and/or admission to the NNU, the data collection process continued. The observations continued until one of the following situations:

- The baby was examined by a HCP and the decision was made that he/she could remain with the parents.
- The father, having visited his baby on the NNU, returned to his partner.

In situations when the father did not stay with his partner the researcher continued to observe him until one of the situations listed above occurred.

#### **4.5.3 Data collection – reflection on the process**

The researcher was present on 41 occasions during which time 22 deliveries were observed. The observations ranged between 24 and 180 minutes in length (mean 77 minutes) and were made at different times of the day and night on weekdays, weekends and bank holidays. The recruitment and data collection processes were time consuming and demanding. There was often considerable delay between consent being obtained and the start of the observation. Consequently the researcher was often within the maternity unit for long periods of time (maximum 22 hours). The researcher had originally anticipated having obtained consent that she would be able to leave the maternity unit returning later to observe the delivery. However, it became apparent that the uncertain nature of childbirth meant she needed to remain within the department until the delivery occurred.

The researcher had to be vigilant to ensure that at the change of shift, the midwife taking over care was aware the parents had agreed to participate in the study. Most midwives provided the researcher with regular updates during the labour. When it became apparent that the second stage was approaching either the midwife herself or someone delegated by her advised the researcher of the situation. There were two occasions when the second stage of labour started before the observations commenced. However, on both occasions only a small amount of data was lost.

#### **4.6 Ethical issues**

General ethical issues pertaining to this study have been explored (Section 2.6) and the consent process and strategies to maintain confidentiality have been described (Sections 2.6.2, 2.6.3, 4.4.2). Therefore within this section issues pertaining to the consent of others and the potential impact on the researcher will be explored.

#### **4.6.1 Ethical issues – the consent of others present**

Whether overt or covert, observational research risks invading the privacy of those involved (Parahoo 2006). Holloway and Wheeler (2002) argue that when carrying out observations in hospital settings, the researcher should aim to inform and seek permission from all those likely to be affected. This should include relatives and HCPs. Others suggest this is a naive view, as it is not possible to inform and obtain consent from every individual who may potentially be involved (Manning 2004). Indeed some argue that people entering a public place should anticipate being susceptible to involvement in such activities (Johnson 1992). However, Holloway and Wheeler (2002) do not support this view. They suggest that a care setting such as a hospital is not the same as a more public environment like a street. Within this phase wherever possible, the researcher introduced herself to those affected by the observation and briefly explained the purpose of the activity. In many cases the midwife caring for the couple explained the researcher's attendance to others. Some HCPs and family members initially required reassurance that they were not the main focus of the observation. Over time HCPs appeared comfortable with the researcher's presence. Throughout the observations the researcher aimed to position herself unobtrusively and it was not apparent that anyone was adversely affected.

#### **4.6.2 Ethical issues – potential impact on the researcher**

General issues regarding the potential impact on the researcher have been discussed (Section 2.6.4). Within this phase the researcher experienced some conflict regarding her role during data collection (Lalor et al 2006; Parahoo 2006). During one observation the midwife asked the researcher to press the emergency buzzer. The father was supporting his partner who was extremely distressed and the midwife was delivering the baby following a rapid second stage. No one else was present. Although it could be argued if the researcher had not been present the midwife would have dealt with the situation on her own, the researcher felt ethically and morally obliged to assist her in this

emergency situation (Nursing and Midwifery Council 2004). The 'crash team' arrived instantly and the researcher continued the observations.

Whilst the researcher endeavoured to remain detached (Caldwell, Atwal 2005), there were occasions when HCPs made comments to her during observations. In most cases, this was general conversation and the researcher felt it would have been rude not to respond (Robson 2002). However, she endeavoured to minimise the interaction and was usually able to do this by moving to a different part of the room. This type of interaction indicates that these particular HCPs were comfortable about the researcher being present. On one occasion, a midwife who appeared irritated by a father's behaviour asked the researcher if she had recorded what he was doing. It could be argued that this HCP was trying to influence the data collection process. On this occasion, the researcher did not respond to her question and moved away.

#### 4.7 Data analysis

This phase generated both quantitative and qualitative data. One of the challenges of a mixed methods study is finding a way to logically amalgamate the findings (Yardley 2008). The findings of each approach should be reported as separate parts of a composite whole (Yardley, Bishop 2008). Consequently, the researcher transcribed the qualitative field notes into a word document. The previously described data analysis process was undertaken (Sections 2.4.1, 3.6). Analysis of the quantitative data will be described in the following section.

#### **4.7.1 Data analysis – quantitative data analysis**

From the structured schedule (Appendix 12) quantitative data concerning behaviours and interactions (verbal communication, physical contact and activity) were coded and entered directly onto a computer using a spreadsheet. Data were then collated and are presented in numbers or proportions as appropriate. These data have been tabulated or are represented diagrammatically because this renders information more accessible (Polit, Beck 2010). The quantitative data were compared in terms of the type of delivery (normal or complicated) and/or the immediate care of the baby (routine care or resuscitation). Where appropriate a Chi Squared ( $\chi^2$ ) test was undertaken in order to determine associations between two variables.

The Chi squared test is a non-parametric test that can be used to analyse the findings obtained from different groups in order to determine the relationship between them (Polit, Beck 2010). The discrepancy between observed and expected frequencies is measured (Field 2009). The obtained probability value indicates how likely the results are to occur by chance or because there is an association between them (Field 2009). A probability value of 0.05 means that if there was no real association 5% of the time this result would occur by chance. If a probability of 0.05 or less is found, it is deemed statistically significant (Botti, Endacott 2005; Field 2009). The test can only be used with frequencies. However, it is not necessary to have equal numbers in each group (Hicks 1990). It is therefore an appropriate test to use in the analysis of the observational data.

#### **4.8 Strategies to enhance trustworthiness**

General issues and strategies employed to enhance the trustworthiness of a study using qualitative methods have been explored (Section 2.4.2). As was the case for phase one, it was not deemed feasible to instigate participant checking (Section 3.7.2). Therefore within this section specific issues regarding observations will be explored.

#### **4.8.1 Strategies to enhance trustworthiness – observations**

Within structured observational research, reliability is allied to the consistency with which the researcher allocates a particular activity or behaviour to the same category during a period of observation (Parahoo 2006). Coding errors can occur when the researcher misinterprets what has been observed, whilst recording errors arise when data are inaccurately documented. These errors are likely to arise when the tool used is either too complicated or lacks precision. These problems can be minimised if the researcher is familiar with the tool that is also specific to the task required. Having personally devised the categories, the researcher was familiar with the tool. The review of the data collection tool previously described (Section 4.5.1) confirmed the schedule was neither too complicated nor simplistic.

Intra-observer reliability refers to consistency in recording observations on separate occasions and it can be assessed through the use of video recordings (Parahoo 2006). Whilst the benefit of using video recordings is acknowledged, this was not feasible. However, the use of clearly defined categories (Appendix 12) facilitated the consistent collection of data. The recording of a brief commentary in addition to the category also enabled confirmation of the appropriate allocation when the data were subsequently reviewed.

The use of two observers has been recommended in order to strengthen reliability (Feher Waltz et al 1991). However inter-observer reliability must first be established, whereby the researchers compare data after observing the same events with the aim of achieving agreement (Polit, Beck 2010). This recommendation is often not logistically possible and within this study it was not appropriate, due to the intrusive nature of additional observers.

A range of strategies has been recommended in order to determine the trustworthiness of an observational study. It has been advocated that to establish content validity, the tool should be scrutinised by other experts (Parahoo 2006). Within this study this was

undertaken (Section 2.1). The researcher should also address the issue of participant reactivity (Feher Waltz et al 1991). Parahoo (2006) claims that the researcher is the most appropriate person to evaluate the effect of their presence on participants. However, this may not always be possible, if as in this case the researcher is carrying out an observation as a one-off event. Whilst it is not possible to determine the level of participant reactivity, there is no evidence to suggest participants changed their behaviour because they were being observed. Within the following sections the findings will be presented.

#### **4.9 Findings**

Each of the 22 observations has been regarded as a separate case study generating both quantitative and qualitative data. The collated quantitative data regarding the nature and extent of physical contact, verbal communication and activity, primarily focusing on the father will be described utilising descriptive statistics. Where relevant, data will be compared in relation to the type of delivery (normal or complicated) and/or the care of the baby (routine care or resuscitation) using a Chi Squared ( $\chi^2$ ) test. The qualitative data will then be presented in key themes from the analysis of the field notes and the researcher's reflective diary. This will be followed by the detailed description of a case study to further illustrate key issues and to demonstrate the richness of the data. The data from this phase will then be compared with the findings of other relevant studies. Firstly however, information regarding the 22 deliveries and their outcomes will be presented in order to establish the context.

#### **4.10 Background information**

Table 4.6 identifies the total amount of data accrued and the range and mean length of the observations. For most of the time both the father and his partner were present. However, during nine cases, observation of the father continued in the absence of his partner when he left the delivery room or operating theatre (total 64 minutes).



<b>TOTAL AMOUNT OF DATA</b>	<b>RANGE OF OBSERVATION LENGTH</b>	<b>MEAN LENGTH OF OBSERVATIONS</b>
1689 minutes	24 – 180 minutes	77 minutes

Table 4.6 Total amount of data accrued and the range and mean length of observations

#### **4.10.1 Background information – planned and actual place of delivery**

The deliveries took place in place in one of three settings: the birthcentre, the delivery suite or the operating theatre (Section 4.2). As shown in Figure 4.2, most deliveries were booked for the delivery suite or birthcentre. One LSCS was arranged antenatally. However, a further seven deliveries took place in the operating theatre due to fetal distress and/or failure to progress in labour. One of these deliveries was booked for the birthcentre and six for the delivery suite. Three deliveries booked for the birthcentre took place in the delivery suite: two because of failure to progress in labour and the third because of premature labour. One delivery booked for the delivery suite took place in the birthcentre. This mother was transferred there in labour at her request. Figure 4.2 shows that plans made antenatally or during early labour regarding place of delivery sometimes alter. These changes, which can be sudden and unexpected, can cause uncertainty for all those involved, and the father in particular (Jackson et al 2003; Sloan et al 2008).

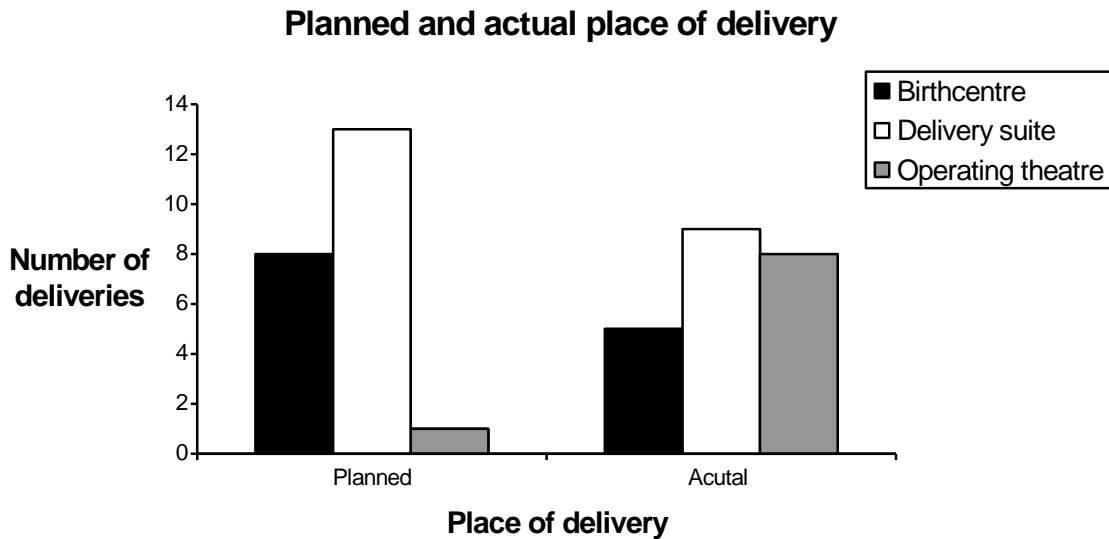


Figure 4.2 Planned and actual place of delivery

#### 4.10.2 Background information – types of delivery and neonatal outcomes

Information regarding the types of delivery, reasons for intervention and the care of the babies is provided in Table 4.7. Twelve normal deliveries were observed, including one water-birth. Whilst there are a number of definitions of normal birth (Maternity Care Working Party 2007; Healthcare Commission 2008), for the purpose of this study this is defined as being a cephalic vaginal delivery without the assistance of forceps or ventouse. Ten complicated deliveries were observed. These consisted of LSCS (7), ventouse (2) and forceps (1) deliveries. Consequently of the deliveries observed, 54.55% were ‘normal’ and the remaining 45.45% ‘complicated.’ This is comparable with the total deliveries at the study-site that year; 56.46% normal, 43.54% complicated (Hospital Trust 2007) and births in the UK generally (Redshaw et al 2007).

Fourteen babies required routine care (RC) only at birth. This is the normal care most babies require. Such babies establish respirations without assistance beyond tactile stimulation. Their care therefore focuses on strategies to promote thermoregulation such as drying, skin-to-skin contact (usually with the mother) and/or wrapping the baby in a

warm towel. Eight babies required some form of resuscitation, which involved interventions beyond RC ranging from oro-pharyngeal suction to manual breaths and the administration of oxygen.

<b>DELIVERY</b>		<b>INDICATION FOR TYPE OF DELIVERY</b>	<b>IMMEDIATE CARE OF THE BABY</b>	
Normal (includes water-birth)	12 1	Not applicable	Routine care (RC) RC plus suction RC plus face mask oxygen RC plus suction, face mask oxygen RC plus suction, manual breaths, oxygen	8 1 1 1 1
Elective LSCS*	1	High head, large baby	RC	1
Urgent LSCS*	4	Fetal distress Failure to progress	RC RC RC plus suction	1 2 1
Crash LSCS*	2	Severe fetal distress	RC plus face mask oxygen RC plus suction, face mask oxygen	1 1
Ventouse	2	Prolonged second stage	RC	2
Forceps (operating theatre)	1	Prolonged second stage	RC plus face mask oxygen	1

\* Classification used by the study-site

Table 4.7 Delivery type, reason for intervention and immediate care of the baby

Further detail about the babies is provided in Table 4.8. This includes information regarding Apgar scores, immediate care and neonatal outcome. Seventeen babies had an Apgar score of eight or more at one minute and all babies had a score of at least eight at five minutes. Consequently most babies, including those who initially required some form of resuscitation remained with their parents. Two babies subsequently required NNU admission.

<i>CHARACTERISTICS</i>		<i>BOYS (n 13)</i>	<i>GIRLS (n 9)</i>
Apgar score at 1 minute:	6	1	2
7		1	1
8		5	0
9		6	6
Apgar score at 5 minutes:	8	1	2
9		9	3
10		3	4
Immediate care of baby:	RC	9	5
RC plus suction		1	1
RC plus face mask oxygen		1	2
RC plus suction and face mask oxygen		1	1
RC plus suction, manual breaths, oxygen		1	0
Outcome:	Admitted to neonatal unit	2	0
	Remained with parents	11	9

\* Includes 1 water-birth

Table 4.8 Apgar scores, immediate care and neonatal outcome

As Table 4.9 indicates, 18 babies cried spontaneously within a few seconds of the delivery. Five of these babies required resuscitation. Four babies did not cry spontaneously at birth including one baby who did not subsequently require resuscitation (water-birth). This shows that the presence or absence of crying at birth does not necessarily indicate whether a baby will subsequently require resuscitation (Section 3.10.3).

<b><i>CRIED AT BIRTH</i></b>	<b><i>TYPE OF DELIVERY</i></b>		<b><i>CARE OF BABY</i></b>	
Yes – (n18)	Normal delivery	10	Routine care	7
			Resuscitation	3
	Complicated	8	Routine care	6
			Resuscitation	2
No – (n4)	Normal delivery*	2	Routine care*	1
			Resuscitation	1
	Complicated	2	Resuscitation	2

\*Includes 1 water-birth

Table 4.9 Babies crying at birth, type of delivery and immediate care of the baby

#### **4.10.3 Background information – present during the observations**

An issue that became apparent during the observations was the number of people present. The frequency with which people entered and left the delivery room / operating theatre was noted. The researcher and the father were present for all of the observations (Section 4.10). One or more family members were present during nine of the observations. They consisted of the mother's mother (7), father's mother (1) and/or the mother's sister (2). Whilst on most occasions family members attended on their own, on one occasion both the mother and father's mother were present. Figure 4.3 shows the number of people present (including the researcher and family members) during the observations in relation to the type of delivery. The period of observation before and after the birth are divided into quartiles. As might be anticipated a higher number of people were present during the observations involving complicated childbirth. As also might be expected, the highest number of people were present immediately before and after the birth (4<sup>th</sup> quartile before, 1<sup>st</sup> and 2<sup>nd</sup> quartile after). The same pattern is apparent in relation to the immediate care of the baby (Figure 4.4). This may explain why fathers sometimes feel excluded and marginalised during the birth (Chandler, Field 1997; Johnson 2002; Kunjappy-Clifton 2008).

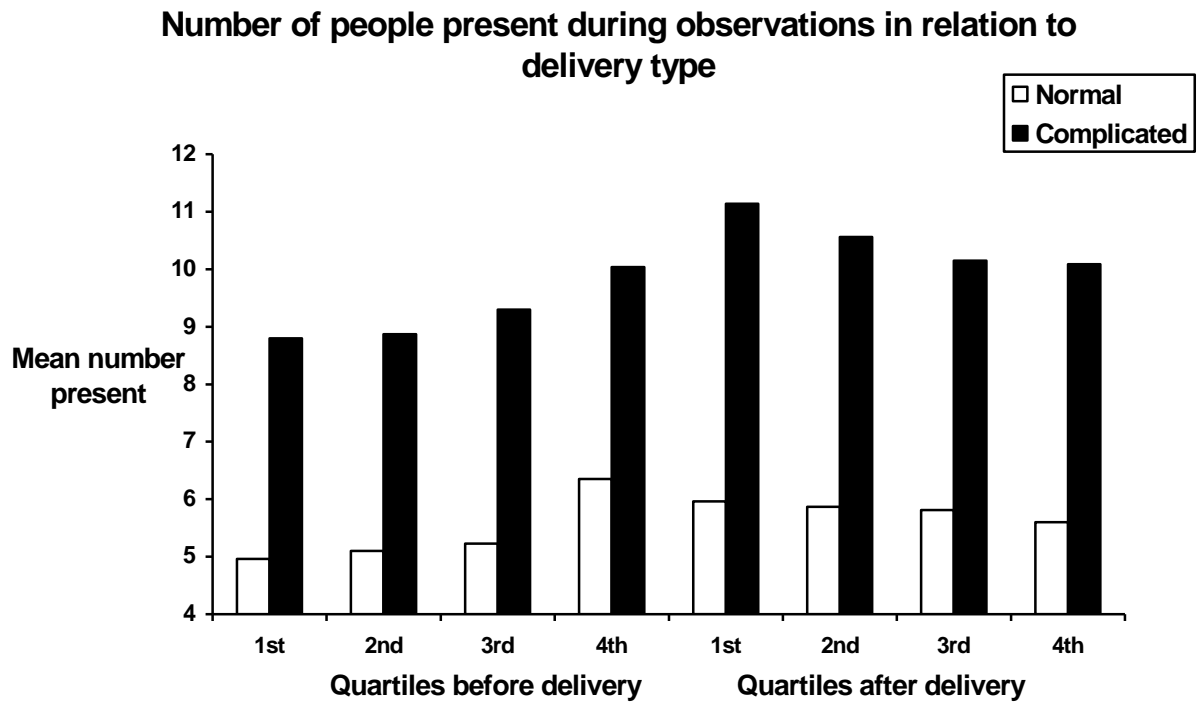


Figure 4.3 Number of people present during observations in relation to delivery type

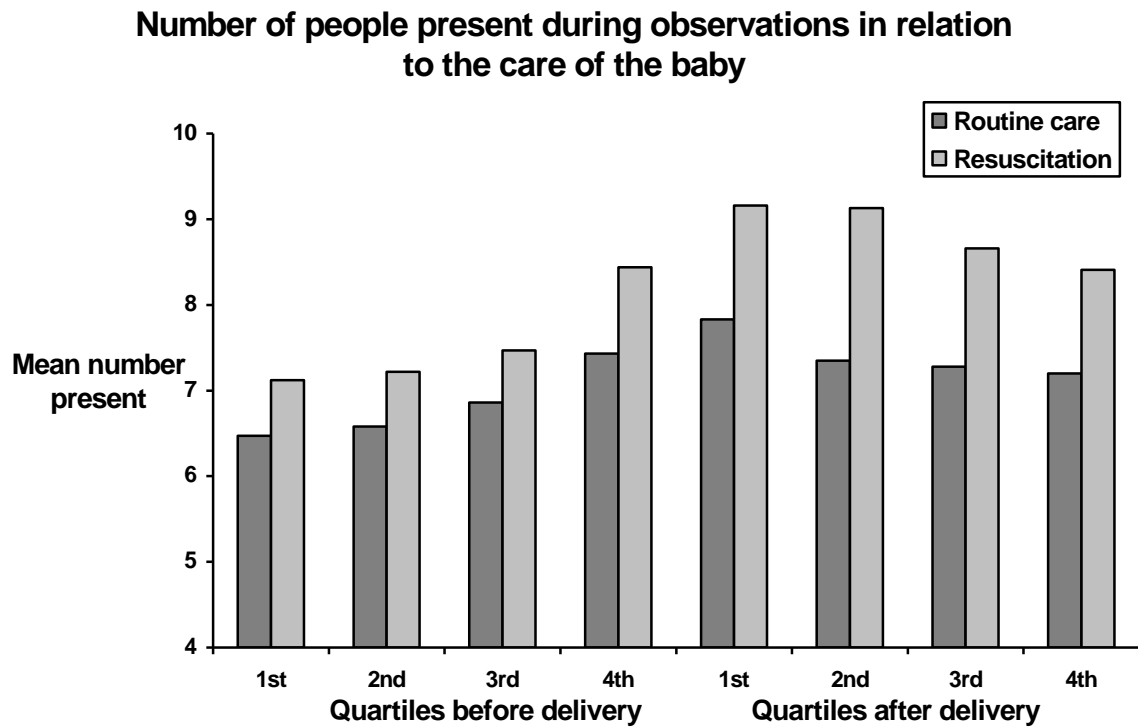


Figure 4.4 Number of people present during observations in relation to the care of the baby

#### 4.10.4 Background information – present at the deliveries

Between five and thirteen people were present at the deliveries (including the researcher). Most people were present for LSCS deliveries (range 10 – 13, mean 12, median 12) and the least for normal deliveries (range 5 – 7, mean 6, median 6). The number of people attending complicated deliveries collectively can be compared with those attending normal deliveries: with a mean of 11.4 and 6, and median of 12 and 6 respectively. The range of people attending deliveries was the same irrespective of whether the baby required RC or resuscitation (5 – 13). However, there was a difference in both the mean (8.21 RC, 8.87 resuscitation) and median (7 RC, 8.5 resuscitation) number of people present.

Midwives, the mother, father and the researcher were present at all deliveries. However others in attendance varied in relation to delivery type (Figure 4.5). Family members attended seven deliveries: five normal and two complicated (both ventouse). Two other family members (both mother's mother) had been present during the observations but did not attend the birth (one normal delivery, one LSCS). There were no significant differences in family member attendance with regard to the type of delivery. However, the type of delivery did influence HCP attendance. Obstetricians (Obs) were present at all complicated deliveries but only attended two normal deliveries ( $\chi^2 = 15.27$ , 1 d.f.,  $p = < 0.001$ ). Paediatricians (Paeds) were present for nine complicated deliveries (all forceps and ventouse deliveries and six LSCSs) and three normal deliveries ( $\chi^2 = 9.30$ , 1 d.f.,  $p = < 0.01$ ). Operating theatre staff (Theatre) were present for eight complicated deliveries (all LSCSs and the forceps delivery) but none of the normal deliveries ( $\chi^2 = 11.9$  1 d.f.,  $p = < 0.001$ ).

Medical students (Med studs) attended one complicated delivery (forceps) and three normal deliveries in an observational capacity as part of their obstetric placement. Student midwives (Stud MWs) attended one complicated delivery (forceps) and three normal deliveries, two of which they conducted. A midwifery assistant (MA) was present for one normal delivery. There were no significant differences in Med studs, MA and

Stud MWs attendance with regard to delivery type. This suggests these HCPs are deemed to have a less significant role to play in determining outcome.

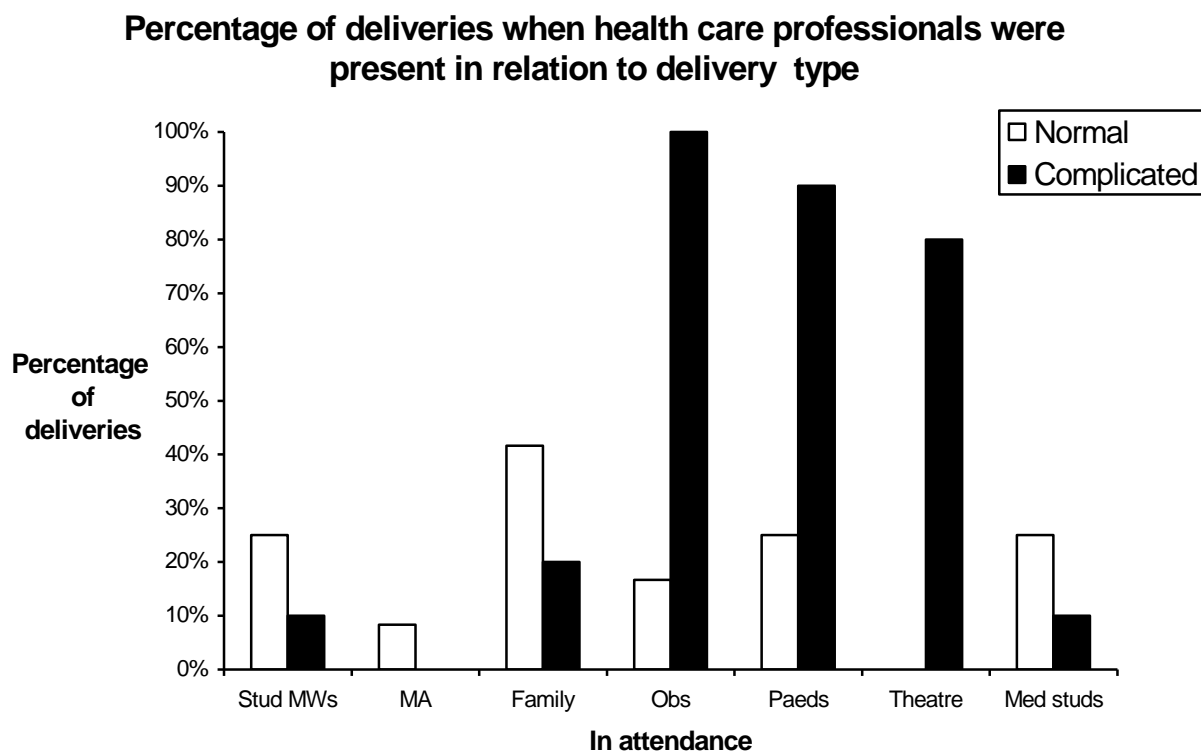


Figure 4.5 Percentage of deliveries when health care professionals were present in relation to delivery type

The type of care the baby required did not generally influence attendance at delivery. Obstetricians and theatre staff were present at five and four deliveries respectively when the baby required resuscitation and seven and four deliveries respectively when RC was required. A family member, midwifery student, midwifery assistant and medical student were present at one delivery when the baby required resuscitation. Family members were present at six deliveries when the baby required RC and student midwives and medical students were present at three (Figure 4.6). There were no significant differences in obstetrician, theatre staff, family member, midwifery student or medical student attendance with regard to the immediate care of the baby. This suggests these



HCPs have a less significant role to play in determining the baby's outcome. The only significant difference was in paediatrician attendance. They were present at seven deliveries when the baby required resuscitation and five when the baby required RC ( $\chi^2 = 5.5$ , 1 d.f.,  $p = < 0.02$ ). It can therefore be suggested paediatrician attendance is influenced by the expectation that they have a role to play determining the baby's outcome.

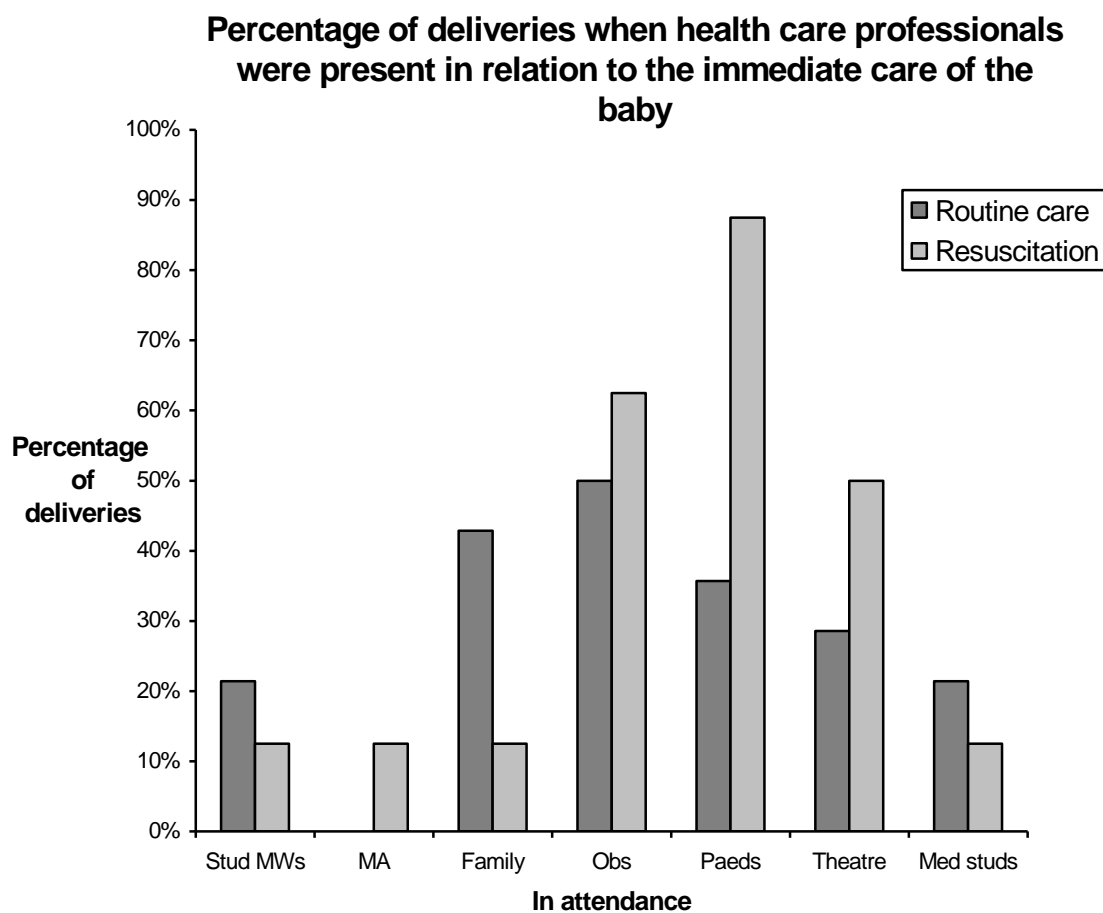


Figure 4.6 Percentage of deliveries when health care professionals were present in relation to the immediate care of the baby

#### 4.11 Quantitative data

The structured data collection tool (Appendix 12) facilitated the collection of data at two-minute intervals. Recordings were made regarding physical contact, verbal communication and activity (Table 4.10). The starting point of each observation was the recording of these behaviours in relation to the father: where he was, what he was doing and with whom he was interacting. The same activities were then documented in relation to the mother and the baby (if present).

<b>BEHAVIOURS</b>	<b>DEFINITION</b>
Physical contact	Direct skin-to-skin contact. Does not include physical contact that may occur as a result of interventions being undertaken
Verbal communication	Any verbal interaction. This therefore includes speaking to, being spoken to and singing
Activity	Includes sitting, standing and kneeling

Table 4.10 Behaviours recorded at two-minute intervals that formed the quantitative data

Most of the data will be compared in relation to the type of delivery and/or the care of the baby using a Chi Squared ( $\chi^2$ ) test to determine significant differences (Section 4.7.1). In order to do this, collated groups will be used where relevant to represent those present (Section 4.10.4). The following groups will therefore be used: 'midwifery' (midwives, students midwives and midwifery assistant), 'obstetricians' (obstetricians and medical students), 'theatre' (anaesthetists and operating theatre staff) and 'family' (mother's mother, father's mother and mother's sister). In the following sections data will be described in relation to whether the father's partner was, or was not present.

#### 4.12 Physical contact

As Figure 4.7 shows, fathers had physical contact (PC) with his partner for just under two thirds of the observations (62.90%). On a few occasions this also involved the baby (5.95%). For nearly a third of the time, fathers did not have PC with anyone (32.10%). For a small amount of time fathers had PC with 'others' (5%). This was mostly the baby, on one occasion this was with the midwife.

**Fathers' physical contact when their partner was present**

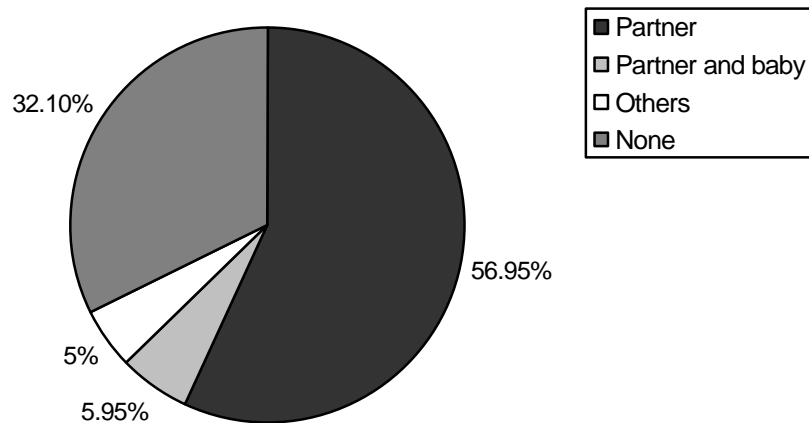


Figure 4.7 Fathers' physical contact when their partner was present

##### 4.12.1 Physical contact – fathers' physical contact with their partner

Figures 4.8 and 4.9 show the percentage of the overall time before and after delivery that fathers had contact with their partner. Regardless of the type of delivery or the care of the baby; fathers had more PC with their partner before the birth. They appeared to use this strategy to support her as the delivery became imminent. There were differences in PC before birth in relation to both type of delivery ( $\chi^2 = 5.27$ , 1 d.f.,  $p < 0.05$ ) and immediate care of the baby ( $\chi^2 = 6.63$ , 1 d.f.,  $p < 0.05$ ). There were also differences after birth in relation to type of delivery ( $\chi^2 = 4.17$ , 1 d.f.,  $p < 0.05$ ) and

immediate care of the baby ( $\chi^2 = 4.26$ , 1 d.f.,  $p = < 0.05$ ). The limited PC between fathers and their partner after the delivery suggests fathers felt this was not required, even when complicated childbirth or resuscitation of their baby was involved. However, other factors may have been influential such as their own emotional response, others present and/or events occurring at the time.

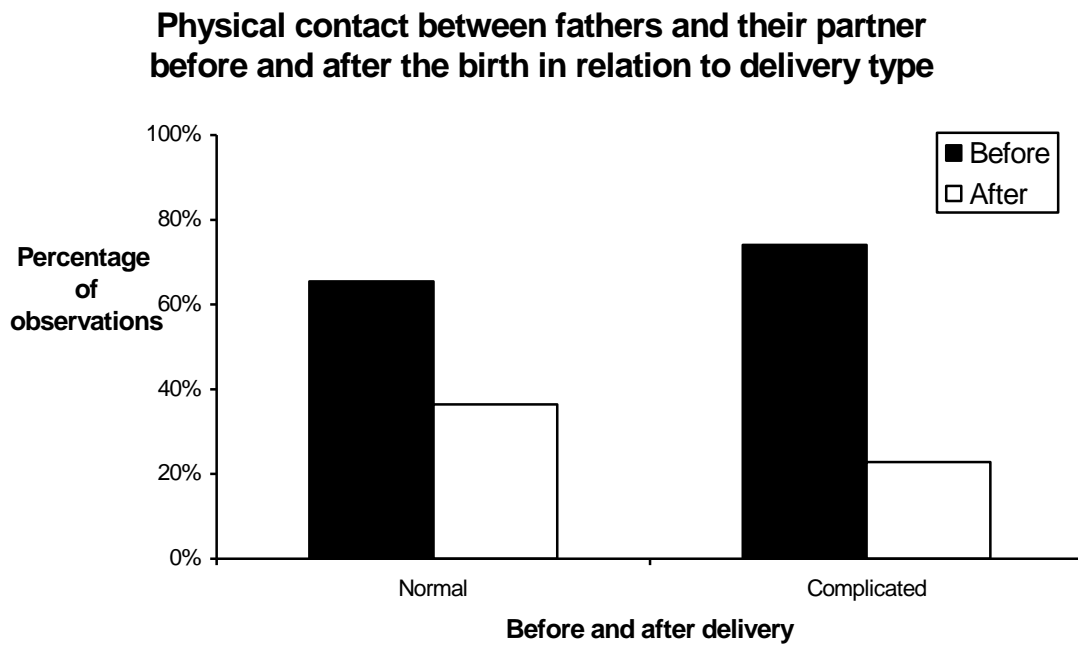


Figure 4.8 Physical contact between fathers and their partner before and after the birth in relation to delivery type

### Physical contact between fathers and their partner before and after the birth in relation to care of the baby

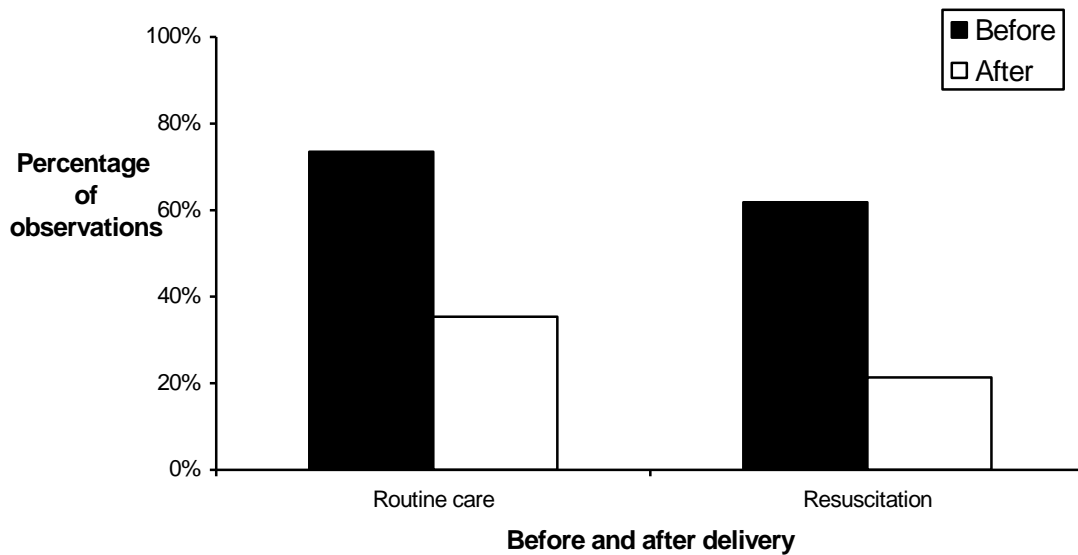


Figure 4.9 Physical contact between fathers and their partner before and after the birth in relation to care of the baby

Figure 4.10 shows that when fathers had PC with his partner he was also communicating with her for just over a third of the time (39.06%). For the remainder he was either communicating with someone else (20.24%) or no-one (40.70%). Whilst some fathers therefore appeared to focus their attention completely on their partner, others focused their attention to some extent elsewhere.

### With whom fathers were communicating during physical contact with their partner

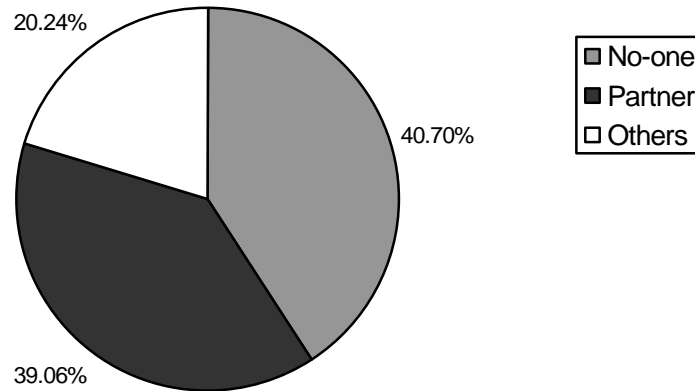


Figure 4.10 With whom fathers were communicating during physical contact with their partner

On a few occasions when fathers had PC with his partner but were communicating with someone else this was his baby (5.7%) or family members (5.7%). However, most commonly fathers were communicating with HCPs (88.55%) and Figure 4.11 identifies this was usually midwifery and theatre HCPs (mostly anaesthetists).

### Health care professionals with whom fathers were communicating during physical contact with his partner

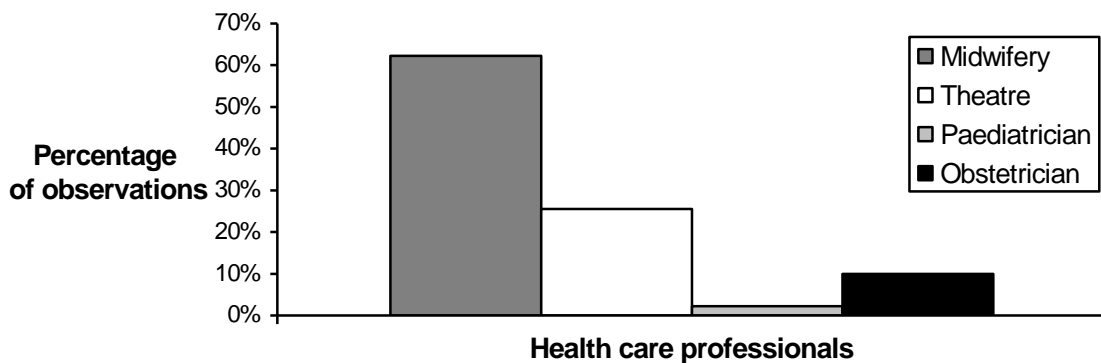


Figure 4.11 Health care professionals with whom fathers were communicating during physical contact with his partner

#### 4.12.2 Physical contact - no physical contact between fathers and their partner

Fathers did not have PC with his partner for just over a third of the time (37.09%) when she was present. Figure 4.12 shows the distance between the father and his partner in relation to delivery type. Despite periods of no PC, fathers were generally within 30cms of their partners. Whilst there was no significant difference in the total amount of time fathers had no PC with their partner in relation to delivery type, there was a difference in relation to distance. Fathers were a greater distance from their partners during normal deliveries ( $\chi^2 = 54.2$ , 1 d.f.,  $p = < 0.001$ ). One father (F120) determined this difference. He had no PC with his partner on 44 out of 46 occasions and for 40 of these, he was more than 30cms distance from her.

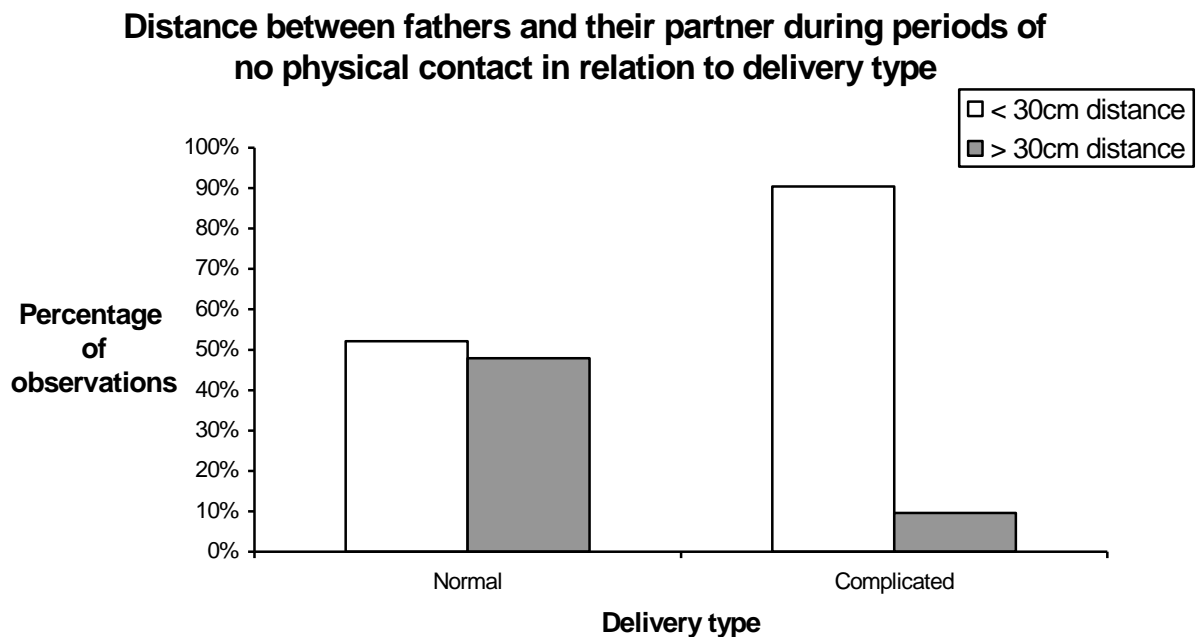


Figure 4.12 Distance between fathers and their partners during periods of no physical contact in relation to delivery type

Figure 4.13 shows the distance between the father and his partner in relation to the care of the baby. There was a significant difference in the total amount of time that fathers had no PC with their partner ( $\chi^2 = 16.34$ , 1 d.f.,  $p = < 0.001$ ). Fathers tended to be a greater distance from their partner when the baby required resuscitation. In some cases this was because they went over to the resuscitaire (Section 4.19.3). However, this was not a significant difference.

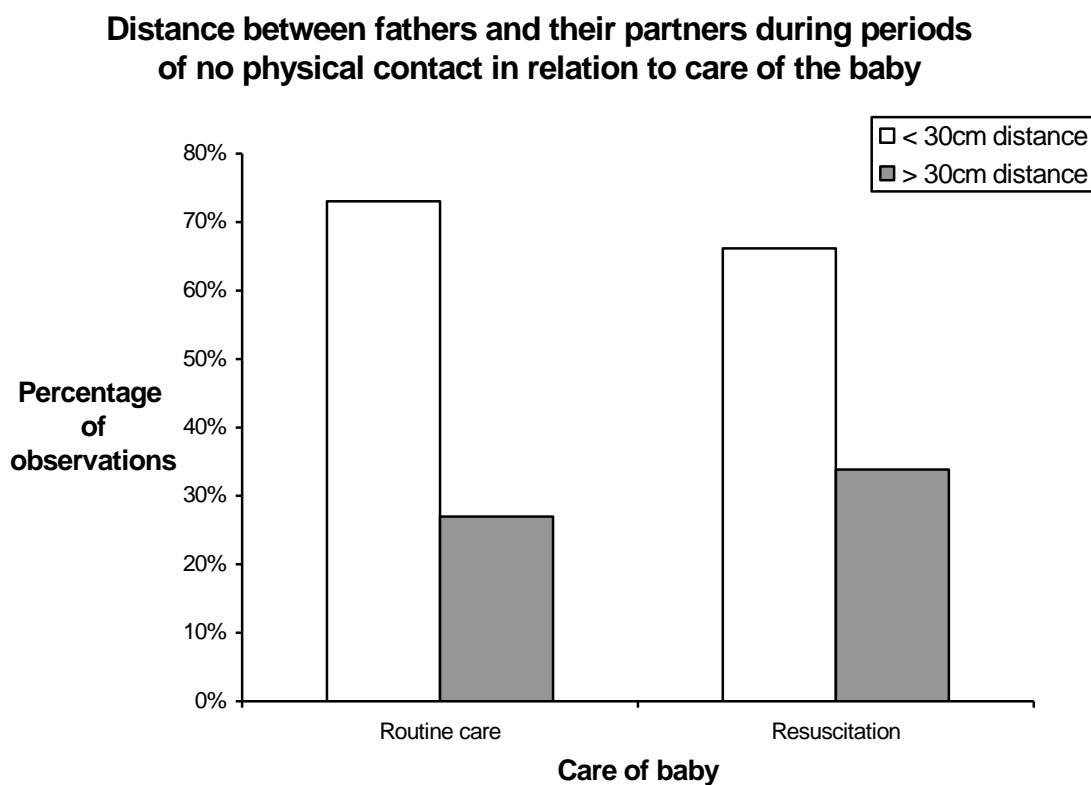


Figure 4.13 Distance between fathers and their partners during periods of no physical contact in relation to care of the baby

Figure 4.14 shows when fathers had no PC with their partner, they were communicating with her for just under a fifth of the time (19.44%). He was not communicating with anyone for just over half the time (51.59%). Fathers were communicating with someone



other than his partner for just over a quarter of the time (28.97%). On a small number of these occasions this was with his baby or family members. Mostly however, fathers were communicating with HCPs, usually midwifery and theatre HCPs.

#### **With whom fathers were communicating when no physical contact with their partner**

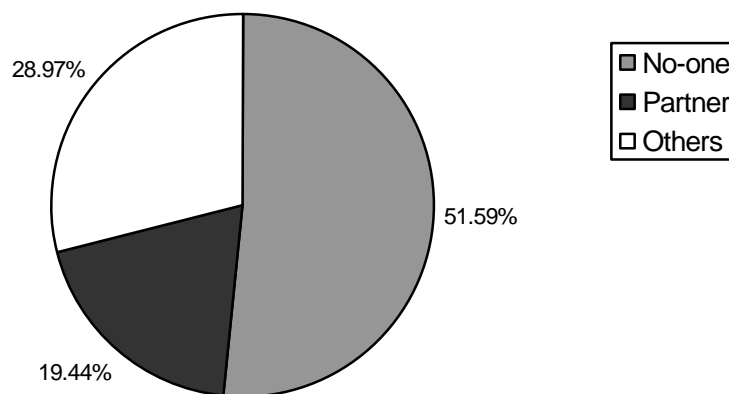


Figure 4.14 With whom fathers were communicating when no physical contact with their partner

#### **4.12.3 Physical contact – fathers’ physical contact with and holding their baby**

During the period of observations when both the father and his partner were present, there was one occasion when a father had PC with the midwife. The only other person with whom fathers had PC was his baby, but this occurred on only a small number of occasions (Section 4.12). Table 4.11 shows the range and mean length of time between the delivery and the fathers’ first PC in relation to delivery type and care of the baby. In this context ‘physical contact’ includes touching and stroking but not holding the baby. The mean length of time between the delivery and this first PC was 9 minutes, 30 seconds. However, fathers had PC with their baby sooner following complicated

deliveries. There were no differences in the mean lengths of time in relation to the care of the baby.

<b><i>CHARACTERISTIC</i></b>	<b><i>RANGE</i></b>	<b><i>MEAN</i></b>
<u>All</u> (n22)	2 – 21 minutes	9 minutes, 30 seconds
<u>Delivery:</u> Normal (n12)	2 – 21 minutes	10 minutes, 18 seconds
Complicated (n10)	4 – 19 minutes	8 minutes, 18 seconds
<u>Immediate care:</u> RC (n14)	2 – 20 minutes	9 minutes, 30 seconds
Resuscitation (n8)	4 – 21 minutes	9 minutes, 30 seconds

Table 4.11 Length of time from delivery to first physical contact between baby and father

Comparisons can be made between the father and his partner with regard to holding their baby. Two fathers and seven mothers did not hold their baby during the observations, although their partner did. Table 4.12 provides information regarding these occasions. Mothers did not hold their baby following delivery in the operating theatre for practical and logistical reasons. In all cases the anaesthetist required access to their intravenous infusions and was monitoring their condition. It was also difficult for mothers to hold their baby when lying supine with a screen almost immediately in front of them. One mother did hold her baby post-LSCS but did so with great difficulty. She needed assistance from the midwife, her partner and the anaesthetist in order to do this.

<b>PARENT</b>	<b>DELIVERY</b>	<b>CARE OF BABY</b>	<b>REASON</b>
Father	Normal	RC plus suction, manual breaths, oxygen	Baby admitted to NNU, no opportunity to hold baby
Father	Ventouse	RC	Father went home without holding baby
Mother	Forceps	RC plus face mask oxygen	Baby taken from theatre before opportunity to hold
Mother	Urgent LSCS	RC	Baby taken from theatre before opportunity to hold
Mother	Elective LSCS	RC	Baby taken from theatre before opportunity to hold
Mother	Crash LSCS	RC plus face mask oxygen	Baby taken from theatre before opportunity to hold
Mother	Urgent LSCS	RC	Baby taken from theatre before opportunity to hold
Mother	Crash LSCS	RC plus suction, face mask oxygen	Baby taken from theatre before opportunity to hold
Mother	Urgent LSCS	RC	Baby taken from theatre before opportunity to hold

Table 4.12 Fathers and mothers who did not hold their baby during the observations

Nine mothers held their baby immediately from birth. The babies were delivered onto her abdomen/chest and required RC only. The length of time from birth until holding their baby can be compared for the remaining six mothers and 20 fathers. Table 4.13 indicates that fathers often waited much longer than their partner.

<b>PARENT</b>	<b>RANGE</b>	<b>MEAN</b>
Fathers* (n20)	4 - 57 minutes	13 minutes, 12 seconds
Mothers** (n6)	5 – 12 minutes	8 minutes, 36 seconds

\* Two fathers did not hold their baby during the observations

\*\* Seven mothers did not hold their baby during the observations and nine mothers held their baby immediately after the birth

Table 4.13 Length of time before fathers and mothers held their baby when they did not hold their baby from birth

Fathers held their baby sooner following complicated deliveries (mean 7 minutes, 5 seconds) in comparison to normal deliveries (mean 18 minutes, 12 seconds). This correlates with data showing that mothers did not usually hold their baby following complicated deliveries (Table 4.12). As might be expected, fathers held their baby more quickly following RC (mean 11 minutes, 18 seconds) in comparison to occasions when the baby required resuscitation (mean 16 minutes, 30 seconds).

Figure 4.15 shows that fathers were communicating with his partner for just over a fifth of the time (22.09%) when they had PC with or held their baby. For most of the remaining time they were communicating with someone other than his partner (65.12%). On most occasions this was his baby or HCPs, usually paediatricians or midwifery HCPs. This suggests that on these occasions fathers had a conflicting focus of attention.

### With whom fathers were communicating whilst holding or during physical contact with their baby

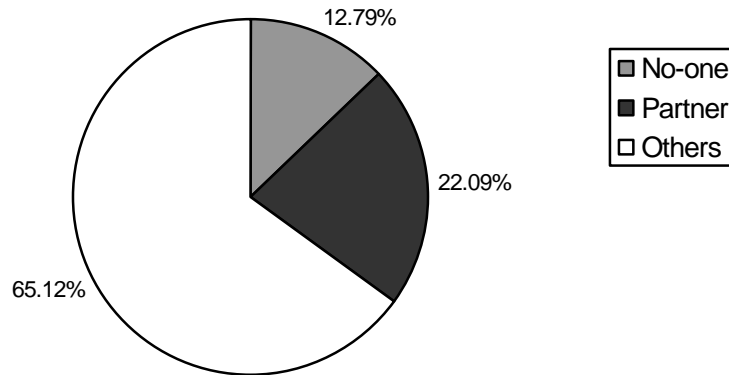


Figure 4.15 With whom fathers were communicating whilst holding or during physical contact with their baby

#### 4.12.4 Physical contact – mothers' physical contact

Mothers had PC with a number of HCPs including theatre HCPs, obstetricians and most commonly, midwifery HCPs. Whilst there were differences in relation to the type of delivery ( $\chi^2 = 47.73$ , 1 d.f.,  $p = < 0.001$ ) there were no differences in relation to the care of the baby. Family members were present for seven deliveries (Section 4.10.4) and they all had PC with the mother at some time, as Figure 4.16 identifies. They did not however, have PC with the father when the mother was also present.

## Physical contact between mothers and family members

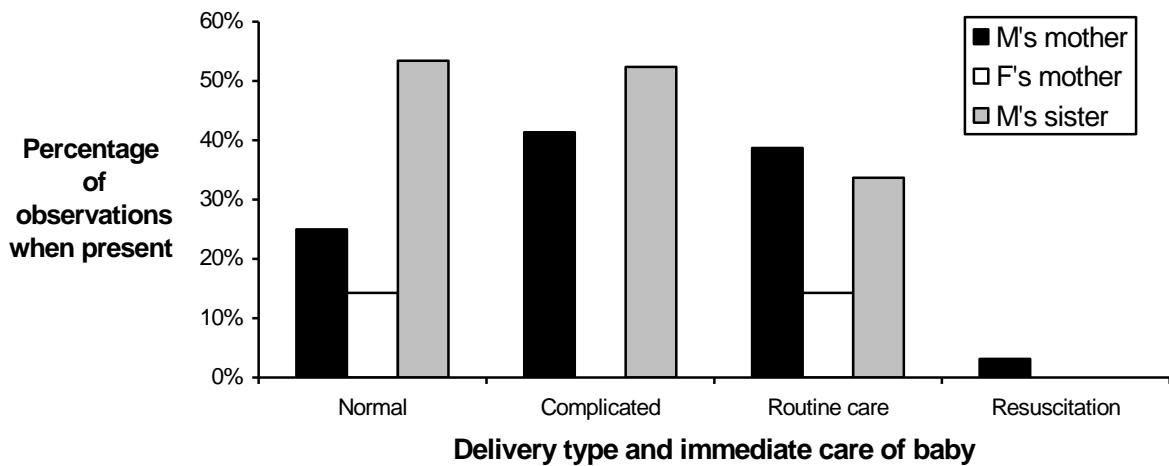


Figure 4.16 Physical contact between mothers and family members

### 4.12.5 Physical contact – discussion

Fathers appeared to use PC and staying within close proximity as ways in which to support their partner. Relinquishing this contact after the birth suggests fathers felt this level of support was no longer required. They may also have felt less useful at this time. Events occurring after the birth and the interventions of others may also have had an impact on this diminished level of contact. Although fathers had PC with and sometimes held their baby after the delivery this was usually after the mother had held the baby. Conversely fathers usually held the baby before their partner following LSCS deliveries. This appeared to be because it was difficult for the mother to hold the baby rather than a specific intention to involve the father.

Whilst family members and some HCPs utilised PC as a strategy to support the mother, neither group used this as a way to support the father. Family members would probably say supporting the father was not their priority. HCPs may also feel their duty of care is to the mother (Section 5.11.2) or do not see supporting fathers as part of their role

(Section 5.10). HCPs may also feel some fathers would regard PC an intrusion, particularly given that in most cases they were previously unknown to the them.

#### 4.13 Verbal communication

Figure 4.17 shows fathers were not engaged in verbal communication (VC) with anyone (no-one) for just under half the observations when their partner was present (42.22%). For a third of the time fathers were communicating with their partner (34.02%). For the remainder fathers were engaged in VC with others; HCPs, the baby and family members.

**Fathers' verbal communication when their partner was present**

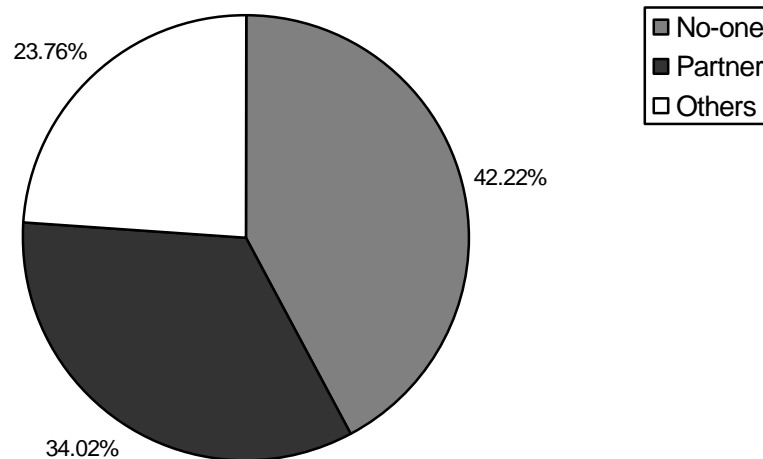


Figure 4.17 Fathers' verbal communication when their partner was present

#### 4.13.1 Verbal communication – verbal communication between fathers and their partner

Figures 4.18 and 4.19 show that regardless of the type of delivery or whether the baby required resuscitation fathers spoke to their partner more than she spoke to him. This will be partly because during a substantial proportion of the observations most mothers were experiencing contractions. No significant differences were identified in fathers being spoken to by their partner in relation to either the type of delivery or care of the baby or fathers speaking to their partner in relation to delivery type. However, a difference was found in relation to fathers speaking to their partner in relation to care of the baby ( $\chi^2 = 6.27, 1 \text{ d.f.}, p = < 0.02$ ). This suggests fathers were not speaking to their partner as a way of reassuring her about the baby.

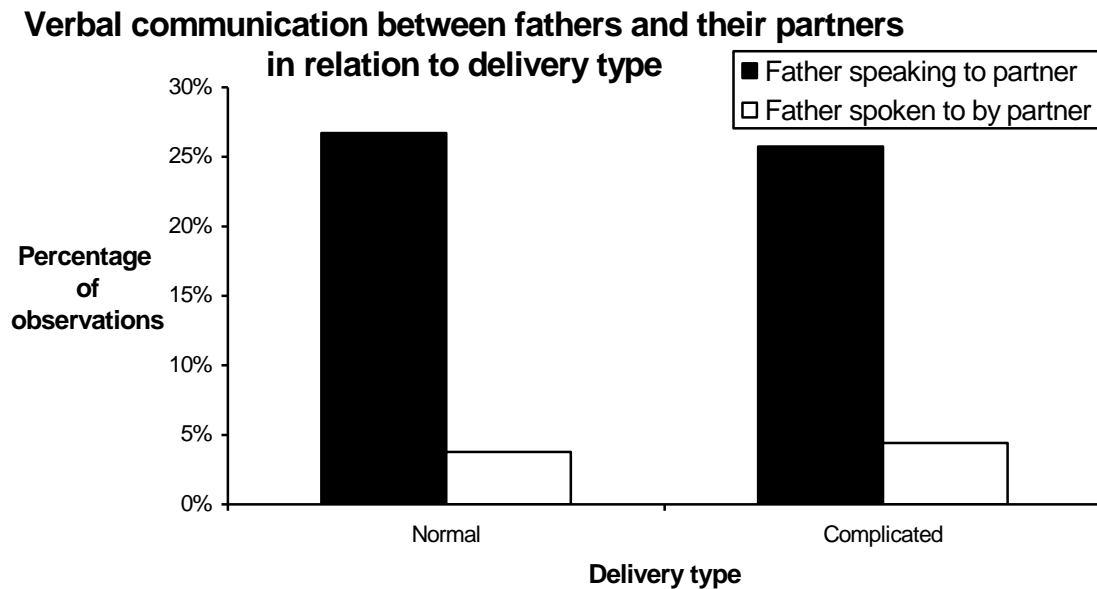


Figure 4.18 Verbal communication between fathers and their partners in relation to delivery type



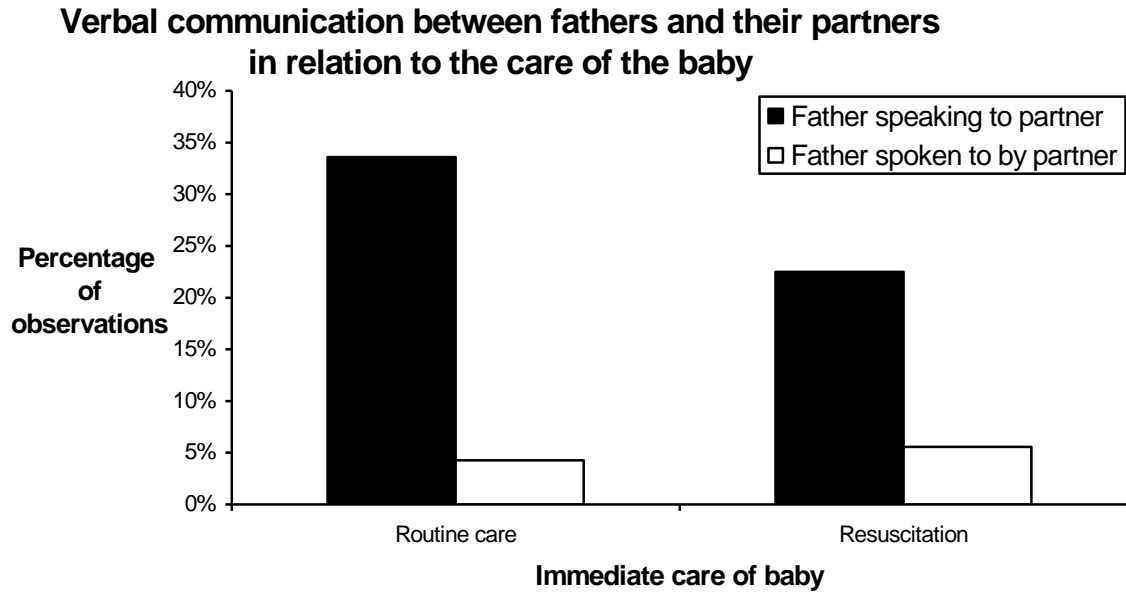


Figure 4.19 Verbal communication between fathers and their partners in relation to the care of the baby

Figure 4.20 shows that fathers spoke to their partner more frequently before the birth. This may be because they were supporting and reassuring her at this time. After the birth their attention was probably also distracted to some extent by the baby. Significant differences were only found in fathers speaking to their partner in relation to care of the baby. Before the birth this was ( $\chi^2 = 4.46$ , 1 d.f.,  $p = < 0.05$ ) and after ( $\chi^2 = 4.41$ , 1 d.f.,  $p = < 0.05$ ). By contrast Figure 4.21 shows that mothers generally spoke to their partner more frequently after the birth. Coping with contractions and other distractions immediately prior to the birth probably restricted their involvement in verbal communication. No significant differences were found in relation to either delivery type or care of the baby.

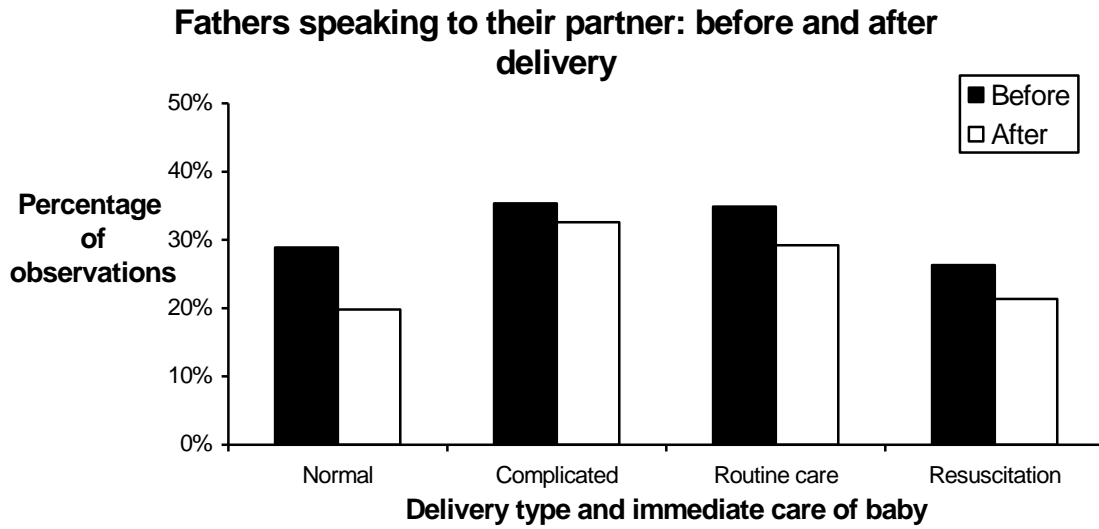


Figure 4.20 Fathers speaking to their partner: before and after delivery

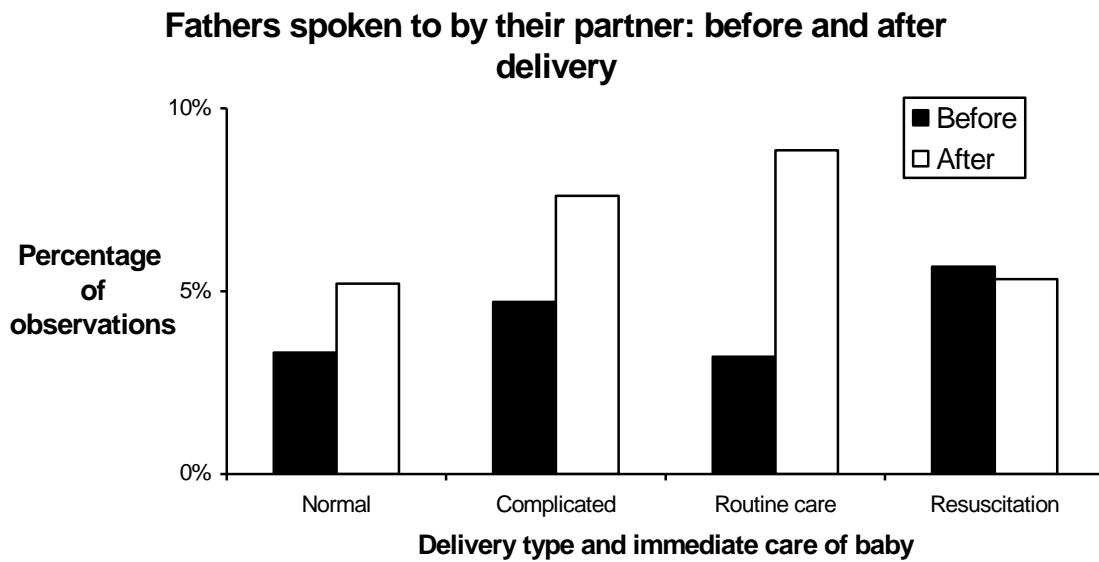


Figure 4.21 Fathers spoken to by their partner: before and after delivery

#### 4.13.2 Verbal communication – verbal communication between fathers and others

Fathers sometimes engaged in VC with HCPs, the baby and family members (Section 4.13) (23.76%) when their partner was present. Figure 4.22 shows the proportion of time fathers were speaking to HCP groups in relation to delivery type and care of the baby. Fathers spoke most frequently to theatre HCPs (usually anaesthetists).

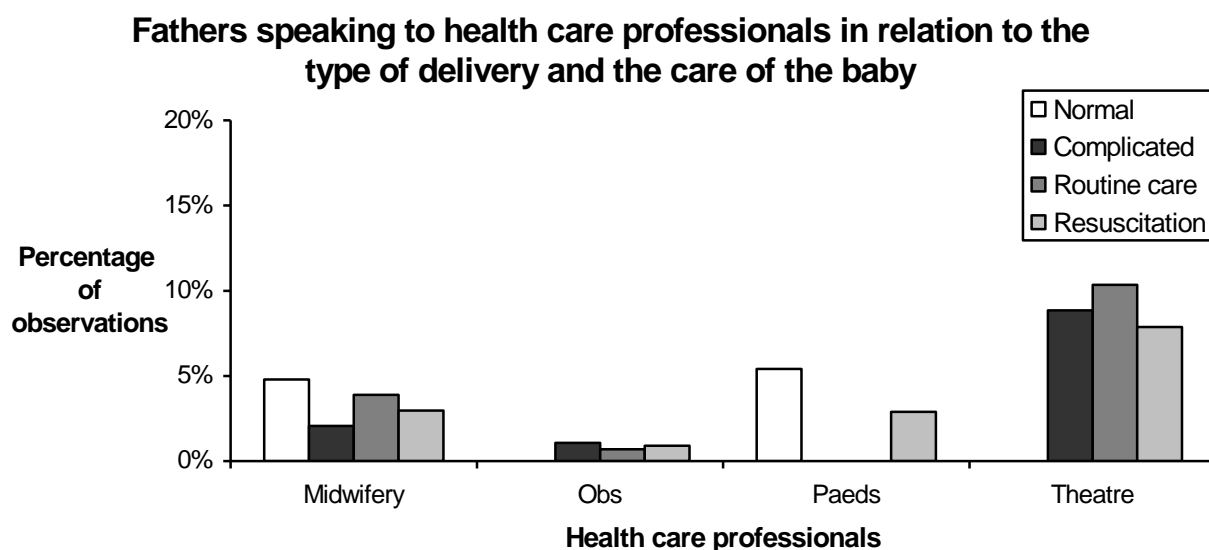


Figure 4.22 Fathers speaking to health care professionals in relation to the type of delivery and the care of the baby

Significant differences were found in fathers speaking to midwifery HCPs ( $\chi^2 = 4.36$ , 1 d.f.,  $p < 0.05$ ) and paediatricians ( $\chi^2 = 3.48$ , 1 d.f.,  $p < 0.10$ ) in relation to the type of delivery. However, no significant differences were found in relation to the care of the baby. Figure 4.23 shows the proportion of time fathers were spoken to by HCP groups in relation to delivery type and care of the baby. Theatre staff and paediatricians most frequently spoke to fathers. This correlates with the findings reported in Figure 4.22.

### Fathers spoken to by health care professionals in relation to the type of delivery and the care of the baby

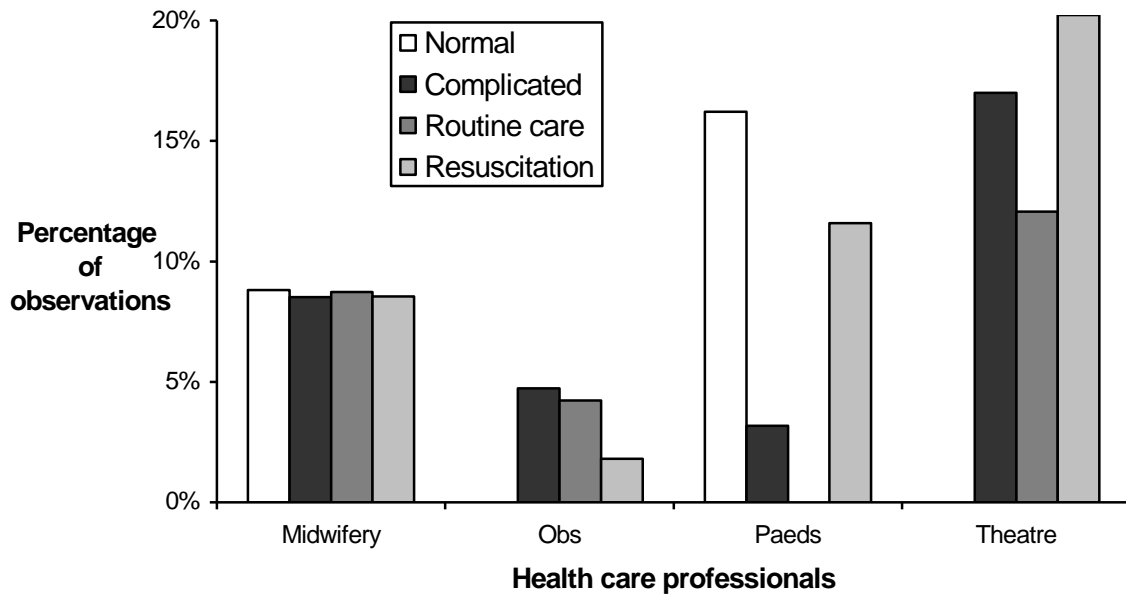


Figure 4.23 Fathers spoken to by health care professionals in relation to the type of delivery and the care of the baby

Significant differences were found in fathers being spoken to by obstetricians ( $\chi^2 = 2.93$ , 1 d.f.,  $p = < 0.10$ ) and paediatricians ( $\chi^2 = 5.39$ , 1 d.f.,  $p = < 0.05$ ) in relation to the type of delivery and by paediatricians ( $\chi^2 = 3.90$ , 1 d.f.,  $p = < 0.05$ ) in relation to the care of the baby. Figure 4.24 compares VC between mothers and fathers and collated HCP groups. Midwifery HCPs most frequently spoke to mothers. By contrast, fathers were most commonly spoken to by theatre HCPs. In every case, mothers were spoken to by HCPs more than she spoke to them. This correlates with the pattern of VC between fathers and their partner (Section 4.13.1).

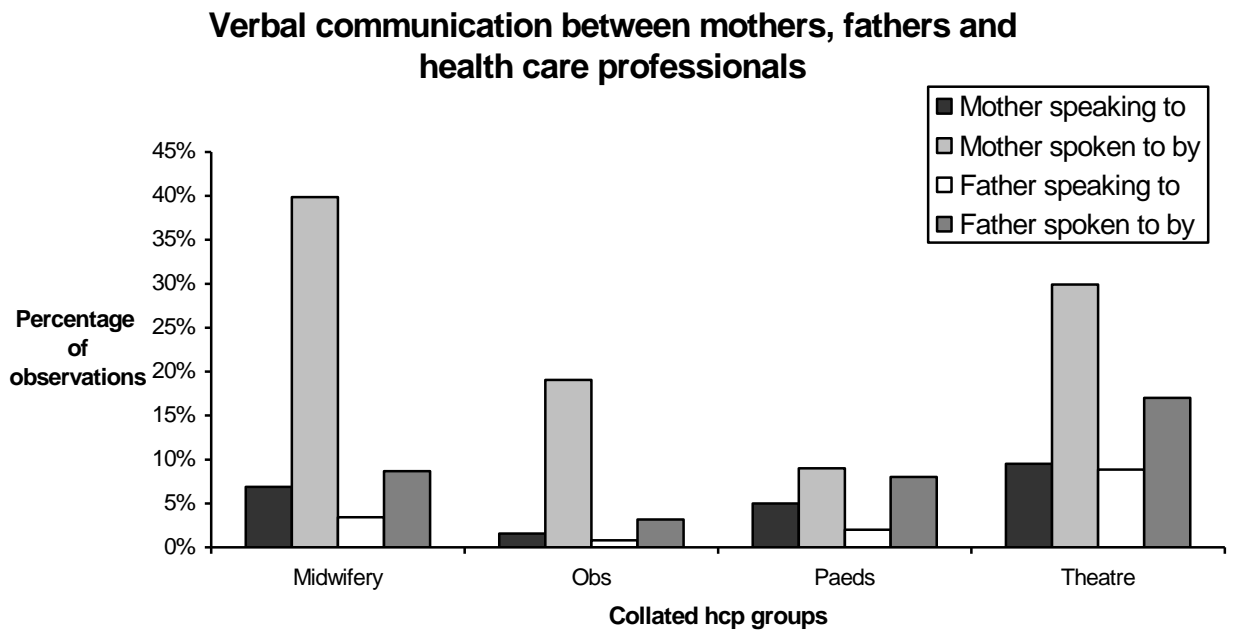


Figure 4.24 Verbal communication between mothers, fathers and health care professionals

Fathers did not speak to their baby before the delivery. They may not have done this during the pregnancy and/or they may have felt uncomfortable doing this in the presence of others. Once the baby was delivered, fathers did speak to their child. Figure 4.25 compares mothers and fathers undertaking this activity. In every situation except normal deliveries fathers spoke to their baby more than the mother. Significant differences were found in relation to complicated deliveries ( $\chi^2 = 9.21$ , 1 d.f.,  $p < 0.01$ ) and resuscitation of the baby ( $\chi^2 = 6.32$ , 1 d.f.,  $p < 0.02$ ).

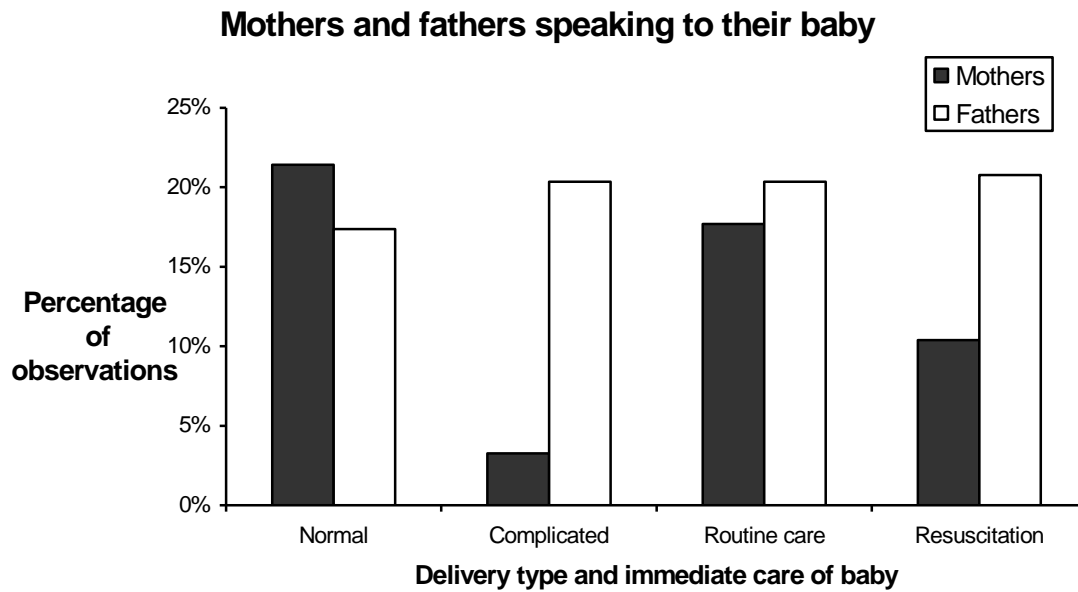


Figure 4.25 Mothers and fathers speaking to their baby

Family members all communicated with the mother, as Figure 4.26 identifies. However, they rarely communicated with the father when his partner was present. Although fathers spoke to their partner’s mother and sister, they rarely spoke to him. There was also no VC between one father (F100) and his own mother. No significant differences were found between fathers and mothers speaking to family members but a significant difference was found in relation to fathers and mothers being spoken to ( $\chi^2 = 10.22$ , 1 d.f.,  $p < 0.01$ ).

### Verbal communication between fathers, his partner and family members

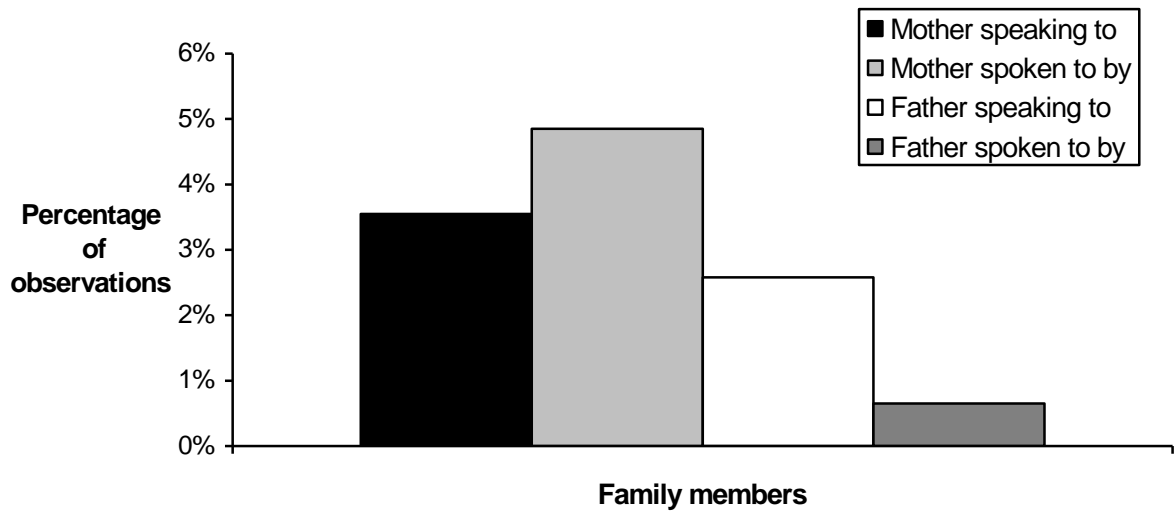


Figure 4.26 Verbal communication between fathers, his partner and family members

#### 4.13.3 Verbal communication – summary

Fathers were not engaged in VC with anyone for almost half the observations. They may have felt it was more important for them to observe events and listen to what others, particularly HCPs were saying. Fathers used VC as a means of supporting their partner to some extent but this was less common after the birth. This strategy was also less frequently used when the baby required resuscitation. On these occasions fathers may have been too distracted or were utilising coping strategies to manage their own emotions (Section 1.7). They may also have not known what to say during these circumstances. As might be anticipated there were differences in the HCP groups with whom mothers and fathers had VC. All HCP groups spoke more frequently to the mother. Fathers generally spoke to their baby more frequently than mothers after the birth. This may have been a father's way of making a connection with the baby whilst their partner held the baby. Mothers may also have been too exhausted to have VC. The limited VC between fathers and family members reflects the limited amount of PC between them (Section 4.12.5).

#### 4.14 Activity – fathers’ activity when his partner was present

Activity of the father has been collated in terms of him standing, kneeling or sitting. Figure 4.27 shows this activity in relation to type of delivery and care of the baby. In all situations fathers were standing for almost two thirds of the time or longer (62.45 – 89.73%). Two fathers briefly knelt during deliveries. One was a water-birth whilst the other took place on a mattress on the floor of the delivery room.

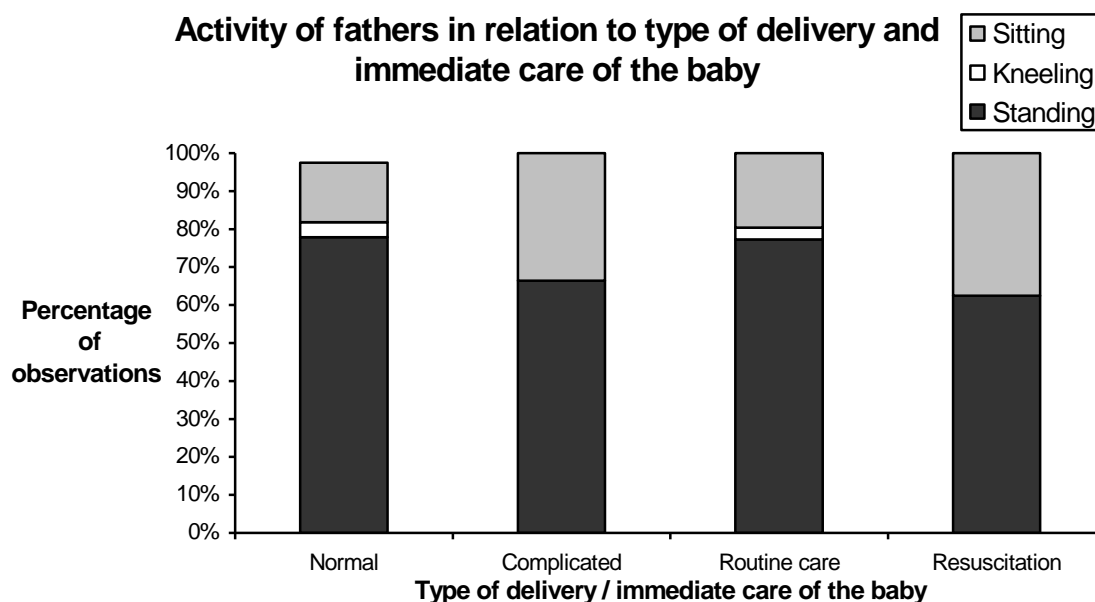


Figure 4.27 Activity of fathers in relation to type of delivery and immediate care of the baby

Figure 4.28 shows fathers were standing for just over three quarters of the time (76.21%) before the delivery and just over half the time (54.25%) after. In some instances when fathers were seated after the delivery he was holding his baby.



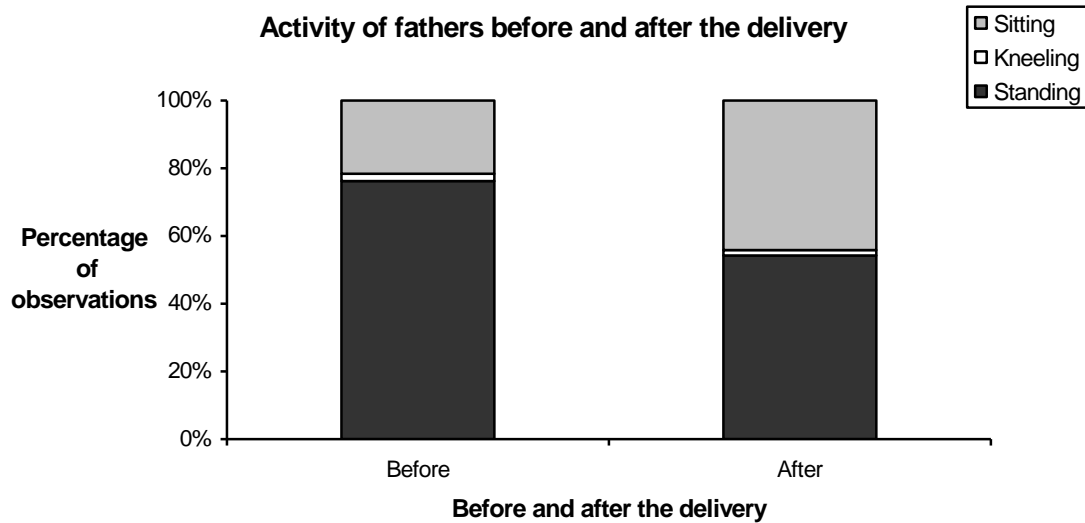


Figure 4.28 Activity of fathers before and after the delivery

#### 4.14.1 Activity – summary

Fathers were standing for most of the observations, which they may well have found exhausting. There were only two occasions when fathers sat for periods of time. The first was during LSCS deliveries when there was no other option. The second was when they held the baby after the birth. On most occasions the midwife indicated they should sit whilst they did this.

#### 4.15 Fathers' physical contact, verbal communication and activity when his partner was not present

There were nine occasions when observations were recorded when the mother was not present (Section 4.10). During these observations most fathers continued to have PC with their baby: range 0 - 100%, mean 31.25%. One father had PC with his partner's mother when he returned to the operating theatre recovery area following a LSCS delivery.

Figure 4.29 shows fathers most commonly communicated with HCPs (midwives and neonatal nurses) (59.37%) when their partner was not present. For a quarter of the observations (24.99%) fathers communicated with others; the baby, his partner's mother and another mother waiting for an elective LSCS. Fathers did not communicate with anyone for a small amount of time (15.64%).

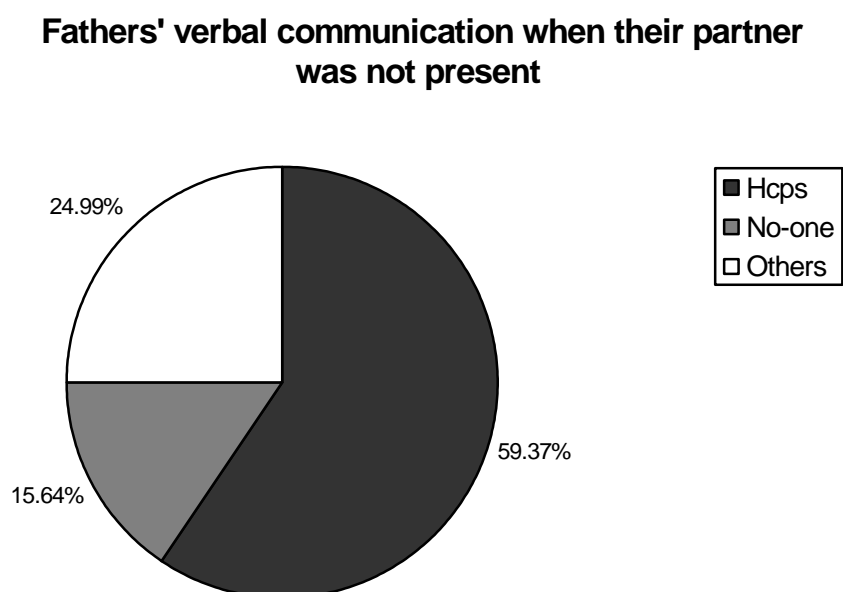


Figure 4.29 Fathers' verbal communication when their partner was not present

With regard to their activity on these occasions, fathers were standing for most of the time (87.5%) and sitting for the remainder. These observations mostly took place in the operating theatre recovery area, where limited seating was available.

#### 4.16 Qualitative data

The subsequent sections provide further detail about the actions and behaviours occurring during the observations. Qualitative data primarily focusing upon the fathers will be described. Four key themes were identified in the analysis: 'being connected', 'not connected' 'the birth and immediate care of the baby' and 'support from others' (Figure 4.30). Extracts from field notes and the researcher's reflective diary will illustrate these themes. For clarity the following codes have been used:

F	Father
M	Mother
B	Baby
MW	Midwife
MWS	Midwifery student
MA	Midwifery assistant
NN	Neonatal nurse
NuN	Nursery nurse
D	Doctor (obstetrician, paediatrician or anaesthetist)
ODP	Operating department practitioner
MS	Medical student
MM	Mother's mother
FM	Father's mother
MSR	Mother's sister
MEH	The researcher's initials

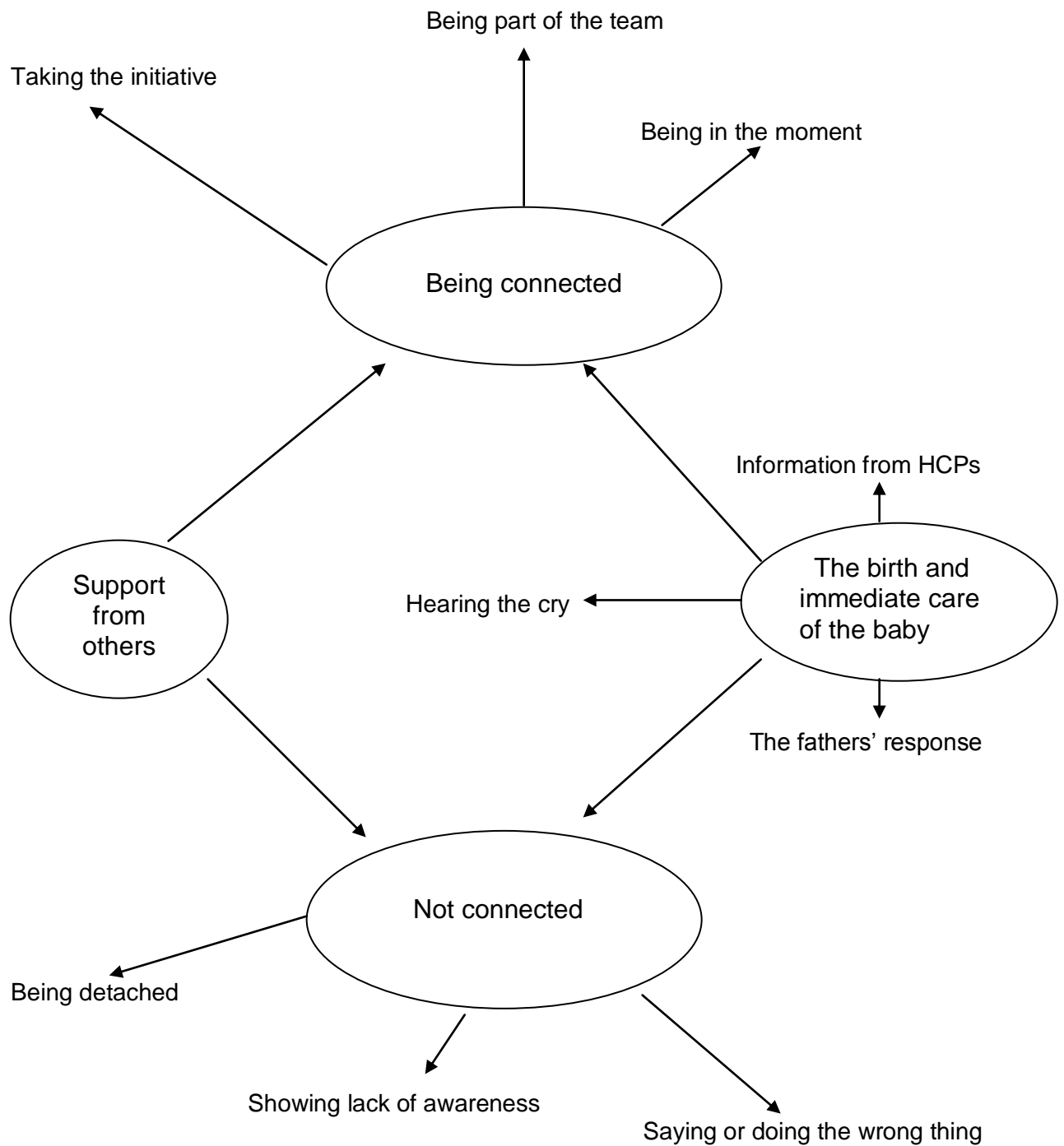


Figure 4.30 Phase two themes

#### **4.17 'Being connected'**

This theme focuses on occasions when fathers appeared to be aware of what was happening and seemed to respond accordingly. All fathers were observed portraying behaviours relating to this theme before, during and/or after the birth. Three sub-themes were identified: 'being in the moment', 'being part of the team' and 'taking the initiative' and these will now be described.

##### **4.17.1 'Being connected' – being in the moment**

At times, fathers appeared to be completely focused on their partner. They maintained eye contact with her or looked at her intently. During contractions, fathers often breathed with her in harmony. Some held their partner in such a way that seemed to exclude others. Fathers often spoke softly to her; at times this was almost in a whisper. One father sang to his partner and held her as he did this. On occasions fathers seemed unaware of anyone else and as such, his 'connection' appeared to be exclusively with his partner. These behaviours were mostly observed before the birth.

##### F123 – Forceps delivery / resuscitation

F123 is holding M123's hand and he is speaking softly to her as she pushes. There's very close eye contact between the two of them.

##### F110 – Normal delivery / routine care

There was fantastic interaction almost throughout between F110 and M110. F110 appeared to be totally focused on her. They were breathing in harmony and for most of the time they maintained eye contact with each other. He seemed to be wrapped up in her world.

Once the baby was delivered, most fathers interacted with him/her in a way that suggested he was making a connection. Both verbal and non-verbal strategies were observed. These included intense gazing and holding the baby close to his face. Fathers often stroked, touched, caressed, rocked, kissed or explored their baby. Two fathers had

skin-to-skin contact with their child. Fathers made faces, smiled and laughed at their baby. They spoke to him/her using gentle tones and sometimes made 'shushing' noises, particularly if he/she was crying. These appeared to be instinctive behaviours and are associated with bonding theories (Section 1.2.3). These behaviours may also have been the fathers' attempt to exclude others. One father spoke to his baby in his native tongue (Spanish). He may have been trying to make this a special moment between the two of them. He may also have spoken to his son this way when in utero.

#### F101 – Urgent LSCS / routine care

F101 kisses B101's forehead and then unwraps his blanket and begins to explore him.

#### F105 – Crash LSCS / resuscitation

F105 continues to hold B105. He is whispering to B105 and rocks her gently.

Other behaviours relating to this theme were observed when fathers became aware something had or was about to happen. Often this was close to the delivery when the atmosphere became tense. Fathers sometimes used strategies to create a diversion such as humour to lighten the situation or starting a conversation. Those present appeared to respond positively to these strategies. It appeared that their judgment in using these approaches was correct.

#### F112 – Urgent LSCS / routine care

F112 ties up M112's hair and says "this isn't my forte, it's not in my contract." F112 goes on to say guidance should be given in pregnancy books about how to tie up hair.

#### F124 – Ventouse delivery / routine care

F124 says "OK, I'm ready, you can have it now" and everyone laughs.

#### **4.17.2 'Being connected' – being part of the team**

Most fathers undertook activities suggesting they wanted to be part of the team. These actions were observed before, during and after the birth. Most often fathers undertook activities without being asked, indicating an awareness of ways in which they could help others. On occasions when asked to help, they appeared to do so willingly. This response may reflect the father's personality. They also may have felt they would be more readily accepted and helping the HCPs would enable them to focus on caring for their partner.

All fathers were observed helping to meet their partner's physical needs, mostly before or during the birth. This was mostly done without their being asked and included helping her to adjust or change her position, fetching her drinks, wiping her face, tidying her hair, helping her change her clothes, straightening the bedclothes and rubbing her back. In more extreme situations fathers were also observed helping his partner. They held her whilst epidurals and intravenous infusions were sited and when blood samples were taken and held bowls when she vomited.

##### F114 – Normal delivery / resuscitation

M114 says that she is going to vomit again. F114 looks for a replacement bowl, finds one and holds it for her.

##### F118 – Normal delivery / routine care

F118 is supporting M118 as she leans away from the pillows so that MWS12 can listen to the fetal heart rate with the sonicaid.

The most frequent behaviours observed in relation to this sub-theme were when fathers provided psychological care by supporting, encouraging and reassuring their partner. Although evident before, during and after the birth, this was less frequent during the latter. Fathers encouraged their partner as she pushed (normal, forceps and ventouse deliveries). They seemed to be trying to motivate her and maintain momentum. They

were positive and upbeat often remarking on how much of the head was visible. A commonly used phrase was 'you're nearly there.' Fathers gave direction and guidance whilst she pushed. These behaviours were generally undertaken with enthusiasm demonstrating a willingness to be involved.

#### F124 – Ventouse delivery / routine care

F124 says to M124 "you can see a bit more of his head every time."

#### F117 – Normal delivery / resuscitation

F117 is holding M117's hand and he is speaking to her. A baby can be heard to cry from the delivery room next door. F117 says to M117 "that'll be ours soon."

Other ways fathers supported their partners included stroking, embracing, kissing and holding. They often spoke quietly, maintaining eye contact and their remarks were usually positive. When mothers became distressed, fathers used strategies to calm them. Although they sometimes spoke more firmly they were still positive. Fathers often used short phrases such as 'it's OK' 'you can do it' and 'you're alright.'

#### F107 – Normal / routine care

M107 begins to scream. F107 says "it's fine, it's fine" with some urgency. MW12 says to M107 "give it some wellie and push her out". F107 says "it's OK, it's Ok."

#### F119 – Normal / routine care

M119 is becoming distressed and says "I just want it out" and "I'm scared of drips." F119 says "you'll be OK."

The final behaviours relating to this sub-theme occurred when fathers helped their partner establish a connection with their baby. This included holding the baby so she could see or kiss him/her after LSCS delivery and giving her information about the baby.



The latter was often done when the baby was being cared for on the resuscitaire. They often referred to her as 'mummy' when they spoke to the baby in her presence. Fathers appeared to sense it was important that their partner and baby made a connection and that they had a key role to play in this. Fathers often appeared to put his partner's needs above his own.

#### F101 – Urgent LSCS / routine care

F101 rocks B101 in his arms and says to him "here's mummy look" and he lifts B101 up to M101 again.

#### F120 – Normal delivery / resuscitation

F120 ((who is standing by the resuscitaire)) looks over to M120 and says, "he's a lovely boy."

### **4.17.3 'Being connected' – taking the initiative**

Before the birth several fathers advocated for his partner. This often happened when events diverted from the anticipated normal course. They seemed to sense a need for intervention. Fathers who had been some distance away often moved closer. They asked questions, made decisions, spoke on her behalf or repeated information to her. In a few extreme cases fathers directed HCPs, sometimes in an aggressive manner to either intervene or stop what they were doing.

#### F119 – Normal / routine care

The obstetricians are debating the plan of care and there appears to be some difference of opinion and confusion. Eventually F119 says "look, what are we doing here?"

#### F122 – Ventouse delivery / routine care

As the delivery is about to take place, D55 enters the room immediately followed by two medical students. D55 says to F122 "can I bring in these two junior doctors?" ((they are not doctors and they are already in the room)). M122 is crying. F122 looks very angry and says to D55 "no fuck off, it's not a bloody circus." MS12 and MS13 immediately retreat.

The other way fathers took initiative was by being vigilant. This occurred on all kinds of occasion, not just emergency situations. Fathers watched what HCPs were doing. They listened to what HCPs were saying to each other. Occasionally when it seemed HCPs did not want them to hear, fathers moved closer to listen to the conversation. Fathers looked around the screen during LSCS deliveries, watched monitors, read medical notes and looked at observation charts. They sometimes asked questions or reported their own observations, usually to the midwife.

#### F100 – Normal delivery / routine care

F100 is standing up. Although he has his arm on M100's back he is watching MW19 intently.

#### F112 – Urgent LSCS / routine care

The fetal heart rate drops slightly during the contraction and F112 immediately looks over to MW33.

It appeared that all fathers were connected with what was occurring at some point. Most observed behaviours and actions were undertaken spontaneously with minimal prompting from others.

### **4.18 'Not connected'**

In contrast to the above, this theme consists of behaviours that suggested fathers were unaware of what was happening and/or they responded in a way that was judged by mothers, HCPs and/or family members to be inappropriate. Although several fathers portrayed behaviours relating to this theme before, during and/or after the birth, this occurred less frequently than the previous theme. Three sub-themes were identified: 'being detached', 'saying or doing the wrong thing' and 'showing lack of awareness' and these will now be described.

#### **4.18.1 'Not connected' – being detached**

Several fathers appeared to become detached from or no longer part of events. Most commonly this happened immediately before or after the birth. These behaviours were observed regardless of the type of delivery or the anticipated outcome. Some fathers relinquished physical contact with their partner, moved away, often with their arms folded. One father retreated into the corner of the room. Fathers reacting in this way appeared to merge into the background. They usually did not speak and they did not respond when spoken to. They often looked into space or stared at the floor. A few seemed to occupy themselves with unrelated activities such as reading a newspaper or playing games on their mobile telephone.

##### F100 – Normal delivery / routine care

M100 is pushing. F100 moves some distance away to the corner of the room and has his arms folded. M100 is crying; she puts her arm out to F100 as if she wants him to take it, but he does not respond to her doing this.

##### F112 – Urgent LSCS / routine care

The atmosphere instantly changed at 15.36. A whole troop of people arrived; it was a bit like the cavalry coming on a mission to rescue M112. F112 seemed to merge into the distance as the HCPs crowd around the bed.

#### **4.18.2 'Not connected' – saying or doing the wrong thing**

In direct contrast to fathers who successfully created a diversion (Section 4.17.1) some used humour that was not appreciated. Attempts to help their partner were also sometimes rejected. It seemed these fathers were either misreading the situation or their judgment regarding strategies were incorrect.

#### F120 – Normal delivery / resuscitation

M120 is pushing and MW46 is encouraging her. MW46 asks F120 “do you want to see the baby’s head with the next push?” F120 says “no, I’m too frightened.” MW46 says “what of?” and F120 says “her” ((M120)) and laughs. M120 says “thanks.” ((M120 appears annoyed by this response)).

#### F122 – Ventouse delivery / routine care

F122 attempts to wipe M122’s face with a damp cloth. She swipes her hand at him and he moves away.

### **4.18.3 ‘Not connected’ – showing lack of awareness**

The other way some fathers appeared not be connected was when they seemed unaware of what was happening. This response was generally observed immediately before or after the birth. A few fathers did not respond to comments made by HCPs about changes in the fetal heart rate or the baby’s potential need for resuscitation. Some fathers did not appear to notice audible changes in the fetal heart rate. However, these responses may have been strategies used by fathers to cope with sudden changes in the situation (Section 1.7). A few fathers misunderstood what they were told or talked at cross-purposes. Several looked confused when events occurred even though HCPs had previously explained what was going to happen. One father was unaware his preterm baby would require NNU admission although the midwife had told him this. Another father thought the midwife told him he had to take the baby home that evening whilst his partner remained in hospital.

#### F111 – Normal delivery / resuscitation

There was some confusion over B111 going to NNU. F111 hadn’t understood the baby required admission.

#### F112 – Urgent LSCS / routine care

MW12 commented on the changes in the fetal heart rate and the baby needing more oxygen. F112 smiled and seemed to be unconcerned.

There were occasions when fathers were unaware of what was occurring. In some instances they had some level of awareness but misjudged the situation. There were occasions when fathers had been given information but appeared subsequently not to remember. To some extent these fathers could have been helped by clearer explanation or repetition of information.

#### **4.19 'The birth and immediate care of the baby'**

This theme focuses on the birth and care of the baby. Thirteen babies were taken immediately to the resuscitaire. Eight of these were delivered in the operating theatre. The midwife responsible for the mother's care took the baby from the obstetrician to the resuscitaire where on most occasions the paediatrician was waiting. The paediatrician then led the care of the baby assisted by the midwife. A paediatrician was not present at one of the deliveries (elective LSCS) and two midwives undertook this baby's care. The remaining five babies (born in a delivery room) were taken to the resuscitaire by the person who conducted the delivery (usually the midwife). In most cases the paediatrician was present, in one case they arrived shortly afterwards. The paediatrician led the care of the baby, assisted by a second midwife. The midwife caring for the mother was usually involved in the third stage of labour. Of the 13 babies taken to the resuscitaire, eight required resuscitation (Table 4.7). Four of these babies were delivered in the operating theatre, the remainder in a delivery room. The five babies who required RC were returned to the parents shortly afterwards. Within this theme events occurring around the time of the baby's birth are described. Three sub-themes: 'information from health care professionals', 'hearing the cry' and the 'the fathers' response' will be explored in the following sections. Whilst fathers are the main focus of this theme, some aspects relate to the parents collectively.

#### **4.19.1 'The birth and immediate care of the baby' – information from health care professionals**

Regardless of the setting, HCPs entering the scene to assist in the care of the baby said very little to the parents. In some cases, particularly in the operating theatre, the parents were probably unaware additional HCPs had been present. By contrast, midwives entering the scene usually did speak but their comments were mainly directed to the mother. When the baby was taken to the resuscitaire a brief comment was sometimes made but there was no reference to the baby's actual or potential need for resuscitation.

##### F104 – Elective LSCS / routine care

MW23 has taken B104 over to the resuscitaire. As she did this she said to M104 "we'll take him and dry him".

##### F117 – Normal delivery / resuscitation

MW43 has cut the cord and carried B117 to the resuscitaire. B117 is blue and limp, making an occasional gasp. No comment is made to the parents.

The anaesthetist (if present) usually gave the parents information whilst the baby was being cared for on the resuscitaire. Sometimes they gave a running commentary of what was happening. They also often talked about general things such as the sex of the baby or the amount and colour of the baby's hair. They were generally positive, their manner was calm and reassuring and on a few occasions humour was used.

##### F121 – Urgent LSCS / resuscitation

D49 looks over to the resuscitaire and says "she's definitely a girl."

##### F101 – Urgent LSCS / routine care

D17 says "he's going to come over in a second. Have a quiet one next time."

Less commonly an obstetrician or midwife gave information to the parents whilst the baby was being cared for on the resuscitaire. As a consequence of a lack of proximity, their comments were usually shouted from the other side of the room.

#### F123 – Forceps delivery / resuscitation

*MW23 calls over from the resuscitaire “she’s fine. We’re just going to wait here until she gives us a big cry.” D51 is drying B123 who is quiet*

Once care of the baby was completed, it was usually the midwife who took him/her back to the parents. She generally gave no or very limited information about the care the baby had received. In a few instances the paediatrician spoke to the parents before he/she left the room. The midwife usually instigated this and on these occasions, information was directed to both parents. In most cases the paediatrician left the scene without having spoken to the parents regardless of whether the baby required resuscitation. This is contra to current practice guidelines (European Resuscitation Council 2006; Resuscitation Council 2006).

#### F117 – Normal delivery / resuscitation

D41 explains to M117 and F117 that B117 had difficulty establishing his breathing and although he is now pink and breathing he is grunting ((grunting is not explained)) and they do not know why. B117 needs to go to the NNU and be given antibiotics.

#### F116 – Urgent LSCS / routine care

D39 places B116 in his cot and then leaves the theatre. She has not at any point spoken to F116 or M116.

Babies who were not taken immediately to the resuscitaire remained with the mother and the midwife assisting at the delivery usually undertook their care. Any information regarding the baby was usually directed to the mother.

#### **4.19.2 'The birth and immediate care of the baby' – hearing the cry**

Most babies cried spontaneously at birth (Table 4.9) and several HCPs used this as a way of reassuring the parents. This was particularly the case when there was concern about the baby. However, Table 4.9 shows that although some babies cry spontaneously at birth they may require some level of resuscitation. Therefore, using the cry as an indicator of wellbeing is not always appropriate. Nevertheless, all fathers appeared to respond to hearing their baby cry in a positive way. They often smiled broadly or laughed, some cried. In a few cases, hearing the cry appeared to bring a sense of relief.

##### F105 – Crash LSCS / resuscitation

D21 says “she really is OK you know” to M105 and F105 and then “listen to her cry.”

##### F116 – Urgent LSCS / routine care

F116 appeared to be very calm when B116 was delivered. However, when B116 cried for the first time, I saw his shoulders drop. I assume with a sigh of relief.

#### **4.19.3 'The birth and immediate care of the baby' – the fathers' response**

Fathers responded in different ways regardless of the type of delivery or the care of their baby. Several fathers made spontaneous comments directly to the researcher whilst the observations were in progress. On each occasion, the researcher subsequently asked the father if she could use these comments and all agreed. Many fathers appeared to be composed during the birth and immediately afterwards. They were often quiet, calm, and used minimal gestures. They generally maintained physical contact with their partner and occasionally spoke softly to her. One father who appeared very relaxed and jovial told the researcher afterwards that he had thought he was going to vomit (normal delivery). Whilst another father's subsequent comment to the researcher indicated that although he appeared composed, he had not been feeling that way:



#### F115 – Crash LSCS / resuscitation

Back in recovery F115 kept saying how scared he had been. He said “I thought my heart was going to give out” and clutched his chest. Yet at the time he appeared to be very composed.

A few fathers appeared to be distressed around the time of the birth. This was often indicated by their facial expressions, they looked flustered and flushed and held their head in their hands. Fathers often looked away when key interventions took place (such as the obstetrician performing an episiotomy) with a look of repulsion. Fathers were also shaking, pacing the floor or crying.

#### F117 – Normal delivery / resuscitation

F117 is standing behind M117’s bed and his arms are resting on the backrest. He is looking over to the resuscitaire his face is very red and although he is not crying he looks very upset.

#### F122 – Ventouse delivery / routine care

D54 extends the episiotomy and F122 shouts “no” very loudly and lunges towards D54 and looks very distressed. MW51 says “it’s alright.”

Several fathers demonstrated responses suggesting fear. They looked tense, pale, agitated, nervous and anxious. When they spoke their voice was often tremulous. They appeared to be in a state of ‘heightened alert’ listening to and watching what happened with their eyes darting back and forth. These behaviours and actions appeared to be reflective of the ‘fright and flight’ response (Ogden 2007).

#### F110 – Normal delivery / routine care

D23 has returned and is watching the CTG monitor as the fetal heart rate drops. D23 speaks directly to M110, saying in a stern voice “it’s very important that we get this baby out as soon as possible”. F110’s expression immediately changes. He looks terrified.

#### F111 – Normal delivery / resuscitation

MW9 says to M111 “he ((F111)) looks more petrified than you do”

Fathers also displayed positive emotions, when they appeared happy and relieved. Some fathers responded this way as soon as the baby was delivered when in some instances, the outcome remained uncertain. Fathers spontaneously grinned, smiled, laughed and punched the air. They often hugged and kissed their partner. Their sudden and dramatic relief of tension was often palpable. Several fathers immediately called the baby by his/her name. Some referred to ‘my baby.’

#### F125 – Normal delivery / routine care

F125’s response to the delivery was sudden and dramatic. He cried out with joy and he kissed and hugged M125.

#### F120 – Normal delivery / resuscitation

F120 is standing at the side of the bed but there is no physical contact between himself and M120. F120 says “Oh my baby.” F120 clenches his fists and punches the air.

At five of the deliveries, which all took place in the delivery room; fathers went to their baby on the resuscitaire. Four went spontaneously (three whilst care was in progress). The paediatrician invited one father once care was completed. Only one father had physical contact with his baby and this occurred spontaneously. None of the HCPs encouraged fathers to touch their baby. The eight deliveries when the fathers did not go to the resuscitaire, all took place in the operating theatre.

#### F111 – Normal delivery / resuscitation

F111 walks over to the resuscitaire and asks D25 about the shape of B111’s head ((D25 is administering face mask oxygen)). D25 explains about caput. F111 looks back at M111 and says, “he’s just done a wee”.

## F120 – Normal delivery / resuscitation

F120 is holding M120's hand. F120 says, "bloody hell, I'm going to collapse" and D47 and MW46 laugh. D48 invites F120 over to the resuscitaire and he goes over. D48 is performing oro-pharyngeal suction.

### **4.20 'Support from others'**

This theme focuses on the support fathers received from family and HCPs around the time of the birth. The theme encompasses actions and behaviours of others that appeared to either enable the father to be engaged and involved with what was occurring: 'making connections' or conversely seemed to prevent this from happening: 'not making connections.'

#### **4.20.1 'Support from others' – not connected**

In a few instances a battle-for-control appeared to occur between the father, family members and/or the midwife. On each occasion the father had previously been involved but his actions were gradually shunned or ignored. In some cases there seemed to be competition to make themselves heard. In some instances, family members slowly usurped the father's role until he became redundant. Although he often remained in close proximity, physical contact with the mother was usually lost. In several instances the atmosphere between family members and the father appeared tense.

On a few occasions, the midwife dictated what the father did and when. On these occasions she was specific about where he should stand and what he should do or say. If he contravened instructions, he was usually reprimanded. Some midwives appeared uncomfortable with the father's level of involvement when it became apparent she felt he was supporting his partner inappropriately. The midwife's irritability was evident in her non-verbal behaviour. However, rather than telling the father in a direct way, the midwife usually told the mother to ignore what he was saying or doing and to follow her directions. In almost all of the battle for control situations, the father lost to others.

#### F117 – Normal delivery / resuscitation

MW43 is encouraging M117 and telling her what to do. Her voice becomes louder as she tries to make her voice heard above F117's. She tells M117 to listen only to her.

#### F100 – Normal delivery / routine care

M100 pushing. F100, MW19, MM100 and FM100 are all encouraging her but are giving her different instructions. FM100 appears to try to take charge of the situation but MW19 continues speaking to M100. MM100 stops talking but has her arm around M100's shoulders and maintains eye contact with her. F100 backs away.

On a number of occasions, HCPs appeared to make no attempt to interact with the father. This particularly occurred during LSCS deliveries when often only the anaesthetist, operating department practitioner (ODP) or midwife spoke to him. Often during this time, banter between other HCPs took place about a range of unrelated issues. This may demonstrate a lack of insight or professionalism by the HCPs. However, they may argue this banter was a deliberate strategy to lighten the situation or relieve their own tension. Other examples of HCPs not interacting with fathers occurred when fathers were waiting in the recovery area to go into the operating theatre. Numerous HCPs would come and go but rarely spoke to him.

#### F104 – Elective LSCS / routine care

The HCPs chat amongst themselves. Throughout the time that F104 was in theatre the only HCPs to interact with him in any way were D20, MW23 and MW24. There was lots of chat / banter between the other HCPs. The LSCS seemed to be almost incidental.

#### F121 – Urgent LSCS / resuscitation

During the time in the recovery area several HCPs came in and out but none spoke to F121

Another way HCPs failed to engage fathers was when they adopted a mother-centred approach to their care. Although all of the midwives and most other HCPs referred to the mother by her first name, the father's first name was much less frequently used. However, the use of names may have been established before the observation

commenced. When information was given, this was usually directed to the mother. Sometimes fathers asked questions that were ignored or his comments did not draw a response. HCPs often did not introduce themselves or explain their role. Sometimes information was given without adequate explanation despite the father's facial expression appearing to indicate he had not understood. During the second stage of labour, midwives sometimes positioned themselves with their back to the father or in such a way that physical contact between him and his partner was disrupted. These behaviours may reflect the HCPs personal philosophy of care, a lack of awareness or a lack of concern about the father. However, these HCPs might argue their duty of care was to the mother and their care therefore reflected this.

Some midwives and student midwives did not involve the father in discussion about the baby's care. Questions about preferences regarding administration of vitamin K or method of feeding were usually directed to the mother. This occurred even when the father was closer to the HCP at the time. Some midwives also prevented or delayed fathers holding their baby.

#### F107 – Normal delivery / routine care

*M107 suggests that F107 holds the baby. MW28 says "no, you must keep her" but does not explain why.*

#### F120 – Normal delivery / resuscitation

MW46 explains to M120 that she has been pushing for an hour and that she needs to tell the doctors. MW46 says "they may decide to help you out." M120 says "what do you mean help? A section?" MW46 says "no a ventouse or forceps." F120 asks MW46 "what's a ventouse?" She does not reply.

### **4.20.2 'Support from others' – being connected**

In contrast to and much more commonly than the above, HCPs and family members enabled fathers to be involved. As the delivery got closer family members stepped back

and became quieter. They sometimes gestured to the father to move closer so he could be 'centre-stage.'

#### F102 – Normal delivery / routine care

At the delivery of B102, MM102 seemed to spontaneously step back from the scene. MM102 appeared to do this to allow M102 and F102 time together.

#### F124 – Ventouse delivery / routine care

As F124 gradually moves closer to M124, so MSR10 moves away into the corner of the room.

On most occasions HCPs involved and supported fathers. Their manner was friendly; they included them in discussions and engaged eye contact. Theatre HCPs, primarily anaesthetists employed strategies to involve fathers. They did this by including them in conversations, answering their questions and using light-hearted banter. They appeared to be able to quickly establish a rapport with the father, even in situations of high tension. In this way they usually managed to keep the mood upbeat.

#### F116 – Urgent LSCS / routine care

D37 chats to F116 about names for the baby.

#### F121 – Urgent LSCS / resuscitation

ODP13 kept the atmosphere buoyant in theatre through his light-hearted chatter with F121, M121 and D49. He seemed to talk about anything and everything.

Midwifery HCPs most commonly supported and included fathers. They showed fathers the head during the second stage, told them what it would feel like when they cut the cord and gave guidance on the best way to support their partner. They also helped them to feel contractions, encouraged them to watch the monitor and involved them in aspects of care. A few midwives involved fathers in a less direct way by encouraging the

mother to respond to him. Midwives advocated for fathers when they encouraged them to rest, enabled them to spend time with their baby or asked the paediatrician to explain the baby's care. Midwifery HCPs often referred to the father as 'daddy' or the baby as 'your son/daughter.' They involved fathers in aspects of the baby's care including checking the baby's nametags, showing them how to put on a nappy and encouraging them to help dress the baby.

#### F106 – Normal delivery / routine care

MWS10 says to F106 "can you see?" and shows him that B106's head is visible by holding a mirror for him to see.

#### F120 – Normal delivery / resuscitation

F120 peeps at M120's perineum. MW46 goes over to F120 and brings him to the side of the bed so he can see properly.

Two babies were transferred from the delivery room to the NNU (Table 4.8). One father went with his baby, the other visited shortly afterwards. On both occasions NNU staff were welcoming and friendly. They explained aspects of the baby's care and chatted about the baby in a general way. One father returned to his partner shortly after his visit, consequently the information he was given about his baby was brief. The other stayed with his baby and after some encouragement from the neonatal nurse held him for a short while. Although the NNU staff continued to chat to the father whilst he held his son, he appeared not to be listening. Neither father was given written information nor was orientated to the NNU. Although on both occasions the NNU was very busy, staff did not appear concerned by the father's presence.

#### F117 – Normal delivery / resuscitation

B117 is now in an open incubator and NN14 is attaching a saturation probe. NN15 is explaining to F117 what NN14 is doing.

## F111 – Normal delivery / resuscitation

NuN10 chats to F111 about B111's name.

Debriefing of the fathers was not observed. However, this may have taken place in the period of time after the observations.

### **4.21 Case study**

Each of the 22 observations has been regarded as a separate case study. One of these has been selected for detailed description in order to further elaborate issues previously highlighted and to demonstrate the overall richness of the data. Quantitative data are presented along with field notes (in italics) and extracts from the researcher's reflective diary. Excerpts from the quantitative data collection tool are also included in the appendices (Appendix 16). The field notes and the reflective diary were recorded and collated immediately after the observation. The selected case involved a normal delivery in the delivery suite. The baby unexpectedly required resuscitation and NNU admission.

#### **4.21.1 Case study – Observation 117**

M117 was admitted to the delivery suite in the early hours of 11<sup>th</sup> February 2007 in labour. She had reached 37<sup>+1</sup> weeks of her pregnancy and was booked for delivery on the delivery suite. The midwife caring for M117 identified to me that M117 and F117 met the study criteria and enabled me to speak with them. Both recalled receiving an information leaflet and consent was obtained at 10.15. They were both enthusiastic about the study. M117's mother (MM117) was also present when consent was obtained. She remained with M117 during her labour and delivery.

M117's progress was slow and syntocinon was commenced. I waited in the staff coffee room as M117's labour progressed. During this time M117 was cared for by three



midwives who worked the shifts during which M117's labour progressed (early, late and night shift). The third midwife (MW43) took over M117's care at 21.00. I introduced myself to her making sure she was aware that M117 and F117 had consented to take part in the study. Observations commenced at 22.40 when the second stage commenced:

22.40: F117 – Physical contact (PC) with and speaking to (SPE) M117, he is standing (SD).

*Present: M117, F117, MW43, MM117, and MEH. M117 is sat upright on the bed and is well supported by pillows. F117 is wiping M117's forehead and is encouraging her. MW36 ((shift leader)) and D42 ((obstetric senior house officer)) enter the room and speak with MW43. MM117 is sitting on a chair in the corner of the room. The room is brightly lit, the main lights are on.*

#### Reflective diary

During the early part of the observations (22.40 – 22.54) F117 was actively involved and encouraged M117 with enthusiasm. He participated in her care, encouraged and reassured her. He was chatty and laughed intermittently. He seemed like an overexcited child. He continued to stand and almost always had PC with M117. There was limited interaction with MW43 who seemed to be busying herself preparing equipment and attending to paperwork. MW43 also left the room several times. Although she returned promptly no explanation was given. MM117 remained seated in the corner of the room and spoke occasionally to M117.

22.46: F117 – PC with and SPE M117, SD.

*F117 is holding M117's hand with his right hand and wiping her forehead with his left hand. M117 says, "I can't do it." F117 encourages her and says, "you can" as M117 pushes. F117 appears to be calm and reassuring. MW43 leaves the room and returns. She neither explained where she was going when she left nor where she had been on her return.*

#### Reflective diary

At 22.54 the situation seemed to change when without any prior warning MW43 set up an infusion of intravenous antibiotics. MW43 explained to M117 what she was doing but not why. MW43 did not involve F117 in the discussion. From this point on, M117

seemed to become more distressed. F117 tried to calm her and in doing so became more vocal and assertive.

22.56: F117 – PC with and SPE with M117, SD.

*F117 is holding M117's hand and is reassuring her. F117 says "come on, you're doing very well." M117 becomes distressed and says, "I can't do it." F117 urges her to take some deep breaths.*

#### Reflective diary

At 23.00 D42 entered the room and told M117 she was progressing well. Although D42 and MW43 did not speak to each other, I observed an exchange of glances between them that F117 did not appear to see. MW43's comments to M117 seemed to become more directional with greater urgency once D42 left the room. MM117 also seemed to sense a change because she moved closer to M117. From this point on, F117's involvement gradually reduced. Although he remained close to M117, there was less PC and whilst he continued to encourage and reassure M117 his voice gradually got quieter. He often repeated MW43's instructions.

23.06: F117 – No physical contact (NPC) < 30cm from M117, SPE M117, SD.

*There is no physical contact between F117 and M117. M117 is pushing. MW43 is encouraging her and telling her what to do. Her voice becomes louder as she tries to make her voice heard above F117's. MM117 is standing at the bottom of the bed. F117 repeats word-for-word what MW43 is saying to M117.*

#### Reflective diary

At 23.14 the fetal heart rate could be heard to drop. MW43 went over to the CTG monitor. MW43 made no comment about this to M117 or F117 but MM117 noticed and watched MW43 closely. At 23.16 MW43 pressed the buzzer without any explanation. MW18, answered almost immediately. MW43 said to her "*I need MW36* ((shift leader)) ***NOW***" and MW18 left the room. F117 appeared to be bemused by this interaction.

23.18: F117 – PC with M117, he is quiet (Q), SD.

*F117 is holding M117's hand. M117 is pushing. MW43 turns on the resuscitaire. MW36 ((shift leader)) enters the room. MW43 and MW36 speak to each other but their conversation cannot be heard. MW36 says that she will "get the doctors" and leaves the room. F117 is quiet throughout but is watching MW43 and MW36 intently.*

#### Reflective diary

MA12 and D42 came into the room at 23.20. MA12 explained to MW43 that she had been sent to help her. D42 spoke to M117 and said, "*we may need to help you out*" but no explanation is given about what this might involve. There was no interaction with F117 at this time. MW43 and MA12 repositioned M117's legs into stirrups and talked to her as they did this. F117 continued to encourage M117 but his voice by now was much softer and he could hardly be heard. MW43 and MA12 appeared to be preparing for a forceps delivery although this was not discussed with either M117 or F117. An obstetric registrar (D43) came into the room and there was a brief inaudible conversation between D42 and D43. They then both left the room without exchanging information with anyone else. Although preparations for a forceps delivery continued, the baby was delivered spontaneously and rapidly at 23.30.

23.30: F117 – NPC, < 30cm from M117, Q, SD.

*There is no physical contact between F117 and M117. F117 is quiet as M117 pushes. MW43 suddenly says "the head's out." B117 is delivered. There is no cry just a few gasps and splutters. Present are: M117, F117, MW43, MA12, MM117 and MEH.*

#### Reflective diary

B117 was delivered onto M117's abdomen. MW43 rubbed him vigorously but there was no response. MW43 asked MA12 to press the emergency buzzer. MW36 came almost immediately and said to MW43 "*what do you want me to do?*" MW43 said, "*I think he needs some oxygen.*" None of this information was directed at or explained to M117 or F117. MM117 however, appeared to be aware that B117 was not breathing and looked alarmed. F117 and M117 appeared unconcerned and were smiling and laughing. MW43 cut the cord and carried B117 to the resuscitaire. B117 was blue and limp, making an occasional gasp. MW36 gave B117 oxygen via bag and mask. F117 remained by M117's bedside but appeared to have become aware of the situation. MW36 said to

MA12 “*crash call the paed, he’s not breathing*” and MA12 left the room. M117 asked MW43 what was happening and MW43 said “*the crash bleep means that we want the baby doctor to come quickly*” but she did not say why the doctor (paediatrician) was required. F117 looked alarmed, but he did not say anything. As the resuscitation continued he looked extremely distressed.

23.34: F117 – NPC, < 30cm from M117, Q, SD.

*There is no physical contact between F117 and M117. F117 is standing behind M117’s bed and his arms are resting on the backrest. He is looking over to the resuscitaire his face is very red and although he is not crying he looks very upset. MW25 has entered the room and speaks briefly to M117 saying she had met her the night before. MW25 then helps MW36 and offers to take cord blood for gas analysis. D40 and D41 ((paediatric senior house officer and registrar)) arrive and go straight to the resuscitaire. Neither of them speaks to M117 or F117. MW36 gives the history to D40 and D41. B117 is grunting. MW43 is delivering the placenta. MA12 has returned.*

#### Reflective diary

As the resuscitation continued no information was given by the HCPs regarding B117’s progress. M117 asked no one in particular “*is he OK?*” and there was no response. All the HCPs appeared to be busy bustling about the room. D40, D41 and MW36 were involved in the resuscitation whilst MA12 helped MW43 to move equipment. Nobody spoke or engaged eye contact with either F117 or M117. MM117 hovered by the resuscitaire but none of the HCPs spoke to her. By 23.40 B117 seemed to have recovered and the immediate care of B117 was completed although he could be heard to be grunting.

23.40: F117 – PC with M117, D41 is speaking to both F117 and M117, SD.

*F117 is stroking M117’s arm. B117 is on the resuscitaire and continues to grunt. D41 explains to M117 and F117 that B117 had difficulty establishing his breathing and although he is now pink and breathing he is grunting ((grunting is not explained)) and they do not know why. B117 needs to go to the neonatal unit and be given antibiotics. D40 is examining B117 on the resuscitaire. F117 spontaneously goes over to the resuscitaire, looks at B117 ((he does not touch him)) and returns straight to M117.*

### Reflective diary

D40 wrapped B117 in a blanket and took him over to M117. M117 whispered to B117 who was grunting and crying intermittently. F117 cooed over B117 but seemed to be distant. He did not touch B117. MM117 left the room to make some telephone calls. MW43 then took B117 back to the resuscitaire to put on his baby labels. F117 was not offered the opportunity to hold him. B117 was then taken to the NNU.

23.46: F117 – NPC, < 30cm from M117, Q, SD.

D40 puts B117 in his cot. B117 is grunting and crying intermittently. D40 explains to M117 that he will take B117 to the NNU. MW43 reassures M117 that she will be able to visit B117 “shortly.” There is no interaction with F117. D40 leaves the room with B117 and F117 follows spontaneously. Although nobody suggested he went with the baby neither MW43 nor D40 attempt to stop him.

### Reflective diary

Once on the NNU B117 was admitted by two neonatal nurses (NN14 and NN15). They work swiftly and efficiently. They both welcomed F117 and explained what they were doing. F117 had his first physical contact with B117 during this time.

23.52: F117 – PC with B117 and is being spoken to by NN15, SD.

B117 has been admitted into XX (*room number*) of the NNU. B117 is now in an open incubator and NN14 is attaching a saturation probe. NN15 is explaining to F117 what NN14 is doing. F117 strokes B117’s forehead. MM117 arrives shortly afterwards.

### Reflective diary

NN15 explained B117’s plan of care to F117. He returned to the delivery suite having not held B117. After a brief conversation with M117 the observation was completed at 23.56 (total 76 minutes). I thanked M117 and F117 and left the room.

#### **4.21.2 Case study – Observation 117, reflection**

This case study provides evidence to support the quantitative and qualitative data analysis. This particular case reflects the most common type of delivery (Table 4.5), the most common planned and actual location of delivery (Figure 4.2) and the mean number of people present for the type of delivery (Figure 4.3). This observation also reflects the situation I particularly wished to explore: the impact of witnessed resuscitation on fathers (Section 2.1).

During the course of the observation, very little information was given to F117 or M117 about what was happening. To some extent I was in the same position. However, I was able to draw on my own knowledge and experience and was usually able to determine what was occurring. Nevertheless I felt frustrated at times particularly when the midwife left and returned to the room without explanation. The impact of not knowing what was happening on F117 and M117 can only be assumed to have been more extreme.

On some occasions, information was directed specifically to M117. HCPs often seemed to ignore F117. However, whilst information was not directed at him he could at least glean information albeit 'second-hand.' Nevertheless, it is possible F117 felt ignored and excluded at times. One of the most striking issues was the number of HCPs involved and the frequency with which they entered and left the room (Section 4.10.3). Information regarding HCP activity was collated, excerpts of which is shown in Table 4.14. Nine different HCPs were involved although some were present only briefly, for example MW18 and D43. During the observation the number and configuration of HCPs changed almost every time recordings were made. There were also occasions when the number of HCPs changed noticeably for example at 23.34 four entered the room whilst at 23.42 three left and one entered. Much of this activity occurred around the time of the birth of the baby at 23.30 and his subsequent resuscitation.

<b>TIME</b>	<b>HEALTH CARE PROFESSIONAL ACTIVITY</b>
22.40	Present: M117, F117, MM117, MW43 and MEH
22.42	MW36 and D42 in and out, MW43 out and in
22.44	MW43 out and in
22.46	MW43 out and in
23.00	D42 in
23.02	D42 out
23.16	MW18 in and out
23.18	MW36 in and out
23.20	MA12 and D42 in
23.22	D42 out
23.26	D42 in
23.28	D42 out, D43 in and out
23.30	<b>Delivery</b>
23.32	MW36 in, MA12 out
23.34	MW25, MA12, D40 and D41 in
23.38	MW25 out
23.42	D41, MW36 and MW43 out, MW25 in
23.44	MM117 and MW25 out, MW43 in

Table 4.14 Health care professional activity during observation 117

Key

In order to distinguish between the HCPs entering and leaving the room, the following colours have been used:

Red	Midwives	MW43, MW36, MW18, MW25
Blue	Obstetricians	D42, D43
Green	Midwifery assistant	MA12
Plum	Paediatricians	D40, D41

## **4.22 Discussion**

The observations were undertaken in a systematic way in a range of different settings yielding extensive quantitative and qualitative data. When consent was obtained, some deliveries were expected to be uneventful, whilst others were likely to be less straightforward. Although some deliveries ultimately occurred without incident, others resulted in complicated childbirth and resuscitation of the baby. Consequently the data includes a diverse range of events and outcomes not found in other similar studies. The fathers were the main focus of each observation. However, important data were also obtained about the activity and behaviours of others.

A number of key issues have been identified in the analysis of both the quantitative and qualitative data. These include the apparent impact upon the fathers and their behaviours in relation to: the mother, baby, HCPs and family members. It is important to note similarities and differences particularly in relation to the type of delivery and the care of the baby because these comparisons have not previously been explored. These issues will now be considered and where relevant, reference will be made to other studies.

### **4.22.1 Discussion – the apparent impact upon fathers**

The data provide evidence suggesting the impact on fathers as reflected by their responses and actions. Several fathers appeared composed and calm (Section 4.19.3) including occasions when unexpected events occurred. These responses may have reflected the father's personality traits, a deliberate emotion-focused coping strategy or they may have responded in the way they felt was expected. However, several fathers revealed to the researcher his outward portrayal of emotions did not reflect the way he was feeling. It is therefore likely other fathers strove to control their emotions as way of reassuring and supporting their partner.



The impact of the actual birth was evident. Hearing the baby cry had a positive effect (Section 4.19.2). The visible relief on hearing the baby cry supports the argument that they had been using coping strategies to control their emotions prior to the birth (Section 1.7). Relief and joy were apparent regardless of events occurring before the birth, even in cases where the outcome remained uncertain (Section 4.19.3). These fathers may not have fully understood the seriousness of the situation. However, it appeared that joy at the birth outweighed, perhaps fleetingly, any other concerns they may have had at the time (Nolan 1996; Strange 2002; Lundqvist, Jakobsson 2003).

There were periods of time when fathers were not communicating with anyone (Section 4.13). There are several possible explanations for this silence. Fathers may have felt uncomfortable speaking in front of others. The nature of the relationship with their partner may also have meant words were unnecessary at this time. Fathers were often watching events and their silence might have been because they were focusing their attention on what was happening. They may also have felt there was nothing they could contribute or that they needed a period of 'timeout.'

Several fathers distanced themselves physically and perhaps also emotionally from what was happening (Section 4.12.2). This seemed to occur immediately before or after the delivery. It is possible these fathers felt they should keep out of the way, particularly when unexpected events occurred. This may have been an altruistic response ensuring the mother and/or baby were the focus of attention. A few fathers portrayed responses suggesting they were repulsed or frightened (Section 4.19.3) and their withdrawal from the scene may have been a deliberate attempt to remove themselves from the situation. They may also have felt excluded or were unsure about their role (Draper 2003; Finnbogadóttir et al 2003; Kunjappy-Clifton 2008). Fathers remained closer to their partner during LSCS deliveries. However, in this situation the positioning of the father is enforced by HCPs. It is possible if given a choice, these fathers would have preferred to have been further from their partner or indeed not present at all.

#### **4.22.2 Discussion – issues relating to the mother**

Data generated by the observations demonstrate that fathers supported their partners in a number of different ways both practically and emotionally (Sections 4.12.1, 4.13.1, 4.17). Strategies employed included maintaining physical contact or staying within close proximity, communicating with her, meeting her physical needs, focusing his attention exclusively on her and advocating for her. These strategies were often undertaken without prompting from HCPs, family members or indeed, the mother herself. Fathers have been described supporting their partner in these ways during normal childbirth (Somers-Smith 1999; Torr 2003; Gungor, Beji 2007). These findings suggest fathers felt their primary role was to support, reassure and protect their partner even when unexpected and in some cases potentially distressing events occurred.

Previous studies have attempted to capture the various aspects of the father's role during childbirth (Berry 1988; Chapman 1992; Johnson 2002; Gungor, Beji 2007). Chapman (1992) suggested that fathers adopt one of three roles: team-mate, coach and witness. Using this model (Chapman 1992) it would appear that whilst fathers demonstrated aspects of all three roles, team-mate was the most common (Section 4.17).

Fathers often portrayed different 'levels' of support to their partner. During the course of an individual observation, this support often changed. Sometimes fathers focused exclusively on his partner (Section 4.17.1). For example when fathers had physical contact with his partner he was also communicating with her for just over a third of the time (39.06%) (Figure 4.10). On other occasions fathers appeared to only partially support her. For example during physical contact with his partner when he was speaking with someone else (20.24%) (Figure 4.10). However, on these occasions they were usually speaking with midwifery and theatre HCPs (Figure 4.11). It could be argued they were still supporting their partner, but in a less direct way by trying to gather information (Alderson et al 2006).

Various aspects of the data show greater involvement of fathers before the birth (Sections 4.12.1, 4.13.1). This suggests they felt mothers needed most support during this time (Chandler, Field 1997). Fathers may also have been uncertain about ways to continue to support her and felt redundant after the birth (Kunjappy-Clifton 2008). The baby also presents a distraction and attending to their partners' needs become less important. It nevertheless should be noted that fathers demonstrated less supportive behaviours towards their partner when the baby required resuscitation. On these occasions fathers may have been too distracted or were utilising coping strategies to deal with their own emotions (Section 1.7). They may also have not known what to do or say during these circumstances.

Many fathers stood for most of time and this may demonstrate a further way in which they supported their partners. From a standing position they could respond more quickly to her needs. It was also easier to maintain eye contact with her from this position because in most cases she was sitting on a raised delivery bed. Fathers may have felt by standing they were demonstrating their resilience and stamina. They may also have felt reluctant to sit at a time when their partner had minimal opportunities to rest. Fathers were more likely to be seated following the delivery (Figure 4.28). It is possible they felt their exertions were over and having in most cases stood for a prolonged period of time they might well have been exhausted. They were also usually seated whilst they held the baby under the instruction of the midwife.

#### **4.22.3 Discussion – issues relating to the baby**

The data demonstrates a number of different ways fathers engaged with their baby (Sections 4.12.3, 4.13, 4.17.1). In some instances this appeared instinctive. On other occasions fathers deferred opportunities for interaction in deference to their partner. Whilst in other cases, HCPs controlled this interaction. Behaviours demonstrated by fathers included physical contact, holding, speaking to the baby and other behaviours described in studies of parent-infant bonding (Goldberg 2000; Field 2007). All fathers

had some physical contact with their baby, but this was often for a short amount of time (10.95%) (Section 4.12). However, not all fathers held their baby (Table 4.12). Making physical contact was usually spontaneous with limited assistance from others, for example whilst his partner was holding the baby. However, actually holding the baby often required the intervention of others, usually the midwife. Whilst the actions of some midwives suggested they felt facilitating father-infant interaction was important, others appeared to see this as less of a priority (Sections 4.20.1, 4.20.2).

The type of delivery and care of the baby influenced how quickly after the birth fathers held their baby (Section 4.12.3). This occurred soonest following complicated deliveries when the baby was usually given to the father. Most mothers did not hold their baby in the operating theatre (Table 4.12). This appeared to be for practical and logistical reasons. Following normal deliveries some fathers seemed to 'hold-back' from holding the baby. Sometimes mothers breast-fed the baby and fathers may not have wanted to disrupt this process. It is also possible these fathers thought the midwife wanted the mother to continue holding the baby (Section 4.20.1). Therefore one positive outcome for fathers of complicated childbirth is the opportunity to hold their baby more promptly (Lupton, Barclay 1997).

When fathers had physical contact with his baby he was not speaking with anyone for a small amount of time (12.79%) (Figure 4.15). They often appeared transfixed by the baby and were perhaps absorbing the moment. For a larger amount of time fathers were speaking with their partner (22.09%). It seemed as though they were trying to divide their attention between their partner and baby. Much of the conversation at this time was about the baby and fathers tried to include their partner as much as possible (Section 4.17.2). For most of the time they were speaking with 'others' (65.12%) (Figure 4.15). Usually this was the baby, maximising opportunities to interact with him/her. When fathers were speaking to HCPs it was usually about the baby who therefore remained the focus of attention.

When compared to their partner, fathers generally spoke more often to the baby (Figure 4.25). Exhaustion following delivery may have restricted mothers doing this and on occasions they were distracted by HCPs who were still involved in aspects of her care. The type of delivery was also influential. Most mothers did not hold their baby following LSCS (Table 4.12). Speaking to the baby when he/she was some distance from her was sometimes difficult. By contrast, mothers spoke to the baby more than the father following a normal delivery (Figure 4.25). This correlates with fathers waiting the longest to hold their baby following this type of delivery (Section 4.12.3).

Four fathers spontaneously went to their baby on the resuscitaire (Section 4.19.3). However, eight fathers were prevented by the logistics of the situation (the delivery took place in the operating theatre). These fathers appeared to make no attempt to go to the resuscitaire. Whilst they might have not wanted to, they may also have realised the HCPs would not support this action or that the route to the resuscitaire was too complicated. The close positioning of relatives to a resuscitation event has been the focus of debate in a number of specialties (Jarvis 1998; Weslien et al 2005; Maxton 2008) although not in relation to fathers in the delivery room.

#### **4.22.4 Discussion – issues relating to health care professionals**

The data provides evidence of positive and negative interactions between fathers and HCPs (Sections 4.17.1, 4.17.2). Some HCPs employed strategies to involve and support fathers. These were often undertaken by midwifery and theatre HCPs (Section 4.20.2). They did this by focusing attention on him periodically and reinforced his importance by referring to him as ‘daddy’ (although some fathers may have found this patronising). Additionally, a few midwives acknowledged a father’s need for rest and refreshment and the potential impact of events on him.

Fathers most commonly communicated with theatre staff (mostly anaesthetists) (Figures 4.22, 4.23). This is worthy of note given that these HCPs were not present at every type

of delivery (Figure 4.5). The actions of anaesthetists during the resuscitation may influence a father's experiences. During these occasions anaesthetists gave information, created a diversion and generally lightened the situation. They seemed to be particularly skilled at putting fathers at their ease (Section 4.20.2). The impact on fathers when an anaesthetist is not present at a delivery must therefore be questioned. Paediatricians also spoke to fathers about the baby (Figure 4.23). However this was less common following complicated deliveries, when fathers may need more reassurance. Most of these deliveries took place in the operating theatre where the layout meant the paediatrician could come and go without face-to-face contact with the parents. A few paediatricians did not speak to the parents in the operating theatre. This suggests they did not regard this as an aspect of their role on these occasions and goes against practice guidelines (European Resuscitation Council 2006; Resuscitation Council 2006).

The qualitative data provides evidence of negative aspects of HCP information giving. On some occasions they seemed to not want fathers to hear conversations with their colleagues (Section 4.20.1). These HCPs may say they did not want to alarm them. Alternatively, they may have not wanted to reveal their own uncertainty about the best course of action. Nevertheless, this raises questions about information giving and professional responsibilities. It was apparent that sometimes fathers did not understand or were unaware of what was happening (Section 4.18.3). In some instances this appeared to be due to a lack of clear explanation from HCPs. However, this lack of information may have been determined by the heightened situation. Little information was given about the baby's resuscitation (Section 4.19.1). The baby was usually taken back to parents by the midwife, and she may have been reluctant to provide information about something she had not been directly involved with. Other studies have also identified that the information needs of fathers around the time of complicated and preterm birth are not always met (Alderson et al 2006; Lindberg et al 2007).

Most HCPs entering the scene in an emergency did not introduce themselves or explain their role (Section 4.19.1). This is contra to current recommendations (European Resuscitation Council 2006; Resuscitation Council 2006). These HCPs would probably

argue they had other priorities at the time. However, in each case there was sufficient time for a brief explanation by someone (not necessarily the HCP themselves). Only one HCP (a paediatrician) invited a father to the resuscitaire (Section 4.19.3). None of the five fathers who went to the resuscitaire was encouraged to touch their baby. On two occasions, care of the baby had been completed by the time the father went to the resuscitaire. If they had touched their baby they would not therefore have disrupted the baby's care. Failure to encourage fathers to engage in physical contact with their baby does not conform with evidence regarding parent-infant bonding and literature surrounding witnessed resuscitation (Goldberg 2000; Grice et al 2003; Baskett et al 2005; Field 2007).

Some HCP behaviours may have left fathers feeling uncomfortable or unwelcome. Some midwives appeared to have expectations about what fathers should or should not do (Section 4.20.1) and made them aware when they contravened these expectations. Some HCPs have questioned whether fathers should attend childbirth (Odent 1999; Longworth 2006; O'Malley 2009) and some midwives here may have supported this view. These behaviours may also reveal a 'rigid-thinking' approach to care and the midwife's insecurities about her practice such that she felt the need to control what happened.

The final way in which the actions and behaviours of HCPs may have left fathers feeling excluded was occasions when fathers were distressed. HCPs did not always appear to notice this and as a consequence fathers sometimes appeared isolated and alone (Section 4.19.3) (Chandler, Field 1997; Draper 2003; Finnbogadóttir et al 2003). However, the father's response may have been more obvious to the researcher given that she was not directly involved with events. It is also possible HCPs expected fathers to respond in this way and were not surprised by the response. HCPs may also have felt their priorities lay elsewhere. Supporting the father may not have been regarded a priority. This may be particularly the case for midwives. In addition to their other responsibilities they were also often supporting students and more junior midwives.

#### **4.22.5 Discussion – issues relating to family members**

Although fathers may have received ‘behind-the-scenes’ support from family members in the way fathers described in phase one (Section 3.13.2), the data indicates that family members rarely interacted with or supported fathers in a direct or overt way (Sections 4.12.5, 4.13.3). However, all but one of the relatives was related to the mother (Section 4.10.3). They would probably argue their main reason for attending was to support the mother and share the experience with her. In the one instance when the father’s mother was present there was no interaction between them to the extent that it appeared that they were not related.

Family members did not make physical contact with the father when the mother was present (Section 4.12). The only occasion this occurred was when a father and his partner’s mother were on their own and he was extremely distressed (Section 4.15). It may therefore be assumed that in most cases family members felt physical contact with the father was inappropriate or unnecessary.

Fathers seemed to lose out in battles-for-control that sometimes took place when family members were present (Section 4.20.1). These fathers may have felt they should relinquish control rather than cause a scene. Alternatively they may have felt outnumbered in a female-dominated situation. They may also have felt they had no control over their situation (Section 1.7). Whatever the case, some family members did not appear concerned about the potential impact these situations had on the father. These responses may have reflected the nature of their relationship.

Nevertheless, most family members supported fathers in a less direct way, particularly as the delivery got closer. They gradually withdrew themselves and became quieter (Section 4.20.2). Whilst they may argue their primary role was to support their daughter or sister, it would appear that they did recognise it was important that the father was involved with the actual birth. In addition to this, fathers may have felt supported by the



presence of family members as a consequence of companionship rather than any direct or overt actions they undertook (Ogden 2007).

#### **4.23 Conclusion**

The ways in which fathers, family members and HCPs responded and interacted provide evidence to support the findings of phase one. Fathers generally appeared to adopt emotion-focused coping strategies (Section 1.7). In many situations HCPs and family members controlled the experiences of fathers and this was done in either a positive or negative way. The findings suggest fathers were generally willing to support their partner and interact with their baby during both normal and complicated childbirth. However, this was less apparent in situations where the baby required resuscitation. Many of the fathers' responses and actions appeared to be instinctive. Whilst direction and guidance from HCPs was generally not required, there were some occasions when HCPs could have facilitated their inclusion. The findings suggest most fathers supported their partners more readily before the birth. Guidance and support from HCPs could facilitate their support and involvement after the delivery. Fathers generally seemed to be comfortable interacting with their baby without encouragement from others.

HCPs generally, and midwives and anaesthetists in particular, appear to have the potential to influence a father's experiences in a positive way. This is particularly the case during complicated childbirth and situations when the baby requires resuscitation. In order to develop a bond with their baby, fathers need assistance from HCPs. Midwives appear to have a role in determining the nature and extent of any father-infant interaction. Anaesthetists appear to be particularly skilled supporting fathers and other HCP groups could incorporate aspects of their practice into their own. In particular there is scope for a review of HCP information giving to parents generally and the father in particular.

The experiences of fathers were further investigated in phase three of this study. Semi-structured interviews were carried out with HCPs using the critical incident approach. The data collection tool for phase three was developed at the start of the overall study (Section 2.3.1). However, when HCPs mentioned the sorts of incidents that fathers had previously described in phase one and/or had been observed in phase two, these incidents were further explored. The findings from phases one and two therefore informed both the data collection and data analysis processes for phase three (Section 2.5). In the following chapter, phase three will be presented and discussed.

## Chapter 5 – Phase Three

### **5.0 Introduction**

The final phase (outlined in Section 2.5.3) explored the experiences and perceptions of HCPs of childbirth, newborn resuscitation and the admission of a baby to the NNU when the baby's father was present. Semi-structured interviews were undertaken with 37 HCPs using the critical incident approach. Within this chapter, the aim and objectives are identified, the sample is described and the research process is explained and appraised. Strategies undertaken to enhance trustworthiness are considered and ethical issues are explored. The key themes identified in the analysis will be described and direct quotes will be used to illustrate them. The findings will be compared with those of other studies.

### **5.1 Phase three - aim and objectives**

The aim of this phase was to gain understanding of events encountered by HCPs involving childbirth, newborn resuscitation and/or NNU admission when the baby's father was present. The objectives were:

3. To conduct interviews utilising the critical incident approach with HCPs who had experience of childbirth, newborn resuscitation and the admission of baby to the NNU when the baby's father was present.
4. To provide an account of the experiences of HCPs of childbirth, newborn resuscitation and the admission of baby to the NNU when the baby's father was present.

## **5.2 Critical incident approach**

Semi-structured interviews were undertaken using a critical incident approach. This facilitates the retrospective exploration of events and identification of the actions and behaviours of those involved. This strategy has been used in other nursing-related studies (Norman, Redfern, Tomalin, Oliver 1992; Keatinge 2002; Sharoff 2008) although not in relation to complicated childbirth, newborn resuscitation and/or NNU admission. Within this section justification and appraisal will be presented for the use of this approach.

### **5.2.1 Critical incident approach – justification**

Flanagan (1954) developed a strategy to analyse critical incidents whilst working for the aviation industry during the Second World War. The intention was to promote understanding of human behaviours that determine success or failure of specific events (Flanagan 1954). The strategy was subsequently developed to assist the investigation of 'near-miss' events with pilots in order to reduce the risk of human error (Lister, Crisp 2007). Flanagan went on to refine the process for use in industrial psychology (Holloway, Wheeler 2002). Since the 1950s the critical incident approach has evolved and been utilised by a variety of disciplines including social work, health care, education and psychology (Kemppainen 2000; Keatinge 2002; Lister, Crisp 2007; Sharoff 2008; Silvester 2008). The focus of the approach is often less on examining errors or near miss events and more on learning through reflection on practice (Lister, Crisp 2007).

The critical incident approach facilitates in-depth exploration of human behaviour (Silvester 2008; Polit, Beck 2010). Data collection usually involves qualitative interviews during which participants identify important or significant incidents relating to the subject under investigation (Holloway, Wheeler 2002; Robson 2002). The information gathering process enables the researcher to acquire detailed information regarding these particular events with an emphasis on the responses and behaviours of those involved (Keatinge 2002). The critical incident approach is therefore a practical and effective way

of gaining insight into complex and multi-faceted events (Kemppainen 2000; Sharoff 2008). Not only does this approach lead to the generation of new knowledge, it can also be the first step in the change process (Kemppainen 2000; Sharoff 2008). This approach therefore adds a valuable dimension to the evaluation of care and service provision (Kemppainen 2000). Consequently, the use of the critical incident approach was an appropriate way to gain understanding of events encountered by HCPs involving childbirth, newborn resuscitation and/or NNU admission when the baby's father was present. Gaining insight into the experiences and perceptions of HCPs in this way adds depth to the overall study. This triangulation of methods (with phases one and two) strengthens the overall trustworthiness of the study (Section 2.3.2) (Patton, 2002; Walsh, Baker, 2004).

### **5.2.2 Critical incident approach – appraisal**

As a research strategy, the origins of the critical incident approach lie within the paradigm of positivism, primarily because of the systematic and structured approach to the exploration of specific events (Kemppainen 2000; Silvester 2008). However, the data collection process often adopts a more qualitative approach. Rich narratives are generated which are comparable to those associated with the phenomenological tradition (Norman et al 1992; Sharoff 2008). The participant usually selects the specific incident(s) to be discussed (Norman et al 1992). This minimises the power relationship between the researcher and the participant. Therefore the approach has been described as researching with, rather than researching on (Keatinge 2002). The presence of both qualitative and quantitative features reflects the paradigm of pragmatism. This approach is appropriate because the underlying philosophy is allied to that of this study (Section 2.3.2).

The critical incident approach requires three elements, the description of an incident, an account of the actions of individuals involved and reflection on the outcome. An incident is defined as being any specific occurrence involving human activity. This definition can therefore include routine or normally occurring events as well as more exceptional or

unusual situations (Lister, Crisp 2007; Silvester 2008). Participants are asked to identify incidents they regard as being 'critical.' In this context, critical is defined as being worthy of note, or an incident that had a marked impact such that the participant remembers what happened (Lister, Crisp 2007; Polit, Beck 2010). Participants often select their most memorable incident for discussion (Sharoff 2008). For some the term 'critical' is unhelpful, because it has negative connotations. Consequently some prefer the term 'revelatory' or 'significant' incident (Keatinge 2002) because it is important to focus on positive as well as negative events (Lister, Crisp 2007). In order to attain narratives relevant to the subject under investigation the critical incident approach requires purposive sampling. Participants must have encountered the events under investigation (Sharoff 2008) and data collection proceeds until data saturation is reached (Kemppainen 2000; Holloway, Wheeler 2002). In order to enhance the critical incident approach, the researcher should be familiar with the environment and the nature of the incidents (Holloway, Wheeler 2002).

Whilst the critical incident approach has an overall structure with a specific focus, beyond that there are no rigid rules. The approach has therefore been described as being versatile, flexible, effective and adaptable (Keatinge 2002; Sharoff 2008). During the course of the interview probing questions are asked in order to elicit specific, factual information (Kemppainen 2000; Sharoff 2008). These probing questions help the participant to recall the details of the event such that richer data are yielded. As a consequence both the participant and the researcher gain an understanding of what happened (Sharoff 2008).

Despite the identified advantages, some difficulties associated with the critical incident approach have been identified. Participants are required to recall incidents from memory (Polit, Beck 2010). They may therefore be tempted to exaggerate or manipulate their narrative to show themselves in a good light (Sharoff 2008). Participants may also genuinely forget some of the detail or describe an amalgamation of events (Sharoff 2008). However, the critical incident approach is akin to the reflective cycle, a key feature of which is the need for honesty. Health care workers generally and nurses and

midwives in particular are encouraged to reflect on their practice during their training and as part of their ongoing professional development (Williams, Lowes 2001; Leamon 2004). The critical incident approach was therefore an appropriate strategy to use, the key features of which it was anticipated HCPs would be familiar.

### **5.3 The sample**

Within this section the sampling framework will be described and the sample inclusion criteria defined. The recruitment process will be outlined and the nature of the sample described.

#### **5.3.1 The sample – the sampling framework**

In accordance with the critical incident approach, a purposive sample was utilised (Baker 2006; Mapp 2008). The only inclusion criterion was that the HCP had experience of childbirth, newborn resuscitation and/or NNU admission when the baby's father was present. No exclusion criteria were identified. It can be difficult to predict the sample size in a study such as this because recruitment continues until data saturation is reached (Kemppainen 2000). Recruitment therefore continued until a range of HCPs who had encountered a variety of experiences was recruited (Broström, Strömberg, Dahlström, Fridlund 2003).

#### **5.3.2 The sample – the recruitment process**

Participants were recruited between April 2007 and February 2008 and a variety of strategies were adopted. Posters inviting HCPs to take part were displayed in various locations within the maternity unit and NNU. As a consequence, eight HCPs volunteered to take part (5 midwives, 3 neonatal nurses). The researcher attended HCP meetings to discuss the study and another six HCPs offered to participate (2 midwives, 2 neonatal

nurses, 1 paediatrician, 1 obstetrician). Some participants recommended other HCPs and four participants were recruited in this way (2 obstetricians, 2 anaesthetists). The researcher also visited the maternity unit and NNU and distributed information leaflets and the remaining HCPs were recruited in this way (Appendix 6). Four participants (all midwives) had been involved in phase two of the study and their code was retained for this phase.

Having discussed the study with potential participants, the HCPs were given a minimum of 24 hours to decide if they would take part. Once confirmation was received, specific arrangements regarding the time and venue for the interview were usually made by email. Six HCPs approached about the study decided not to take part (2 midwives, 4 neonatal nurses). Another six said they would take part but unexpected practical and/or logistical issues prevented the interview from taking place (2 midwives, 2 neonatal nurses, 1 paediatrician, 1 obstetrician). Most of the interviews took place on weekday afternoons within the HCP's working day. Informed consent was taken immediately prior to the start of the interview (Appendix 17) (Section 5.4.2).

### **5.3.3 The sample – the nature of the sample**

#### Midwives, neonatal nurses, neonatal nurse practitioners

It was important to include midwives, neonatal nurses and neonatal nurse practitioners (NNPs) in the sample. At the study-site, midwives provide care for women during labour, conduct normal deliveries, care for women during complicated childbirth and care for mothers and healthy babies postnatally. Neonatal nurses care for babies within the NNU and at this study-site accompany paediatricians and NNPs to deliveries of babies at less than 32 weeks gestation and/or when newborn resuscitation is anticipated. NNPs are neonatal nurses with extensive experience who have completed additional training that enables them to practice at a higher level. NNPs often lead newborn resuscitation at delivery.



Table 5.1 identifies the biographical details of these HCPs. Participant codes have not been given in this table in order to protect their identity. Participants were between 23 and 55 years of age (mean 36 years, 7 months) and all were female. At the time of data collection there were no male NNPs or midwives employed by the Trust. One male neonatal nurse was working within the NNU but left during the period of recruitment. The length of time since qualification ranged between one and 32 years (mean 13 years, 3 months) and the length of time in their current post ranged between 6 months and 22 years (mean 4 years, 6 months). 'Agenda for change' bands ranged between band 5 and 8a. Seven of the midwives were 'core' midwives, which meant they worked exclusively on the delivery suite and/or birthcentre. Two midwives had 'rotational' posts and so worked for periods of time on the wards (postnatal and antenatal care), the delivery suite and in the community. One neonatal nurse had a community post that was funded and managed by the NNU.

#### Obstetricians, anaesthetists, paediatricians

Obstetricians were included in the sample because they manage the care of women when problems are identified during the antenatal period and/or labour. They also conduct complicated deliveries. Anaesthetists are responsible for anaesthesia and/or interventions such as epidurals. They are therefore present at most types of complicated childbirth. They also sometimes lead or assist newborn resuscitation. Paediatricians manage the care of babies within the NNU and usually lead newborn resuscitation at delivery. Table 5.2 shows the biographical details of these HCPs. Participant codes have not been given in order to protect their identity. They were between 26 and 58 years of age (mean 35 years, 9 months). Six were female and seven male. The length of time since qualification ranged between two and 33 years (mean 12 years, 1 month) and the length of time in their current post ranged between two and a half months and 18 years (mean 3 years, 9 months).

<b>AGE</b>	<b>ETHNICITY*</b>	<b>YEAR QUALIFIED</b>	<b>JOB TITLE AND BAND</b>	<b>LENGTH TIME CURRENT POST</b>
52	Chinese	1976	Sister NNU - 7	20 years
55	Malaysian	1975	Sister NNU - 7	22 years
36	Indian	1992	Sister NNU - 7	2 years, 6 months
39	White British	2005	Staff nurse NNU - 5	2 years
41	Mixed race	1989	Community nurse - 6	6 months
52	White British	1977	Sister NNU - 7	4 years
26	White British	2004	Staff nurse NNU - 5	3 years, 6 months
32	White British	2000	NNP - 7	6 months
31	African	1998	Staff nurse NNU - 6	2 years, 6 months
25	White British	2004	Staff nurse NNU - 5	3 years, 6 months
50	White British	1979	Staff nurse NNU - 6	16 years
55	White English	1988	NNP – 8a	7 years
26	White British	2005	Midwife – core - 6	6 months
27	White British	2001	Research midwife - 7	2 years, 6 months
23	White British	2006	Midwife – rotating - 5	6 months
25	White British	2004	Midwife – core - 6	1 year, 6 months
29	White British	2002	Research midwife - 7	2 years
46	White British	1982	Consultant midwife – 8a	5 years
26	White British	2005	Midwife – rotating - 5	1 year
28	White British	2004	Midwife – core - 6	1 year, 6 months
29	White British	2004	Midwife – core - 6	2 years, 6 months
50	White British	1978	Midwife – core - 7	1 year, 6 months
28	Asian	2001	Midwife – core - 6	1 year, 6 months
47	West African	1981	Midwife – core - 7	4 years

\* As described by participants

Table 5.1 Phase three – neonatal nurse, NNP and midwife biographical details

<b>SEX</b>	<b>AGE</b>	<b>ETHNICITY*</b>	<b>YEAR QUALIFIED</b>	<b>JOB TITLE</b>	<b>LENGTH TIME CURRENT POST</b>
M	27	White British	2004	Senior House Officer (neonatal care)	6 months
M	55	Malaysian Indian	1995	Consultant (neonatology)	3 months
F	34	White British	1997	Specialist Registrar (obstetrics)	6 years
F	33	White British	1998	Registrar (obstetrics)	3 years
M	26	Indian	2005	Senior House Officer (neonatal care)	2.5 months
F	31	White British	1999	Registrar (neonatal care)	7 months
M	39	Caucasian	1991	Consultant (anaesthetics)	6 years
M	39	British Pakistani	1992	Consultant (anaesthetics)	4 years
M	58	White British	1974	Consultant (neonatology)	18 years
F	38	White British	1992	Consultant (anaesthetics)	6 years
M	31	White British	2000	Clinical Research Fellow (neonatal care)	2 years
F	44	Scottish Caucasian	1985	Consultant (obstetrics / fetal medicine)	1 year
F	29	Indian	2002	Registrar (anaesthetics)	1 year

*\* As described by participants*

Table 5.2 Phase three – obstetrician, anaesthetist and paediatrician biographical details

The total sample included 37 HCPs from a range of ethnic backgrounds that correspond with the main groups represented in the study site's local population. The sample includes participants with a range of clinical backgrounds and experience (O'Leary 2004).

## **5.4 Data collection**

Interviews are the most commonly used method of data collection when the critical incident approach is adopted (Norman et al 1992; Robson 2002). Within this section the development of the interview schedule will be described. The interview process will be discussed with reference to the practical and logistical challenges associated with this method of data collection. The ways in which these issues were addressed will be described and this will include an exploration of the researcher skills required. Reflection will also be presented on the data collection process.

### **5.4.1 Data collection – development of the interview schedule**

Within this study the intention was to ask HCPs to identify and describe incidents involving complicated and preterm birth, newborn resuscitation and/or NNU admission when the baby's father was present. The HCPs were therefore asked to describe what happened and how individuals, particularly the father responded (Norman et al 1992; Broström et al 2003; Sharoff 2008). The researcher's role was therefore to facilitate the HCPs' descriptions (Norman et al 1992; Silvester 2008). In order to ensure both positive and negative scenarios were explored, the researcher asked participants to describe contrasting incidents (Robson 2002; Silvester 2008).

When the critical incident approach is adopted the researcher must establish the purpose of the interview at the outset (Norman et al 1992). Therefore an opening question was devised which it was hoped would initiate the HCP's description of a specific incident (Appendix 18). With phenomenological interviews (Section 3.4.1) it is difficult to determine in advance the exact format of questions to be used (Kvale 2007) because of the flexible nature of the interview process. The researcher therefore developed a loose set of open-ended questions and possible probes (Appendix 18) (Dearnley 2005; Todres, Holloway 2006; Kvale, Brinkmann 2009). These probing questions were used to explore issues raised by the HCP in order to yield clearer, deeper and richer descriptions (Johnson 2000; Baker 2006). As is the case for all types

of interview, the researcher endeavoured to ensure questions were brief and straightforward (Kvale 2007; Kvale, Brinkmann 2009).

A number of factors influenced the development of the interview schedule for this phase. These included discussion with the researcher's supervisor, senior academics and senior post-holders at the study-site (Section 2.1) and consideration of related research. An interview schedule was developed consisting of key questions to trigger the HCPs' descriptions. Possible follow-up questions, or probes were identified in italics. The interview schedule also included biographical questions about the HCP (Appendix 18).

#### **5.4.2 Data collection – the interview process**

Most of the interviews (33) took place in a quiet, private, comfortable room within the NNU. The remaining interviews (4) took place in the respective HCP's office. The same strategies were adopted regarding the provision of refreshments and the researcher's style of dress as previously described (Section 3.4.2). Immediately prior to the start of the interview the consent process was completed (Appendix 17) (Section 5.3.2) and the recording equipment checked (Dearnley 2005). The interviews were tape-recorded to enable verbatim transcription (Mapp 2008; Kvale, Brinkmann 2009). HCPs were reminded of their right not to answer specific questions and that they could temporarily stop or completely discontinue the interview at any time (Corbin, Morse 2003; Kvale, Brinkmann 2009). In the event, although several HCPs became distressed during the interview, all wanted to continue (Section 5.5.1). HCPs were reminded their anonymity was assured and all names mentioned during the interview would be replaced with a code. It is particularly important to protect the identity of named individuals when the critical incident approach is adopted (Silvester 2008). HCPs were asked if any issues required clarification before the interview started. This approach set the tone of the interview and facilitated the development of trust (Corbin, Morse 2003). Once recording commenced, an opening statement defined the purpose of the study (Appendix 18).

The initial questions related to some of the HCP's biographical details and the frequency with which they were involved in the type of incidents to be explored (Appendix 18). It was anticipated they would feel comfortable answering these questions. This information also explained the context. The HCP was then asked to describe an incident they had been involved with during which the baby's father was present (Appendix 18). Subsequent questions were then determined by the HCP's description of the father's response. When HCPs mentioned issues that had been identified in phases one and two, these incidents were further explored. The findings from the earlier phases therefore informed the data collection process for this phase (Section 2.5). The overall format of each interview was slightly different. Having explored a particular event, the researcher asked the HCP if they thought the incident was a positive or negative experience for the father. They were then asked to describe a contrasting incident.

The subsequent interview process followed a similar format to that described elsewhere (Section 3.4.2). The same rationale applied regarding the judicious use of probing questions (Price 2002; Corbin, Morse 2003; Kvale 2007) (Section 3.4.2). It was particularly important that the researcher adopted a non-threatening approach to her questioning so HCPs did not feel she was apportioning blame. Strategies and researcher skills previously described were important factors in establishing trust between participant and researcher (Section 3.4.2).

It was essential not to finish the interview with emotionally sensitive questions (Corbin, Morse 2003; Rogers 2008). Therefore outstanding questions regarding the HCP's biographical details were asked at the end. The HCPs were thanked and once the recording was discontinued they were given an interview-debriefing sheet identifying potential sources of support (Appendix 19) (Baker 2006; Rogers 2008; Kvale, Brinkmann 2009). In accordance with Kvale and Brinkmann's (2009) recommendation, the researcher reflected on the interview as soon as possible in her reflective diary. Issues reflected on included ways in which the interview was conducted and ways in which questions and probes could be refined (Richards 2005; Kvale, Brinkmann 2009).

### **5.4.3 Data collection – reflection on the process**

The 37 interviews ranged between 26 minutes, 27 seconds and 75 minutes, 6 seconds (mean 46 minutes). Whilst the process was time consuming (Corbin, Morse 2003; Mapp 2008), the data provided insight into a range of experiences, responses and feelings. All HCPs felt able to make negative comments at some point during their interview. This suggests they trusted the researcher and were reassured their comments would be anonymised. Whilst the researcher had to take accounts on trust, there is no evidence to suggest participants deliberately manipulated or falsified information.

Most HCPs seemed comfortable with the critical incident approach. Some selected a recent event to discuss whilst others described incidents that had occurred some time ago that remained a poignant memory. Some HCPs preferred talking about fathers in a more general way and there maybe a number of reasons for this. HCPs with extensive experience found it difficult to piece together a story about a specific case. Drawing on several cases may have been a way of validating their experiences and views. There may also have been a reluctance to focus specifically on certain cases because of the distress it would cause. Some HCPs initially described a specific incident and then related this to other occasions when similar events occurred. This may have been another way of validating their experiences.

Participants sometimes reveal additional information once tape-recording has ceased (Section 3.4.3). They may choose not to disclose information during the recording because they do not want it included in the analysis. This presents the researcher with a dilemma regarding management of this additional information (Kvale, Brinkmann 2009). This situation occurred occasionally during this phase. Generally the type of information participants revealed once the recording was stopped related to their personal experiences of childbirth. It has been suggested that researchers should have the facility to make notes about any additional comments participants make once an interview is completed (Mapp 2008). However, this raises ethical questions regarding the consent process and should only be done with the participant's full agreement (Kvale, Brinkmann

2009). Whilst the additional experiences HCPs described may have shaped their perception of events, these personal experiences were not included in the data analysis process.

## **5.5 Ethical issues**

General ethical issues pertaining to this study have been explored (Section 2.6) and the consent process and strategies to maintain confidentiality described (Sections 2.6.3, 5.3.2, 5.4.2). Within this section issues regarding the potential impact on the participant and the transcriber will be explored.

### **5.5.1 Ethical issues – potential impact on participants**

There was the possibility that participants would be adversely affected (Corbin, Morse 2003; Rogers 2008). Reflecting on their feelings and experiences has the potential to cause participant anxiety (Kvale, Brinkmann 2009). However individuals who think they will be distressed or are uncomfortable about being interviewed usually decline participation (Corbin, Morse 2003). Nevertheless, the researcher constantly evaluated the apparent impact on the HCPs during the interviews (Rogers 2008). Five HCPs (midwives and neonatal nurses) became distressed during their interview, three wanted to continue without a break. The researcher briefly stopped two interviews, but both participants wanted to resume after a short break. All of these HCPs were surprised by their response. One neonatal nurse described an incident that had occurred some months ago and was astonished that reflecting on the event evoked such a powerful reaction. Many HCPs said thinking about the incident from the father's perspective had made them realise for the first time the likely impact on him. This deeper insight is not uncommon when the critical incident approach is adopted (Ashworth 2008; Sharoff 2008). The researcher's responsibility to participants does not end with the completion of data collection. Therefore HCPs were given a debriefing sheet, identifying sources of ongoing support (Appendix 19) (Baker 2006; Rogers 2008).



### **5.5.2 Ethical issues – potential impact on the transcriber**

During this phase, a third party transcribed some of the interviews. In situations such as this, the researcher should consider the potential impact on the transcriber (Rager 2005) because the content of interview recordings can sometimes cause anxiety. Lalor et al (2006) provide a description of the difficulties that may occur when an external person transcribes interviews of a sensitive nature. Within Lalor et al's (2006) study the transcription process had far-reaching and unanticipated consequences for the transcriber. It is partly for this reason that the researcher undertook the transcription of the phase one interviews (Section 3.7.1). However, for this phase it was felt to be appropriate for some of the transcription to be undertaken by an external person (20 interviews). However, the researcher carefully selected which tapes this person transcribed. Recordings of interviews that involved the discussion of highly emotional incidents and/or when participants became distressed were not included. The researcher maintained regular contact with the transcriber during the transcription process (Lalor et al 2006) and was reassured that she was not adversely affected by the content.

### **5.6 Data analysis**

In order to promote trustworthiness of the data analysis process, the researcher undertook auditing of the interviews transcribed by the third party (Section 5.5.2) to confirm accuracy (Tuckett 2005). In addition to the criteria identified above (Section 5.5.2) the researcher also selected recordings that involved minimal use of jargon or complex terminology. The subsequent processes of data analysis and strategies to enhance trustworthiness have been described (see Sections 2.4.2; 3.6). As was the case for the previous phases, it was not deemed feasible or desirable to instigate participant checking (see Sections 3.7.2, 4.8). The findings presented in the following sections are therefore based on the researcher's interpretation of the data as discussed with her supervisor (Baker 2006).

## 5.7 Findings

The HCPs described incidents that occurred before the birth, during the delivery and resuscitation and/or during the father's first NNU visit. Before birth involved incidents during an antenatal tour of the NNU, whilst the father waited in the recovery area of the operating theatre and/or interactions with parents in the fetal medicine department or on the delivery suite. The deliveries occurred in a range of settings (birthcentre, delivery suite or operating theatre) (Section 4.2). Whilst in some cases the resuscitation and/or NNU admission was predicted, others occurred unexpectedly. Not all HCP groups described incidents occurring in all contexts. This was largely determined by their role, for example neonatal nurses (NNs) did not describe events whilst the father waited in the operating theatre recovery area and anaesthetists did not describe incidents within the NNU. Whilst in most cases participants initially described what happened, they often subsequently reflected upon what should have happened in the context of best practice. They also often related the scenario to other similar events. Most events were regarded as being negative from the father's point of view even if the outcome for the mother and/or baby was ultimately positive (Section 5.4.2). Some HCPs found it difficult to identify a contrasting event. It was the realisation of the impact on the father that caused some midwives and NNs to become distressed during the interview (Section 5.5.1). In the more rare cases where the scenario was felt to be a positive experience for the father, the role of the midwife was felt to be usually influential. Analysis of the data identified five themes: how fathers responded, giving information, engaging and involving, exclusion and HCP issues (Figure 5.1). These themes will now be described and direct quotes will be used to illustrate them.

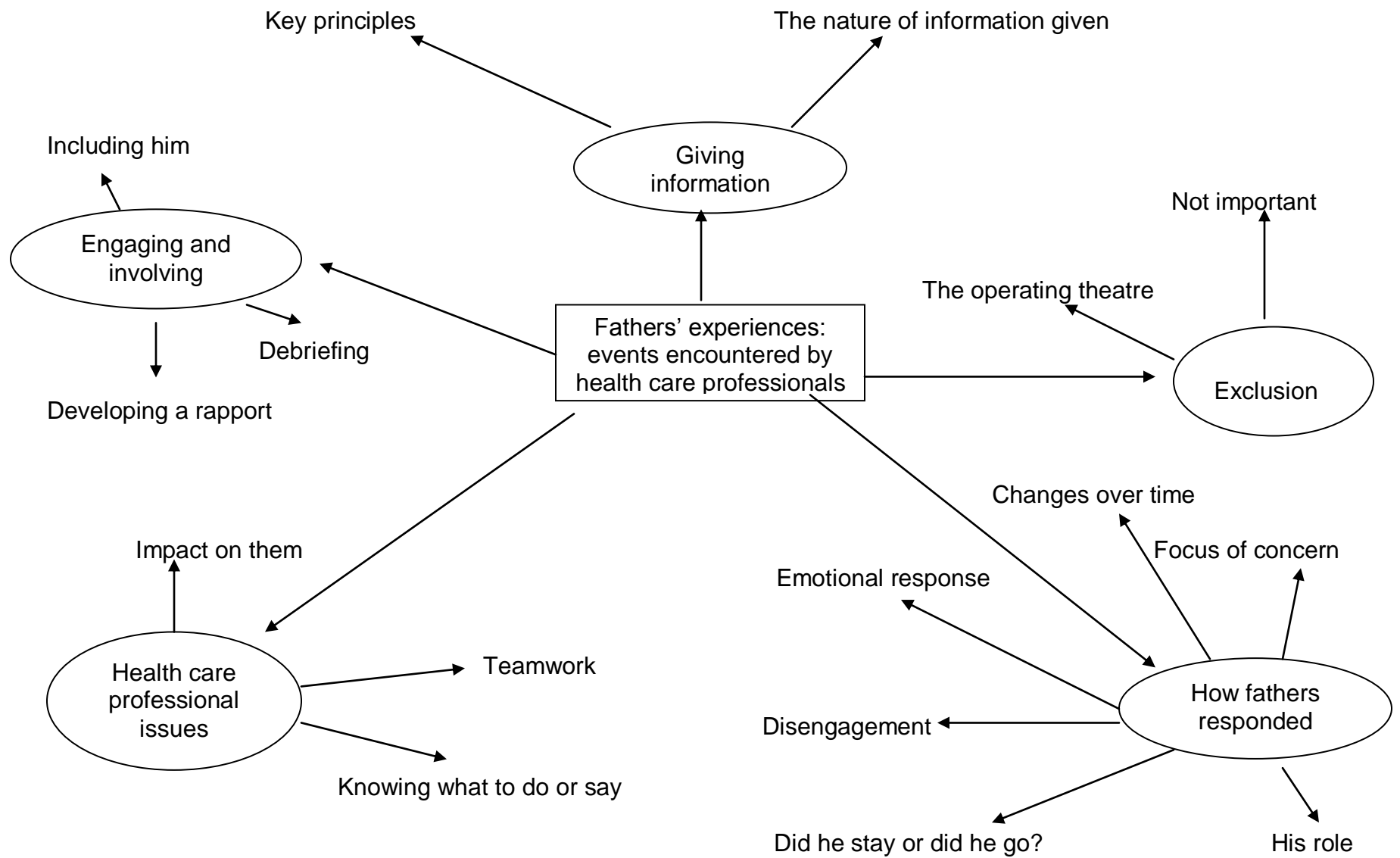


Figure 5.1 Phase three themes

## **5.8 'How fathers responded'**

The HCPs described ways in which fathers responded before, during and after the birth (Figure 5.1). This theme consists of six sub-themes. Focus of concern identifies whether fathers were more concerned about their partner or the baby. Emotional response describes the fathers' reaction to events, whilst his role identifies activities they undertook as events occurred. Did he stay or did he go? describes whether fathers went to their baby on the resuscitaire and/or with the baby to the NNU. Disengagement describes fathers who appeared to be detached from events. During more general discussion a further sub-theme: changes over time, was identified when many HCPs noted differences in the ways fathers now respond in comparison to the past (Figure 5.1). These sub-themes will now be described.

### **5.8.1 'How fathers responded' – focus of concern**

In almost all situations fathers were reported to be more concerned about their partner than the baby. This was the case even in situations when there was no immediate anxiety about the mother's health or long-term outcomes and/or whilst the baby was being resuscitated. Their concern increased as outcomes became more uncertain and fathers often became more protective towards their partner.

#### MW9

*"The, the dad although he was concerned about the baby and was asking what will happen, he tended to focus on what will be happening to his partner."*

#### D13

*"I think he was thinking about his partner and then their newborn baby."*

#### D9

*“So they’re always worried about the person they are with and so I think for them the important thing is that they’re ok and potentially, not that baby is secondary but certainly in a sort of calmer emotional state and it’s often the case that they’ll worry about baby later.”*

In contrast to other HCP groups, paediatricians were unable to recall the fathers’ focus of concern during the resuscitation. Whilst this might be because their attention was focused on the baby, this could also have been the case for the NNPs and yet they made spontaneous comments about this.

#### D11

*“I don’t know where he was or what he was doing to be honest.”*

#### NN14

*“Well he was there, he stayed with his wife. I know he was talking to her and was holding her hand.”*

When fathers first visited their baby on the NNU, the NNs, NNPs and paediatricians recalled most fathers focusing exclusively on their child. Less commonly, fathers looked at other babies, the equipment and/or the observation charts. In a few cases, the NNs thought the fathers were hypnotised by the monitors. This may have been a continuation of behaviours adopted during the labour/birth when fathers watched monitors (Section 4.17.3). These fathers may also have been trying to understand what was happening by accessing whatever information they could.

#### NN6

*“He was more focused on his own baby at that point at that time you know, sort of just worried for his own baby. Oblivious to what was going on. He just wanted to make sure his baby was happy and settled and ok.”*

## NN1

*"I had a situation where the father kept on looking at the machine rather than the baby. I kept bringing him back and said the machine is only there to help your baby but I think the most important thing is your baby."*

Although most fathers focused their attention on their baby during this NNU visit, HCPs still felt they were more concerned about their partner. Fathers tended to stay no more than 20 minutes and it was felt they wanted to return to their partner as quickly as possible.

## NN6

*"He probably stayed 15, 20 minutes at the most. Then he said he was going to go back down to mum, just update mum with what we'd said."*

### **5.8.2 'How fathers responded' – emotional response**

The HCPs most commonly described fathers portraying negative emotional responses before, during and/or after the birth. Acknowledgement of these responses seemed to be a significant factor in their judgment that the event had been a negative experience for the father (Section 5.7). The HCPs recalled fathers being anxious, afraid, distressed and shocked. In some scenarios fathers were described as being overwhelmed, bewildered, shell-shocked or stunned. Although fathers sometimes cried, they generally tried to hide this from their partner. One of the midwives who previously worked in the community, provided further insight into the tension and anxiety fathers experience around this time. She said several had told her they temporarily left the room during the resuscitation in order to have some time to themselves.

## MW9

*"He was very, very emotional and he kept like holding her hand and she was crying a lot and then he would have like intermittent phases of crying as well."*

### MW15

*"I remember, this is not just once or twice, but I can remember fathers telling me once they got home when I was doing the visits at home, is the husbands telling me he went to the toilet and cried or they went to the toilet and prayed. They prayed that their wife would not die or he prayed that he could escape from this situation, not that he would physically die himself but please could someone take me away from it because he felt that he couldn't cope any more."*

Less commonly midwives and obstetricians gave examples of fathers displaying positive emotional responses such as relief and happiness. This kind of response appeared to be associated with action being taken such as referral to specialist services or when plans were made for the delivery. Responses of this nature were also noted in a few fathers when they visited their child on the NNU following earlier concern about the baby's survival. In a few more extreme cases, HCPs felt the father's upbeat response was misplaced when he was overly optimistic. They thought this response either reflected the father's way of coping or was the macho response he thought others would expect.

### MW10

*"I think he was more, you know, more relieved because he kind of knew what was going to happen at last ((the delivery))."*

### D12

*"He was ecstatically happy that he'd got a sort of much wanted baby that they never thought they were going to have."*

A number of HCPs described situations where the father's response was that of pragmatism, taking a matter-of-fact or stoical approach to events. They thought this was probably the father's coping strategy and by controlling his emotions he was conforming to his expectations about how he should respond. Midwives and obstetricians seemed to particularly note fathers responding in this way immediately before the birth or during the resuscitation. In a few more extreme cases, midwives were surprised when the father discussed what they felt were inappropriate topics whilst the baby was being

resuscitated. They assumed these fathers were trying to normalise the situation or were attempting to block out what was happening.

#### D9

*“When she became upset when we were talking about a very sick baby then he just said oh you know, we can’t worry about that now, we’ll worry about that later. You know, lets just do one step at a time.”*

#### MW8

*“He just kept talking about the baby clothes and the baby seat and what he hadn’t brought and what he had and I don’t know if that was kind of to reassure himself. Maybe that was again putting on a brave face.”*

### **5.8.3 ‘How fathers responded’ – his role**

The HCPs described the role(s) the father assumed before, during and after the birth. This included supporting his partner and taking charge of the situation. However, the most common role described was the retrieval of information. Fathers were recalled doing this in a variety of ways including looking, listening and asking questions. In many cases HCPs described the fathers as a go-between reporting information to his partner. Although they also described fathers accessing information by observing non-verbal communication and listening to conversations they did not want them to hear, this was a less common occurrence.

#### MW9

*“He was watching everything first hand and he, he was looking around seeing people’s faces.”*

#### MW13

*“He was just watching really. He just seemed a little bit quiet. He was just listening. He was just listening kind of intently. Then he asked how she ((the baby)) was doing. Is she alright? Is she going to be alright?”*



The HCPs recalled the different ways the fathers supported their partner. This often involved calming, reassuring and comforting her and helping with her physical care. Supporting his partner in these ways enabled the HCPs to undertake other aspects of their role.

#### D62

*“If anything having him present makes our lives easier because he’s providing support for his partner while we may be busy with other issues where we’re not really free to be providing that direct support to her.”*

#### MW18

*“He was reassuring her and saying you know, don’t worry. Its fine, it’s a live child de da, de da, de da, this, that and the other.”*

More rarely HCPs recalled fathers taking charge of the situation before the birth. In doing this they became more vocal, took the lead in making decisions and in a few instances became overbearing. HCPs suggested this was the father’s way of coping with the situation. This response may also have reflected the couple’s relationship and/or they may have previously agreed he would take the lead. Taking this approach was regarded by a few HCPs as positive behaviour whereby he was advocating for his partner. Others however, were uncomfortable with this response and in some instances felt undermined or were concerned about the potential impact on his partner.

#### D32

*“The minority would be where dads are very vocal, almost with the mums being a sort of a submissive part of the consultation and dads will tend to take over and be quite demanding and that isn’t indicative of any particular race or religion in my experience but it just sometimes happens that the dads, some people would view it as being bolshie or bossy but it’s maybe just their way of dealing with it.”*

## MW11

*“There are occasions when a partner may dominate the questions and that’s fine because I would be taking on board that as a couple they had probably agreed that he would take the lead in decision making.”*

In some of the scenarios they described, the HCPs felt the fathers did not have a role. They assumed these fathers felt helpless and useless. Most HCPs who suggested this were male participants who in this part of the interview often referred to their own experiences of childbirth.

## D32

*“I can understand how dads feel a little bit of a loose part, not really being able to get involved. Wondering about mum being in pain. But I think that underlies the fact that blokes I think generally feel helpless and useless and don’t know what to do in a normal delivery. And then you superimpose a preterm birth, they don’t know where to go.”*

## D13

*“I’m sure they sometimes feel a bit of a spare part, that they’ve just been kind of shifted from place to place and not sure of their role or what’s going on.”*

### **5.8.4 ‘How fathers responded’ – did he stay or did he go?**

The HCPs described two issues in relation to this sub-theme: whether fathers went to their baby on the resuscitaire and the timing of fathers’ first visit to the NNU. With regard to going to the resuscitaire, the fathers were described responding in one of five possible ways: stayed with his partner, attempted to go to the resuscitaire but was prevented, went spontaneously, went following encouragement or hovered between his partner and baby. Most fathers stayed with their partner whilst the baby was being resuscitated. HCPs assumed they did this because they did not want to hinder the resuscitation, were afraid of what they would see and/or were more concerned about their partner (Section 5.8.1). Several HCPs described scenarios where the father was

stopped either by themselves or their colleagues when he attempted to go to the resuscitaire. Usually this was because access was difficult and the operating theatre was particularly problematic in this respect. However, sometimes fathers were stopped because it was felt they would disrupt the resuscitation or react in an unpredictable way.

#### D61

*“If they wander about and they touch the drips and the sterile areas, there’s an issue about that. There are sometimes wires and that about that they can trip over plus the resuscitaire’s very small and when you’ve got two or three folk around the baby there isn’t physically space for someone else to get in and see what’s going on. So you know, you would sort of say, please just sit down and give people the space to do their job.”*

Most fathers who went to the resuscitaire were invited to do so. The HCPs felt fathers generally want to know they have permission before going to see their baby. To support this view, HCPs described fathers edging towards the resuscitaire and responding positively when told he could proceed. Another way fathers responded was when they either hovered in no-man’s land between the resuscitaire and their partner or went backwards and forwards between the two. The final and much less frequent response was when they went spontaneously to the resuscitaire. In some instances these fathers appeared unaware of the severity of the situation.

#### D8

*“My practice has always been no matter how sick the baby is you always have to let him see them because that might be the last chance. Sometimes they might die before you bring them to the unit.”*

#### MW12

*“He kind of walked between the two. He was with her and then he went and had another look”*

The other scenario relating to this sub-theme is the timing of fathers’ first visit to the NNU. On the basis of her previous experience, the researcher assumed most fathers

accompanied their child when he/she was taken from the delivery room to the NNU. The findings of phase one suggest this is not always the case (see Section 3.11.1) and the HCPs concurred with this view. Phase two provides contrasting evidence regarding the two babies requiring NNU admission. One father accompanied his child to the NNU whilst the other visited very shortly afterwards (see Table 4.8, Section 4.20.2). However, this finding could have occurred by chance and generalisations should not be made from such small numbers. The findings of phases one and three suggest that fathers are more likely to remain with their partner in the delivery room. In most cases, HCPs described fathers making no attempt to go with their baby. They felt this was probably because it had already been indicated he should stay with his partner. On the rare occasion when fathers were invited to accompany the baby they preferred to stay with their partner. The HCPs assumed this was because they felt more useful supporting her. It is also possible they were afraid of what they might see on the NNU or were aware the HCPs needed time to stabilise the baby. Fathers usually only accompanied the baby at their partner's suggestion.

#### NN9

*“Normally we’d say right, we’re off, I’m just going to take baby round now. We’ll see you later kind of thing so whether that gives him the message, the hint, that you’re staying put.”*

#### NN8

*“Sometimes the wife will say can you, can you go with the baby. Make sure everything’s alright. So sometimes the wife will usher him like that, make sure you go.”*

The HCPs sometimes described fathers who appeared to want to go with the baby but were prevented by the neonatal team or midwife. They generally thought this was appropriate because time was required to stabilise the baby without any unnecessary distractions. They also believed observing stabilisation procedures would distress the father and commented that many HCPs do not like being watched when performing these tasks.

## D12

*"I think he wanted, he wanted to come and obviously, it wasn't possible, there's not much space. It's not that we don't want them to be there when we do it, it's just that there isn't the space if we needed to reintubate the baby if it wasn't able to breath and it's more sort of logistical rather than not necessarily not wanting him there. It can be a bit unnerving for the nursing staff as well. A bit of pressure you know to get the tube in first time if dad's watching."*

HCPs initially felt it would be more distressing for a father to be turned away from the NNU than not go to the unit in the first place. However, during the interviews they reflected on this and subsequently suggested if fathers accompanied their baby to the NNU they would at least know to which nursery their child had been admitted.

## NN7

*"So we find that settling the baby and then getting them in as quickly as possible, it's easier for the baby you know, to sort it out. I suppose we could, dads could come and just see where baby is and then we could start. I never thought of it like that actually."*

When fathers did not accompany their baby to the NNU there was often considerable delay before seeing their child again. This was another factor that contributed to the HCP's view that the event they described had been a negative experience for the father. Whilst midwives usually tried to ensure a father saw his baby as soon as possible, they said constraints enforced by the neonatal team caused delays and gave examples of fathers waiting up to three hours. A few midwives described spontaneously taking the father to the NNU without seeking permission from the NNU team. On a small number of occasions, fathers became so frustrated that they went to the NNU unannounced, but were turned away. In the following quote, the midwife emphasises the point by repeating the last phrase:

## MW8

*"He got so fed up of waiting, he was winding himself up so much. I thought he'd gone for a coffee but he went to the unit, but they wouldn't let him in, they wouldn't let him in."*

Several midwives offered to accompany the father on his first visit because they felt this was an important part of their role. Paediatricians, NNPs, MAs or student midwives also accompanied fathers, but this occurred less frequently. Much more commonly, fathers went by themselves. This was usually because no-one was available to accompany them. Although most fathers were willing to go on their own, the HCPs acknowledged that the NNU environment could be intimidating. It was also reported that fathers sometimes got lost and returned to their partner in a bewildered state, particularly if they had been given bad news about the baby.

#### MW11

*“Yes, definitely, I always do. Because they don’t know where they’re going and they don’t know what the situation might be when they get through the door. It’s, I would hope my reason for doing it would be that they would feel more comfortable having a member of staff to take them straight to where they need to be as quickly as they need.”*

#### MW14

*“Ideally, I would have liked to go with him but staffing wise very rarely I do. I tend to send them on their own.”*

Several of the comments HCPs made in relation to this sub-theme do not comply with their other comments about involving fathers (Section 5.10.2). It would seem that fathers are treated differently on these occasions. It may therefore be the case that in this context, fathers are regarded as being the wrong parent. Indeed, one senior paediatrician who it could be assumed would not be concerned about his own practice, expressed the following view about fathers going with their baby to the NNU:

#### D15

*“That would be unique in my experience and I would say oh, this is interesting. This father is different from the others and what I’d be thinking was, because this father is behaving exceptionally then he will be an exception. And what I would worry is that he is a very controlling you know, individual, who does not trust professionals and he doesn’t trust me with his son, daughter. There’s very often reasons for these sort of things which are very important to know.”*

### 5.8.5 'How fathers responded' – disengagement

The final response HCPs described was when fathers appeared to be disengaged from the situation. Before or during the delivery / resuscitation some fathers were reported to be quiet, withdrawn, shunned information, physically moved away, did not ask questions and appeared to not want to be involved. All HCP groups recalled fathers becoming disengaged, but the midwives were predominantly aware of this response. They particularly recalled fathers who stopped participating in their partner's care. Such behaviours may have been less apparent to other HCPs because they were focusing on their own role at the time. The midwife may therefore have had a broader view of what was happening. HCPs felt this disengagement may have occurred because the father was disinterested. However, they thought it was more likely that he felt helpless, shy or awkward and did not want to attract attention or was withdrawing because of anxiety or repulsion. Whatever the cause, the HCPs said it was more difficult to meet the needs of fathers who responded in this way. When asked if the scenario they described was a positive or negative experience for the father, the HCPs often correlated apparent disengagement with a negative experience.

#### MW12

*"It was hard because he just wouldn't speak to me."*

#### D9

*"The most common reaction is for the partner to recoil almost. They do almost tend to walk backwards into the corner. And I think that's sad when that happens."*

Descriptions of behaviours suggesting fathers were disengaged were much less common in relation to their first NNU visit. It is possible this is because fathers were less able to respond this way in this setting. The need to retrieve information for their partner necessitated some level of interaction with the HCPs. Fathers also stayed for only a short while, so there was less opportunity for them to appear disengaged.

However, one behaviour that suggested disengagement was apparent during the NNU visit when NNs recalled some fathers being reluctant to touch or hold the baby. Usually this was because they were afraid of harming their child. NNs also said fathers often believe the mother should be the first person to hold the baby. However, one NN questioned this view.

#### NN6

*“He said, Oh can I touch? You know he was a bit shocked. They think that these babies should be in this cocoon and you know, they shouldn’t really be touched or whatever I think they sort of really think that all babies here must be very poorly. I’ve got to leave baby alone.”*

#### NN7

*“They always want to let mum have the first hold but I don’t know what gives the mum the right to be the first person every time. But they think the mum is much more deserving than they are you know? I don’t know are they? I don’t know if it was me whether I think dad should have the first hold or I should have the first hold but if the baby’s there and the baby can be held, the baby should be held by whoever because its you know, it knows both of you.”*

### **5.8.6 ‘How fathers responded’ – changes over time**

When discussing issues more generally, experienced HCPs commented on changes they had seen in the ways fathers respond. They were reported to be more involved in all aspects of childbirth and better informed, largely because of information accessed via the Internet. Several HCPs gave examples of fathers using their knowledge as a basis to their questions. It was also suggested that a stronger knowledge base meant fathers were generally less accepting of information given by HCPs and that they are now more likely to challenge practice.

#### MW10

*“I think they’re more knowledgeable, probably more knowledgeable. Perhaps more, in the media more.”*



#### NN4

*"I think they're much more vocal, they push themselves forward as well which is a good thing and if they don't like you not answering the question, they will tell you and I think that's a good thing."*

As a consequence several HCPs thought fathers have higher and in some cases unrealistic expectations about what can be done for their partner and/or child. This possibly reflects the general population's perception that the NHS can and should resolve any health care related problem.

#### D15

*"They believe in the health service, that when the chips are down the NHS is there and it will make sure that you are alright and you will come out alright and you will be normal because they do marvellous things these days. Everything's fixable."*

A final change noted by HCPs is that fathers of all races and ethnicities are more willing to be involved in childbirth generally and complicated childbirth in particular. As a consequence anaesthetists and obstetricians said they see far fewer female relatives or friends attending complicated childbirth in the place of the father.

#### D10

*"I think the thing that I've noticed that has changed is how much more fathers do want to be involved. So when I first started out, there was a lot of situations where fathers would leave the room if you were doing an instrumental delivery or if you went to theatre the father wouldn't come. It would be the mother or the grandmother to be. And now I think fathers, I'm noticing it more and more, they do want to be more involved."*

## 5.9 'Giving information'

The HCPs described issues relating to this theme before, during and after the birth. They all felt the father's most important need during the incidents they described was for information. However, the type and extent of information given differed in the events they recalled. These differences are encompassed in the sub-theme: the nature of information given. When recalling specific events HCPs often identified guidelines for good practice in relation to information giving. These are described in the sub-theme: key principles (Figure 5.1).

### 5.9.1 'Giving information' – the nature of information given

During the tour of the NNU before the birth, NNs described giving information in a general way about the layout of the unit, different types of equipment and care of the babies. Subsequent detail was given in response to the specific questions parents / fathers asked. The HCPs' rationale for this approach was based on their concern that too much information would increase parental anxiety. Fathers were recalled asking practical questions relating to the short-term situation such as the visiting policy, how soon he would be able to visit and how long the baby would stay in the intensive care nursery. However, NNs recalled most that fathers did not ask questions during the tour, suggesting they preferred to take a 'backseat'. NNs rarely described focusing information directly to the father. On occasions when this was done, the information related to his role in the time immediately following the baby's admission.

#### NN13

*"Well I think trying to give them an overall view of what it will be like when they arrive and I think then they lead it because I think they ask the questions and I just answer as much as I can what they're asking. Try not to bombard them with too much information."*

#### NN1

*"I don't find the dad asking a lot of questions."*

#### NN4

*"I tend to also talk to him about the layout when he comes because he's the one that's going to come and when I take them to room XX ((the intensive care nursery)), again I would say to him you will be coming on your own, this is what you do, this is what you'll see and this is what you will be faced with."*

Several HCPs recalled interactions with parents in the fetal medicine department or on the delivery suite before the birth. In these settings paediatricians and obstetricians described giving medically orientated information about what would happen at the birth and who would be involved. In addition to this type of information, midwives and NNPs recalled giving information about what the father would see, where he would be in the room and what he could do to support his partner. Midwives and NNPs therefore appeared to be taking a more holistic approach to the information-needs of fathers. Although some HCPs described showing the father the resuscitaire almost all gave limited, non-specific information about the resuscitation the baby was likely to require.

#### D12

*"This is what's going to happen, so he knew what to expect at the time of delivery and that there will be a large number of people in the room. The baby may have respiratory problems initially. The baby may or may not breathe and may need help with breathing. I usually show them the resuscitaire if I can if I'm in the delivery suite room to show them what it is. Because a lot of them don't always know what it is, the funny machine in the corner. That's where the baby will come. That the first priority is to get them breathing."*

#### MW14

*"I talked to him directly saying look you know, there's going to be so many paediatricians by the resuscitaire. Baby will go straight there. You can look if you wish but if you just want to wait by your wife and then we will show you the baby if the baby's stable enough and then and then you would walk with them. I do a step-by-step account and they tend to appreciate that."*

Any further information given to fathers before the birth was again determined by the questions they asked. They used questions to clarify their understanding or challenge the plan of care. In most cases questions focused on practicalities, immediate management, the skills and experience of the HCPs and the likelihood of a positive short-term outcome. Although the HCPs tried to be positive, they said it was not always possible to assure a good outcome. None of the HCPs recalled fathers specifically asking about newborn resuscitation and only a few remembered fathers asking questions about the long-term situation such as the likelihood of handicap or implications for the rest of the family.

#### D61

*“What he wanted to know was, you know, is my child going to be handicapped at the end of it? So he was looking more at the long term rather than the immediate what’s going to happen right away. That’s quite unusual in my experience”*

#### MW14

*“....he just wanted to know it’s all going to be ok.”*

The HCPs acknowledged that limited information was given to fathers during the delivery and resuscitation. This was usually because they were focusing on delivering care to the mother and/or baby. Any information HCPs did give at this time was generally directed to the mother. This was thought appropriate because unlike the father, the mother usually could not see what was happening. In addition, although information was not directed at him they felt the father could hear what was said. On occasions when a baby unexpectedly required resuscitation the midwife conducting or assisting the delivery took the baby to the resuscitaire whilst a call for assistance was made. These midwives made some comment to the parents about the baby’s need for support, but their sense of urgency usually prevented any detailed explanation from being given.

### M11

*“So I kind of just said right, I’m just borrowing your baby because it looks a bit blue.”*

### MW13

*“I just said that I was concerned about her colour and she seemed a bit slow to establish her breathing rate so I wanted to, that’s why I called for help, obviously I explained that to mum.”*

In most cases, when information was given during the resuscitation this was done by obstetricians, anaesthetists or the midwife caring for the mother. This was usually non-specific because they were often uncertain of the exactly nature of the resuscitation or how the baby was responding. They also did not feel it was their responsibility to be giving detailed information at this time. However, they felt they had to be honest particularly if the father could see what was happening. Some midwives described not knowing what to say and the uncomfortable silence when the resuscitation was prolonged. However, other midwives and anaesthetists said no matter how serious the situation, they tried to say something positive such as commenting on the baby’s hair or the fact that the baby was showing signs of recovery, albeit slowly. On occasions when the resuscitation was prolonged NNs sometimes went over to the parents to explain what was happening. Again, this information was mostly directed to the mother.

### D14

*“I think to leave them with nothing is worse actually. I think they need to know what is going on, so I said you know, the baby is requiring help with breathing. I mean they were expecting the baby to be healthy and alive. It is very difficult but I think they’d hate me if I didn’t tell them the truth really. So I tried to tell them as honesty and as clearly as I could, with the limited information I had and I said you know once the paediatrician’s happy with the baby, they’ll come and tell you what’s going on.”*

### MW15

*“Mum was saying why isn’t he crying? Why isn’t he crying? And I was explaining to her that you know the baby is very shocked and that they’re just helping the baby with that now. There was meconium liquor and they wanted to clear that away as well, I explained that. And then I said about the inflation breaths.”*

## NN5

*"I at that time I could not speak to dad because we, our priority was the baby and baby needed intubating and we had a lot of problems with that. Then the ET tube needed fixing. Once that was done I was able to then go and speak to mum just to give her brief information of what was going on, how the baby was."*

Once the resuscitation was completed some babies required NNU admission, whilst others were able to remain with the parents. Paediatricians, NNPs and NNs described the information they gave parents at this time. This ranged between detailed information and a more general summary of events. Needing to get the baby to the NNU as quickly as possible appeared to influence the nature and extent of information given. Consequently parents whose baby required more extensive support often appeared to be given the least amount of information. Midwives recalled sometimes advocating on behalf of the parents by ensuring someone from the neonatal team spoke to the parents before they left the delivery room.

## D7

*"I was able to take the baby round to the father and he said, was it difficult? I said, yes it was not the easiest of things but baby's now very well and I think that we just need to keep a close eye on the baby. Then I went on to explain to them a little bit about what we'd done and why we'd done it."*

## NN13

*"We explained quite quickly you know, we've had to put down a tube for breathing and we're now going to move the baby. We let them have a look and then we went."*

Paediatricians, NNPs and NNs recalled the information they gave fathers during his first visit to the NNU. They described giving a brief summary of the baby's care and this involved information about respiratory support and feeding. Minimal information was given about the equipment on this occasion. A few HCPs said they referred to other babies in the nursery. However, it was acknowledged this should be done with caution

and that confidentiality should not be breached. The fathers did not usually ask about long-term problems during their first visit. However, some asked when the baby would be discharged home. This could have been an alternative way of asking about potential complications.

#### NN4

*"I think they just like you to tell them as it is .... something that they can grasp. This has happened and answering their questions."*

#### D15

*"The only time I use other babies is saying your baby might need phototherapy like that baby over there. That's, that's the only situation that I use anything and they can just see a baby lying there under the lights you know? Because otherwise they say, phototherapy, what on earth's that?"*

In addition to information about the baby, HCPs gave fathers practical information about the NNU. This included visiting and hand washing policies, information about facilities available and car parking arrangements. It appeared that some HCPs felt this was more important than information about the baby and they appeared to be setting the ground-rules for future visits. Although this NNU provides written information for parents, this was not always given to the father during his first visit. This was because the NNs believed this should be given to the parents when they visited together or specifically to the mother.

#### NN13

*"I don't think it's terribly important at that point. Because I think they're more, he wants to know who he can bring to see the baby and when maybe mum can come. And I think if you bombard them with all this leaflets and stuff, I think there's time for all of that perhaps on the next visit."*

## 5.9.2 'Giving information' – key principles

The HCPs identified a number of key principles that should be adhered to regarding the nature, extent and timing of information given on these sorts of occasion. Whilst there was agreement that information should be realistic this sometimes presented challenges. For example, it was not always possible to predict the level of care a baby would require at birth. This could be why in the incidents described HCPs gave generally non-specific information about the potential resuscitation (Section 5.9.1).

### MW11

*"If I anticipated a problem I would be as open and as honest about the problem that I would anticipate as I possibly could be. I wouldn't be wanting to hold anything back; I would be as open as possible."*

### MW18

*"You can have a situation where it's very hard to predict the level of resuscitation that is going to be required."*

On occasions when there was an opportunity to reinforce or repeat information, this was felt to have been helpful. It was usually the midwife who did this. The HCPs believed repeating information helped parents who were initially overwhelmed or did not fully understand the situation. They also felt it demonstrated that HCPs were in agreement about the care management. Information reiterated by the neonatal team was also felt to enable parents to establish a relationship with HCPs who would be responsible for their baby's care within the NNU. However, there were several occasions when it was not possible to reinforce information because of a lack of time.

### MW12

*"He was quite prepared for kind of what was going to happen because it had been reinforced by both me and the paediatrician."*



## D13

*“It’s a time issue isn’t it? You haven’t got the time. Sometimes I haven’t got the time to properly feel that you’ve fully informed the mother about what’s going to happen let alone include the husband or the partner in it.”*

Some HCPs described needing to be careful about what they said in front of the parents. These were occasions when they were discussing care strategies with colleagues or when there was uncertainty about outcomes. For example this NN described reminding the paediatrician that the father could hear what he was saying during the resuscitation.

## NN9

*“The paed said something so I sort of nudged him and sort of, look over your shoulder as if to say careful, you’re being listened to, watch it.”*

## **5.10 ‘Engaging and involving’**

This theme describes the strategies HCPs used to engage and involve the fathers before, during and after the birth. Three sub-themes were identified within the analysis: developing a rapport, including him and debriefing (Figure 5.1) and these will now be described.

### **5.10.1 ‘Engaging and involving’ – developing a rapport**

Midwives and anaesthetists described trying to establish a good rapport with the father before the birth. They recalled making an effort to be friendly through conversation hoping this would put him at his ease. They adopted this strategy regardless of anticipated events. When an unexpected emergency such as neonatal resuscitation

occurred, this rapport was felt to help fathers feel more supported and make the event a less negative experience.

#### MW9

*"I think it makes them feel a lot more relaxed because they know that they can talk to you and I think then it makes them feel like they can trust you. And then once you've been able to have a giggle about something they do start asking more questions than about anything that they don't understand because I think then they feel that they can. So I think chatting to dads is sort of like, it can help."*

Paediatricians, NNPs and NNs also described trying to adopt this approach when the father visited the NNU. However, gender issues and personal experiences appeared to influence the extent to which this strategy was pursued. Male paediatricians felt they were more empathetic since becoming a father themselves. In recognition of a 'mother-centred' philosophy they made particular effort to establish a rapport with the father and this started during the first visit. One male paediatrician also felt less comfortable establishing a rapport with mothers and therefore focused his attention on the father. By contrast, the NNs described difficulties they encountered establishing a rapport with fathers and junior NNs were reported to have experienced problems in this area.

#### D7

*"Sometimes quite personal relations develop when you work with parents who are here for a long time. I've got on better with the dads. I don't know why that is and I suppose because it's almost unprofessional to become good friends with the mothers. So therefore you can become more friendly with the dads because it's seen as more acceptable. I had to distance myself once because a mum was getting too attached and I felt uncomfortable. But as with dads you can talk a lot more about general things as well without seeming unprofessional."*

#### NN12

*"It's harder to relate to them. Obviously being female, I think it can be easier to relate to the mums because you can imagine what they're feeling. Whereas the dad I think it's different. It's more difficult to see things from their point of view."*

### 5.10.2 'Engaging and involving' – including him

The HCPs described a number of ways in which they tried to include the father. This was frequently mentioned when they described information giving before the birth. The HCPs felt they had the same right to information as mothers. Indeed, the parents were often referred to as being a partnership. As a consequence HCPs often described delaying giving information until the father was present. Other strategies to engage fathers included making eye contact, inviting questions and occasionally, the use of humour. However, HCPs reported that despite an awareness of the need to involve fathers, information was sometimes directed specifically to the mother.

#### D61

*"When you're, we're doing fetal medicine when you're talking about abnormality, I mean I'm very clear, this is THEIR child, it's not HER child, it's THEIR child and they have to make decisions and receive information as a partnership."*

#### D7

*"I'm conscious of the fact that we usually talk to mothers. That's why I found this ((study)) to be interesting because I'm aware of dads and I try and talk to dads, I'll try and talk to both parents if the dad happens to be there. But I think you still find yourself talking more to the mother."*

Another less common way that midwives and paediatricians involved fathers was when they took him from the delivery suite to visit the NNU before the birth. These were occasions when the parents had not had a pre-admission visit. These HCPs said this was not common practice and they only did this because time permitted.

#### D7

*"I said to the dad, do you want to come and see round the neonatal unit so you can see where baby's going to come?"*

During the delivery midwives and obstetricians described trying to involve the father in some way. They felt giving him something practical to do enabled him to feel part of the team. One of the ways this was done was by encouraging him to cut the cord during normal, ventouse or forceps deliveries. This has previously been described as a way of involving fathers (Price, Johnson 2006). However, none of the HCPs mentioned using strategies to involve fathers once the resuscitation was in progress.

#### D10

*"I always try to involve the father in the delivery even though it's an instrumental delivery so they can cut the cord."*

#### MW12

*"I try and bring it in through the birth plan. You know, is there anything both of you wanted for delivery? You know did you want to cut the cord?"*

### **5.10.3 'Engaging and involving' – debriefing**

All HCP groups discussed whether they debriefed the fathers after the event. Obstetricians and midwives described cases where they had initiated the process. Indeed, most midwives felt they had a 'duty of care' to ensure this occurred. They felt debriefing provided the opportunity to explain what had happened and correct misunderstandings. Although parents were often debriefed together, midwives also described ensuring they spoke to the father by himself. However, in many cases debriefing of fathers by these HCPs did not occur. Usually this was due to time constraints or lack of staff. It was also reported that some fathers did not want to discuss what happened. Midwives and obstetricians assumed fathers responded in this way because they preferred to look forward or felt uncomfortable disclosing their feelings about recent events to people they hardly knew.

The anaesthetists felt it was less important for them to debrief fathers. When this did occur, it usually happened by chance when they met him after the delivery or if he happened to be present when they debriefed the mother. Paediatricians, NNPs and NNS

recalled instances when they debriefed fathers about the resuscitation whilst the baby was being cared for in the NNU. When this occurred, the HCPs sometimes initiated the process but more commonly the father asked to talk about what happened. A general reluctance to get involved in these discussions was reported, particularly amongst NNs. They felt uncomfortable discussing events particularly if they thought the father would become distressed. They were also concerned about being asked questions they could not answer.

#### MW6

*"I made sure that I spoke to him on his own. They might not want to get upset in front of their wives or partners."*

#### NN5

*"It's not my place, just in case he asked me sensitive questions that I'm not able to answer. It's very difficult in that situation especially if you've got a very sick baby. I would not take part in that at all."*

### **5.11 'Exclusion'**

This theme describes situations when fathers were excluded from what was occurring before, during and after the birth. Scenarios where in the HCPs' opinion the father was excluded seemed to be a significant factor in their judgment that the event had been a negative experience for him (Section 5.7). Two sub-themes were identified within the analysis: the operating theatre and not important (Figure 5.1) and will now be described.

#### **5.11.1 'Exclusion' – the operating theatre**

Within the phase one interviews some fathers described waiting in the recovery area of the operating theatre (Section 3.10.3). When midwives, obstetricians and anaesthetists

referred to similar events, the incident was further explored. At the time of data collection, fathers were unable to be with their partner whilst an epidural was sited in the operating theatre or when a LSCS delivery took place under general anaesthetic (GA). This was a department policy at the time. When the rationale for this was explored these HCPs gave a number of reasons why fathers were excluded. These included concern that fathers would cause a distraction, or find it difficult to remain in a fixed position (seated) whereby safety and infection control would be compromised. Absence of the father also meant HCPs could focus their attention on the mother. To reinforce this point, they said if a father became distressed there would be insufficient staff to support him. Several obstetricians and anaesthetists also felt there was no reason why a father should attend a LSCS under GA. They argued fathers would be unable to support their partner at this time and felt there was no other reason why he should be present at a delivery.

#### D14

*“...it’s easier for us to be able to work quickly. Fathers all very well meaning can sometimes, are you know, have the tendency to ask questions which may slow us down. In an emergency situation there may not be the time to be able to, to engage in a long conversation about something and also they may react variably to what is being done.”*

#### D61

*“Because their partners are there to support the woman. If the woman’s asleep she doesn’t need the support and then that is just someone else that we then have to look after when we’re supposed to be focusing on the mother.”*

However, not all HCPs supported the exclusion of fathers and a few obstetricians and anaesthetists recalled situations where they made exceptions to the rule. They did this when the father was required to act as interpreter for his partner or if the mother was extremely distressed. These HCPs said on occasions when fathers had been present, the problems suggested by their colleagues had not arisen.

#### D16

*"I do still bring the father in if the mother doesn't speak English or speaks little English and the husband does speak English. Then I bring them in to help translate for us, or if they're very anxious. I personally have no problem at all. I'd be quite happy for the father to come in."*

#### D62

*"...yes I've not had, I must admit I've not had too much of those problems."*

Midwives also did not support this practice and described the impact on the father when he was excluded. Mostly negative affects were recalled including distress, abandonment, shock, anxiety and fear. In more extreme cases fathers became angry and aggressive. The particular awareness of midwives of the impact on the father may have been because in most cases they had to tell him he could not go with his partner, so they took the brunt of his response. Having established some sort of relationship with the couple prior to this incident, the midwife was aware of the effect of the separation.

#### MW18

*"He was petrified sitting in recovery I think it was the worst thing that you know, that could have happened for him because he was just sitting there absolutely petrified."*

#### D13

*"Occasionally you have a situation where the, the husband doesn't really understand why they're not immediately allowed into theatre or doesn't understand why they're being excluded, it's a general anaesthetic. And very, very occasionally that can become violent. We had one case when a father had to be removed by the police because they, they became so difficult that you know, that was considered inappropriate."*

Much less commonly midwives recalled fathers portraying a more positive response to their exclusion. They felt it gave fathers a legitimate reason for not being present. It also provided the opportunity for him to receive some, albeit brief attention.

## MW10

*“If someone’s going to theatre for a caesarean and the dad’s having to wait while their partners are having a spinal then, I think that’s a really good opportunity on their own while you’re getting them in the gown and just say, are you ok? Do you understand what’s happening?”*

Midwives and obstetricians also recalled the impact on the mother when her partner was excluded. They felt she had to adapt to a new group of HCPs at a time when she was likely to be feeling vulnerable and frightened. Without her partner’s support, these feelings were felt to escalate. Midwives also described the impact of the exclusion of fathers on themselves. They found it difficult telling him he could not accompany his partner and it often made their job more difficult because they had to become the main source of support to the mother at a time when they had other responsibilities and tasks to perform.

## MW9

*“I do find it difficult when they’re not allowed to be during the operation ..... if anything it sounds lazy but I’d rather them be there to support her and just hold her hand while I can get on with my job without me supporting her and then rushing around doing everything else.”*

Almost all midwives and some obstetricians and anaesthetists were frustrated by the policy and spontaneously referred to it as being ‘awful’, ‘ridiculous’ and ‘wrong.’ Some of these HCPs had worked in different hospitals where fathers were able to be present in theatre when an epidural was being sited. They described trying to gain support for a change of practice with varying success. Anaesthetists and theatre staff were generally felt to be resistant to change.

## D16

*“And the objections that we’ve met are; what happens if the partner gets up and starts wandering round theatre? What happens if they go over when they’re trying to resuscitate the baby? What happens if they faint or they vomit, who’s going to look after them? What happens if they start getting aggressive? All these scenarios are exactly the same when the woman’s in a delivery room. And we don’t ask partners to go out when women’s getting an epidural sited for pain relief in a delivery room.”*



### 5.11.2 'Exclusion' – not important

Although all HCP groups said the fathers needed support during the resuscitation, it was acknowledged this often did not happen. This was felt to be a particular problem when unexpected situations arose or during night shifts when less staff were available. In most cases HCPs had other priorities: the baby or the mother. Although it was felt the midwife, obstetrician or anaesthetist might be in a better position than other HCPs to support the father it was recognised that this often was not possible. Midwives said they had a duty of care to the mother and were often involved in her ongoing care such as delivering the placenta. Obstetricians and anaesthetists said the mother was their patient and they therefore were usually involved in aspects of her care. Paediatricians and NNPs were focusing on the resuscitation and the NNs felt their main role was to support their medical colleagues and advocate for the baby. Consequently in the incidents described there was usually no one available to support the father and no one was specifically delegated to take on that role.

#### D14

*“My main focus is to make sure the mother is supported. I think that’s, I think it’s important to understand that because the mother’s my patient, the father’s not my patient.”*

#### MW9

*“When the baby was born and she needed resuscitating, he ran out the room crying. I felt like I should have ran after him really which I couldn’t at the time because I was trying to like stop her ((the mother)) from bleeding. So it was difficult but I did think, oh my God.”*

Several HCPs were aware that in other care settings a designated HCP often supports relatives when they witness resuscitation events (Goldstein et al 1997; Robinson et al 1998; Grice et al 2003). Whilst it was suggested this would be beneficial for fathers it was felt staff shortages and lack of resources prevented this from happening.

#### D13

*"...unless we employed an extra member of staff just to look after, just to look after the father, but we can't do that."*

Paediatricians, NNPs and NNs also felt the father's needs were sometimes not met when he first visited his baby on the NNU. Reasons for this included: lack of time, the way care was organised and staff shortages. The ongoing need to stabilise the baby limited the opportunity for staff to focus on the father or for him to interact with his child. It was also felt the NNU had a mother-centred approach to care and this was portrayed in a number of ways. These include the availability of a 'patient' rather than 'parent only' toilet and the lack of overnight accommodation for fathers. As a consequence, they thought some of the fathers in the scenarios they described probably left the NNU feeling unwelcome and unimportant.

#### NN4

*"Even I do it at times, we're so busy with the baby you're just sort of answering questions and doing, we don't actually see what they are feeling if you like when you're so busy and it can happen in this place when you're running round doing things and you know you've not done your job properly, and you've not been fair to him with his baby."*

#### NN10

*"We're very, we can be, we're very mother-orientated and dad gets pushed to the side, he's no use nor ornament. Well actually that's not the case, but I think it's very easy to neglect the needs of the fathers."*

The other way in which fathers were deemed unimportant was in the lack of resources for them within the maternity unit. HCPs commented that there was nowhere private that fathers could go if they needed some quiet time on their own. Comparisons were made between facilities available in paediatric care settings and those within the study-site. Paediatric care was thought to reflect a family-centred philosophy of care whereby fathers are treated in the same way as a child's mother. Within the study-site, resources

for fathers were reported to be limited and the lack of overnight accommodation was specifically mentioned.

#### MW15

*“On this Delivery Suite if they want to go for a few minutes there’s nowhere to go. They have to leave the department. And if they’re hanging about in corridors they get moved on. Their only choice is to go into the public areas or to go home or to go and sit in the car. I suspect quite a few go and sit in the car.”*

#### NN7

*“I think it’s terrible that you know the mum has the baby at four o’clock in the morning and within an hour dad’s like told he’s got to go home. Do you know what I mean? And if the baby’s really sick there’s nowhere for him to stay or to sleep for the night and you know, I think that is terrible.”*

### **5.12 ‘Health care professional issues’**

Although the main purpose of the interviews was to explore the HCPs’ recollection of fathers’ experiences (Section 5.1) they also reflected upon factors affecting themselves. Three sub-themes were identified within the analysis: knowing what to do or say, teamwork and the impact on them (Figure 5.1). These will now be described.

#### **5.12.1 ‘Health care professional issues’ – knowing what to do or say**

When HCPs recalled incidents involving fathers they also described the actions of themselves and their colleagues. They usually reflected on factors that influenced their practice. Being able to draw on previous experience and background knowledge was felt to be useful during interactions with parents before the birth. Some obstetricians and midwives had previous neonatal experience and said this was invaluable whilst others felt their lack of knowledge and experience sometimes had a negative impact upon information they gave. The HCPs’ perceived level competence and confidence therefore appears to have an impact on their provision of information on these occasions.

#### MW14

*"I was a neonatal nursery nurse and at this hospital. So I know the ins and the outs of admissions and protocols. More from an inside point of view and so I think that has benefited me greatly. And so because of that I tend to go into a bit more detail."*

#### MW15

*"I haven't had any formal training about the neonatal unit. I never worked on one, only as a student midwife and I feel very much out of my comfort zone when talking about it."*

Most HCPs had not received any formal education or training about supporting fathers, either generally or in specific situations such as during newborn resuscitation. More senior HCPs also said they did not address these issues in their teaching. Some had received teaching on more general topics that they applied to supporting fathers such as: counselling skills, breaking bad news and family-centred care. However, they felt teaching generally focused on the needs of parents collectively or mothers specifically. Midwives who had trained more recently had received some teaching about supporting fathers generally, but this was minimal.

#### D16

*"I don't think it's anything that anybody's spoken about and I suppose I don't really speak to the trainees who come through about it either"*

#### MW8

*"No, not really at all. We talked a lot about supporting mothers you know, through pregnancy loss and things like that but fathers hardly get mentioned at all."*

#### MW6

*"We've had tiny, tiny mentions about dads in modules before at Uni. I can vaguely remember but not, not a lot."*

All HCPs felt their way of supporting fathers had evolved through experience and confidence. For example some midwives and anaesthetists felt they had become skilled

at observing non-verbal cues and this enabled them to support fathers more effectively. Other HCPs drew on experience in related specialties, their own reading, discussions with fathers and reflection on practice. They felt each HCP develops their own philosophy of care and this may or may not include supporting fathers.

#### MW10

*"When it's an emergency situation I think naturally because of the fact that I'm a midwife, we're more aware of people's reactions, we support the fathers a bit more."*

#### MW15

*"I think my practice is probably based on what I've heard husbands and partners tell me and how they felt."*

#### NN4

*"I think over the years you sort of learn to recognise .... Just a few minutes of asking maybe specific questions would probably tell me a lot to know how then I would put across things to him, how much information to give.... One of the things is the type of questions they ask or when they don't say anything. The look in their faces.... So I would say experience in seeing dads really."*

In developing their way of working, HCPs said they drew on two other elements: observing the practice of others and thinking about how they would like to be treated. All HCPs described learning from mentors, senior colleagues, their peers or junior staff and recalled positive and negative scenarios they had observed. Obstetricians often specifically mentioned learning good practice from midwives. Senior HCPs were also aware they were role models to junior staff and endeavoured to provide a good example.

#### D15

*"I have a series of horror stories of observing my consultant teachers in days of yore making a complete and utter hash of it. And I use that you know and I just, you just learn by thinking, right, if I live a thousand years as a neonatologist, I will never do that"*

### MW11

*“Midwives when I was a student I think as much as anything. Nurses who were qualified and people who you admire, who you think and it’s sometimes, it can be junior staff actually and you think, that was really well handled and so you think actually that’s, you’ve learnt from that. So it’s sometimes their relationship with the dad and it’s sometimes just, what you’ve sort of learnt from what you’ve seen.”*

The second factor that influenced the way HCPs supported fathers was thinking about how they would like to be treated. Several used the phrase ‘putting yourself in their shoes.’ Female HCPs transferred this approach to thinking about how they would like their partner to be treated or felt they were able to consider the father’s perspective themselves.

### D61

*“I always say to juniors, speak to people how you want to be spoken to. Treat them the way you want to be treated and just put yourself in their situation. You know, it’s your partner that’s having a baby and somebody’s not even acknowledging that you’re there, how would that make you feel?”*

### MW8

*“I put myself in that situation and think what I’d feel like. You know, if I was left in the lurch and didn’t know what was happening. How petrified I’d be.”*

## **5.12.2 ‘Health care professional issues’ – teamwork**

On several occasions during the interviews, HCPs mentioned the importance of effective teamwork. Situations where the team worked well together were felt to lessen the overall negative impact of the event on the father. Obstetricians, midwives, paediatricians and NNPs felt effective liaison with their colleagues before the birth enabled them to give the fathers / parents prompt and appropriate information. Examples of good communication

between HCPs included direct discussion, written documentation and early referral to the neonatal team.

#### D10

*“...a lot of what I would tell them will be taken from what’s written in the notes about what’s to be expected for the baby.”*

#### D8

*“I was called to come and counsel the parents on the fetal medicine unit. So I had involvement at such an early stage with the parents.”*

The importance of good teamwork during resuscitation events was also identified by most HCPs. They felt when the team worked well the situation was usually dealt with quickly and smoothly to the benefit of all concerned, including the father. Senior HCPs described having an instinctive way of working with their colleagues such that verbal communication was not required. They described scenarios when those present spontaneously took on different roles and responsibilities assisting and supporting each other. Obstetricians recalled distracting the father so their colleagues could focus on the resuscitation. Anaesthetists described assisting with the resuscitation, particularly when a junior paediatrician appeared to be having difficulties. Several midwives described responding to a crash call. As the second midwife they were the ‘go-between’ relaying information between the neonatal and obstetric teams and the parents. The importance of senior midwives supporting junior staff was also identified. It was felt enabling junior midwives to take time out after a resuscitation episode enabled them to support the parents more effectively.

#### D10

*“If I’m happy the mother’s suturing is done and mum’s not bleeding, mum’s fine and everybody is working on the baby then I will stay and do whatever I can whether it’s fetching for the paediatrician or whether it’s staying and supporting mum and dad because the midwife’s helping the paediatrician.”*

## MW9

*"I think that's really the Shift Leader's role as well to make sure that all her staff are supported through the day whatever situation they're in. It's like yesterday the shoulder dystocia, that lady, their baby needed to be resuscitated. We said afterwards, me and the Shift Leader talked about like you know, you go over it like, oh that was awful and. Oh he was crying, oh it was terrible and you just talk about it and then that helps you to kind of deal with what's happening so you can go back into the room and think about what you need to do to support them now that now that I've dealt with that."*

### **5.12.3 'Health care professional issues' – impact on them**

During the interviews, the HCPs frequently reflected on the impact of the event on themselves and breaking bad news was reported to be particularly difficult. During the resuscitation, HCPs described trying to adopt a calm and self-assured manner regardless of how they were feeling at the time. They hoped this attitude would be transmitted to the father and as a consequence he would be comforted and reassured. Many midwives however, said it was difficult to adopt this approach and when recounting specific events described them as being 'awful', 'horrendous', 'terrible' and 'shocking.' Five HCPs (midwives and neonatal nurses) cried as they recalled the resuscitation and on two occasions, the recording was temporarily stopped. In a less extreme way, when they reflected on specific events, several midwives felt they should have done more to support the father.

## D8

*"It can be quite difficult and stressful for both the parents and for us."*

## MW8

*"I went home and cried. Went home and cried and cried and cried. It was horrible."*

## MW12

*"You try and support the fathers and meet their needs when it happens. I do have days where I go home deflated thinking I really wish I could have done more for him that day."*



A less extreme issue some paediatricians and NNPs described was when the father went to the resuscitaire. This is an issue that has been explored in the literature regarding witnessed resuscitation in other care settings (Hanson, Strawser 1992; Schilling 1994; Jarvis 1998). Some were comfortable about this and felt it did not impact on their practice. Others however, felt uneasy being watched so closely and felt it placed additional stress on them in an already pressurised situation.

#### NN14

*"I don't mind it at all. I'm used to people watching what I do and I think he needs to see anyway."*

#### D7

*"I don't like it. Not because it's a worry to me it's just because I don't happen to like being watched when I'm working."*

The HCPs rarely said the event they described had a positive impact on them. Their relief and satisfaction when all was well after the event was usually implied rather than stated. This may be because in many cases, the busy nature of the care setting meant HCPs working in the maternity unit often became immediately involved in the care of other parents. Whilst for the neonatal team their involvement with the baby was ongoing, with limited opportunity to reflect back on what had happened. Midwives were the only HCPs who described becoming emotional at the delivery when the outcome was positive. This is probably because in most cases they had been most directly involved in the couple's care.

#### MW7

*"Yes. Even now, after all this time, there are some difficult deliveries and you want to, kind of, you share in all of that emotion and it's very easy to kind of get prickly eyes when things are OK."*

### 5.13 Discussion

The interviews give detailed insight into the experiences and attitudes of HCPs involved in incidents when fathers were present around the time of the birth of his baby. A broad picture is provided and a range of participants and different experiences are described. Their role, responsibilities and areas of work determined their description of incidents. It was therefore important to include a range of HCPs in the sample to ensure aspects of fathers' experiences described in the previous phases (Chapters 3, 4) were explored.

When recalling specific scenarios some HCPs initially focused their comments on the parents or the mother and it was only with subsequent probing that issues relating to the father were revealed. Primarily referring to the parents or the mother was seen across all HCP groups. Focusing on the parents collectively is perhaps understandable in some contexts such as before the birth when parents were usually seen together. It may also reflect the HCPs' view that they have an equal responsibility to both the father and mother. However, in some cases HCPs could not identify specific issues relating to the father. For example when NNs discussed the tour of the NNU only a few described issues specific to the father (Section 5.9.1).

It is also possible that the term 'parents' may have been a way of avoiding use of 'mother.' This is not uncommon (see Section 1.2) and it may indicate a view that the father is less important. Alternatively their needs are perhaps seen to be no different to those of mothers. Even in situations when the parents were separated, for example when the father was unable to go into the operating theatre, HCPs often described what happened to the mother first. This was possibly because they felt they had to explain the context. Alternatively, it may suggest they felt the father was less important.

The HCPs were generally supportive of the need to involve and engage fathers. However, this was a self-selecting group (Section 5.3.2). Several HCPs might also have been influenced by their personal experiences of childbirth (Section 5.4.3). A few participants retold personal and deeply moving stories either as part of the interview or

once the recording was completed. Although none of this information was used in the analysis these experiences may nevertheless have influenced their views in a more general way. It is reassuring that participants were willing to share these personal stories because this indicates that the researcher was trusted. The participants may also have used this interaction as an opportunity to debrief themselves. Some said they had not previously discussed these events with anyone else. Ultimately it is difficult to determine the extent to which participants were influenced by their personal rather than professional experiences. However, several HCPs felt their views were similar to those of their colleagues. A number of issues pertaining to the fathers, the HCPs and the care setting were identified across the interviews. These will now be explored with reference to other relevant studies.

#### **5.13.1 Discussion – issues pertaining to the fathers**

HCPs had an awareness of how fathers responded, particularly in times of crisis (Section 5.8). Negative responses were often described which correlates with the findings of other childbirth studies (Sommers-Smith 1999; Johnson 2002; Eriksson et al 2006). In some instances all HCP groups were critical of the fathers' responses. This suggests they had expectations about how fathers should behave when they described what they felt were inappropriate responses particularly during the resuscitation. However, these fathers may not have understood what was occurring or they may have responded in this way as a coping strategy (Van der Molen 1999; Pinelli 2000; Ogden 2007). Occasions when fathers became extremely agitated were also described. This most commonly occurred when fathers were unable to go into the operating theatre and therefore had no control over events (Sections 1.7, 5.11.1). Although fathers may experience similar feelings of a lack of control at other times for example during the resuscitation, the responses described on other occasions were less extreme. In these other contexts fathers could see action being taken and may have received some, albeit minimal support. The agitation portrayed by fathers unable to go into the operating theatre may therefore have been compounded by a lack of information and support.

HCPs described fathers attempting to control their emotions (Section 5.8.2), this was particularly noticed by midwives. This was most extensively described before the birth and during the resuscitation. This is perhaps not surprising because these were two situations when the parents were together. Of all the scenarios described, the resuscitation could also be regarded as being the crisis point and therefore the most highly charged emotionally. Behaviours associated with the control of emotions were described by the HCPs in the context of pressure to conform, male stereotypes and a strategy to protect his partner (Lee, Miles, Holditch-Davis 2006; Shaw et al 2006; Lee et al 2009). The fathers may also have been using emotion-focused coping strategies (Section 1.7). All HCP groups described fathers portraying mostly negative emotional responses which suggests their attempts to control their emotions whilst recognised, were generally unsuccessful. However, these responses may have been more apparent to the HCPs than the mother.

Fathers were consistently felt to be more concerned about their partner than the baby. Neonatal nurses also reported that fathers visiting their baby often return to their partner as quickly as possible. This concurs with current evidence (Koppel, Kaiser 2001; Taylor et al 2002; Lundqvist et al 2007). The father's concern was therefore directed to the person he knew and had a relationship with, as reported by fathers in phase one (Section 3.10.2).

Fathers tended to concentrate on the here-and-now rather than the long-term situation. HCPs consistently said fathers asked practical questions and took a one-step-at-a-time approach to the situation. Events may have been too overwhelming for them to consider the longer-term view. This may also have been a coping strategy (Lazarus 1999; Ginzburg et al 2002; Myers et al 2004). One situation where fathers did ask about the longer term was in the NNU when they asked when the baby would be discharged home (Section 5.9.1). This may have been a less direct way of asking about the long-term outcomes.

A number of behaviours and responses were described that suggested fathers were attempting to take charge of the situation (Section 5.8.3). These fathers could have been attempting to use problem-focused coping strategies (Section 1.7). HCPs gave examples of fathers responding in a direct way such as asking questions, becoming more vocal and making decisions on behalf of his partner. However, some less direct behaviours were also identified such as instinctively going with the baby to the NNU. The agitation described in fathers who were unable to go into the operating theatre may also be a manifestation of an attempt to take charge of the situation, albeit unsuccessfully. This response was much less commonly described in relation to the resuscitation of the baby perhaps indicating this is the occasion when fathers feel least empowered. Given the current drive to engage and involve fathers (NICE 2006; DH 2007; Shribman 2007) it is important to note some HCPs felt uncomfortable when fathers attempted to become more involved. Fathers who attempted to advocate on behalf of his family disturbed a number of HCPs.

As a direct contrast to fathers taking charge of the situation were those who seemed to merge into the background. This response opposes that often seen when men in other situations take the lead and initiate action (Sarafino 2006). In this context the response may reflect their feelings of powerlessness and a lack of control (Section 1.7). The HCPs suggested a number of other reasons why fathers might respond in this way including fear, helplessness or lack of interest (Section 5.8.5). However, fathers may have noted cues indicating they should take a step back. Alternatively the 'mother-centred' approach of many HCPs may have left them feeling unimportant. Although consistently reported, the response of withdrawal was less frequently mentioned when describing the father's first visit to the NNU. In this situation if visiting alone, there would be less opportunity to hide from view. Having become used to his partner and baby being the focus of attention, fathers may have felt this was an opportunity to receive focused attention and begin to regain some level of control events (Section 1.7).

The fathers' need for information was consistently identified as being important. Large sections of the interviews were spent discussing issues relating to communication and

the provision of information. HCP opinion about the nature and extent of information fathers require was often determined by the questions they asked. However varying emphasis was placed on what fathers specifically needed to know, particularly in relation to the possible resuscitation of the baby (Section 5.9.1). Having identified the need for information all HCP groups acknowledged this was often not addressed due to lack of time or because information was directed specifically to the mother. Lack of information was acknowledged when fathers were unable to go into the operating theatre. However, this could be the time when their need for information is at its greatest. If this need had been addressed some of the more extreme responses of agitation could possibly have been averted.

Many HCPs spoke about fathers retrieving information for their partner. Fathers could also have been trying to access information as part of a problem-focussed coping strategy (Section 1.7). Attempts to retrieve information were particularly highlighted during the resuscitation and their first NNU visit (Sections 5.8.3; 5.8.4). HCPs were aware that fathers often resorted to less direct ways of obtaining information, particularly during the resuscitation. However, HCPs did not make a connection between these behaviours and the possibility that information they gave in a more direct way was not meeting the fathers' needs. HCPs appeared to be comfortable discussing aspects of care in public places and yet did not always want fathers to hear (Section 5.8.3). Fathers listening to discussions about care between obstetricians and midwives were regarded in some instances as an intrusion. It appears in this context, these HCPs were not treating fathers as part of the team.

All HCP groups and midwives in particular believed parents should have equal status. They often referred to the baby as being 'their' child and that the parents were a partnership. However, this is not completely borne out in the scenarios they described or their comments about fathers generally. A mother-centred approach was often described and as a consequence the needs of fathers were neglected. An example of this contradiction is provided when a father is prevented from going into the operating theatre. Midwives, obstetricians and anaesthetists generally stated fathers have a right

to be present at the birth and acknowledged the importance of their involvement for themselves, their partner and the baby. However, justification for the exclusion of fathers from the operating theatre was generally based on the argument that the only reason a father is present during childbirth is to support his partner. In situations when this was not possible, for example during LSCS deliveries under GA, some obstetricians and anaesthetists believed there was no other reason why the father should be present. By the time that data collection for this phase ended a trial was underway whereby fathers were able to accompany their partner to the operating theatre prior to elective LSCS. Whilst the presence of fathers during LSCS deliveries under GA has been explored (Oakley, Richards 1990; Koppel, Kaiser 2001) it remains to be seen if a change of practice to include these types of delivery will be supported.

#### **5.13.2 Discussion – issues pertaining to the health care professionals**

There was much discussion about which HCPs should support fathers at the various different time points. There would seem to be heavy reliance placed upon the midwife. Indeed in many of the incidents described, the way in which the midwife acted or responded often determined whether the HCPs regarded the incident a positive or negative experience for the father. In this context midwives therefore seemed to control the father's experiences (Section 1.7), albeit sometimes in an implicit way. Midwives have a consistent presence throughout the scenarios described. Although they do not have such a high profile in relation to the father's first NNU visit they were often instrumental in enabling the father to visit his baby as soon as possible and sometimes went with him (Section 5.8.4). The responsibility described by midwives suggests whilst they thought supporting fathers was not their specific duty, they felt the onus was on them to do this. They often felt responsible when a father's needs were not met. As identified in the other phases, the role of the anaesthetist also seems to be key (see Sections 3.14.2, 4.20.2). The way they supported, reassured and/or distracted the father sometimes took the pressure off other HCPs. It is possible that the general reluctance amongst anaesthetists for fathers to be present at all times in the operating theatre

indicates their awareness that the onus would be placed on them to support and interact with the fathers.

Many HCPs described the impact of events on them and aspects they found difficult. An issue that occurred several times was breaking bad news, for example: about the anticipated outcome, turning fathers away from the operating theatre or not knowing what to say during prolonged resuscitation. In some instances this was because they feared confrontation. More commonly it was because they did not know what to say and they did not want to cause the father additional distress. It is possible they were also concerned about becoming distressed themselves. Experienced HCPs as well as those who had only been working in the specialty for a short time identified this difficulty. Although this issue was consistently reported it appeared to be most prevalent during the resuscitation. This is probably because this is the most critical time in terms of the baby's survival when the situation can change suddenly and dramatically. It was mostly midwives who felt uncertain what to say on these occasions. Other HCPs were usually involved in other activities at the time and it seems that information-giving in addition to other aspects of parental support were left to the midwife.

All HCP groups, but mainly midwives spoke about the challenge they faced when trying to meet the needs of fathers who appeared disengaged or uninterested (Section 5.8.5). Whilst this was consistently reported it appeared to be less of an issue on the NNU. This is probably because in this situation NNs can focus their attention on the father. A number of strategies to involve fathers were described and often a simple approach such as making eye contact was felt to be beneficial. Individual reflection on practice and discussion with colleagues could reveal other ways to engage fathers.

The most acute distress displayed by midwives and NNs during the interviews was in relation to the resuscitation. In some cases this was because they felt the situation was not handled well and felt culpable to some extent. Obstetricians, anaesthetists and paediatricians were more 'matter-of-fact' about what happened and did not appear to feel responsible when a father's needs were not met. Paediatricians did however;



describe their discomfort when fathers came to the resuscitaire. This may indicate a lack of confidence in their ability or their recognition that the presence of the father causes additional pressure at an already stressful time. HCPs have expressed similar issues in studies undertaken in other critical care settings (Jarvis 1998; Grice et al 2003; MacLean et al 2003). The importance of support and teamwork was identified, particularly the need for senior midwives to support those with less experience. The interviews provide strong evidence of the impact these events have on HCPs. Whilst to some extent these situations are part of their normal working day there is a danger in becoming blasé about them. Some midwives and NNs became distressed when discussing events some of which occurred some time ago but remained a strong memory. This suggests there is a need for greater recognition of the impact of resuscitation events and the need for formal and informal reflection on practice, debriefing and support.

### **5.13.3 Discussion – issues pertaining to the care setting**

All HCP groups repeatedly said the fathers' needs were often not met because of lack of staff and/or time. This was generally less of an issue once the father was with his baby on the NNU. However, a lack of resources was often blamed for the delay in a father going to see his baby. Many HCPs, and midwives in particular were frustrated they were not able to support fathers in the way they would have liked. In more extreme cases this caused them distress. In many of the emergency situations described, it was difficult for them to even attempt to meet the needs of the fathers. Staff shortages and lack of time appeared to exacerbate the challenge. However, in some instances these factors may provide a convenient explanation for their failure to support fathers. Adherence to this view may stop the service trying to find solutions or looking for new ways of working.

Despite the growing body of evidence relating to the needs of fathers it is disappointing that most HCPs had not received any formal education or training specifically about supporting fathers (Section 5.12.1). Given the important role midwives appear to play (Sections 5.13.2) it is reassuring that midwifery training is beginning to incorporate some

albeit minimal aspects in the curricula. It would appear the most common way HCPs learnt to support fathers was through observation of the practice of others (Section 5.12.1). This appears to be a combination of the traditional way of learning particularly in vocational settings of 'see one, do one, teach one' combined with elements of 'trial and error' and reflection on practice. Whilst these ways of learning have their place it would seem that the inclusion of more formal structured learning based on current evidence and guidelines within specialist training and professional development programmes is required, particularly in relation to newborn resuscitation. In the context of witnessed resuscitation it has been acknowledged that HCPs require education and ongoing professional development about crisis management, breaking bad news, the grieving process, bereavement counselling and communication skills (Jarvis 1998; Grice et al 2003; Baskett et al 2005). It seems reasonable to assume that HCPs who support fathers during newborn resuscitation require the same educational input.

Some of the changes noted in fathers over time probably reflect societal changes in the wider context. In recent years, the public has become increasingly encouraged to be better informed and involved (DH 2008, Pricewaterhouse Coopers 2009). It is therefore perhaps not surprising that fathers were felt to access sources of information more readily than in the past and that they were more questioning of information given. The higher expectations of fathers about what the NHS can achieve maybe as a consequence of high profile miracle stories sometimes presented in the media. Midwives, obstetricians and anaesthetists also reported that fathers are now more willing to be involved in childbirth generally and complicated childbirth in particular. This reflects wider changes in the role of fathers in recent years and the move away from the traditional paternal role (Section 1.2). Alternatively, fathers may feel under increasing pressure to conform and their opportunities to avoid involvement are rapidly diminishing.

#### **5.14 Conclusion**

A number of key findings can be determined from this phase. HCPs are generally aware of the needs of fathers and can identify ways in which these can be met. However, a

number of difficulties and challenges impact on the ways in which HCPs support fathers. Although there is increasing evidence pertaining to the needs of fathers, in maternity care HCPs generally focus on the needs of mothers and babies (McVeigh et al 2002). Duty of care determines this and for HCPs this centres on the mother and/or baby in most circumstances. Other factors that impact negatively on the way HCPs support fathers include staff shortages and lack of HCP training. Whilst supporting the father is not a designated aspect of any HCP role, it often falls to the midwife. The long-term impact of newborn resuscitation on HCPs is apparent and warrants further investigation.

The critical incident approach was an appropriate strategy to use as a way of exploring HCPs' experiences of specific events. The majority of the scenarios described were felt to be a negative experience for the father. Factors that appeared to contribute to this assessment were the father's portrayal of negative emotions, a lack of information at key points, situations where he was excluded or marginalised and/or occasions when there was a delay before he could visit his baby on the NNU. Most events were regarded as being negative even if the outcome for the mother and/or baby was ultimately positive (Section 5.4.2). Asking the HCPs to focus on the father's experience enabled some to consider for the first time the extent of the potential impact of such events on fathers. Some strategies to involve and inform fathers were felt to be successful and these were felt to reduce the overall negative impact of the event. Despite these strategies in most cases, the event was still felt to be a negative experience for the father overall.

The scenarios described by the HCPs provide evidence that supports the findings of phase one and two. Fathers generally appeared to adopt emotion-focused coping strategies (Section 1.7). In many situations HCPs and/or the care setting controlled the experiences of fathers and this was done in either a positive or negative way. In the following chapter a synthesis of the findings from the three phases of the study will be presented (Section 2.5).

## **Chapter 6 – Synthesis of the findings and the theoretical framework**

### **6.0 Introduction**

There has been a drive in recent years to engage and involve fathers in all aspects of their child's life (DH, DES 2004; DH 2007; White et al 2008; Department for Children, Schools and Families, DH 2009). A positive relationship between a father and his child can have far reaching benefits not only for the immediate family, but also society in general (Beardshaw 2001; Friedewald et al 2005; Fatherhood Institute 2007; World Health Organisation 2007). The child's birth can play a significant part in the development of this relationship and the benefits of fathers feeling included at this time have been identified (McVeigh et al 2002; Burgess 2008). Gaining an understanding of fathers' experiences when birth does not conform to the more usual pattern of events is therefore crucial if the needs of fathers and families are to be met. Unlike any other research, this study provides insight into fathers' experiences of complicated and preterm childbirth, newborn resuscitation and/or their first NNU visit. In this chapter, synthesis of the findings will be presented with reference to other relevant studies. The findings will also be considered in the context of the theoretical framework of coping strategies.

### **6.1 Synthesis of the findings**

Synthesis of the findings from the three phases was undertaken once the data analysis for each phase had been completed (Section 2.5). Consequently, the findings from each phase were converged (Creswell, Plano Clark 2007). This triangulation of the findings revealed that three sources of influence determined the extent to which fathers were involved or connected with events: father influenced, HCP influenced and service influenced (Section 2.3.2) (Figure 6.1). Within the following section facilitating and counter examples of these three sources will be explored.

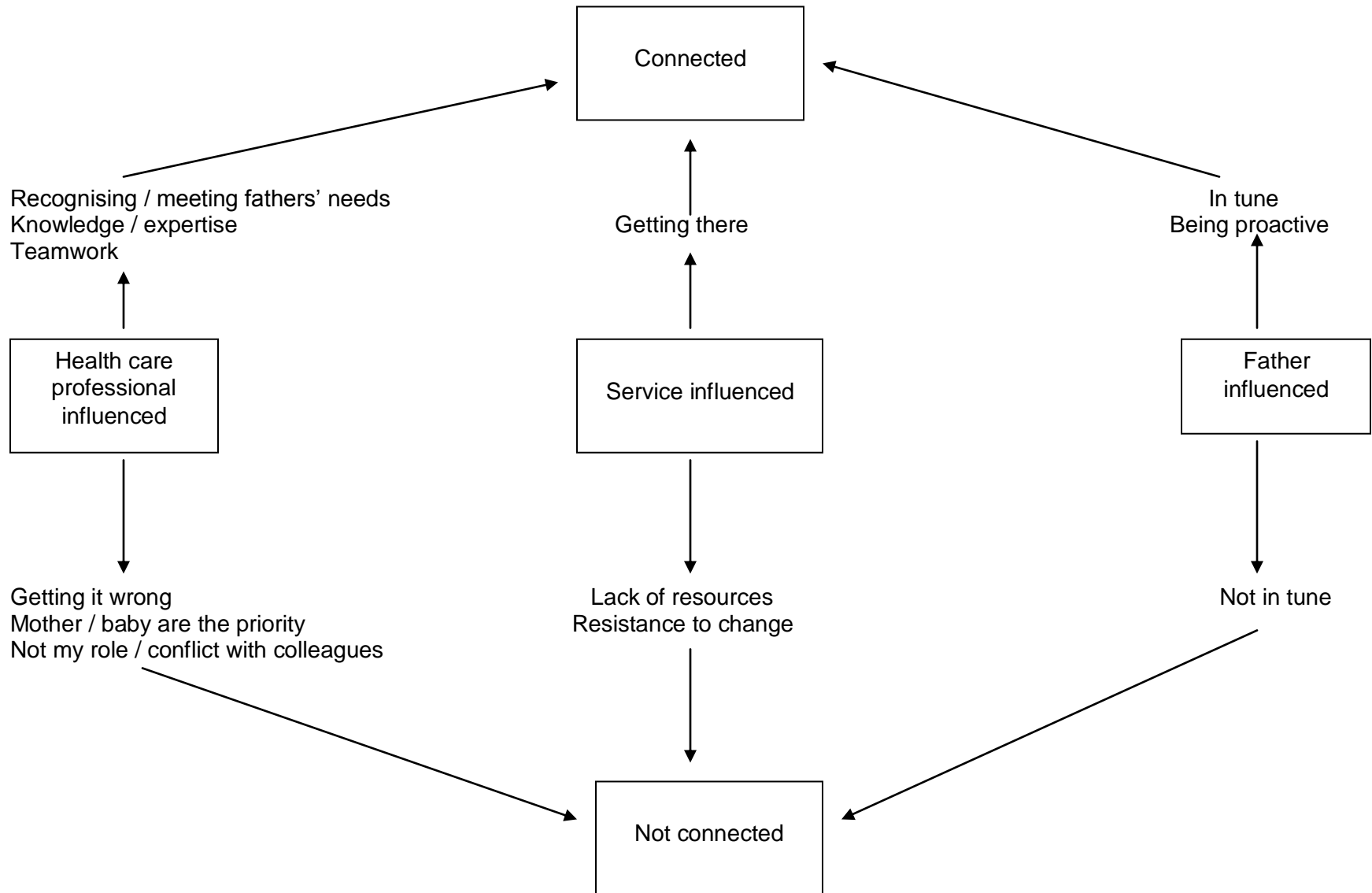


Figure 6.1 Key themes – overall study

### **6.1.1 Synthesis of the findings – father influenced**

The interviews with fathers and HCPs and the direct observations provide examples of fathers connecting with events with minimal assistance from others. Many fathers appeared to be ‘in tune’ with what was occurring. This was demonstrated when they appeared to understand what was happening and found ways to contribute to the situation. Fathers also initiated their connection by ‘being proactive’ when they spontaneously took steps to increase their involvement (Figure 6.1). Similar examples of these two responses were identified in the analysis of all three phases, thereby validating the findings through triangulation.

Each phase provides evidence of fathers being ‘in tune’ with events. Some were able to recall events in detail (Section 3.4.3) whilst others made comments and asked questions which suggested they understood what was happening (Sections 4.17.3, 5.8.6). In many cases fathers were aware of the seriousness of the situation and their concern increased as the situation worsened. Fathers described their fear, anxiety and distress (Section 3.10.3) and some were aware of the possibility their partner and/or baby may die (Section 3.10.2). Fathers displaying these emotions were also observed (Section 4.19.3) and recalled by HCPs (Section 5.8.2). The impact on the father of hearing the baby cry was also identified (Sections 3.10.3, 4.19.2). Their relief suggests they understood their child’s survival was in jeopardy (Chandler, Field 1997). In order to remain in tune with what was happening fathers utilised information obtained directly or indirectly from HCPs, watched monitors and asked questions (Sections 3.13.1, 4.17.3, 5.8.3, 5.9.1). Their vigilance and focused attention therefore helped them to connect with their experience. Asking questions may also have enhanced their sense of control and/or been a way of asking for support (Section 1.7) (Torr 2003; Arockiasamy et al 2008). Many fathers also appeared to know what to do or say at specific moments. This is demonstrated in the way they supported their partner during contractions, participated in her physical care, interacted with their baby and in their use of humour (Sections 3.12, 4.17.2, 5.8.3). A father’s judgement about using these strategies may also have been determined by his relationship with his partner.

A number of proactive strategies used by fathers before, during and after the birth were identified. Fathers demonstrated their determination to play a key role and thereby connect with their experience, in their preparation for the birth and fatherhood (Section 3.9). The intentions of some fathers were disrupted by premature birth, the diagnosis of problems during pregnancy and/or logistical issues regarding the accessibility of parentcraft classes. However, their initial motivation to prepare albeit for normal childbirth and the delivery of a healthy term baby was apparent. A general willingness of fathers to do this was also endorsed by HCPs who commented on the increasing number of fathers accessing information via the Internet (Section 5.8.6). Fathers who deliberately avoided preparation did this because they underestimated the value of this, rather than an intention not to connect with the event. Other fathers did not prepare for the birth as a consequence of problems identified during the pregnancy (Sections 3.9.1, 3.9.2). It could be argued these strategies were employed to avoid making a connection. However, they intended to be present at the birth. By using emotion-focused coping strategies they were trying to help their partner to the best of their ability in the way they felt was most appropriate (Lazarus 1999; Van Der Molen 1999; Ogden 2007). Thus demonstrating their intention to support their partner during the birth.

During and after the birth fathers undertook a number of proactive strategies that facilitated their connection with events. They described taking direct action in a number of ways such as supporting and reassuring their partner, advocating for both her and the baby and interacting with their baby on the NNU (Sections 3.11.3, 3.12.1, 3.12.2). Many illustrations of these or similar proactive strategies were noted in the direct observations. For example, fathers maintained physical contact with their partner for the majority of the time (Section 4.12) and their specific behaviours demonstrated their willingness to take the initiative and play a key role (Sections 4.17). Similarly HCPs gave examples of fathers spontaneously initiating their involvement (Sections 5.8.3, 5.8.4). This was done by participating readily in decision-making, supporting their partner during the resuscitation of their baby and going to the resuscitaire. HCPs also commented on the increasing number of fathers attending complicated deliveries (Section 5.8.6).

Fathers who proactively took steps to involve themselves were generally regarded in a positive way by HCPs. However, in some instances, a father's eagerness to do this was interpreted more negatively as an attempt to usurp control and dominate proceedings (Section 5.8.3). Similar battles-for-control were occasionally noted during the observations (Section 4.20.1). A father's overzealous attempts to be involved may occur for a number of reasons, which could include a desire to take control of the situation (Sarafino 2006). Alternatively they may have felt under pressure to participate and conform to preconceived expectations of others. Fathers who are given inadequate guidance and support by HCPs or who feel sidelined or who are afraid may also respond in this way. Indeed, some fathers spoke about their lack of control (Section 3.10.3). Whatever the reason, it would appear that some HCPs were uncomfortable when fathers were proactive (Section 5.8.3). These views may be more indicative of their insecurities and personal philosophies of care rather than any intent of the fathers to control proceedings.

By contrast, the three phases provide examples of fathers who were 'not in tune' with proceedings around the time of the birth (Figure 6.1). As a consequence they were not connected with events. Similar examples were identified in the analysis of all three phases. The findings are therefore corroborated. Some fathers said they were at times disengaged from the situation (Section 3.10.3), whilst others did not understand what had happened (Section 3.10.1). During the observations some fathers were noted to have limited physical contact and/or verbal communication with their partner (Sections 4.12.2, 4.13.1), backed down in a battle-for-control with others, spent time engaged in other activities and/or merged into the background (Sections 4.18.1, 4.20.1). In some instances these behaviours may have been as a consequence of the presence of other family members (Sections 4.10.3, 4.10.4). HCPs also described fathers displaying similar behaviours suggesting their disengagement (Section 5.8.5). The HCPs felt some fathers deliberately ensured they were not connected with proceedings and felt this sometimes occurred because of the father's lack of interest. Although some fathers described deliberately distancing themselves both physically and mentally, their explanations for these behaviours suggest these were coping strategies used as a way



to support their partner (Section 3.10.4). On other occasions, fathers felt they were deliberately excluded or marginalised by HCPs (Section 3.10.3). Therefore fathers in phases two and three who appeared not to be in tune may, like the fathers in phase one have been using strategies to cope with the situation (Section 1.7), or found themselves excluded. Indeed, comments subsequently made to the researcher by some of the observed fathers indicated that although they were aware what was happening, they had been striving to control their emotions (Section 4.19.3). Although some HCPs were aware fathers often controlled their emotions or felt excluded (Sections 5.8.2, 5.8.5, 5.11), it is possible HCPs could sometimes misinterpret these behaviours.

During the observations some fathers appeared not to be aware what was occurring when they said or did the wrong thing (Sections 4.18.2, 4.18.3). Sometimes they appeared to be making genuine attempts to be involved but in their efforts, misjudged the feelings or expectations of others. Fathers endorsed this by saying they sometimes felt powerless, inadequate and helpless (Sections 3.10.3, 3.12.1). HCPs also described fathers occasionally responding inappropriately. This implied to them that the fathers were unaware of the situation (Section 5.8.2). However, fathers who behaved this way may not have had the social skills to assess the needs and expectations of others. Their misplaced actions could also have been due to fear or coping strategies used in an attempt to normalise the situation (Section 1.7) (Ogden 2007; Lee et al 2009). These inappropriate behaviours may also have been acceptable to the mother.

The willingness of most fathers to be involved and take personal responsibility for this involvement was demonstrated in all three phases. This reflects a general increase in the involvement of fathers in childbirth and their children's lives (Beardshaw 2001; Torr 2003; St John et al 2005). It may also be a response to the increasing medicalisation of childbirth and the exclusion of fathers that still continues to some extent. In an attempt to overcome these potential barriers these fathers may have made a deliberate effort to ensure their involvement. Fathers who were in tune with what was occurring facilitated their involvement and subsequent connection. Their enthusiasm and motivation to continue to be involved was generally not deterred by unexpected and/or distressing

events. Indeed, in many cases fathers intensified their involvement on these occasions. Many of the examples of proactive steps taken by fathers occurred without prompting from others. This demonstrates a willingness to be involved and acceptance of responsibility. Fathers encountering unexpected and crisis situations often found they triggered unexpected assertive and protective behaviours (Sections 3.12.2, 3.12.4). However, these fathers may have felt under pressure to be actively involved and displayed behaviours they believed others expected. Advocating and protecting behaviours may also have been a father's way of gaining some control over the situation (Arockiasamy et al 2008).

On some occasions, fathers appeared not to be in tune with what was occurring. Sometimes events and individuals over which fathers had limited control appeared to conspire against them. It was not unusual for fathers to feel powerless and uncertain about ways in which they could contribute in a positive way (Section 3.12.1). In some instances the nature of the situation, particular HCPs and the specific environment limited a father's actions and behaviours (Sections 3.10.3, 4.19.3). Help and encouragement from HCPs may have enabled fathers to feel more connected. Sometimes the father's lack of understanding was a factor and HCPs have an important role to play ensuring fathers are aware of what is happening. In some instances fathers may have disengaged themselves as a coping strategy to ensure self-preservation and to maximise HCP involvement in their partner or baby's care (Section 1.7). In some cases however, fathers may have been uninterested or distracted and deliberately avoided being involved. The potential negative impact of childbirth on fathers has been identified (Longworth 2006; White 2007). It is possible these effects would be more extreme if the father had not wanted to be present in the first place.

### **6.1.2 Synthesis of the findings – health care professional influenced**

Whilst most fathers appear to want to play a constructive role around the time of the birth of their baby, their ability and opportunity to do this was enhanced by guidance,

support and encouragement from HCPs. The interviews with fathers and HCPs and the direct observations of deliveries provide examples of HCPs employing strategies to enable fathers to make connections with events before, during and after the birth. Three key factors appeared to be important: 'recognising / meeting fathers' needs', their 'knowledge / expertise' and 'teamwork' (Figure 6.1). Similar examples were identified in the analysis of the three phases, thereby triangulating the findings.

HCPs and fathers unanimously agreed a father's most pressing need around the time of the birth is for information (Sections 3.13.1, 5.9). Examples were identified of HCPs fulfilling this need in a direct way (Sections 3.13.1, 4.19.1, 5.9.1). HCPs were aware of the importance of how and when fathers were told what was happening (Sections 4.19.1, 5.9.2). Examples of HCPs recognising and meeting fathers' other needs were less explicit (Sections 3.13.3, 4.20.2). They often justified this by saying their duty of care lay with the mother and/or baby (Section 5.11.2). However, some HCPs felt they did have a role to play advocating for fathers and tried to ensure their needs for reassurance and support were met (Sections 5.9.1, 5.10.2). Examples of HCPs doing this can be found in all three phases (Sections 3.14.2, 4.20.2, 5.10.2). When interacting with fathers, HCPs felt their manner and personality was important (Section 5.10.1) and these behaviours were mentioned by fathers and noted during the observations (Sections 3.14.2, 4.20.2).

The knowledge and expertise of HCPs appeared to be influential in their involvement of fathers. Fathers valued input from more senior HCPs (Sections 3.13.1) and HCPs described drawing on their previous experience when deciding how to handle specific situations (Section 5.12.1). The specialist knowledge and skills of individual HCP groups such as anaesthetists, obstetricians, paediatricians and neonatal nurses helped fathers to make connections at specific junctures in all three phases (Sections 3.14.2, 4.20.2, 5.12.1). By contrast, the midwife played a consistently central role. In the scenarios described and cases observed, a designated midwife was usually present most of the time. The way in which the midwife responded was often influential in determining the extent to which fathers engaged with events (Sections 3.14.2, 4.20.2). Other HCP

groups recognised the significance of midwives by saying they had learned ways to engage fathers by observing the practice of their midwifery colleagues (Section 5.12.1). Most other HCP groups said meeting the needs of fathers was primarily the responsibility of the midwife (Section 5.9.1). However, this could be a way of absolving themselves of any responsibility. Midwives have expressed concern about officially taking on the role of supporting fathers saying this would be an unacceptable, additional pressure (Davies, Iredale 2006). It is also possible that the general reluctance amongst anaesthetists for fathers to be present at all times in the operating theatre indicates their awareness that the onus would be placed on them to support and interact with the fathers on these occasions.

In contrast to working individually, the final way in which HCPs had a positive impact on the fathers' involvement was when they worked collectively. The value of teamwork and effective communication was recognised by both fathers and HCPs (Sections 3.13.1, 5.12.2) and was observed in practice (Section 4.20.2). HCPs felt being well supported by their colleagues, particularly during and immediately after emergency situations enabled them to remain calm and support fathers more effectively (Section 5.12.2). Working with the same colleagues over a period of time also enabled HCPs to develop ways of working without the need for verbal communication (Section 5.12.2). HCPs believed that in these situations emergency cases were managed more smoothly. The by-product was a more satisfactory experience for the father (Section 5.12.2). The importance of senior colleagues supporting junior staff was also recognised and the delivery suite midwife shift leader role was often important (Sections 3.13.1, 4.21.1, 5.12.2). Aspects of this role include support, coordination and delegation to ensure the efficient running of the department. If this is achieved, it is possible the needs of fathers will be more likely to be met, even if this is not the primary motivation.

The interviews with fathers and HCPs and the direct observations of deliveries also provide examples of HCPs not enabling fathers to make connections with events before, during and after the birth. Three key factors were identified: 'getting it wrong', 'mother / baby are the priority' and 'not my role / conflict with colleagues' (Figure 6.1). Similar

examples were identified in the initial analysis of the three phases. The findings are therefore corroborated.

There are different kinds of support HCPs could provide fathers during these events including advice, companionship, practical help, information and emotional support (Section 1.6.1) (Schwarzer et al 2004; Ogden 2007). Given the other roles and responsibilities of HCPs, it may be unreasonable to expect them to provide fathers with most of these types of support. Indeed, examples of HCPs recognising and meeting fathers' needs for reassurance and emotional support were limited (Sections 3.13.2, 4.20.1). Giving emotional support in particular may be considered inappropriate and render HCPs susceptible to burnout. Whilst HCPs and fathers unanimously agreed a father's greatest need is for information (Sections 3.13.1, 5.9.1), examples were identified when this type of support was also not provided (Sections 3.10.1, 3.13.1, 4.19.1, 4.20.1, 4.21.1, 5.11.1). Instances were recounted or observed when the timing, nature and extent of information given by HCPs appeared to be unhelpful to the father and in some cases was destructive (Sections 3.13.1, 4.20.1, 5.11.1). Whilst most fathers regarded their personal needs as being unimportant in comparison to those of their partner and/or baby (Section 3.13.4), they wanted to be acknowledged and included in discussions about care (Section 3.13.1). Several examples were found during the observations when HCPs entering the delivery room did not make eye contact with the father or acknowledge his presence (Section 4.19.1, 4.20.1, 4.21.1).

Although most HCPs demonstrated an accurate insight into the feelings of fathers, they were sometimes critical of the ways in which they responded (Section 5.8.3). This suggests whilst HCPs had some empathy for fathers, they also had a view about the ways in which they should behave and respond. Fathers who did not conform to these behaviours were regarded in a negative way (Section 5.8.3). Rather than advocate for fathers, some HCPs controlled or limited the nature and extent to which they were involved. These actions were identified in all three phases (Sections 3.10.2, 3.11.1, 4.19.3, 5.8.4, 5.11.1). In some instances HCPs said they did this because they were trying to protect the father (Sections 5.8.4, 5.11.1). However, fathers did not always

appreciate this paternalistic approach (Sections 3.14.2). In some extreme cases, HCPs were observed deliberately taking direct action which appeared to disrupt or inhibit the extent to which fathers connected with what was occurring (Section 4.20.1). For example, the position of the midwife sometimes prevented fathers from maintaining contact with their partner. Although HCPs may have had a rationale for doing this (Sections 5.8.4, 5.11.1), these particular fathers appeared to become removed from the situation both physically and emotionally (Section 4.20.1).

Further instances when HCPs had a negative influence on fathers becoming connected occurred when there was conflict with their HCP colleagues or when they felt supporting fathers was not part of their role. Disagreement between HCPs about the best course of action sometimes occurred (Sections 3.13.1, 4.17.3). Discussion between HCPs enables them to reflect upon their point of view and usually leads to a consensus decision. In many instances this debate occurs when there is an urgent need for a decision to be made. Consequently for practical and logistical reasons this discussion may take place in the presence of the father. Nevertheless, HCPs should recognise that being present during this debate sometimes leaves fathers feeling concerned (Section 3.13.1). Situations where HCPs do not work well together, particularly in emergency situations can by implication have a negative impact (Section 5.12.2). This not only affects HCPs personally but also as a direct consequence, their ability to support the father (Section 5.12.3). During the phase three interviews apportioning blame to other HCP groups was sometimes identified. This occurred when scenarios were recalled when in their opinion a father's needs had not been met (Sections 5.8.4, 5.11.2). To some extent this is understandable given the pressure under which individuals work, particularly in emergency situations. However, these attitudes undermine the current drive for interprofessional working and negate the rationale underpinning team simulation-based training programmes (DH 2000; Wayman et al 2007).

Some HCP groups were also noted to be resistant to change. This frustrated other HCPs who had ideas about ways in which fathers could be supported more effectively (Section 5.11.1) In some instances, specific HCP groups identified that supporting

fathers at key points in time was not part of their role, for example during newborn resuscitation (Section 5.11.2). In some instances the view of their role was rationalised in relation to their knowledge, skills and professional responsibilities (Section 5.11.2). However, in some cases HCPs appeared to demonstrate rigid thinking about their role and absolved themselves of any direct responsibility when recounting situations when a particular father's needs were not met (Section 5.11.2).

In some instances the failure to meet a father's needs occurred because the best interests of the mother and/or baby took priority. This was particularly apparent in emergency situations (Sections 4.20.1, 5.11.2). Indeed, in crisis situations fathers themselves support this approach (Section 3.13.4). On such occasions it was readily identified that HCPs focus their attention on the mother and/or baby. Consequently there was nobody available to support the father (Sections 4.19.3, 4.20.1, 5.8.4, 5.11.2). This is in direct contrast to resuscitation events occurring in other care settings. In these specialities an HCP is delegated to chaperone and subsequently debrief relatives who attend resuscitation events. The value of this role has been established (Robinson et al 1998; Grice et al 2003; Baskett et al 2005). Whilst several HCPs were aware of this practice in other settings most felt it was inappropriate for someone to take on this role during neonatal resuscitation (Section 5.11.2). In the maternity care setting most HCPs have two individuals to consider: the baby and the mother. Even if the mother is well, she requires some level of attention post-delivery. Nevertheless, failure to delegate a chaperone to support a father implies a view that his needs are less important than those of relatives attending resuscitation events in other care settings. Indeed, the case study illustrates that despite the number of HCPs involved around the time of the resuscitation of the baby, nobody attempted to support the father (Section 4.21.1).

Even in more routine situations, a generally mother/baby-centred ethos was apparent and this was identified in all three phases (Sections 3.14.2, 4.20.1, 5.9.2, 5.10.2). Several HCPs acknowledged that whilst not explicitly stated in the Trust's philosophy of care, this approach influenced the way in which many HCPs worked. Whilst it was recognised this attitude could result in fathers feeling excluded, HCPs often did not

question this philosophy (Section 5.11.2). In more extreme cases, some HCPs were felt by their colleagues to be reluctant to acknowledge that fathers had any needs at all (Sections 5.11.1, 5.11.2).

It would appear therefore that most HCPs recognise the needs of fathers and ways in which they can be helped to connect with their experience. However, it was identified that fathers' needs are not always met. In some instances, direct action by HCPs prevented or disrupted a father's involvement. Whilst some HCPs were prepared to take personal responsibility for involving fathers, others were not. The key role that midwives play has been established and in many cases they appear to 'make or break' a father's experience (Singh, Newburn 2003). However, HCPs do not work in isolation and the value of effective teamwork was also identified.

HCPs must work in accordance with Trust policies, procedures and professional role boundaries. The ways in which they work will also be influenced by the Trust philosophy of care, either as stated or implied. However, there appears to be scope for HCP groups to review aspects of their role and ways in which they work in order that fathers are supported more effectively. HCPs can sometimes feel powerless to challenge the practice or override the decisions of others (Parkin 2009). It would therefore be beneficial to develop a culture in which practice can be regularly reviewed and challenged in a non-threatening way. Whilst this happens to some extent during perinatal mortality meetings, these discussions review cases where babies have died. HCPs attending these meetings usually only include those who were directly involved in a specific case. There would appear to be scope for a forum accessible to all HCPs where the care of all families can be reviewed in an open and less formal way.

### **6.1.3 Synthesis of the findings – service influenced**

Fathers and HCPs sometimes felt powerless to act in the way they would wish. The service influences the ways in which HCPs work and thereby the nature and extent to



which the involvement of fathers can be achieved. Maternity and neonatal services are evolving and are being organised into networks (DH 2003, Redshaw et al 2007). Although networks and Trusts must work within current legislation and adhere to guidelines and standards from the Department of Health, they have a level of control over care delivery, the ethos of which will be evident in the philosophy of care. Changes in policy and practice can therefore be initiated locally, regionally or nationally. These changes may be prompted by a number of factors including new evidence, a review of services or public pressure.

The interviews with fathers and HCPs and the direct observations of deliveries provide examples of ways in which the service influenced the extent to which fathers made connections with events. These can be explored in relation to 'getting there' (Figure 6.1). Comparable examples were identified in the analysis of the three phases, thereby validating the findings. In recent decades strategies have been implemented which have enabled fathers to play a more prominent role during childbirth. Fathers are now encouraged to attend all types of delivery including complicated childbirth (Chan, Paterson-Brown 2002; Castle et al 2008; Kunjappy-Clifton 2008). This change in attitude has occurred during an era of increased medicalisation of childbirth (Section 1.3.1). Fathers are now often encouraged to take on an active role during childbirth rather than be present merely as a witness (Sections 3.12, 4.20.2, 5.8.3) (Chapman 1992; Johnson 2002; Gungor, Beji 2007). Concurrent with this change of approach, is a shift towards empowering and engaging clients and significant others such that they take a more central role in decision-making and care delivery (DH 2008, Pricewaterhouse Coopers 2009). HCPs who had been involved in this type of care for some time, acknowledged a gradual improvement in the way the service encouraged the involvement of fathers (Section 5.8.6). A specific example of this is the change in policy regarding fathers waiting in the recovery area whilst spinal anaesthetic is administered to their partner in theatre prior to an elective LSCS delivery (Section 5.13.1).

Previous restrictions regarding family and friends attending childbirth, visiting the NNU or being present at the hospital have been relaxed in recent years. Recognition of the

benefits of their support and a move towards family-centred care has contributed to these changes (Brazy, Anderson, Becker, Becker 2001; Davis, Mohay, Edwards 2003; Schear 2007). There has also been a small increase in homebirths over the last few years and a more noticeable rise in births in 'home-like' settings such as birthcentres (Redshaw et al 2007). It was identified in this study that family and friends support fathers directly and indirectly around the time of the birth (Sections 3.13.2, 4.20.2). This is important given the limited emotional support fathers received from HCPs (Sections 3.13.2, 4.20.1). Although little interaction between fathers and family members was noted during the observations (Sections 4.12.5, 4.13.2), fathers felt reassured when they were present (Section 3.13.2). This suggests that during this social support it was their presence rather than anything done in a direct way that helped fathers to feel supported (Schwarzer et al 2004; Ogden 2007). The service facilitates this support by enabling family members to be present at most types of delivery (Section 4.10.4).

Recognition of the need to engage and involve fathers is gaining a higher profile (Section 1.2.4). As a consequence, this is becoming a feature of both initial registration and professional development programmes (Section 5.13.2). Many HCPs identified that they had taken responsibility for their learning in relation to supporting fathers (Section 5.12.1). However, the service also has a responsibility to ensure HCPs have access to a range of professional development opportunities both within and beyond the Trust.

Despite the positive ways in which the service influenced fathers making connections with events, it would seem there is still work to be done. The ways in which the service had a negative impact can be explored in relation to 'lack of resources' and 'resistance to change' (Figure 6.1). Similar examples were identified in the analysis of the three phases. The findings are therefore corroborated. There was nowhere private for fathers to 'take time out' either on the delivery suite or the NNU (Sections 3.10.3, 3.13.3, 5.8.2, 5.11.2), there was a lack of appropriate parentcraft provision (Section 3.9.1) and nowhere for fathers to shower and change. Many fathers were unable to stay with their partner after the birth because of a lack of suitable overnight accommodation (Sections 3.13.4, 5.11.2). Other personnel who could help address the needs of fathers such as

an independent NNU counsellor or someone to chaperone them during the resuscitation were also noted (Sections 3.13.3, 5.11.2). It was suggested that this lack of facilities and HCP posts occurs because of insufficient funding (Section 5.11.2). However, it may be more reflective of a lack of importance placed on the provision of these resources by budget-holders. This lack of resources for fathers does not equate with those provided for families in paediatric care settings (Peterson, Cohen, Parsons 2004). This suggests maternity and neonatal services have not fully embraced the concept of family-centred-care or appreciated the specific needs of fathers. Whilst recently published principles of neonatal care may lead to improvements in facilities for fathers (DH 2009), time will be required to put them in place. In the meantime, this lack of resources insidiously implies that fathers are less important and corroborates the mother / baby-centred philosophy of care.

Examples of ways in which the lack of appropriate staff had a negative impact on the experiences of fathers were identified. Fathers and HCPs recognised the implications of staff shortages and inadequate skill mix (Sections 3.11.1, 3.11.3, 3.13.1, 5.11.2). This had a direct impact on fathers; they sometimes felt excluded and marginalised (Sections 3.10.3). They could have raised their concerns via the Patient Advice and Liaison Service. However, they were generally reluctant to do this for a number of reasons. They were aware that the HCPs were extremely busy and often had excessive workloads (Sections 3.11.1, 3.11.3). Consequently fathers greatly appreciated the care they were given, albeit in a sometimes-compromised way. They also did not want to jeopardise their partner and/or baby's ongoing care, which may have occurred if they made a complaint. In addition, they were aware that other families might have had more pressing needs than their own (Section 3.13.1). This lack of formal complaints may give those responsible for service delivery a distorted view of patient / client satisfaction.

The final way the service had a negative impact on the experience of fathers relates to a 'resistance to change' (Figure 7.1). Some aspects of practice appeared to have become entrenched with a subsequent reluctance to question or change practice. The change process can be challenging particularly if those resistant to change are senior HCPs in

positions of authority (Parkin 2009). For example some senior anaesthetists resisted a change of policy regarding fathers being present at all times in the operating theatre (Section 5.11.1). More junior staff felt powerless in the face of such opposition (Section 5.11.1).

#### **6.1.4 Synthesis of the findings – summary**

This study provides the first detailed insight into the experiences of fathers of complicated and preterm childbirth, newborn resuscitation and initial NNU care. It is apparent that most fathers wanted to be proactive and maximised opportunities to connect with events. Many made attempts to play an active role and advocate for themselves. However, they were sometimes thwarted in their efforts and this study provides evidence of the ways in which fathers were marginalised particularly when outcomes were unknown or uncertain. The drive, enthusiasm and motivation of most fathers were evident but this needed to be nurtured, harnessed and directed in a more supportive way. In order to be truly engaged and involved fathers needed guidance, support and encouragement from HCPs, particularly delivery suite midwives.

It would appear that whilst fathers and HCPs had a role to play, the service often determined the extent to which fathers were involved. The philosophy of care, lack of facilities and resources and to some extent entrenched ways of working often restricted the extent to which fathers were included. The organisation and delivery of midwifery and neonatal care appeared to be built around the needs of mothers and babies. Occasions when the needs of fathers were met were generally coincidental. Fathers encountering complicated and preterm birth, newborn resuscitation and NNU admission are expected to play a central role in their child's life in the same way as those for whom childbirth is more straightforward. In order to do this all fathers must be supported in their transition to fatherhood particularly when adverse and unexpected events occur.

Coping strategies provided the theoretical framework for this study (Section 1.7). The findings of the three phases provide evidence of the ways in which fathers coped, the extent to which HCPs recognised these strategies and the ways in which individual HCPs and the service more generally influenced a father's behaviours and responses. In the following section the findings of this study will be specifically related to the theoretical framework of coping strategies.

## **6.2 Theoretical framework – coping strategies**

The coping strategies adopted by the fathers in this study, have been considered in relation to the model of problem and emotion-focused coping originally described by Folkman and Lazarus (1980). The findings suggest that fathers who encounter adverse situations surrounding the birth and immediate care of their baby adopt a range of coping strategies, as denoted by their actions and behaviour.

Problem-focused coping includes strategies that moderate or confront the stressor in an attempt to deal with the stressor in a direct way to facilitate adjustment (Ludwick-Rosenthal, Neufeld 1993; Levy-Shiff et al 1998; Shaw et al 2006). Problem-focused strategies include seeking information, accessing help and/or support and/or taking direct action (Van Der Molen 1999; Pinelli 2000; Schwarzer et al 2004; Ogden 2007). Although some fathers in this study demonstrated problem-focused coping strategies, this was generally very limited. The most consistent problem-focused coping strategy they used was when they accessed information. This was done in a variety of ways including asking questions, watching monitors and listening to conversations between HCPs (Sections 3.13.1, 4.17.3, 5.8.3, 5.9.1). In a few other instances fathers sought help and support for their partner and baby (Sections 3.12.2, 4.17.3). It could be argued that in doing this, fathers were also seeking support for themselves.

Emotion-focused coping strategies were much more commonly adopted. Emotion-focused coping includes strategies to regulate stressful emotions by changing their meaning (Lazarus 1999). These may involve avoidance, detachment, apportioning blame, distraction, minimising and/or consumption of alcohol or smoking (Ludwick-Rosenthal, Neufeld 1993; Levy-Shiff et al 1998; Van Der Molen 1999; Ogden 2007). Numerous examples can be found of fathers using these sorts of strategies. For example some fathers did not prepare for the birth when problems were identified during the pregnancy (Sections 3.9.1, 3.9.2) whilst other fathers displayed detachment and distraction behaviours during the birth and immediate care of the baby (Sections 3.10.4, 4.18.1, 4.20.1, 5.8.5). Fathers often acknowledged that they had deliberately distanced themselves both physically and mentally and their explanations for these behaviours suggest these were coping strategies used in part to promote self-preservation (Sections 3.10.4, 4.19.3). It is important to note however, that in some instances HCPs may have misunderstood a father's emotion-focused behaviour, believing instead that he was displaying a lack of interest or commitment.

It must be acknowledged that a person's self-confidence, age, gender and/or personality can have an influence on which coping strategy they use (Folkman 1984; Lazarus 1999; Recchia, Lemétayer 2005; Ogden 2007). The selection of coping strategies can also depend on the situation, resources available and the level of control a person feels they have at the time. Emotion-focused strategies are more commonly used in situations when individuals feel they have limited control (Ludwick-Rosenthal, Neufeld 1993; Lazarus 1999). By altering the meaning of a situation individuals can gain some level of control (Folkman 1984). Fathers often spoke about their lack of control, feelings of powerlessness and helplessness (Sections 3.10.3, 3.12.1) and in some situations HCPs appeared to minimise or eliminate what little control a father had (Sections 3.10.3, 4.19.3, 5.8.4, 5.11.1). In other instances care was organised in such a way that fathers and indeed HCPs were powerless to act in the way they might have wished (Sections 3.11.1, 3.11.3, 3.13.1, 4.19.3, 4.20.1, 5.8.4, 5.11.1, 5.11.2).

Although examples can be found of fathers assuming control in a direct way, these were more limited. In situations when fathers did initiate some control, this was often facilitated by a HCP, usually the midwife (Sections 3.14.2, 4.20.2, 5.9.1, 5.10.2). In contrast to this, there were examples of HCPs criticising fathers when they tried to attain control over their situation (Section 5.8.3). The more limited examples of fathers taking control may in part explain the lower incidence of problem-focused coping strategies. Attribution of the cause of the stressor, the meaning of the situation and the context in which the event occurs, influences person's appraisal of their control (Folkman 1984; Ogden 2007). This enables them to determine situations that are within or beyond their control (Ogden 2007). Fathers with an external locus of control who believe they have no control over the situation, will feel less able to take direct action using problem-focused coping strategies.

The literature on coping strategies has provided a theoretical framework that underpins this study. In so doing, theories of coping offer a rationale and an explanation for the ways in which fathers behaved and responded. In the final chapter and evaluation of the study will be presented along with recommendations for future practice, an assessment of the potential impact of the study and suggestions for further research.

## **Chapter 7 – Evaluation of the study and discussion**

### **7.0 Introduction**

The aim of this study was to gain an understanding of the experiences and perceptions of fathers attending the birth and immediate care of their baby (Section 2.2). It was anticipated that this insight would add to the body of evidence relating to fatherhood in a way that reflects the current drive to gain understanding of the experiences of fathers (Lundqvist et al 2007; Sloan et al 2008; Lee et al 2009). It was also anticipated that evidence generated by the study would inform HCP education and training and the development of policy and health education such that the needs of fathers encountering complicated and preterm birth, newborn resuscitation and NNU admission would be more adequately addressed. However, before the findings are disseminated, the study must be appraised. Consequently within this chapter, an evaluation will be presented. Each phase will be considered separately prior to an evaluation of the whole study. As part of this overall evaluation an assessment of the study's trustworthiness will be presented. This will be followed by an appraisal using Yardley's (2008) more detailed framework. This consists of four core principles, which facilitates evaluation of the study in a more comprehensive way (Yardley 2008). Judgment about the study using this range of methods will assist the appraisal of the potential impact of the study. Following the evaluation recommendations for future practice will be made. The chapter will conclude with suggestions for future research.

### **7.1 Evaluation of the study**

Within this section each phase will be considered separately prior to an evaluation of the study as a whole. Judgments will be made about the achievement of the objectives. The methods used will also be appraised.



### **7.1.1 Evaluation of the study – phase one**

The aim of this phase was to explore the experiences and perceptions of fathers of events surrounding the birth and immediate care of their baby (Section 3.1). The phenomenological approach was successfully utilised. The semi-structured interviews enabled fathers to recount their experiences when they encountered what may prove to be one of the most challenging episodes of their life. Their narratives bear witness to their experiences (Richards 2005) and it is therefore argued that the aim and objectives of this phase have been achieved.

The challenges associated with both the phenomenological approach and interviews have been acknowledged (Sections 3.2.2, 3.4.2, 3.4.3). These were addressed wherever feasible (Section 3.4.2). It is not possible to determine to what extent, if at all, the researcher influenced the research process in a negative way. However, strategies were put in place to minimise any detrimental effects. These included discussing the transcripts and data analysis with the researcher's supervisor (Sections 2.4.1, 2.4.2, 3.7). It can also not be determined whether fathers intentionally gave inaccurate accounts of their experiences. However, the phenomenological approach was used to gain an account of the fathers' interpretation of what happened (Johnson 2000; Dykes 2004; Mapp 2008) rather than generate a factual report of the event. Many fathers said they participated in the study because they wanted to help others facing similar situations (Section 3.5.1). It is therefore anticipated that their accounts were truthful and accurate.

### **7.1.2 Evaluation of the study – phase two**

The aim of this phase was to gain insight into issues occurring around the time of the delivery of a baby when the father was present (Section 4.1). The direct collection of qualitative and quantitative data in the settings in which events occurred provided accurate and detailed information about fathers' experiences and the context (Richards

2005; Watson, Whyte 2006). Different types of birth occurring in a variety of settings with varying outcomes were described. Although fathers' experiences of NNU admission are described in phases one and three, it would have been advantageous if the sample for this phase had included more babies requiring this level of care. However, the number of babies (2/22) correlates with the 7 – 10% babies needing NNU care in the UK (DH 2009). It is therefore argued that the aim and objectives of this phase have been achieved.

There are challenges associated with the use of observation (Sections 4.3.2, 4.5.2, 4.5.3). These were addressed wherever possible (Sections 4.3.2, 4.5.1, 4.8.1). Ultimately it is not possible to determine to what extent, if at all, the researcher made assumptions about what was being observed, recorded inaccurate information, detrimentally affected those being observed or became distracted by others. However, steps were taken to minimise these potential problems (Sections 4.3.2, 4.5.1, 4.8.1). There is no reason to assume the researcher's interpretation of events would be any different to those of others. Whilst some fathers, mothers, family members and HCPs forgot they were being observed others remained aware of the researcher's presence (Section 4.6.2). It is not possible to assess whether the latter group changed their behaviour as a consequence of being observed. However, there is no reason to assume one participant responded to being observed any differently from the others. Consequently it is argued that the strengths of this phase of the study outweigh any potential weaknesses.

### **7.1.3 Evaluation of the study – phase three**

The aim of this phase was to identify the experiences and perceptions of HCPs supporting fathers around the time of the delivery of a baby requiring resuscitation and/or admission to the NNU (Section 5.1). The critical incident approach was used successfully, although some participants found it more straightforward than others (Section 5.4.3). HCPs recalled a range of contrasting events. Their first-hand accounts

described these experiences in detail (Richards 2005) and the aim and objectives of this phase were achieved.

There are challenges associated with the critical incident approach and the method of data collection used (Sections 5.2.2, 5.4.2, 5.4.3). It is not possible to determine to what extent, if at all, the researcher influenced the research process in a negative way. However, strategies were put in place to minimise any detrimental effects (Sections 2.4.1, 2.4.2, 3.7). Whilst the researcher had to take the participants' accounts on trust, there is no evidence to suggest they deliberately manipulated or falsified information. Many HCPs referred to their personal experiences of childbirth during or after the interview (Section 5.4.3, 5.8.3). These experiences may have shaped their perception of events encountered as part of their professional role. However, the extent to which that is the case cannot be determined.

#### **7.1.4 Evaluation of the study – the overall study**

When the overall study is considered, it is apparent that relatively large and diverse samples have been involved particularly when compared with other similar studies (Jackson et al 2003; Lundqvist, Jakobsson 2003; Lee et al 2009). It was important to involve only first-time fathers (Sections 3.3.1, 4.4.1) in order to ensure their behaviours and responses were not influenced by previous childbirth experiences. However, some fathers may have had relevant related experiences and knowledge that influenced their feelings and how they responded. This might include knowledge obtained via parentcraft classes, personal preparation for childbirth, their professional role or watching childbirth or resuscitation events, either real or enacted. The extent to which this was the case cannot be determined.

The paradigm of pragmatism enhanced the conduct of the study (Section 2.3.1). It facilitated a mixed methods study, which involved the collection of qualitative and quantitative data. As a consequence a more complete picture of fathers' experiences

were described (Creswell, Plano Clark 2007; Yardley, Bishop 2008; Doyle et al 2009). The researcher was able to employ the strengths of interpretivism and positivism whereby appropriate and complementary methods and approaches were used. Whilst four participants were involved in both phases two and three of the study different fathers were involved in phases one and two (Sections 3.3.3, 4.4.3). However, the triangulation of methods generated quantitative and qualitative data that facilitates understanding of fathers' experiences from a variety of perspectives (Section 2.3.2) (Richards 2005; Baker 2006; Yardley 2008). The purpose of triangulation is not to verify findings but to provide a better understanding of the phenomena under investigation (Gibson, Brown 2009). Consequently a more complete picture, based on first-hand evidence is provided.

Many of the study's findings have been substantiated by similar studies (Jackson et al 2003; Gungor, Beji 2007; Lindberg et al 2007). Others who have had similar experiences may also corroborate the findings (Angen 2000; Yardley 2008, Gibson, Brown 2009). As this study's findings are time and situation bound, they should appear plausible and may resonate with other similar populations and/or settings (Angen 2000; Baker 2006; Yardley 2008). The written account of a research study should invoke in the reader a feeling of authenticity and realism (Angen 2000). To facilitate this process information has been provided regarding the characteristics of participants and the setting (Plummer-D'Amato 2008) (Sections 3.3.3, 4.2, 4.4.3, 5.3.3). Whilst part of the examination process will consider the plausibility of this work, it is also important to disseminate the study to a wider audience through publications in peer review journals and conference presentations (Appendix 3). In this way others will determine whether the work is believable and the extent to which the findings relate to their own experiences. More formalised processes can also be utilised to evaluate the study. In the following section, the study's trustworthiness will therefore be considered.

## **7.2 Evaluation of the study's trustworthiness**

Although a structured approach was taken (Section 2.3.1) this study used predominantly qualitative methods. It is therefore appropriate to focus the evaluation on the qualitative methods used. There is a lack of consensus regarding frameworks to use when doing this (Angen 2000; Braun, Clarke 2006; Coyle 2007). Whilst determining validity, reliability and generalisability have become the definitive ways in which to judge quantitative research (Angen 2000, Coyle 2007) these elements have been deemed inappropriate for the evaluation of qualitative research (Silverman 2006; Plummer-D'Amato 2008; Gibson, Brown 2009).

A number of approaches are available to evaluate qualitative studies (Braun, Clarke 2006). This study has been reviewed in relation to the concept of trustworthiness, which is generally acknowledged as being the cornerstone of qualitative methods evaluation (Morgan 2004; Parahoo 2006; Polit, Beck 2010). The notion of trustworthiness focuses on the context and methods of data collection rather than intrinsic truthfulness (Gibson, Brown 2009). Table 7.1 provides evidence of this study's trustworthiness using suggested criteria (Robson 2002; Endacott 2005; Tuckett 2005; Silverman 2006; Coyle 2007; Creswell 2009).

<b>CRITERIA</b>	<b>EVIDENCE</b>
Purposive sampling	Sections: 3.3.1, 4.4.1, 5.3.1
Triangulation	Chapters: 3, 4 and 5
Thick description	Chapters: 3, 4 and 5
Standardisation of the transcription process	Sections: 3.7.1, 4.7, 5.5.2, 5.6
Inductive analysis	Section: 2.4.1
Peer review of the data analysis	Sections: 2.4.1, 2.4.2
Acknowledgement of conflicting evidence	Chapters: 3, 4 and 5
Use of verbatim quotes / excerpts from field notes	Chapters: 3, 4 and 5
Presentation of data from all participants	Chapters: 3, 4 and 5
A detailed account of the research process	Chapters: 3, 4 and 5
Acknowledgement of potential researcher bias	Sections: 2.4.2, 2.7

Table 7.1 Evidence of the study's trustworthiness

If these criteria are fulfilled, then a study can be deemed to be rigorous (Giorgi, Giorgi 2008). Further evidence to support the claim of trustworthiness can be drawn from the audit trail, supervision reports and the researcher's reflective diary (Tuckett 2005; Plummer-D'Amato 2008). Aspects of these have been sourced within this thesis (Chapter four). Yardley (2008) offers an alternative framework against which a qualitative study can be evaluated. An assessment using this framework will be presented in the following section.

### **7.3 Evaluation of the study – using Yardley's (2008) framework**

Yardley's framework was first published in 2000 and is based on earlier work (Yardley 1997). The framework consists of four core principles: 'sensitivity to context',

'commitment and rigour', 'coherence and transparency' and 'impact and importance' (Yardley 2000; Yardley 2008: 243-244). A criticism of many other frameworks is that criteria cannot always be applied to a diverse range of approaches (Braun, Clarke 2006). This framework however, can be used with a variety of qualitative methods (Yardley 2008) and its use is therefore appropriate for this study. Table 7.2 identifies the key features of the framework's four core principles (Yardley 2008) that provide a thorough and detailed means by which a study can be evaluated. Table 7.3 provides evidence of the achievement of these principles.

<b>CORE PRINCIPLES</b>	<b>KEY FEATURES</b>
Sensitivity to context	Use of relevant theoretical literature. Sensitive to socio-cultural setting and participants' perspectives. Ethical issues identified and addressed. Generation of empirical data.
Commitment and rigour	Thorough data collection. Depth and breadth of analysis. Methodological competence and skill. In-depth engagement with topic.
Coherence and transparency	Clarity and power of argument. Fit between theory and method. Transparent methods and data presentation. Reflexivity.
Impact and importance	Practical and applied. Theoretical. Socio-cultural.

Adapted from Yardley (2008: 243-246)

Table 7.2 Yardley's (2008) framework

<b><i>CORE PRINCIPLES</i></b>	<b><i>EVIDENCE</i></b>
Sensitivity to context	Chapters 1, 2, 3, 4, 5 and 7
Commitment and rigour	Chapters 2, 3, 4 and 5
Coherence and transparency	Chapters 2, 3, 4 and 5
Impact and importance	Chapter 7

Table 7.3 Achievement of Yardley's (2008) four core principles

Regarding sensitivity to context (Yardley 2000; Yardley 2008) this study draws on relevant work from a range of disciplines relating to the subject under investigation (Chapter 1). Although comparatively little is known about fathers' experiences of preterm and complicated childbirth, newborn resuscitation and NNU admission, more general work provided the foundation for this research. This study has therefore been developed from what was previously known. This other work has also been used in the data analysis (Chapters 3, 4, 5, 7). Within this study, the researcher tried to ensure she remained sensitive to and respectful of both the participants and the setting. This can be demonstrated in the participant recruitment and data collection processes (Sections 3.3.2, 3.4.2, 4.4.2, 4.5.2, 5.3.2, 5.4.2). Whilst there was a risk that the researcher's prior knowledge and preconceived ideas were superimposed on the analysis of the data, strategies were put in place to minimise the chances of this occurring (Section 2.7). Counter themes and inconsistencies are also acknowledged (Chapters 3, 4, 5). Although this study was undertaken following LREC, Trust R&D and University ethics approval (Section 2.10) it was essential to ensure ethical issues were constantly monitored and addressed (Yardley 2008) (Sections 2.6, 3.5, 4.6, 5.5).



Evidence can be provided throughout this thesis of the researcher's commitment and rigour (Yardley 2000; Yardley 2008) although time pressures placed some restrictions on participant recruitment. Purposive sampling (Sections 3.3.2, 4.4.2, 5.3.2), extensive and prolonged data collection (Sections 3.4.3, 4.5.3, 5.4.3) and detailed data analysis (Sections 2.4.1, 3.6, 4.7.1, 5.6) all demonstrate understanding of the methodological processes and ongoing commitment. This study also required the support and involvement of others, including the participants, key players within the Trust and the researcher's supervisor (Sections 2.1, 2.6.4, 3.3.2, 4.4.2, 5.3.2). Indeed the involvement of midwives and neonatal nurses in the recruitment of participants to phases one and two was essential. In recognition and appreciation of this commitment, it was important to ensure the researcher had the research skills required to ensure successful completion of the study (Angen 2000; Baker 2006). The ways in which this was addressed have been identified (Section 2.8).

Yardley's (2000; 2008) recognition of the need for coherence and transparency has been addressed in a number of ways. The researcher's clarity of expression and the power of her argument are for others to judge. Nevertheless the researcher has endeavoured to ensure sufficient detail has been provided of the research processes and in particular regarding data analysis (Sections 2.4.1, 3.6, 4.7.1, 5.6). The researcher has also contemporaneously maintained a reflective diary (Sections 2.4.2, 2.7) and a detailed audit trail can be provided if required. An appropriate range of methods and approaches were used in ways reflecting their theoretical background (Sections 3.2.2, 4.3.2, 5.2.2). An extensive range of data has been presented and the researcher has been careful to ensure the findings have not been generalised to the wider population. However, ways in which the findings maybe applied in a wider context will be indicated in the following chapter.

The final aspect of Yardley's (2000; 2008) framework focuses on the study's impact and importance. The extent to which the study provides a better understanding of the phenomena under investigation should be explicit. Implications for practice should be apparent. Many studies can be the catalyst for change. The findings of the study may

also indicate the need for further research. These issues will be explored in more detail in subsequent sections (Sections 7.6, 7.7), which provide evidence of the fulfillment of this particular requirement. It is therefore argued that the four core principles of Yardley's (2000; 2008) framework have been achieved.

#### **7.4 Evaluation of the study – summary**

This chapter provides evidence that the study's aims and objectives have been achieved both in relation to the accounts provided of the experiences of fathers and the methodological approaches adopted. Evaluation of the research process has also shown that strategies used to promote the study's trustworthiness were successfully deployed. A more detailed evaluation of the study using Yardley's (2008) framework has also revealed that its four core principles have been achieved. It is therefore argued that this study can be regarded as being rigorous (Giorgi, Giorgi 2008). In the following sections of this chapter, recommendations for future practice will be made, the potential impact of the study will be assessed and suggestions for future research will be indicated.

#### **7.5 Recommendations for practice**

The increasing incidence of complicated and preterm birth and newborn resuscitation (Section 1.4.1) (Murphy et al 2003; Shennan, Bewley 2006) necessitates an urgent need to find ways of engaging and involving fathers when these events occur. The involvement of a father in his child's life has long-term social and economic benefit not only for the father himself but also for the child, the mother and society in general (Burghes et al 1997; Beardshaw 2001; Friedewald et al 2005). Pregnancy and childbirth provide ideal opportunities to promote this involvement (Burgess 2008). It is therefore important to ensure any detrimental affects that fathers experience as a consequence of being present during adverse childbirth events are minimised. In so doing the likelihood

of long-term problems associated with absent fathers or psychological problems such as PTSD that may jeopardise a father's future relationship with his partner and/or child should be reduced (Sullivan-Lyons 1998; Mander 2004; Parfitt, Ayers 2009). These detrimental affects can be minimised by ensuring the provision of maternity and neonatal care that includes and supports the needs of fathers in addition to those of mothers and babies.

This study raises a number of pertinent issues for consideration. Many of the recommendations arising from this study have also been identified in recently published guidelines and principles of care that were developed through consultation with experienced HCPs and parents (Bliss 2009, DH 2009). This study provides substantive evidence that endorse these guidelines and principles. It is therefore important that the findings from this study are disseminated to relevant parties including parents, user groups, charities, HCP groups, service providers, budget holders and policy makers. This will enable individuals to consider the extent to which the findings reflect their own experiences and practice. The findings may also facilitate consideration of ways in which the service could be developed. Recommendations for fathers, individual HCPs and those responsible for the wider service are presented in the following sections.

### **7.5.1 Recommendations for practice – fathers**

Evidence from this study suggests that most fathers want to play a constructive role around the time of the birth of their baby (Section 6.1.1). Whilst a father's ability and opportunity to be involved can be enhanced through guidance, support and encouragement from HCPs (Section 6.1.2) the findings highlight a number of issues for prospective fathers to consider to enhance their childbirth experiences. The recommendations relate to preparation for the birth, strategies to employ during and immediately after the birth and ways of addressing their own needs.

Fathers can facilitate their involvement before the birth regardless of whether or not problems have been anticipated. Ways fathers can prepare for the birth include attending parentcraft classes, reading books, accessing information via the Internet or talking to other fathers about their childbirth experiences (Section 3.9). Awareness that normal childbirth can be an emotional and stressful experience for fathers (Vehviläinen-Julkunen, Liukkonen 1998; Somers-Smith 1999; Kunjappy-Clifton 2008) may help them to prepare more effectively. In the same way, knowing it is not unusual for fathers to feel powerless at some point during the proceedings (Sections 3.10.2, 3.10.3) (Draper 2003; Rosich-Medina, Shetty 2007) may help them cope with these feelings. Fathers may also find it useful to identify their preferred coping strategy (Section 3.10.4) (Lazarus 1999; Ogden 2007) and to discuss specific strategies with their partner and HCPs. It would also be prudent for fathers to think in advance about their own support needs and in particular the value of having a family member or friend as a 'point of contact' (Section 3.13.2).

Fathers who experience complicated and preterm birth and newborn resuscitation can promote their involvement during and immediately after the birth. Strategies include asking questions, being vigilant, advocating for their partner, baby and themselves and getting involved in their partner's care (Sections 3.12.1, 3.12.2, 3.12.4, 4.17). Fathers could also consider the importance of maintaining physical contact with their partner as much as possible. At the same time knowing that it is not unusual for relatives and fathers to feel the need to take 'time-out' (Sections 3.10.4, 3.13.2, 5.8.2), may help fathers to cope with the situation (Goldstein et al 1997; Jenni 2000; Maxton 2008).

Prospective fathers could also consider their own needs around the time of childbirth. This could include making preparations to ensure their own physical and hygiene needs are met (Section 3.13.4). However, fathers have limited opportunities to implement many of these recommendations without the guidance, support and encouragement of HCPs involved in their care (Sections 6.1.1, 6.1.2).

## **7.5.2 Recommendations for practice – individual health care professionals**

The findings of this study raise a number of issues for HCPs to consider when fathers encounter complicated and preterm birth, newborn resuscitation and/or NNU admission. Whilst some may feel these recommendations are already encompassed within their practice, evidence from this study suggests that this may not always be the case (Section 6.1.2). Whereas the service influences ways in which HCPs work to some extent (Section 6.1.3), the following recommendations provide an opportunity for HCPs to consider ways in which their own practice could be enhanced. Recommendations relate to strategies that could be employed during the antenatal period, during and immediately after the delivery, specific approaches in relation to information giving and other more general aspects of care.

There is scope for HCPs to emphasise the importance of antenatal preparation (Section 3.9). They could also make general recommendations regarding books to read and/or websites to access (Sections 3.9.2, 3.9.3). In situations when it becomes apparent that NNU admission will be required, HCPs play a key role in ensuring parents have the opportunity to visit the NNU (Griffin et al 1997; Bliss 2009; Wilkinson et al 2009). Midwives could ensure fathers are offered the chance to do this whilst their partner is being cared for on the delivery suite if they have not previously had the opportunity to do so (Sections 3.9.5, 5.10.2). They could also discuss with fathers the possibility that they will feel divided loyalty once the baby is delivered (Section 3.11.1) (Koppel, Kaiser 2001; Lindberg et al 2007). Alerting fathers to these feelings may help them to consider potential coping strategies and if possible, discuss these with their partner. Having done this, fathers may feel less guilty about these feelings once the baby is born (Section 3.10.2). When problems have been identified antenatally, HCPs could also suggest fathers identify their own sources of support (possibly their own father) to help them around the time of the birth (Section 3.13.2) (Schwarzer et al 2004).

There is scope for more detailed guidance for fathers about appropriate ways of supporting their partner during and immediately after delivery (Sections 3.12, 4.18).

HCPs could also consider utilising opportunities to advocate for the father, particularly in relation to touching or holding the baby (Section 4.20.2) (Bliss 2009). In situations where the baby requires resuscitation, HCPs could volunteer or nominate another HCP to support the father during the process, as is the case in other care settings (Baskett et al 2005; Goldstein et al 1997). This may include taking him to the resuscitaire and encouraging him to touch his baby (Section 6.1.2) (Sullivan 1999; Jackson et al 2003). If the baby requires NNU admission, HCPs could consider enabling the father to go with his baby or visit as soon as possible afterwards (Section 3.11.1) (Gavey 2007). HCPs could also offer the opportunity to discuss what happened after the event in the form of a debriefing (Section 3.13.3).

Several recommendations for HCPs relate to the process of information giving. There is a need for more extensive explanations beforehand about what might happen at the birth (Ryan 2009). There is also scope for greater recognition of the importance of eye contact, body language and non-verbal communication between HCPs (Sections 3.13.1, 4.19.1). HCPs could also reflect on the potential affect of what they do not say. For example, fathers assume they cannot go to the resuscitaire or with their baby to the NNU if HCPs do not invite them to do so (Sections 3.10.2, 3.11.1). Paediatricians could also consider ensuring they speak with the father before they leave the delivery room, irrespective of the baby's need for resuscitation and/or NNU admission (Section 6.1.2) (European Resuscitation Council 2006; Resuscitation Council 2006).

More general recommendations for HCPs to consider include recognising the value fathers place on the involvement of senior HCPs in their care (Section 3.13.1) and the importance of senior HCPs adequately supporting junior staff (Section 5.12.2). Individual HCPs could also reflect on their personal philosophy of care. In particular the extent to which they demonstrate a family-centred approach and whether they feel they have a duty of care to the father (Section 6.1.2) (DH 2009; Ryan 2009). Many of these recommendations relate to person-centred care delivery. In many situations the most straightforward way HCPs can ensure they meet a father's needs is to ask him his

preferences at the outset. However, HCPs should consider ways of doing this such that he feels he genuinely has a choice (Sections 3.10.2, 3.11.1).

### **7.5.3 Recommendations for practice – the wider service**

Given the influence that the service had on the nature and extent of father-involvement (Section 6.1.3) the findings of this study raise a number of important issues for consideration by user groups and those responsible for the wider service. Within this context, the wider service includes those with managerial responsibility in local Trusts and networks and policy makers at both local and national levels. The following recommendations focus on the ways in which care and support for fathers may be enhanced. They could also lead to the development of local and/or national protocols and guidelines for practice. These recommendations include strategies that could be employed before the birth, resources for fathers within the care setting, HCP training and professional development and philosophies of care.

The accessibility, timing and content of parentcraft classes should be reviewed. Concern has been expressed about the reduced availability of this resource over recent years (Clift-Matthews 2007; Bainbridge 2009b). This is contra to the ethos of recent directives to engage and involve fathers during pregnancy (DH, DES 2004; Department for Children, Schools and Families, DH 2009). Greater availability and flexibility of delivery would enable more fathers to attend classes. Many of these programmes take place in the daytime when fathers are unable to participate (Deave et al 2008; Mottram 2008). The inclusion of content regarding preterm birth, complicated childbirth and newborn resuscitation may be worthwhile. Running specific classes for parents when preterm birth, newborn resuscitation and/or NNU admission is predicted may be resource-intensive and logistically difficult to organise. It may also be difficult to meet the needs of individual parents unless provided on a one-to-one basis. However, these factors should not preclude prospective parents having access to classes that meet their needs in a more effective way (Section 3.9.1).

There is scope for streamlining the process by which parents are referred for a tour of the NNU to ensure more parents have this opportunity (Wilkinson et al 2009). There may also be value in developing guidelines regarding information to be given and who should conduct the tour. Strategies could also be put in place, which enable fathers to visit the NNU for a tour from the delivery suite. It may also be prudent to develop alternative ways of informing parents generally and fathers in particular about the NNU (Bliss 2009). Other strategies could include photograph albums, leaflets, booklets, DVDs, virtual tours, web-based information and/or a visit to the parents on the antenatal ward / delivery suite by a neonatal nurse to specifically discuss aspects of nursing care (Section 3.9). Guidelines could also be developed for HCPs about the more general provision of information (Alderson et al 2006; Lindberg et al 2007). HCPs expressed uncertainty about the nature, extent and timing of information they gave to fathers (Sections 5.9.1; 5.9.2). It appears that decisions about this important aspect of care are usually left to the individual HCP. Whilst it would not be appropriate to be too prescriptive, there is scope for broad guidelines that would facilitate this process.

Several of the recommendations relate to the availability of resources for fathers. The importance of somewhere private for fathers to take 'time-out,' overnight accommodation and facilities for fathers to shower and change have been identified (Sections 5.11.2) (Fatherhood Institute 2008; Bliss 2009; DH 2009). There is also scope to consider the provision of information regarding resources and sources of support for fathers within Trusts (Section 3.13). User groups or charities such as Bliss could produce this in a standard format that could be adapted to suit the needs of individual Trusts. Similar types of resources could be made available for relatives about ways in which they can support fathers in these sorts of situations. There could be benefit in producing these and other information in a variety of formats such as audio or web-based material in addition to the more usual written format (Section 3.13.2) (Dartnell et al 2005; Bliss 2009).

The negative impact of staff shortages on the experiences of fathers has also been identified (Section 6.1.3). There is scope to consider the potential benefit of improving



staffing levels and skill mix generally and of midwives in particular. The calculation of staffing ratios could take into consideration the needs of fathers, in addition to the needs of mothers and babies. The recruitment of additional personnel such as an independent NNU counsellor or someone to chaperone fathers during the resuscitation of their baby at delivery could also be considered (Section 6.1.3) (Grice et al 2003; Baskett et al 2005; Bliss 2009).

Changes could also be made on a national level regarding HCP education and professional development to ensure the needs of fathers are included in the curricula for all HCP groups. Given the significance of the role of the midwife (Section 6.1.2) it is particularly important that meeting fathers' needs features more extensively in midwifery training and professional development programmes. In addition, guidance about supporting fathers could be incorporated into the nationally recognised newborn resuscitation training programmes for all HCPs (European Resuscitation Council 2006; Resuscitation Council 2006). Whilst HCPs have a personal responsibility for their learning needs beyond their initial registration, the organisation in which they work also has a responsibility to ensure they have access to a range of learning opportunities both within and beyond the Trust. The extent to which HCPs are currently provided with these opportunities could be explored. The need for skills training especially in relation to breaking bad news and information giving during emergency situations could also be considered (Section 5.12.1) (DH 2009). It would also be valuable to ensure HCPs have a sound understanding of theories of coping and can recognise different coping strategies. Reflection on practice to determine ways in which HCPs control or facilitate the experiences of fathers could also be included. There may also be benefit in providing more formalised opportunities for different HCP groups to share aspects of their practice and learn from each other. This may lead to the development a culture in which practice can be regularly reviewed and challenged in a non-threatening way (Section 6.1.2). It may also lead to HCPs having a clearer understanding of their individual roles and responsibilities and promote interprofessional working (DH 2000).

Ways in which the engagement and involvement of fathers could be enhanced by addressing the overall philosophy of care at Trust level can also be identified within this study. A family-centred philosophy of care that is evident throughout the Trust should provide seamless, integrated care and support for fathers. This will also promote communication and liaison between departments (Sections 3.13.1, 5.12.2). Trusts therefore need to go beyond the endorsement of the philosophy and ensure it is implemented. It is likely this will require additional resources and staff training (Peterson et al 2004; Ryan 2009). To ensure any of these and other strategies already in place meet the needs of fathers their views should be specifically targeted in patient / user satisfaction surveys.

The findings of this study suggest fathers want to play a constructive role around the time of the birth of their baby and HCPs have a key role in enabling this to happen (Sections 6.1.1, 6.1.2). The Trust shapes the way in which HCPs carry out their role (Section 6.1.3) and the wider service influences the ways in which they function. The recommendations from this study highlight that most are pertinent to those with managerial responsibility in local Trusts and networks, policy makers at both local and national levels and key players within national organisations such as charities and user groups. The recognition by policy makers of the need for additional resources and facilities for fathers may prompt individual Trusts to ensure they are available in the future.

## **7.6 Impact of study**

The extent to which the recommendations are implemented will determine the overall impact of the study. Nevertheless, this study has the potential to enable HCPs to reflect on their own practice and the philosophy of care within their workplace. It is anticipated that scrutiny of the current provision of care and support for fathers will lead to development of the service and reallocation of resources such that their needs will be

more adequately met. The findings of this study could also be utilised to support the recruitment of additional HCPs generally and midwives in particular.

It is anticipated that some of the recommendations will be incorporated into guidelines for prospective fathers. Bliss has approached the researcher to assist in the redevelopment of their information leaflet for fathers who are expecting or have experienced preterm birth. It is anticipated this will be available for all fathers in a range of formats. There is also the potential for the development of other similar material for family members and friends of parents anticipating complicated or preterm birth, newborn resuscitation and/or NNU admission.

Ultimately it is predicted this study will raise awareness of the experiences and needs of fathers who encounter complicated and preterm childbirth, newborn resuscitation and the NNU admission. As a consequence the implementation of the recommended strategies will facilitate the engagement and involvement of fathers thereby endorsing the ethos of family-centred care and supporting their transition to fatherhood. This study therefore adds to the body of evidence about fatherhood more generally. This reflects the increasing drive to gain an understanding of health care users' perception of care (Kemppainen 2000). It also generates new knowledge that will inform HCP education and training and the development of policy and health education. The quality of care provision will thereby be enhanced such that the needs of fathers will be more adequately addressed (DH, DES 2004, Department for Children, Schools and Families, DH 2009).

## **7.7 Future studies**

As the drive to engage and involve fathers continues and the experiences of fathers come under greater scrutiny (Burghes et al 1997; McVeigh et al 2002; Schoppe-Sullivan et al 2008), further research in this area may facilitate the continued development of strategies to support transition to fatherhood. It may be beneficial to replicate this study

in different types of care settings both within the UK and internationally. It would be particularly useful to evaluate any of the previously identified recommendations put in place to enhance the experiences of fathers (Section 7.5). It would also be of value to undertake a similar study focusing specifically on the observation of the first visit of fathers to the NNU (Section 7.1.2).

In order to gain a broader view of fathers' experiences, it would be useful to undertake a similar study with groups of fathers not involved in this research. These groups could include fathers under 18 years of age, non-English speakers, experienced fathers and/or fathers of multiple births (World Health Organisation 2007). It may also be beneficial to undertake a similar study that focuses on situations where the baby did not survive. This could include stillbirths, unsuccessful resuscitation attempts at birth and/or neonatal deaths during the first few weeks of life. Although such a study would present difficult and sensitive ethical issues, it would provide insight into situations about which there is a dearth of information in relation to the experiences of fathers (McCreight 2004; Turton et al 2006).

The findings of this study could also be used to develop a quantitative survey or Q-methods study that could be undertaken with a larger number and broader range of fathers. A larger quantitative study would provide further insight into the experiences of fathers that could be generalised to the wider population (Polit, Beck 2010). A larger study would also enable comparisons to be made between geographical areas, types of care setting, types of delivery and different groups of fathers. A larger study could be administered in a number of ways locally or nationally.

It may also be beneficial to undertake a longitudinal study in order to evaluate the impact of the experiences of fathers over time, particularly in relation to their transition to fatherhood. A study of this nature would provide evidence regarding the impact of adverse childbirth events on the father-child relationship over time, the incidence of PTSD and/or the presence of paternal mental health problems. A body of evidence has developed regarding the incidence of maternal PTSD following childbirth (Creedy,

Shochet, Horsfall 2000; Soet, Brack, Dilorio 2003, Beck 2004). However, little is known about fathers' experiences of this. Similarly the incidence and risk factors associated with maternal post-natal depression are well documented (Ingram, Taylor 2007; Redshaw, van den Akker 2007). Whilst the body of evidence is slowly growing in relation to paternal perinatal depression (Eriksson et al 2006; Parfitt, Ayers 2009) there is still much work to be done in this area, particularly in relation to underlying causes and risk factors. Any evidence linking paternal PTSD and/or perinatal depression to complicated and preterm childbirth, newborn resuscitation and/or NNU admission could lead to the implementation of preventative measures and strategies to support fathers experiencing these sorts of events.

There is scope to explore the impact on others of adverse events occurring around the birth of a baby. This study provides evidence that it is not uncommon for other family members to be present during childbirth. In this study these were usually relatives of the mother (Sections 4.10.3, 4.10.4). It would be useful to gain insight into their motivation for attending and their experiences, particularly in relation to newborn resuscitation. It would also be useful to compare these experiences with those of the fathers. This would not only provide insight into the experiences of family members but may also reveal other ways in which fathers could be supported more effectively. This study highlighted the importance of social support, particularly that provided by a father's own father (Section 3.15). A future study could explore this issue in more depth. It may be the case that fathers support their sons around the time of childbirth in ways that others cannot. A study such as this would add to the body of knowledge regarding fatherhood in a more general way.

This study also demonstrates the impact of newborn resuscitation on HCPs, particularly midwives (Section 5.12). More extensive exploration of these issues with a larger number of HCPs may identify specific areas to be addressed in HCP training and professional development and ways in which HCPs can support each other more effectively during such events. There may also be scope to undertake a similar study with both mothers and fathers in order to compare their experiences and needs. This

evidence could guide fathers to the most effective ways of supporting their partner. It could also identify to HCPs the differing needs of couples and how best to address them when caring for both a mother and her partner.

## **7.8 Conclusion**

Childbirth and transition to fatherhood are major life events. Whilst for many men these events are straightforward, for some this is not the case. Preterm and complicated childbirth, resuscitation of the baby and/or NNU admission are events in which fathers are increasingly involved (Murphy et al 2004; Langhoff-Roos et al 2006; Healthcare Commission 2008). This independent study documents the experiences of fathers encountering these situations. Despite recent initiatives to involve fathers during childbirth (DH 2004; NICE 2006), this study demonstrates that when adverse events occur they often do not have a place in the maternity care system. The recommendations made as a consequence of this study, particularly those in relation to the wider service will be important factors in changing this situation.

The timing of this study is particularly significant given the increasing awareness of the need to engage and involve fathers (Beardshaw 2001; Friedewald et al 2005; Burgess 2008). This study adds to the growing body of knowledge about fathers and fatherhood by providing both qualitative and quantitative evidence collected in a direct way about the experiences of fathers. The paradigm of pragmatism was therefore appropriate because it enabled the researcher undertake a mixed methods study which drew on the strengths of interpretivism and positivism (Sections 2.3.1, 2.3.2, 7.1.4). It is anticipated that the findings of this study will shape the future organisation and delivery of maternity and neonatal care. This study will also be an important foundation for other similar studies (Section 7.7). This study was therefore both timely and important.

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## LIST OF ABBREVIATIONS

A&E	Accident and Emergency
AICU	Adult Intensive Care Unit
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy
CTG	Cardiotocograph
ELBW	Extremely Low Birth Weight Baby
ET	Endo-tracheal
GA	General anaesthetic
HCP	Health care professional
LBW	Low birthweight
LREC	Local Research Ethics Committee
LSCS	Lower Segment Caesarean Section
MA	Midwifery assistant
Med Stud	Medical student
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NN	Neonatal nurse
NNP	Neonatal Nurse Practitioner
NNU	Neonatal Unit
NPC	No physical contact
NPEU	National Perinatal Epidemiology Unit
NSF	National Service Framework
Obs	Obstetrician
ODP	Operating department practitioner
Paed	Paediatrician
PC	Physical contact
PICU	Paediatric Intensive Care Unit
PTSD	Post-traumatic stress disorder
Q	Quiet
R&D	Research and Development
RC	Routine care
SCBU	Special Care Baby Unit
SD	Standing
SPE	Speaking to
Stud MW	Student midwife
VC	Verbal communication
WR	Witnessed resuscitation

## GLOSSARY OF TERMS USED

ABO incompatibility	Blood group incompatibility between mother (group O) and baby (group A or B). Can lead to destruction of fetal red blood cells and the production of bilirubin.
Agenda for Change	Pay structure implemented in 2004 for all NHS employees except doctors, dentists and senior managers. Consists of nine bands (1 – 9) with four additional incremental points at band eight (8a – 8d). The higher the band, the more senior / experienced the post-holder.
Apgar score	Scale with a maximum score of ten used to assess newborn babies at one and five minutes of age.
Complicated delivery	For the purpose of this study: a delivery by LSCS or a vaginal delivery occurring with the aid of forceps or ventouse.
Core midwife	Midwife working exclusively in delivery suite and/or the birthcentre.
Crash bleep	System to alert specific health care professionals in an emergency.
Crash call	System to alert health care professionals in an emergency using a continuous bell that can be heard within the maternity department.
Crash LSCS	Decision to deliver baby by LSCS immediately.
Crash team	Team attending an emergency call. In maternity care this includes obstetricians, anaesthetists, midwives, paediatricians and/or NNPs.
CTG monitoring	Simultaneous monitoring of the fetal heart rate and intensity of uterine contractions in order to identify fetal distress.
Elective LSCS	Planned LSCS.
Endo-tracheal tube	Plastic tube placed in the trachea in order to provide respiratory support.
Epidural	Local anaesthetic introduced into the epidural space. Used as a method of pain relief during childbirth.
Episiotomy	Perineal incision to assist the delivery of a baby.
Extremely low birthweight	Birthweight less than 1 Kg.
Failure to progress	Failure of labour or delivery to progress over the length of time considered normal.
Family-centred care	An approach to care based on the philosophy of partnership and collaboration between the family and health care providers.
Father	For the purpose of this study; a man who is assumed to be the biological father and/or is assigned paternal responsibility.
Fetal distress	Lack of oxygen to the fetus in utero. Often indicated by a change in the fetal heart rate or the presence of meconium stained liquor.

Forceps delivery	Obstetric forceps applied to the fetal head in order to accelerate or assist the delivery of a baby.
Grasp reflex	Flexion of the fingers or toes in response to a finger being placed on the palmar surface of the hand or plantar surface of the foot.
Grunting	Abnormal expiratory sound caused by the baby exhaling against a closed or partially closed glottis.
Health care professionals	Any health care worker. For the purpose of this study this group may include midwives, midwifery assistants, obstetricians, anaesthetists, neonatal nurses, neonatal nurse practitioners and/or paediatricians.
High dependency care	Patients requiring a greater level of monitoring and specialist observation than that provided for patients requiring normal or routine care.
Inflation or manual breaths	Inflation of the lungs by the resuscitator using positive pressure ventilation.
Intensive care	Category of neonatal care defined by the British Association of Perinatal Medicine (2001). Includes babies receiving respiratory support via an endo-tracheal tube, unstable babies requiring 1:1 nursing care and babies of less than 29 weeks gestation.
Intubation	Passage of an endo-tracheal tube via the naso or oropharynx through the larynx into the trachea in order to ventilate the lungs.
Level three neonatal unit	Neonatal unit located in an acute general hospital or regional centre that provides care for babies requiring long-term intensive care.
Low birthweight	Birthweight less than 2.5 Kgs.
LSCS	Delivery of the fetus through an incision in the mother's abdominal wall and the lower part of the uterus.
Meconium	First stool of the newborn. Dark green and consists of epithelial cells, mucus and bile.
Midwifery assistant	Unqualified support worker who assists midwives with fundamental aspects of maternity care for which they have had some training.
Neonatal Nurse Practitioner	Neonatal nurses with extensive neonatal nursing experience who have successfully completed additional training which extends their knowledge and skills to practice at a higher level. The role often includes aspects of the junior or middle grade doctor role and nursing care.
Neonatal unit	Hospital department providing specialist care at varying levels for sick and/or premature newborn babies.
Normal delivery	For the purpose of this study: cephalic vaginal delivery occurring without the aid of forceps or ventouse.
Phototherapy	Commonly used treatment for jaundice traditionally administered via overhead white or blue lights.

Physical contact	For the purpose of this study this includes direct skin-to-skin contact but not contact that may occur as a result of interventions being undertaken such as suturing or blood pressure monitoring. When the baby is involved this includes touching and stroking but not holding the baby.
Post-traumatic stress disorder	Immediate or delayed reaction to a stressful event. Symptoms may include anxiety, insomnia, depression, nightmares and flashbacks.
Pre-eclampsia	Condition unique to pregnancy that involves hypertension, proteinuria and systemic dysfunction.
Preterm baby	Baby born before 37 completed weeks gestation.
Prolonged second stage	The second stage of labour exceeds the length of time considered appropriate.
Resuscitaire	Purpose built item of equipment that resembles a trolley with an overhead heater. Has the facility to provide respiratory support, suction and warmth and is used when babies require support following delivery.
Resuscitation	For the purpose of this study: interventions beyond routine care at birth in order to establish cardio-respiratory function.
Rotating midwife	Midwife working for blocks of time on the delivery suite, birthcentre, the ward (antenatal and postnatal care) and the community.
Routine care	Normal care that most babies require at birth. Babies establish respirations spontaneously so care focuses on strategies to promote thermoregulation.
Saturation probe	Probe used to measure oxygen saturation levels of the blood.
Second stage of labour	Phase between full dilatation of the cervix and delivery of the baby.
Term baby	Baby born between 37 and 42 completed weeks gestation.
Third stage of labour	The phase between the delivery of the baby and complete expulsion of the placenta and membranes.
Triage	Assessment of a patient on admission to determine care required.
Ultrasound scan	Non-invasive creation of an image by bouncing sound waves off a selected target such as the brain or pregnant uterus. The image is projected onto a screen.
Urgent LSCS	Identified need for LSCS delivery which normally takes place within 30 – 45 minutes of decision being made.
Ventouse delivery	Suction apparatus applied to the head of a fetus in order to accelerate or assist the cephalic vaginal delivery of the baby.
Verbal communication	For the purpose of this study this includes any verbal interaction such as speaking to, being spoken to and singing.
Witnessed resuscitation	Resuscitation of a patient during which relatives and/or close friends are present.

## APPENDIX 1

### Study outline – BLISS Neonatal Nurse Research Fellow Post

#### **The impact of witnessed resuscitation on the fathers of newborn babies**

Work relating to witnessed resuscitation in adult and paediatric settings has described the impact of this on the family and their need for adequate support (Mason 2003; Woning van der 1999). Whilst it is now common practice in the United Kingdom for the father to be present at delivery (Somers-Smith 1999) no work has been identified regarding paternal witnessed resuscitation.

A study taking a phenomenological approach is proposed. This would be appropriate for this type of study as the intention is to explore the experiences and perceptions of fathers who have witnessed the resuscitation of their baby (Robson 2002).

The main source of data will be in-depth conversations (interviews), with the researcher and fathers as co-participants. The discussions could include exploration of the fathers' perceptions and experiences regarding witnessed resuscitation, the impact that this has had upon them and how they have dealt with the experience subsequently. It would also be valuable to determine both the nature of preparation they received from health care professionals prior to the resuscitation and the support that they received after the event.

The sample of 15 - 20 fathers should include those from a range of cultures and ethnic groups whose singleton baby has survived with minimal long-term complications. It is proposed that the interviews take place prior to the baby's discharge home. The exact timing and location of the interviews must be sensitive to the father's needs and the state of their baby's health. Although these are potential problems, they have been addressed appropriately in other studies involving parents (McHaffie 2001; Redshaw et al 1999).

It is also proposed that focus group(s) with approximately 5 fathers will be undertaken and the Bliss fathers' group could be approached to recruit participants (Mills 2000). Whilst it is acknowledged that the focus groups will almost certainly contain fathers with varying lengths of time since they witnessed their baby's resuscitation, it is suggested that valuable data will nevertheless be obtained.

Ethical approval would be required for the study. Informed consent must be obtained from participants and an information leaflet regarding the study will be produced. It is essential that support after the interview / focus group(s) is available for the fathers, should they require it.

In the main, qualitative data will be generated and this will be analysed accordingly. Subsequently a questionnaire could be developed which could be sent to a larger sample of fathers.

This study will generate new knowledge that could inform training and the development of policy thereby enhancing the quality of care provision.

## **APPENDIX 2**

### **Checklist to facilitate effective thematic analysis**

<b><i>PROCESS</i></b>	<b><i>CRITERIA</i></b>
Transcription	Data transcribed to an appropriate level of detail. Transcripts checked for accuracy.
Coding	Each data item given equal attention in coding process. Coding process thorough, inclusive and comprehensive. All relevant extracts for all themes collated. Themes checked against each other and original data set. Themes coherent, consistent and distinctive.
Analysis	Data have been analysed rather than paraphrased or described. Extracts illustrate analysis. Analysis presents a convincing and well-organised argument.
Overall	Enough time allocated to adequately complete the analysis.
Writing report	Assumptions about and specific approach to analysis clearly explicated. Described method and reported analysis are consistent. Language and concepts used are consistent with epistemological position of analysis. Researcher active in the process, themes have not just emerged.

Adapted from Braun and Clarke (2006: 96)



## APPENDIX 3

### Papers presented at conferences and meetings

Fathers attending the birth and immediate care of their baby – the proposed study. N<sub>3</sub>R – Network of Neonatal Nurse Researchers Conference. London, England. May 2005.

Fathers attending the birth and immediate care of their baby: The story so far. N<sub>3</sub>R – Network of Neonatal Nurses Conference. London, England. May 2007.

The experiences of fathers attending complicated childbirth and the resuscitation of their baby. Society of Reproductive and Infant Psychology Conference. Oxford, England. September 2007.

The experiences of fathers attending complicated childbirth and the resuscitation of their baby. 6<sup>th</sup> International Neonatal Nursing Conference. New Delhi, India. September 2007.

The experiences of fathers attending complicated childbirth and the resuscitation of their baby. Research Conference, Birmingham City University, Birmingham, England. November 2007.

First impressions: the experiences and perceptions of fathers of their first visit to the neonatal unit. Health and Human Development Research Group Seminar, Aston University, Birmingham, England. April 2008.

First impressions: the experiences and perceptions of fathers of their first visit to the neonatal unit. Advanced Practice Forum, Washington, United States. June 2008.

First impressions: the experiences and perceptions of fathers of their first visit to the neonatal unit. Perinatal Medicine Conference, Harrogate, England. June 2008.

Fathers attending complicated childbirth and the immediate care of their baby. Research Conference, Birmingham City University, Birmingham, England. November 2008.

Fathers' experiences and perceptions of their first visit to the neonatal unit. Quad Network Research Conference, Coventry, England. November 2008.

The experiences and perceptions of fathers attending the birth and immediate care of their baby. Postgraduate Research Student Seminar, Aston University, Birmingham, England. April 2009.

## **APPENDIX 4**

### **Phase one – Information leaflet**

#### **NHS TRUST HEADED PAPER**

##### **Introduction**

My name is Merryl Harvey; I am a neonatal nurse and I teach nurses who work in neonatal units. I also have a part-time research nurse post at the National Perinatal Epidemiology Unit in Oxford. This research nurse post is funded by the newborn baby charity Bliss. I am studying for a post-graduate degree at Aston University, which involves me carrying out a research study, and I would be grateful for your help.

You are being invited to take part in a research study. Before you decide, it is important that you understand why the study is being done and what it will involve. Please take time to read this information sheet and to decide if you would like to take part in this study. Please let me know if you would like more information about the study. Thank you for reading this.

##### **What is the study about?**

Although it is quite usual nowadays for fathers in this country to attend the delivery of their baby, there is limited published information about the affect that childbirth has on fathers. This is especially the case when a baby needs help to breathe at birth and is then admitted to a neonatal unit. The aim of this study is to discover the experiences of fathers who find themselves in this particular situation. This study is part of a larger project and it is anticipated that the findings from this part of the study will identify issues to be explored in later parts of the project.

##### **Why have I been asked to take part?**

I am hoping to recruit 15 – 20 first-time fathers who attended the birth of their baby and whose baby was then admitted to the neonatal unit. I understand that you are part of this group. This leaflet is being given to you now to give you time to think about taking part in the study.

##### **Do I have to take part?**

Involvement in this study is entirely voluntary. It is up to you to decide if you want to take part. If you would like to participate, you will be asked to sign a consent form and you will be given a copy to keep. If you decide to take part you can still withdraw from the study at any time without having to give a reason. If you decide not to take part or withdraw from the study, the care that you and your family receive will not be affected in any way.

##### **What will happen if I agree to take part?**

I would like you to let me talk with you about the birth of your baby and what happened immediately afterwards. This interview will be tape-recorded and this will enable me to compare what fathers say about their experiences. The interview will be as informal as possible; it will take place in a mutually agreeable place and will last approximately 45 minutes. You will not incur any costs or be paid any money to take part in the study.

### **What are the possible risks of taking part?**

It is possible that you might become upset whilst talking about your recent experiences; therefore you are under no obligation to take part in this study. If you agree to take part in the study and then change your mind, you can withdraw from the study at any time. This includes before, during or after the interview. Once the interview has been completed I will give you a list of places where you can get support, if you feel that you need it.

### **What are the possible benefits of taking part?**

It is hoped that information gained will give us a better understanding of the affect that childbirth has on fathers particularly when the baby needs help to breathe at birth and is admitted to a neonatal unit. It is anticipated that this new knowledge will enable us to review and if necessary improve the quality of care provided.

### **What if something goes wrong?**

If you feel at any time that you have cause for complaint arising from this study, please let me know. In addition, the usual National Health Service complaints mechanisms are available to you. For further information refer to PALS, the 'Patient Advice and Liaison Service' Tel: XXXX or XXXX (Trust website).

### **Will my involvement in this study be kept confidential?**

Your consent will be necessary before you take part in the study and any personal information such as your name will be kept strictly confidential. All documents and tapes from this study will be securely stored; these will not be available to anyone other than my research supervisor, the person transcribing the tapes (neither of whom will have access to your name) and myself. The tapes and any documentation that identifies participants will be destroyed at the end of the study. None of your personal details will be included in any reports or publications arising from this study.

### **What will happen at the end of the study?**

I will be submitting my thesis, a copy of which will be held at Aston University library. The findings of this study will also be published in health care journals and presented at conferences. Your personal details and the name of the hospital where your baby was born will not be included in any of these. If you would like information regarding the findings of this study, please let me know.

### **Who has reviewed this study?**

This study has been reviewed and approved by XX Local Research Ethics Committee and X X Hospital Research and Development department.

### **Contact for further information**

If after reading this you have any questions or need some further information, please contact me:  
[harveyme@aston.ac.uk](mailto:harveyme@aston.ac.uk)      [merryl.harvey@npeu.ox.ac.uk](mailto:merryl.harvey@npeu.ox.ac.uk)

National Perinatal Epidemiology Unit: 01865 289715. For further information regarding the National Perinatal Epidemiology Unit or Bliss please see: [www.npeu.ox.ac.uk](http://www.npeu.ox.ac.uk)      [www.bliss.org.uk](http://www.bliss.org.uk)

Whatever you decide thank you for taking the time to read this information leaflet.  
Merryl E Harvey - Bliss Neonatal Nurse Research Fellow

COREC-V2, MEH-V5 30-01-06

## **APPENDIX 5**

### **Phase two – Information leaflet**

#### **NHS TRUST HEADED PAPER**

##### **Introduction**

My name is Merryl Harvey; I am a neonatal nurse and I teach nurses who work in neonatal units. I also have a part-time research nurse post at the National Perinatal Epidemiology Unit in Oxford. This research nurse post is funded by the newborn baby charity Bliss. I am studying for a post-graduate degree at Aston University, which involves me carrying out a research study, and I would be grateful for your help. You are being invited to take part in a research study. Before you decide, it is important that you understand why the study is being done and what it will involve. Please take time to read this information sheet and to decide if you would like to take part in this study. Please let me know if you would like more information about the study.

##### **What is the study about?**

Although it is quite usual nowadays for fathers in this country to attend the delivery of their baby, there is limited published information about the affect that childbirth has on fathers. The aim of this study is to describe what occurs at delivery when the baby's father is present. This study is part of a larger project and it is anticipated that the findings from this part of the study will identify issues to be explored in later parts of the project.

##### **Why have we been asked to take part?**

I am hoping to recruit parents expecting their first baby during October 2006 to March 2007. This leaflet is being distributed to parents whose baby is due during this time to give them time to think about taking part in the study.

##### **Do we have to take part?**

Involvement in this study is entirely voluntary. It is up to you to decide if you want to take part. If you would like to participate, you will be asked to sign a consent form and you will be given a copy to keep. If you decide to take part you can still withdraw from the study at any time without having to give a reason. If you decide not to take part or withdraw from the study, the care that you and your family receive will not be affected in any way.

##### **What will happen if we agree to take part?**

I would like you to let me observe the birth of your baby. As part of this observation I will be making written notes about what happens over the period of time from the start of the delivery until your newborn baby has been examined. If your baby needs some help with his / her breathing immediately after the birth and / or if your baby needs to be admitted to the neonatal unit this may be included in my observations. The notes that I make will help me with later parts of the study. You will not incur any costs or be paid any money to take part in the study. I will be carrying out this study during October 2006 to March 2007 and if I am at the hospital on the day that your baby is born it is possible that I will ask you if you would like to take part in this study.

### **What are the possible risks of taking part?**

There is the risk that by being present at the delivery, that I will get in the way. However, I have carried out observation studies before and as a midwife and neonatal nurse I am aware that I must not do anything that might interfere with the safety of both mother and baby. I will therefore ensure that I am as inconspicuous as possible. Also, because the delivery of a baby can be a highly emotional time for everyone involved you might feel uncomfortable about me being present. I would like to reassure you that I will not be making any judgment about your responses or reactions during the delivery and your personal details will be kept confidential (see below). However, if you wish me to discontinue the observation at any point during the delivery or afterwards, then I will of course do so.

### **What are the possible benefits of taking part?**

It is hoped that information gained will give us a better understanding of the affect that childbirth has on fathers and that this new knowledge will enable us to review and if necessary improve the quality of care provision.

### **What if something goes wrong?**

If you feel at any time that you have cause for complaint arising from this study, please let me know. In addition, the usual National Health Service complaints mechanisms are available to you. For further information refer to PALS, the 'Patient Advice and Liaison Service' Tel: XXXX or XXXX (trust website).

### **Will our involvement in this study be kept confidential?**

Your consent will be necessary before you take part in the study and any personal information such as your names will be kept strictly confidential. All documents from this study will be securely stored; these will not be available to anyone other than my research supervisor, the person transcribing my notes (neither of whom will have access to your name) and myself. Documentation that identifies participants will be destroyed at the end of the study. None of your personal details will be included in any reports or publications arising from this study.

### **What will happen at the end of the study?**

I will be submitting my thesis, a copy of which will be held at Aston University library. The findings of this study will also be published in health care journals and presented at conferences. Your personal details and the name of the hospital where your baby was born will not be included in any of these. If you would like information regarding the findings of this study, please let me know.

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If after reading this you have any questions or need some further information, please contact me:  
[harveyme@aston.ac.uk](mailto:harveyme@aston.ac.uk)                      [merryl.harvey@npeu.ox.ac.uk](mailto:merryl.harvey@npeu.ox.ac.uk)

National Perinatal Epidemiology Unit: 01865 289715. For further information regarding the National Perinatal Epidemiology Unit or Bliss please see: [www.npeu.ox.ac.uk](http://www.npeu.ox.ac.uk)                      [www.bliss.org.uk](http://www.bliss.org.uk)

Whatever you decide thank you for taking the time to read this information leaflet.

Merryl E Harvey - Bliss Neonatal Nurse Research Fellow

COREC-V2, MEH-V6 30-01-06

## **APPENDIX 6**

### **Phase three – Information leaflet**

#### **NHS TRUST HEADED PAPER**

##### **Introduction**

My name is Merryl Harvey; I am a neonatal nurse lecturer and I also have a part-time research nurse post at the National Perinatal Epidemiology Unit in Oxford. This research nurse post is funded by the newborn baby charity Bliss. I am studying for a post-graduate degree at Aston University, which involves me carrying out a research study, and I would be grateful for your help. You are being invited to take part in a research study. Before you decide, it is important that you understand why the study is being done and what it will involve. Please take time to read this information sheet and to decide if you would like to take part in this study. Please let me know if you would like more information about the study.

##### **What is the study about?**

Although it is quite usual nowadays for fathers in this country to attend the delivery of their baby, there is limited published evidence regarding the affect that childbirth has on fathers. This is especially the case when a baby requires resuscitation at birth and is then admitted to a neonatal unit. The aim of this study is to identify the experiences and perceptions of health care professionals supporting fathers around the time of the delivery of a compromised baby.

##### **Why have I been asked to take part?**

I am hoping to recruit approximately 40 health care professionals who have experience of supporting fathers of babies requiring resuscitation at birth and / or admission to a neonatal unit. I understand that you are part of this group. This leaflet is being given to you now to give you time to think about taking part in the study.

##### **Do I have to take part?**

Involvement in this study is entirely voluntary. It is up to you to decide if you want to take part. If you would like to participate, you will be asked to sign a consent form and you will be given a copy to keep. If you decide to take part you can still withdraw from the study at any time without having to give a reason without being discriminated against in any way.

##### **What will happen if I agree to take part?**

I would like to interview you about your experiences supporting fathers of babies requiring resuscitation at birth and / or admission to a neonatal unit. This interview will be tape-recorded and this will enable me to compare what health care professionals have to say. The interview will be as informal as possible; it will take place in a mutually agreeable location and will last approximately 45 minutes. You will not incur any costs or be paid any money to take part in the study. Findings from this part of the study may be used to develop a questionnaire that could be sent to a larger sample of health care professionals.

### **What are the possible risks of taking part?**

It is possible that you might become upset whilst talking about your experiences; therefore you are under no obligation to take part in this study. If you agree to take part in the study and then change your mind, you can withdraw from the study at any time. This includes before, during or after the interview. Once the interview has been completed I can give you a list of places where you can get support, if you feel that you need it.

### **What are the possible benefits of taking part?**

It is hoped that information gained will provide a better understanding of issues relating to the provision of support to fathers around the time of complicated childbirth. It is anticipated that this new knowledge will enable the provision of care and health care professional education and support to be reviewed and if necessary developed.

### **Will my involvement in this study be kept confidential?**

Your consent will be necessary before you take part in the study and any personal information such as your name will be kept strictly confidential. All documents and tapes from this study will be securely stored; these will not be available to anyone other than my research supervisor, the person transcribing the tapes (neither of whom will have access to your name) and myself. The tapes and any documentation that identifies participants will be destroyed at the end of the study. None of your personal details will be included in any reports or publications arising from this study.

### **What if something goes wrong?**

If you feel at any time that you have cause for complaint arising from this study, please let me know. In addition, the usual National Health Service staff complaints mechanisms are available to you.

### **What will happen at the end of the study?**

I will be submitting my thesis, a copy of which will be held at Aston University library. The findings of this study will also be published in health care journals and presented at conferences. Your personal details will not be included in any of these.

### **Who has reviewed this study?**

This study has been reviewed and approved by XX Local Research Ethics Committee and X X Hospital Research and Development department.

### **Contact for further information**

If after reading this you have any questions or need some further information, please contact me: [harveyme@aston.ac.uk](mailto:harveyme@aston.ac.uk) [merryl.harvey@npeu.ox.ac.uk](mailto:merryl.harvey@npeu.ox.ac.uk) NPEU: 01865 289700.

For further information regarding the National Perinatal Epidemiology Unit or Bliss please see: [www.npeu.ox.ac.uk](http://www.npeu.ox.ac.uk) [www.bliss.org.uk](http://www.bliss.org.uk)

Whatever you decide, thank you for taking the time to read this information leaflet.

Merryl E Harvey Bliss Neonatal Nurse Research Fellow

COREC-V1, MEH-V4 13-10-05

## APPENDIX 7

### Phase one – Interview schedule

Opening statement: **I am interested in what happened around the time of your baby's birth. By that I mean the time from when your baby was being born (for example: when your partner started 'pushing' or the delivery commenced) until you went with your baby to the NNU (or your baby was taken from the delivery room to the NNU).**

**Before we start, can I confirm some information about your baby?**

- **Baby: boy / girl**
- **Gestation at birth:**
- **Type of delivery:**
- **Where baby was born:**
- **Reason as far as you know for baby's resuscitation / admission to the neonatal unit:**
- **Age of baby now:**

**Can you tell me about your baby's birth?**

*Follow up any specific information to clarify father's description of events.*

*Did you plan to be at the delivery?*

*Establish information about what he did / where he was in the room.*

**You've told me what happened, is this what you were expecting?**

*Clarify differences between expectations & what actually happened.*

*From whom / in what format was information given prior to delivery?*

*Did friends / colleagues tell you what might happen / what you might see?*

*If you sought information yourself prior to the delivery, why did you do this? & where did you get information from?*

*If you didn't want to know beforehand what might happen – why?*

**Can you describe what you were feeling as your baby was being born?**

*Was this how you thought you might feel?*

*If no – what were you expecting to feel?*

**I want to think now about the time during which your baby was being helped with his / her breathing (being resuscitated). What happened to you during this time?**

*Did you go over to watch what was happening? – why? / why not?*

*Did anyone tell you what was happening? – if so – who? what did they say? did they speak just to you or to your partner as well?*

*Did health care professionals introduce themselves?*

*If no one told you what was happening – why do you think this was? Were they speaking just to your partner?*



*Did you ask questions about what was happening? If so – who? – what did you ask? – did they give you an answer?*

*Did your partner ask you to do / say anything?*

*What were you feeling at this time?*

*Were your concerns for your partner or your baby?*

**I would like to think now about the time during which your baby was being admitted to the neonatal unit. What happened to you during this time?**

*If you didn't accompany the baby to the neonatal unit – why not? – did you want to go with your baby but were stopped from doing so? - if so, who stopped you & why? - how did you feel about this at the time?*

*If you did accompany the baby to the neonatal unit – why did you go with your baby?*

*When you got to the neonatal unit did anyone tell you what was happening to your baby? – if so – who? what did they say? did they speak directly to you?*

*If when you got to neonatal unit no one told you what was happening – why do you think this was?*

*Did you ask questions about what was happening? If so – who? – what did you ask? – did they give you an answer?*

*What were you feeling at this time?*

**Has anybody talked to you since your baby's birth about what happened at the delivery?**

*Who? what were the circumstances of this discussion?*

**Looking back now, what effect do you think being at your baby's birth & seeing what happened immediately afterwards has had on you?**

*Do these feelings surprise you?*

*How have you coped with these feelings?*

*Has anyone helped you re: this? (formally / informally) e.g. own parents / other parents / partner / support groups / health care professionals*

*How do you think these experiences have effected how you feel about your baby? And the way that you view his / her health?*

**Do you have any suggestions about ways that the hospital / hospital staff could help fathers who experience what you have, in the future?**

*Follow-up any specific issues that he might have raised earlier.*

*What advice would you give to a father who might be about to experience what you have done?*

**Is there anything else that you would like to tell me about your baby's birth?**

**Can I end by asking some information about yourself?**

- **Age?**
- **Occupation?**
- **How would you describe your ethnicity?**

Thank-you very much for your help with this part of the study.

## APPENDIX 8

### Phase one – Consent form

#### NHS TRUST HEADED PAPER

#### STUDY CODE:

Researcher: Merryl E Harvey, Bliss Neonatal Research Fellow  
National Perinatal Epidemiology Unit, University of Oxford

Please read and sign each statement in the presence of the researcher.

1. I confirm that I have read and understand the information leaflet:  
COREC-V2, MEH-V5 30-01-06 for the above named study and I have had the  
opportunity to discuss the study with the researcher.  
-----
2. I understand that my involvement in the study is voluntary and that I can withdraw from  
the study at any time, without giving any reason and without being discriminated against  
in any way.  
-----
3. I understand that my participation in the study will involve the researcher interviewing me  
about my baby's birth and admission to the neonatal unit, and that the interview will be  
tape-recorded.  
-----
4. I am aware that any personal details that could identify me will only be accessed by the  
researcher. These details and the tape-recordings will be securely stored during the  
study and they will be destroyed when the study is completed.  
-----
5. Having signed all of the above, I agree to take part in the study.

----- Name of participant	----- Date	----- Signature
----- Name of researcher	----- Date	----- Signature



## APPENDIX 10

### Transcription conventions

CAPITALS	Stress or emphasis in the text
ITALICS	Spoken loudly
(0.5)	Pause in tenths of a second
(( ))	Explanation or additional information
-	Word cut off, self-termination by speaker
( )	Inaudible speech
[ ]	Overlapped speech

Taken from Gibson and Brown (2009: 120–121)

## **APPENDIX 11**

### **Criteria for delivery in the birthcentre**

- No complications have been identified.
- Normal pregnancy.
- Anticipating a normal birth.
- Mother aged 16 to 40 years.
- Body mass index of mother in the normal range (18-35).
- Cephalic presentation.
- Placenta is not low lying.
- No Group B streptococcus infection during this pregnancy.
- Maternal haemoglobin level 9.5 or above and no blood clotting problems.
- Delivery between 37-42 weeks.
- Normal blood pressure throughout pregnancy, no proteinuria.
- Well grown baby and the midwife assesses that the baby is of an appropriate size.
- Labour starts naturally following induction for post-date (with up to two prostin pessaries).
- Labour starts naturally within 24 hours of rupture of membranes (the Birthcentre may be an option if labour starts within 72 hours if antibiotics and continuous fetal heart rate monitoring are declined).
- Normal fetal movements.

Information taken from Hospital Trust Website - 2007

## **APPENDIX 12**

### **Phase two – Observation schedule and categories**

Date:

Study number:

Parents have copy of information leaflet:                      Yes / No

Consent obtained from parents:      Yes / No

Date obtained:

*If no – observation must not proceed*

Time observation commenced:

Time observation concluded:

Type of delivery:

Delivery conducted by:

Total number present at delivery:

Present at delivery:

Initial care of baby led by:

Involved in care of baby:

Sex of baby:    Male / Female

Gestation of baby:

Immediate care of baby:

Baby outcome:              remained with mum & dad

transferred to another hospital

admitted to NNU

other – state:

Date:

Study number:

Time observation commenced:

Time observation concluded:

Parents have copy of information leaflet: Yes / No

*(should have received a copy at 20/40 scan, researcher will provide a second copy if parents have not retained original)*

Consent obtained from parents: Yes / No

Date obtained:

*(can not proceed without consent from both parents)*

Type of delivery: *state*

Delivery conducted by: *which health care professional(s), names not recorded*

Total number present at delivery: *include mother, father & researcher*

Present at delivery:

*(state number of each)*

Mother, Father, researcher

M *midwife*

StM *student midwife*

DrO *obstetric doctor*

DrP *paediatric doctor*

NNP *neonatal nurse practitioner*

NN *neonatal nurse*

A *anaesthetist*

ODA *operating dept assistant*

O *other - state*

Care of baby led by:

M *midwife*

StM *student midwife*

NNP *neonatal nurse practitioner*

NN *neonatal nurse*

DrP *paediatric doctor*

Initial care of baby led by: *identify hcp delegated to lead care for baby*

Involved in care of baby: *list all hcps involved in care of baby*

Sex of baby: Male / Female

Gestation of baby: *weeks & days /40*

Immediate care of baby:

NC *normal care*

R *resuscitation – state maximum intervention*

Baby outcome:

*(tick)*

remained with mum & dad

admitted to NNU

transferred to another hospital

other – state:

The father, mother and baby will be the focus of the observation. Recordings will be made at two-minute intervals in relation to the father & mother and three key behaviours:

- PC - Physical contact
- C – Communication (verbal & non-verbal)
- A – Activities

Recordings will also be made at two-minute intervals in relation to ‘what’s happening to the baby’ before and after birth. Interactions between the father, mother and baby involving ‘others’ (usually health care professionals) will be documented in the relevant column (see schedule). At the start of each set of recordings the father’s activities will always be scored first. Therefore any activity involving both the father and /or the mother or baby will be recorded in the ‘father’ column. For each recording the relevant code & brief details (one or two words) will be documented, including information re: non-verbal communication (eye contact, avoidance of eye contact etc). In the ‘Misc’ column additional relevant activities / issues will be recorded (for example: people entering / leaving the room etc.)

### FATHER

#### PC – PHYSICAL CONTACT

PCB physical contact with baby – *state nature of*  
 PCM physical contact with mother – *state nature of*  
 PCO physical contact with ‘other’ – *state nature of & with whom*  
 N none – *state distance from nearest person*

#### C – COMMUNICATION

SPO spoken to – *state by whom*  
 SPE speaking to – *state who to*  
 Q quiet (silent)  
 L laughing  
 C crying

#### A - ACTIVITY

SG sitting down  
 SD standing up  
 W watching – *state what*

### MOTHER

#### PC – PHYSICAL CONTACT

PCB physical contact with baby – *state nature of*  
 PCO physical contact with ‘other’ – *state nature of & with whom*  
 N none – *state distance from nearest person*

#### C – COMMUNICATION

SPO spoken to – *state by whom*  
 SPE speaking to – *state who to*  
 Q quiet (silent)  
 L laughing  
 C crying

#### A - ACTIVITY

L laughing  
 C crying  
 W watching – *state what*  
 P pushing  
 Pa panting  
 BF breast-feeding

### BABY

#### BEFORE BIRTH

PPNV presenting part not visible  
 PPV presenting part visible  
 DH delivery of head  
 DS delivery of shoulders  
 DB delivery of body

#### AFTER BIRTH

PCO physical contact with ‘other’ – *state nature of & with whom*  
 NPC no physical contact – *state distance from nearest person*  
 C crying  
 Q quiet (silent)



<i>FATHER</i>		<i>MOTHER</i>		<i>BABY</i>	<i>MISC</i>
PC		PC			
C		C			
A		A			
PC		PC			
C		C			
A		A			
PC		PC			
C		C			
A		A			
PC		PC			
C		C			
A		A			
PC		PC			
C		C			
A		A			
PC		PC			
C		C			
A		A			
PC		PC			
C		C			
A		A			

## APPENDIX 13

### Phase two – Participant recruitment process

Parents must have had access to information regarding the study before being approached for their consent when the mother was admitted to delivery suite in labour / for delivery. Information leaflets were distributed to parents at the routine 20/40 antenatal ultrasound scan appointment. The observations were therefore timed to correspond with the distribution of this information, see below:



Distribution of information at 20/40 scan \*  
Collection of observation data

figure in red

Information leaflets were distributed during the first 4-week period to mothers attending their 20-week ultrasound scan. These mothers reached term during period 5, 6 and 7 when the observations were undertaken.

Information leaflets continued to be distributed until period 5 to capture mothers who delivered until period 10.

## APPENDIX 14

Phase two – Fathers’ consent form

STUDY CODE:

### NHS TRUST HEADED PAPER

Fathers attending the birth and immediate care of their baby - Consent form - fathers

Researcher: Merryl E Harvey, Bliss Neonatal Research Fellow  
National Perinatal Epidemiology Unit, University of Oxford

Please read and sign each statement in the presence of the researcher.

1. I confirm that I have read and understand the observation information leaflet COREC-V2, MEH-V6 30-01-06 for the above named study and I have had the opportunity to discuss the study with the researcher.  
-----
2. I understand that my involvement in the study is voluntary and that I can withdraw from the study at any time, without giving any reason and without being discriminated against in any way.  
-----
3. I understand that my participation in the study will involve the researcher observing the delivery of my baby and that she will be making notes during the birth.  
-----
4. I am aware that any personal details that could identify me will only be accessed by the researcher. These details will be securely stored during the study and will be destroyed when the study is completed.  
-----
5. I understand that whilst I have given my consent to participate, the delivery of my baby might not be observed.  
-----
6. Having signed all of the above, I agree to take part in the study.

----- Name of participant	----- Date	----- Signature
----- Name of researcher	----- Date	----- Signature

COREC-V2, MEH-V5 30-01-06

# APPENDIX 15

Phase two – Mothers’ consent form

STUDY CODE:

## NHS TRUST HEADED PAPER

Fathers attending the birth and immediate care of their baby - Consent form - mothers

Researcher: Merryl E Harvey, Bliss Neonatal Research Fellow  
National Perinatal Epidemiology Unit, University of Oxford

Please read and sign each statement in the presence of the researcher.

1. I confirm that I have read and understand the observation information leaflet COREC-V2, MEH-V6 30-01-06 for the above named study and I have had the opportunity to discuss the study with the researcher.

-----

2. I understand that my involvement in the study is voluntary and that I can withdraw from the study at any time, without giving any reason and without being discriminated against in any way.

-----

3. I understand that my participation in the study will involve the researcher observing the delivery of my baby and that she will be making notes during the birth.

-----

4. I am aware that any personal details that could identify me will only be accessed by the researcher. These details will be securely stored during the study and will be destroyed when the study is completed.

-----

5. I understand that whilst I have given my consent to participate, the delivery of my baby might not be observed.

-----

6. Having signed all of the above, I agree to take part in the study.

-----  
Name of participant                      Date                      Signature

-----  
Name of researcher                      Date                      Signature

COREC-V2, MEH-V5 30-01-06

## APPENDIX 16

### Excerpts F117 observation schedule 22.40 – 22.50

<i>FATHER</i>		<i>MOTHER</i>		<i>BABY</i>	<i>MISC</i>
PC	PCM – wiping forehead	PC	←	PPNV	F117 encouraging M117. MM117 chair. F117 Rt side bed. MW43 M117's Lt NPC.
C	SPE M117	C	Q, SPO F117		
A	SD	A	SG on bed		
PC	PCM – Lt hand on Rt arm	PC	←	PPNV	F117 – well done, you're brilliant. D42 & MW36 in, speak MW43 – no info. D42 & MW36 out. MW43 out & in – no info.
C	SPE M117	C	Q, SPO F117		
A	SD	A	SG on bed Co - P		
PC	PCM – Lt hand on Rt arm	PC	←	PPNV	Baby cry other room – that'll be ours soon. MW43 out & in – no info
C	SPE M117	C	Q, SPO F117		
A	SD	A	SG on bed		
PC	PCM – wiping forehead	PC	←	PPNV	MW43 out & in – no info. M117- I can't do it. F117 - you can. MM117 stands up, sits down
C	SPE M117 SPO M117	C	SPE F117 SPO F117		
A	SD	A	SG on bed Co - P		
PC	PCM – wiping forehead	PC	←	PPNV	MW43 – you can do it, keep going – preparing packs. MW43 M117's Lt NPC. F117 – you can do it
C	SPE M117	C	Q, SPO MW43 & F117		
A	SD	A	SG on bed Co - P		
PC	PCM – Lt hand behind neck	PC	←	PPNV	MW43 – Head's coming down – writing notes. MW43 M117's Lt NPC. F117 encouraging.
C	SPE M117	C	Q, SPO F117 & MW43		
A	SD	A	SG on bed		

Excerpts F117 observation schedule 23.26 – 23.36

<i>FATHER</i>		<i>MOTHER</i>		<i>BABY</i>	<i>MISC</i>
PC	PCM – Lt hand, Rt arm	PC	←	PPV	D42 in. D42 – very good, excellent. We may need to help you out (no info). MW43 & MA12 prepare stirrups – no info.
C	Q	C	SPO D42		
A	SD	A	SG on bed Co - P		
PC	N < 30 cm M117	PC	←	PPV	D43 in, speaks D42 (no info) both out. F117 encouraging – speaking softly, inaudible.
C	SPE M117	C	SPO F117		
A	SD	A	SG on bed Co - P		
PC	N < 30 cm M117	PC	←	DH, DS, DB Q	MW43 – The head's out. MW43 rubs B117. MW43 to MA12 - press buzzer. Cuts cord, to resuscitaire.
C	Q	C	Q		
A	SD	A	SG on bed Co - P		
PC	PCM – wiping forehead	PC	←	Q – few gasps On resuscitaire MW43 face mask O <sub>2</sub>	MW36 in – what want me to do? MW43 - needs O <sub>2</sub> MM117 watching. F117 comments inaudible - smiling. MW36 - crash call paed not breathing. MA12 out.
C	SPE M117	C	C, SPO F117		
A	SD	A	SG on bed		
PC	N < 30 cm M117	PC	←	Q On resuscitaire MW36 bag & mask	M25, MA12, D40 & D41 in. MW25 met last night. M117 - what's happening? MW43 - need baby Dr
C	Q	C	SPO MW25, MW43 SPE MW43		
A	SD	A	SG on bed		
PC	N < 30 cm M117	PC	←	Q On resuscitaire grunting breathing in air	D40 & D41 to resuscitaire. MW25 takes cord gas. MW43 delivers placenta. MM117 to resuscitaire & back.
C	Q	C	Q, SPO MW25		
A	SD	A	SG on bed		

# APPENDIX 17

Phase three – Consent form

STUDY CODE:

## NHS TRUST HEADED PAPER

### Fathers attending the birth and immediate care of their baby – phase three

Researcher: Merryl E Harvey, Bliss Neonatal Research Fellow  
National Perinatal Epidemiology Unit, University of Oxford

Please read and sign each statement in the presence of the researcher.

1. I confirm that I have read and understand the information leaflet (COREC-V1, MEH-V4 13-10-05) for the above named study and I have had the opportunity to discuss the study with the researcher.

-----

2. I understand that my involvement in the study is voluntary and that I can withdraw from the study at any time, without giving any reason and without being discriminated against in any way.

-----

3. I understand that my participation in the study will involve the researcher interviewing me about my experiences supporting fathers of babies requiring resuscitation at birth and / or admission to a neonatal unit, and that the interview will be tape-recorded.

-----

4. I am aware that any personal details that could identify me will only be accessed by the researcher. These details and the tape recordings will be securely stored during the study and they will be destroyed when the study is completed.

-----

5. Having signed all of the above, I agree to take part in the study.

----- Name of participant	----- Date	----- Signature
----- Name of researcher	----- Date	----- Signature

COREC-V1 / MEH-V3 13-10-05

## APPENDIX 18

### Phase three – Interview schedule

Opening statement: **This interview forms part of a larger study that aims to gain an understanding of the experiences and perceptions of fathers who attend the birth of their baby, especially when the baby has required resuscitation at birth and / or admission to a neonatal unit.**

**Within this interview I am particularly interested in your experience of situations when a sick / preterm baby is delivered, requires resuscitation at birth and / or admission to a neonatal unit, and the baby's father is present. Before consideration of key issues, can I clarify the following?**

**Job title / Qualifications / Length of time qualified / Length of time this post**

### KEY ISSUES TO EXPLORE

There are a variety of situations that you might have experienced:

- **The antenatal preparation of fathers (i.e. before labour has started) particularly if the birth of a sick / preterm baby is anticipated.**
- **Being at the delivery of a sick / preterm baby when the baby's father is also present.**
- **Being at the resuscitation of a newborn baby when the baby's father is also present.**
- **Being present when a baby is admitted to the neonatal unit when the baby's father is also present.**

**Which of the above do you have experience of?**

**When was the last time that you encountered each situation?**

*(check each individual situation)*

**So, for the purpose of this interview we'll be talking about you .....**

- *Being involved in the antenatal preparation of fathers (i.e. before labour has started) particularly if the birth of a sick / preterm baby is anticipated.*
- *Being at the delivery of a sick / preterm baby when the baby's father is also present.*
- *Being at the resuscitation of a newborn baby when the baby's father is also present.*
- *Being present when a baby is admitted to the neonatal unit when the baby's father is also present.*

**Can you recall an occasion you were involved with relating to .....**

*Follow up any specific information to clarify description of events.*

*Clarify participant's role in the situation – what did you do / say?*

*Why does this case particularly spring to mind?*

**Is there anything that you'd like to add, particularly regarding what happened to the father?**

*Follow up any specific information to clarify description of events.*

*Clarify participant's role in the situation – what did you do / say?*

*Do you know if the father wanted to be there?*



**Thinking back to that occasion, do you think that the situation went well or not as well as it could have done?**

*Why do you think this was the case?*

**What about the father in this case? – looking at it from his perspective – did it go well or not as well as it could have done?**

*Why do you think this was the case?*

**Can you recall a contrasting situation you were involved with, by that I mean one that didn't / did go well?– can you tell me about that?**

*Follow up any specific information to clarify description of events.*

*Clarify details / participant's role in the situation – what did you do / say?*

**What do you think were the key issues that made this situation different to the previous case?**

*Why does this case particularly spring to mind?*

**Is there anything that you'd like to add, particularly regarding what happened to the father?**

*Follow up any specific information to clarify description of events.*

*Clarify participant's role in the situation – what did you do / say?*

*From his perspective do you think that he'd say it went well or not as well as it could have done?*

*Clarify participant's role in the situation – what did you do / say?*

**What do you suppose fathers feel that they need in terms of information / support antenatally / prior to the delivery / resuscitation / admission of their baby?**

*On what basis do you say this?*

*In your experience, do you think this happens in reality?*

*Why does / doesn't this happen?*

*What do you think are the issues that a health care professional should consider when supporting a father at this time?*

*Do you think that different fathers have different needs? – if so – how do you determine individual needs?*

*Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?*

**What do you suppose fathers feel that they need in terms of information / support during the delivery / resuscitation / admission of their baby?**

*On what basis do you say this?*

*In your experience, do you think this happens in reality?*

*Why does / doesn't this happen?*

*What do you think are the issues that a health care professional should consider when supporting a father at this time?*

*Do you think that different fathers have different needs? – if so – how do you determine individual needs?*

*How do you determine if the father wants to be there?*

*Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?*

**What do you suppose fathers feel that they need in terms of information / support after the delivery / resuscitation / admission of their baby?**

*On what basis do you say this?*

*What impact do you think being present at..... has on fathers?*

*In your experience, do you think this happens in reality?*

*Why does / doesn't this happen?*

*What do you think are the issues that a health care professional should consider when supporting a father at this time?*

*Do you think that different fathers have different needs? – if so – how do you determine individual needs? Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?*

**Can you tell me about the nature / extent of any educational preparation you've received regarding the provision of support specifically for fathers during delivery / resuscitation / admission to the neonatal unit?**

*Clarify details.*

*Have you participated in 'mock' incidents? For example: labour ward drill?).*

*Was it father / mother / parent focused?*

*Has this been adequate?*

*If no how do you now know what to do / say in these situations? What additional educational preparation do you feel you need?*

*Apart from more formal educational preparation, how else have you learned what to do / say in these situations?*

**We've talked quite a lot about the health care professional role when supporting fathers – I'd like now to ask you to think about the impact that carrying out this role has on you – can you tell me about that?**

*Positive / negative impact – particularly re: helping / supporting fathers.*

*Short & long-term effects.*

*Is this always the case or just sometimes?*

*If sometimes – what key factors trigger this effect on you?*

*Re: negative effects – how do you deal / cope with this?*

*In these situations is there anything that fathers could do to help you?*

**Do you have any suggestions about ways that hospitals / health care professionals could help fathers who experience the situations we've discussed?**

*Follow-up any specific issues that might have been raised earlier.*

*Does the hospital have policies / procedures / guidelines re: supporting / care of fathers? – if yes – clarify details – if not – why not? – do you think that there should be policies / procedures / guidelines in place?*

*What advice would you give to another health care professional who might be about to support a father in one of these situations for the first time?*

**Are there any other issues that you would like to raise in relation to these issues?**

**Can I end by asking some more information about yourself?**

**Age / How would you describe your ethnicity /**

**Thank-you very much for your help with this part of the study.**

## APPENDIX 19

### Phase three – End of interview debriefing sheet

#### NHS TRUST HEADED PAPER

#### Fathers attending the birth & immediate care of their baby

Thank you for taking part in this study. This information leaflet is being given to all health care professionals who have taken part in the study.

I realise that some of the issues we have discussed today might have been difficult for you to talk about and I appreciate your participation and your honesty.

I am certain that the information that I have gained from this interview will add to our understanding of issues relating to the provision of support to fathers around the time of childbirth.

Please be reassured that your personal details will be kept strictly confidential. All documents and tapes relating to this study will be securely stored and they will be available only to myself, my research supervisor and the person transcribing the tapes (who will not have access to your name). The tapes and any documentation that identifies you will be destroyed at the end of the study. None of your personal details will be included in any reports arising from this study.

Listed below are some sources of support that may be relevant to you:

Your supervisor of midwives / clinical supervisor

Your professional organisation, for example: [www.nmc-uk.org](http://www.nmc-uk.org)  
[www.gmc-uk.org](http://www.gmc-uk.org)

Your professional association, for example: [www.rcm.org.uk](http://www.rcm.org.uk)  
[www.rcn.org.uk](http://www.rcn.org.uk)  
[www.bma.org.uk](http://www.bma.org.uk)

Staff Support Officer – X X Hospital – Tel: XXXX

Thank you once again, Meryll E Harvey, Bliss Neonatal Research Fellow

COREC-V2, MEH-V5 30-01-06