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Published in:
Sexual & Reproductive HealthCare

DOI:
10.1016/j.srhc.2017.11.006

Publication date:
2018

Document version
Accepted manuscript

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Citation for published version (APA):

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PII: S1877-5756(17)30112-X
DOI: https://doi.org/10.1016/j.srhc.2017.11.006
Reference: SRHC 335

To appear in: Sexual & Reproductive Healthcare

Received Date: 7 April 2017
Revised Date: 13 November 2017
Accepted Date: 20 November 2017

Please cite this article as: M.M. Feenstra, I. Nilsson, D.B. Danbjørg, “Dad – a practical guy in the shadow”: fathers’ experiences of their paternal role as a father during early discharge after birth and readmission of their newborns, Sexual & Reproductive Healthcare (2017), doi: https://doi.org/10.1016/j.srhc.2017.11.006

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Title

“Dad – a practical guy in the shadow”: fathers’ experiences of their paternal role as a father during early discharge after birth and readmission of their newborns

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Acknowledgments: We would like to thank the fathers who shared their experiences with us.

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Author contribution: All authors have contributed to this article and all three authors have approved the final article. All three authors were involved in the study conception. MMF arranged the data collection and the inclusion of participants. DBD conducted the interviews. MMF and DBD conducted the initial data analysis, where IN discussed the results and contributed to the discussions. IN made the first drafting of the background section. MMF made the first drafting of the results and discussion. DBD made the first drafting of method section. IN and DBD have been doing critical revisions of the manuscript.

Funding: No funding.

COI: We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no financial support for this work that could have influenced its outcome. We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

Ethical approval: The participants were informed both verbally and in writing about the study, and were included after providing their informed consent in compliance with the Helsinki Declaration.

The study was approved by The Danish Data Protection Agency (2008-58-0035), but due to national legislation in Denmark it was not submitted to the Scientific Ethics Committee.
“Dad – a practical guy in the shadow”: fathers’ experiences of their paternal role as a father during early discharge after birth and readmission of their newborns

Abstract

Objectives: The aim is to explore how new fathers experience early discharge after birth and readmission of their newborn in relation to their role and involvement as a father. Fathers of today are active participants during pregnancy, birth and in the care of the newborn. Still studies demonstrate that health care professionals are unsuccessful at involving fathers in ante- and postnatal care. How fathers experience their paternal role in the early postnatal period may affect the well-being of the new family.

Study design: A qualitative study inspired by the hermeneutic approach. Data was collected through telephone interviews. The study was conducted in the Region of Southern Denmark in a University Hospital setting. Convenience sampling was applied. Eight fathers were included from November 2015 till February 2016 and six were interviewed.

Results: The data analysis revealed three categories: Early discharge – ups and downs, Readmission – waiting but being in good hands, and Practical guy in the shadow.

Conclusions: Our study points at fathers being comfortable with being discharged early, but experienced insecurity when at home. The fathers experienced to be categorized by health care professionals as the practical guy, who had to assist the mother. Yet fathers saw themselves as equal to the mothers. Fathers also saw themselves in the shadow of the mother and showed greater considerations for the mother’s feelings than their own. Fathers can be insecure in their paternal role when being met as just the practical guy.

Keywords: Early discharge, fathers, paternal role, postnatal, readmission.

Introduction

The paternal role of fathers has changed over time. From the 1960s and early 1970s fathers waited outside the delivery ward, while mothers’ gave birth. Today fathers wish to be active participants during pregnancy, delivery, and early parenthood (1). The implementation of early discharge following birth has been argued to emphasize the involvement of the father and a more family-centered approach (2). The advantages of early postnatal discharge are the opportunity for the family to be together, the possibility for bonding and increase in parental confidence in taking care of the newborn in their own home (2, 3). Still the debate about early postnatal discharge has been ongoing. Sceptics point out potential negative consequences,
such as delays in detecting and treating maternal and newborn morbidity, breastfeeding problems leading to early weaning, decreased maternal confidence, higher prevalence of maternal depression and increase in readmissions of mother and newborn (2, 4). In Denmark, readmissions of newborns due to nutritional problems have increased remarkable during the last 10 years where length of hospital stay has decreased (5).

Several studies regarding parental experiences of early postnatal discharge have been performed. Many studies focus on mothers’ perspectives, leaving fathers’ experiences less explored. Persson et al (6) reveals that fathers’ experiences during childbirth and the postnatal period can affect their wellbeing (7, 8), their relationship with their partner (8, 9) and attachment to their newborn (8). Readmission of the newborn might be a negative experience during the early postnatal period which may impact the new family. However, parent’s experiences of being readmitted with their newborn after early postnatal discharge seem unexplored in the literature.

Becoming a father involves as much as for the mothers (10) and requires adjustment and reconstruction of behaviors for the new role (11). A meta-synthesis points at close relations between parents’ experiences of postnatal care and support and becoming a parent (Blinded for review). This stresses the importance of supporting new fathers in their transition to fatherhood. According to Plantin et al, fathers’ involvement during pregnancy, birth and postnatal is essential for the family's physical and psychical wellbeing (12). Persson et al found that the fathers’ sense of early postnatal security may be enhanced by giving the fathers a real chance to participate in the process and by allowing them to stay overnight at the hospital after the birth. By treating and listening to fathers’ as individuals the fathering role might be strengthened (6). Fathers’ involvement during breastfeeding problems also prolongs mothers’ breastfeeding duration (13). Despite a focus on the family-centered approach, studies still demonstrate that health care professionals are unsuccessful at involving fathers in ante- and postnatal care (14-16). To provide optimal care and support to new fathers, it is therefore needed to investigate fathers’ experiences of being discharged early after birth and readmitted with their newborn.

Aim

The aim is to explore how new fathers experience early discharge after birth and readmission of their newborn in relation to their role and involvement as a father.

Methods
The study is a qualitative study and inspired from hermeneutics philosophy (17). The perspective has been to understand the fathers’ experiences in relation to their role as a father, and how they have been involved during admission and readmission. The interpretative approach focuses on understanding the new fathers’ experiences of early discharge after birth and readmission and relates the results to relevant research and theories. The study also includes maternal experiences of early discharge after birth and readmission. These results are reported elsewhere.

Context

The study was conducted in the Region of Southern Denmark in a University Hospital setting. The general offer after the new policy (18) is that mothers, who have had an uncomplicated pregnancy and delivery, are discharged within 24 hours after delivery. The postnatal care takes place in the parents’ home. In order to support new parents after discharge, outpatient clinics are available for check-ups, telephone and online consultations are accessible around the clock as well as homevisits for first-time parents are available if needed. The check-ups are performed by nurses, health visitors and midwives, working closely together to ensure the well-being of the families. The health visitor from the municipality contacts the family within the first week at home.

Sample

Convenience sampling was applied (19), i.e. participants were randomly selected when nurses and midwives had time during their working day. Inclusion criteria adhere to the postnatal policy, i.e. mothers who have had an uncomplicated pregnancy and birth, and who were discharged within 24 hours after delivery. Families, who themselves chose to be discharged within 24 hours though they were offered admission after birth, were also included. Cause of admission could be a major rupture after giving birth, caesarean section or need of breastfeeding guidance. Only physically and mentally healthy parents of term (e.g. newborn born in the period between 37 and 42 weeks of gestation) and healthy newborns were included. Readmission should be due to the following diagnosis: dehydration, hypernatremia, failure to thrive or malnutrition and eating problems (5) and should consist of minimum one overnight stay at the hospital. The exclusion criteria were fathers who did not speak Danish, English, Swedish or Norwegian. Fathers were invited to participate in the study during their readmission, where they were given verbal and written information about the purpose of the study and that participating in the study would mean that they accepted being interviewed about their experiences with early discharge and readmission in relation to their role as a father.
The possible participants were given time to consider their participation, why the informed consent was gathered when ready; e.g. either before or after discharge. Time of interview was agreed with the fathers. Eight participants were included from November 2015 till February 2016 and six were interviewed. One family didn’t respond to our enquiry, and one father chose not to participate.

Data Collection

We chose to conduct telephone interviews (20), as it suited the participants’ life situation. We took into account that the families had just been in a stressful and vulnerable situation due to the readmission of their newborn. The interviewer used open questions in order to let the participants talk spontaneously, and allow for the option of asking additional questions.

The interview guide concentrated on the following main themes: (a) Fathers’ experiences of early discharge; (b) Fathers’ experiences of readmission; (c) Fathers’ experience of their role and involvement in the care of the newborn.

The interviews were conducted two to five weeks after the newborn’s birthday. None of the fathers had trouble recalling the incidents, experiences or emotions from the time of birth to their readmission.

The last author conducted all interviews. The interviews lasted between 7 and 24 minutes, on average 17 minutes, and were audio-recorded and transcribed.

Data analysis

The data analysis was inspired by Malterud’s systematic text condensation (STC) (21) and organized according to the steps taken in the analysis, as shown in Table 1. Firstly, we captured a general impression of the data and extracted preliminary themes. The themes represented a first data-based step in the organisation of the material. It was also the foundation for the further analysis, as the first themes were the foundation for the codes that we used later in the analysis.

Secondly, the data were allocated into meaningful units, which were related to the study question. The transcripts were systematically read line by line to identify meaningful units. A meaningful unit is a text section that represents information about the research question. Thirdly, the meaningful units were condensed and coded. The codes were developed based on the preliminary themes identified in the first step. The coding classified the meaningful units and finally, the findings were synthesized, including a shift from condensation to descriptions and categories.
In order to enhance validation, the first and last authors worked together on the analysis. The analysis was done with the transcripts printed. The meaningful units were highlighted with a marker and the codes were discussed between the two authors. They discussed the analysis with the second author afterwards.

Our findings were discussed in relation to relevant literature (14-16) and the theoretical concept Postnatal sense of security (6).

Ethical considerations

The participants were informed both orally and in writing about the study, and were included after providing their informed consent in compliance with the Helsinki Declaration. The study was not submitted to the Scientific Ethics Committee according to national legislation in Denmark. The Danish Data Protection Agency registered the study (2008-58-0035). Throughout the research process, the generation, handling and publication of data were consistent with the guidelines of Danish research ethics committees and the Danish Act on Processing of Personal Data.

Results

Fathers’ ages ranged from 24 to 45 years. They all cohabited with the mother of their newborn and were all employed. Three of them were first-time fathers (Table 2).

Based on the data analysis the following categories appeared: Early discharge – ups and downs, Readmission – waiting but being in good hands and Practical guy in the shadow. The first category consisted of two sub-categories: Stressful hospital environment and Nice to be home, but unprepared.

Early discharge - ups and downs

Stressful hospital environment

Some fathers reported that they had decided before the birth that they wanted to be discharged early postnatal. This was due to earlier experiences with sick newborns, and the reason why they did not want to stay at the hospital after delivery unless it was absolutely necessary.

“We wanted to be discharged early. Because we previously had been admitted with our first child. So this time it would be nice if we would not be admitted after birth. That was what we wanted” (father).

The majority of fathers experienced the time up to early postnatal discharge as stressful and hectic. Busy midwives, a lot of information and waiting time, characterized the time at the hospital. Midwives left the labor room several times to return some time later, to provide more information.
“We sat there and waited, and then she (e.g. midwife) came back, and then he (e.g. baby) should be breastfed [---] Then she left us again, and we were thinking: “Should he not be weighed and measured?” Two hours passed before that happened [---] Then she just said that this and this will happen, and then you have to come in and have a test in a couple of days [---] She returned 15 minutes later and said that we could go home today, but that we just had to finish this. Then an hour more passed, and we said to ourselves, that we did not want to sit here and wait anymore. We did not get any new information, so then we just went home” (first-time father).

Most families were discharged directly from the maternity ward within 4-6 hours after delivery, while others were hospitalized up till 24 hours at the postnatal ward. One family was hospitalized for a short time at the postnatal ward after the birth. They were not met in their need of quiet and private surroundings.

“We should share a room with another couple at the ward. We were given a very small bed, and it was a very sterile environment. Like we were sick. As we were admitted with a disease, and not because we had become parents. It was a strange feeling, actually unpleasant” (first-time father).

The physical surroundings did not correspond well with the fathers’ view upon their newly started parenthood, because everything was sterile, and they slept in a hospital bed. On top of that they experienced that the nurses were busy and did not have time to give information. It left the fathers with unanswered questions about breastfeeding etc.

Nice to be home, but unprepared

Yet the fathers felt good about being discharged early. They wanted to nest at home, and start their family life in quiet and familiar surroundings. The majority of the fathers felt confident when going home early postnatal.

“It was nice to come home, because it is always more comfortable and relaxing to be home. It was as we hoped for; more peaceful and quiet” (father).

One father mentioned that they made preparations before giving birth in regard to coming home, changing the linen and had expected the first time at home to be cosy. Others reported that their relatives came by to visit and everything appeared fine.

As time passed some fathers were not expecting anything to go wrong, before going to the outpatient clinic for the planned follow up visit. Others felt nervous and were concerned about their newborn’s health, as their newborn got more and more unsettled or slept more and more.
“Is there something wrong with her? Is there something wrong with the mother’s milk?” (first-time father).

One family received a home visit by a midwife checking up on the ‘basic needs’ of the family. Reflecting on the period at home, fathers needed more information and had a lot of unanswered questions. One father felt unprepared and insecure in regard to mothers’ recreation after birth and what to expect, as she was in pain.

“I was worried and sad. I said that she needed help and had to see a professional about the situation. But we did not really know how, so we called the outpatient clinic” (first-time father).

Some fathers stated that they would have preferred more information about what to expect during the time after the birth. Others wanted more time to settle as a family after the birth. To get adjusted to breastfeeding, allowing the new family to have a tranquil beginning.

“If we have had some more information during the time at the maternity ward. If the time was better utilized with guidance” (first-time father).

The situation at home challenged parenthood, family life and breastfeeding as mothers and fathers were stressed. Lack of sleep, inexperience and insecurity left fathers’ ill prepared for the time at home and in need of help. Some felt powerless.

“She was very sad and worried about having permanent injuries from given birth. She was also angry with me, because I did not understand her well enough. So there were many emotions, and it also reflected upon breastfeeding, the insecurity and everything [---]” (first-time father).

**Readmission – waiting but being in good hands**

Going back to the hospital fathers again experienced a lot of waiting time before actually being readmitted. Firstly they had to speak to a nurse, and then they had to go to another department to wait for a pediatrician to see their newborn. Finally a plan for the newborn was made. But fathers felt that they were in good hands all the time.

“As soon as we were admitted and were given our room, we received the help we needed. It was safe. You got this feeling that it was a routine job, in a good way, clearly making us feel that we got the help we needed. They knew what they were doing” (father).
The fathers were also very satisfied with the physical surroundings. It was at a ‘patient hotel’ at the hospital. They enjoyed having their own room with private bathroom and a television. This influenced their experience of the readmission as a whole.

“It was practically a hotel room with our own bathroom and television. It was so nice” (first-time father).

Sometimes the treatment methods such as frequent weighing of the newborn, did not always make sense to the fathers and also created a stressful atmosphere during the readmission. The many weighings and observations seemed somehow controlling. The fathers did not always find it necessary and were comfortable relying on their intuition and by observing their newborn. Others turned to relatives for reassurance and advice.

“Everytime we have had a control weighing or called the outpatient clinic, they have said some of the same things I had already said to xx (e.g. the mother) we should try. So I think we can manage on our own. But xx would like some numbers, that he has gained so and so much weight. Whereas I just look at him and think, that he has gained weight and everything is going fine. He is active, quick, looking around and wants to breastfeed, so I just expect that he has gained weight” (first-time father).

Practical guy in the shadow

Fathers viewed themselves as equal partners and they felt a shared responsibility in taking care of the newborn. They were eager to participate, to assist the mothers while breastfeeding or help with bottle feeding and had skin-to-skin contact with the newborn.

“She (e.g. the newborn) is lying on my chest, as we were recommended. It is really nice and I can feel that she likes it. And I do too. And so does my wife, because then she can also get some rest” (first-time father).

Nevertheless fathers often felt treated as “a practical guy” by nurses and midwives. The fathers spoke of their role during birth and readmission as the health care professionals’ “assistant” or “helper”.

“It is natural, that focus is on the mother and the newborn. And in relation to the nurse I am a helping assistant (father)”

When reflecting on the readmission fathers again saw themselves having a practical role. The nurses and midwives placed them in this role.

“I got the role as an assistant. If there were things that needed be lifted, or when he (e.g. the newborn) had to be breastfed I could focus on placing and latching him on” (first-time father).
The majority of the fathers felt that they were on the side line, when being at the hospital.

“There was no one that turned to me directly as such. But I was a part of the family, and got the same information as xx (e.g. the mother). But I can as such not see how much more I can be drawn into this. It was my understanding that we talked about the things, and I do the things that xx cannot. It’s teamwork! But as such I probably was not there in their eyes” (father).

The fathers’ meeting with the nurses and midwives were mixed. Some felt that they were met “eye to eye” in their need of information, involvement and equality as fathers. Others felt that they were denied responsibility and participation, when not being allowed to go get the breast pump and bring the breastmilk to the department’s refrigerator during the readmission.

Some fathers were unsatisfied and unpleased with the role they were given during the readmission. They felt neglected, not spoken to and overheard as fathers. Some even felt their responsibility as a father was taken away from them, when they were at the hospital. In some situations fathers accepted that their role couldn’t be any different.

“I do not think they as such looked at me. Focus was on the mother and the newborn. And that is all right. At that point I was more on the sideline” (father).

Even though they were given a more practical role during delivery and readmission, the fathers were strongly engaged in taking part in caring for their newborn and viewed parenthood as teamwork and a common matter. One father reflected on his own childhood, wishing to play a part of his child’s life unlike his own father.

“My own father did not participate very much and was very occupied with working. He was a sole provider with three children, so he had his reasons […]. So I try to participate in as much as possible from they are newborns, because I want a good relationship with them” (father).

The fathers also told that they somewhat neglected their own feelings because they had a strong focus on the mothers’ needs and feelings, and reported how affected they were, when their wife was in pain or feeling sad. It made them feel upset and felt helpless. They explained that they did not worry as much as the mother, but even though they did not share the worries, they tried to be supportive.

“I think she overreacted sometimes. She was way too nervous and she was crying. At some point they both were crying (e.g. mother and newborn). That I think was hard. But I tried to keep calm and stay in control, so that I did not say anything stupid” (first-time father).
Some fathers described that they were more likely to try new things and different strategies to solve the problems; they described mothers preferred to contact the outpatient clinic.

“I think my experience is very different from xx’s (e.g. the mother’s), because I was very much to making it work, was active and supported xx with what I could contribute with” (first-time father).

Fathers, who beforehand were concerned about the mother and newborn’s health, felt relieved, when they were readmitted. Fathers felt good when seeing their partner feeling better and being reassured about the situation.

“It was fantastic to see what a relief it was for my wife. It was fine for me, but the best thing was that she felt relieved” (first-time father).

Discussion

We found that fathers experienced that they were the practical guy in the shadow in the early postnatal period, and it was compounded by the readmission. The health care professionals treated them as an assistant and someone who could help with the practical things. This left the fathers in the shadow of the mothers. Fathers also revealed that they tried to be supportive of the mother and they worried for the mother’s feelings. They experienced a hectic and uninviting environment at the hospital, which made the time before early discharge stressful. When they were at home for the first days they experienced ups and downs in the early postnatal period, where they did not feel prepared for the challenges. When readmitted they experienced too much waiting time, but felt secure as they were in good hands with a competent staff, yet being reduced to a practical guy.

Practical guy in the shadow

We found that fathers’ experienced their role as fathers’ as “practical guys”, where they were treated as assistants by nurses and midwives during early discharge and readmission. Several studies support this finding, where headlines as “Not-patient and not-visitor”, “We feel like one, they see us as two”, “Still behind the glasswall?” reveal that fathers are not met as equal partners in postnatal care (14-16). Ellberg et al point out that fathers were treated as outsiders and that postnatal care was experienced as a ‘woman’s world’, where men had no place (14). This is in line with our findings, where the fathers reported that the staff mostly addressed the mother. Today the role of the father has changed; fathers participate in antenatal care, are present during birth and in postnatal care, and fathers as well as policy makers underline that health care professionals should involve both mothers and fathers, when they become a family (1, 14-16, 22, 23). But there seems to be lack of knowledge in how to involve fathers, when nurses
and midwives primarily involve fathers in practical things concerning the mother and newborn. This does not provide fathers with the support and involvement they seek and need as also identified by Persson (6). In Denmark, maternity and postnatal wards have been through several reductions in numbers of hospital beds and staff, which have resulted in very busy working conditions and less time for each family. This might make midwives and nurses focus on the primary outcome; the health of the mother and newborn, so they can be discharged as early as possible. This leaves sparse focus on and time for fathers, and they are used as assistants.

Meanwhile we also found that the fathers placed themselves “in the shadow” of the mother and newborn. Their focus was on the mother’s and newborn’s needs, and not their own. But at the same time, when asked, they said that they viewed themselves as equal to the mother in respect of the parental role. Several studies have found that expectant and new fathers wish to receive information about the mother and newborn’s health (14, 15, 23) to be properly prepared for early discharge. Our study showed that this comes before the fathers’ own needs. The fathers felt a great responsibility when at home. When not prepared and properly informed of what to expect fathers feel worried and anxious. This is supported by Steen et al, where fathers felt secure at the hospital because medical professionals were present. But at home fathers felt insecure because of their lack of knowledge (16). A review of paternal mental health showed that men are at increased risk of mental health problems in the transition to fatherhood (24), underlining that fathers’ transition to parenthood involves as much as the mothers’ (10) and requires adjustment and reconstruction of behaviors for the new role (11). In order to make this transition fathers are in need of support (6) before they are able to support their partner. The transition involves fathers bonding to their newborn and redefining themselves in their new role (6). When fathers are not supported the wellbeing of the entire family is at risk.

Persson et al have investigated fathers’ sense of security in the first postnatal week in relation to develop an instrument to measure this phenomenon. Fathers commented that participation during pregnancy, birth and early parenthood were essential for them to feel secure. Also to share the responsibility and be together as a family were important. Though it was vital for fathers to know who to ask, when in doubt, and that health care professionals were available 24 hours a day (6). In the postnatal setting of our study fathers are already able to stay overnight with the family, outpatient clinics are available around the clock and health care professionals have knowledge of the importance of fathers’ involvement in postnatal care. However Madsen and Munck address vital areas with need for improvements. To ensure equality in the care of fathers and mothers, health care professionals need to address that fathers are welcome in all aspects during pregnancy, birth and postnatal care. This involves every contact with midwives, doctors and
nurses; invitations to pregnancy related check-ups should address both mother and father, consultations should also focus on issues in relation to fathers, his situation and the importance of his participation (22). In our setting invitations are technically limited to one person and not two, fathers’ should pay for their own meals during hospitalization, and consultations during pregnancy and in postnatal care are limited in time with extensive demands for documentation, which create barriers for involvement of fathers. Further development of these areas will help to promote involvement of new fathers.

Excluding environment

The postnatal environment was to be of great importance for the fathers’ experience of the early postnatal period as a whole. Fathers reported that the time at the delivery- and maternity ward was hectic and stressful and characterized by disease. Research and initiatives have been made in regard to the birth environment (25, 26), but our study points out that the postnatal environment is also of importance in regard of fathers’ experience of their role as a father and their sense of security. Fathers wish for a tranquil environment like home. When readmitted at the patient hotel the families were given their own room with a bathroom, which created more peace and privacy like at home. Other studies support this finding (15, 27). Similarly, Gaboury et al found that when the hospital environment is not in accordance with the families’ goals it is an inhibiting factor when supporting new families. Noise and nursing interventions could disturb new families and have a negative influence on mothers’ breastfeeding and restitution after birth (27). In Denmark they are currently building new super-hospitals and delivery wards, and the focus is on creating an environment that supports the families’ needs. For example in the Region Hospital West Jutland delivery rooms are furnished and provided with light and sound-design to create a calm and inviting atmosphere (26). The effects of the interventions are not yet reported.

Early discharge – but unprepared

We also found that the fathers in our study experienced that they were overloaded with too much information in relation to their early discharge, yet they also stated that they didn’t feel prepared for the days at home in the early postnatal period. This is also reported in other studies (Blinded for Anonymity), where the early discharge minimises the possibility for offering new families with tailored information, and the new families felt that they got a lot of information that they could not relate to. This can make new parents feel unconfident. It can have the reverse effect, as they, instead of feeling well informed, they experience doubts. A new study on breastfeeding guidance in an early discharge setting found that limiting information to the individual parent’s individual situation increases the mothers’ breastfeeding duration and reduces readmission of newborns due to nutritional problems (Blinded for Anonymity).
The fathers wanted to be at home, yet they did not feel prepared. Technology can be a new way to guide the new fathers when at home in the postnatal period. Studies have explored the use of technology in the postnatal period, where findings by Lindberg et al have shown that the use of video calls can provide information and guidance for the parents at home in the postnatal period (28). A study has looked into the use of an app, where automatic messages sent out every 12 hours from the time of birth provided the new parents with timely information. This made the new parents feel supported and in control of the situation (Blinded for Anonymity).

Strength and limitations

The limitation of our study is that it was a small-scale study. We have provided rich descriptions of the fathers’ experiences, which allow the readers to judge whether the work is potentially transferable to their own contexts. The results cannot claim statistical generalizability, but analytical generalisation (29) which develops by means of the dialectic between theory and practice.

We conducted telephone interviews, where the participants were asked open-ended questions, where they could unfold their experiences. Shuy emphasises the advantages of doing interviews face-to-face instead, such as more precise responses, time to think thoroughly about responses and more self-generating answers (20). Yet we experienced that some of the fathers revealed personal information, why it is concluded that the telephone interviews generated interesting, personal and varied data that matched the in-person interviews. A possible bias could be that fathers had often overheard the mothers’ interview, when taking care of the newborn. Sometimes fathers felt things had already been said in regard to the readmission, but we then focused on the overall theme.

Conclusion and implications for practice

Our study points out that the fathers in this study were comfortable being discharged early, yet they experienced the early postnatal discharge as stressful due to their earlier experiences at the hospital prior to discharge.

All fathers experienced being categorized as the practical guy in the shadow, who were supposed to assist the mother. They oppose to that role, as they saw themselves equally important as the mothers. However, they mostly accepted that the health care professionals in general address the mothers. The fathers also saw themselves as in the shadow of the mother and prioritized the mother’s feelings before their own.

To be given the role as the practical guy in the shadow there is a risk that the father will be insecure in his paternal role.


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Table 1 Process of Analysis – examples from the analysis

<table>
<thead>
<tr>
<th>Step 1: From medley to themes: Superior themes extracted after the first open reading.</th>
<th>Step 2: From themes to codes. Identifying meaningful units. The meaningful units are coded based on the superior themes.</th>
<th>Step 3: From codes to meaning. The meaningful units are sorted into groups; hereby overall categories arise from the coding process.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Helping</strong></td>
<td><strong>QUOTATIONS</strong></td>
<td><strong>[code]</strong></td>
</tr>
<tr>
<td></td>
<td>“It is natural, that focus is on the mother and the infant. And in relation to the nurse I am a helping assistant (multiparous, 2b)”</td>
<td><strong>[assistant]</strong></td>
</tr>
<tr>
<td></td>
<td>“She was very sad and worried about having permanent injuries from given birth. She was also angry with me, because I did not understand her well enough. So there</td>
<td><strong>Practical guy in the shadow</strong></td>
</tr>
<tr>
<td>Insecurity Mothers’ feelings</td>
<td>were many emotions, and it also reflected upon breastfeeding, the insecurity and everything [---]” (first-time father).</td>
<td>[insecurity]</td>
</tr>
<tr>
<td>Table 2 Study population (N= 6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fathers parity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-time father</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Multiparous father</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Age range</strong></td>
<td>24-45</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None-short</td>
<td>0*</td>
<td></td>
</tr>
<tr>
<td>Intermediate-long</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Workstatus</strong></td>
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<td></td>
</tr>
<tr>
<td>Employed</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Under education</td>
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</tr>
<tr>
<td><strong>Paternity leave after early discharge (14 days or more)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5*</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for readmission of newborn</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional problems such as excessive weight loss, dehydration</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Age of newborn when admitted</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 24 hours</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>24-48 hours</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>&gt; 48 hours</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Length of readmission</strong></td>
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<td></td>
</tr>
<tr>
<td>24-48 hours</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>&gt; 48 hours</td>
<td>2</td>
<td></td>
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<tr>
<td><strong>Breastfeeding status of newborn</strong></td>
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<td></td>
</tr>
<tr>
<td>Breastfed before readmission</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Breastfed after readmission</td>
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<td></td>
</tr>
</tbody>
</table>

* Missing answer
Highlights

New fathers experience to be categorized by health care professionals as the practical guy, who has to assist the mother. Yet the fathers see themselves equally important as the mothers.

New fathers also see themselves as in the shadow of the mother and prioritize the mother’s feelings before their own.

Fathers can be insecure in their paternal role when being met as just the practical guy. How fathers experience their paternal role in the early postnatal period may affect the well-being of the new family negatively or positively.