Father-staff relationships in a neonatal unit: being judged and judging

Providing effective care and support for parents in neonatal units requires an understanding of the factors that contribute to the diversity of individual experience and how people respond to these stressful life events. Little is known about how health professionals and fathers interact in these situations and how this affects a father's overall experience. This article discusses findings from a study exploring the experiences of fathers following preterm birth and highlights some of the challenges for fathers whose behaviour is being judged while they simultaneously adjudicate on others.

Kevin Hugill
PhD, MSc, BSc (Hons), RN
Senior Lecturer
School of Health, University of Central Lancashire, Preston
khugill@uclan.ac.uk

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Key points

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1. Fathers and health professionals routinely make judgments, at times ill informed, about the behaviours and motivations of each other.
2. Health professionals need to be sensitised to the effects that their attitudes towards men might have upon their communications and relationships with fathers.
3. Increased awareness about facets of father and health professional relationships could inform the development of interventions and strategies to better meet the specific needs of fathers, which could be potentially useful in clinical practice.

Fathers' experiences have traditionally not featured prominently in the neonatal parenthood literature. However recent years have seen the emergence of a growing body of research that has begun to address this imbalance. While there remain numerous gaps in our knowledge about fathers in neonatal units, recent research has found that fathers find the situation emotionally challenging[1,2] and in general they face the same feelings of fear, exclusion and powerlessness that mothers experience[3-5].

While fathers' and mothers' experiences after preterm birth share commonalities, they differ in significant ways. Several studies involving fathers, report that they encounter additional sources of stress that are usually seen less in mothers' accounts. For example, many fathers report difficulties in balancing employment demands, supporting family life and being present on the neonatal unit[2,5,6]; while other studies have drawn attention to fathers self-censuring their own emotions and editing information in a bid to protect their partner from further emotional worry[1,2,7].

Research studies that have sought to quantify measures of psychological stress in fathers are inconsistent. Some have reported that fathers experience more overall stress than mothers[8] while others report the reverse[9]. Possible reasons for this might be that the existing standardised tools fail to fully capture gender-based variations in stress response patterns or that fathers' stresses are highly contextual and subject to other influences beyond the immediate focus of these studies. While the exact relationships are likely to be complex, it seems likely that gendered and interpersonal psychological differences play a role in how fathers react to preterm birth[10] and these factors need to be accounted for in father-staff interactions.

To clarify those factors that facilitate or impede a father's level of involvement with their hospitalised infant, Feely and colleagues[11] conducted an interview study with Canadian fathers. They identified three major groupings of factors, which resonate with influences known to affect a father's involvement in more usual situations[12,13]:

1. Infant factors
2. Interpersonal factors
3. Environmental factors

The unique attributes of the physical and social environment of the neonatal unit were identified by fathers as important and problematic barriers limiting their greater involvement. In particular, the frequent use of complex medical language, contradictory communications and the gatekeeping behaviours of staff. For mothers, the quality of their relationships with health professionals and the amount of psychosocial support received are important in determining their levels of stress and satisfaction during their time on the neonatal unit[14,15]. However for fathers, the effects of these relationships and what affects their quality is less analysed; this study sought to illuminate some of the relational influences that might affect individual father experience.

Methodology and study design

The experiences of fathers following preterm birth in a neonatal unit and

factors that affected these experiences were investigated. Ethnography is a flexible and wide-ranging methodological approach to studying people's lives and their culture – beliefs, social norms and rules of behaviour[16]. This study used the focused ethnography method[17]. In ethnography, data is invariably collected from multiple sources and different points of view[18]; which can include the researcher's opinion[19]. Commonly data collection involves observation, field note recording and questioning of participants[16,18,20]. The intention is to gain a more complete picture of the phenomenon under study and its meanings.

The choice of study site, a large English neonatal unit, was pragmatic and all participants were chosen purposively. Fieldwork data was collected over a prolonged period involving 260 hours of recorded observation and conversations with fathers, mothers and healthcare professionals, in-depth interviews with 10 consenting fathers together with an ethnographic survey[20] with health professionals. All data were concurrently analysed thematically[21].

Findings and discussion

Writing about and presenting ethnographic data cannot be separated from the theoretical frame of reference, the analytic processes and situational context[18]; for the purposes of brevity this detail is more fully described elsewhere[1,19]. This section integrates the findings of the theme 'judging and being judged' from the wider study.

Backstage talk

Neonatal units are a discrete social grouping defined by occupational, situational and environmental factors. Fathers unwillingly enter this space following preterm birth or sickness in their newborn. It is a world they are unprepared for and they lack key insights and understanding about social norms of behaviour[19].

Erving Goffman, an influential social ethnographer[22,23], used the metaphor of a staged drama with front- and backstage areas, an audience and actors to explain social interactions. Using this metaphor, spaces that parents (as the audience) occupied were 'front of stage' and those they were excluded from by the staff (actors) were 'backstage areas'. Here beyond the hearing of parents, staff would more freely converse. These conversations would range from social talk (humour, chit chat, gossip and the like), to professional discussions about an infant's therapy. Sometimes this conversation included ill-informed comment about fathers. One example concerned a conversation observed during a medical ward round as staff discussed one infant:

> Senior doctor: "Anything else, any other issues?"
> Junior doctor: "It says here [pointing to the patient notes], history of domestic violence."
> Senior doctor: "He looks the type."
> [Apparently referring to the father.]
> Nurse: "No this was her [the infant's mother] previous relationship, not this one."

The assumption that the father was implicated in domestic violence, while corrected, went unchallenged and the conversation shifted towards summarising the clinical management; nothing more was said about the father. This one quite brief conversational interaction reveals considerable detail about attitudes towards certain fathers based upon nothing more than his 'looking the type', whatever the domestically violent look is. Labelling men (in this case entirely without foundation) as abusive might make staff fearful and affect how they relate to them[24]; this could add to fathers' feelings of marginalisation.

The concept of family-centred care is widely adopted among neonatal units[25]. While it is intuitively understood the concept is incompletely articulated[26], its effectiveness is unproven[27] and its implementation remains challenging[28]. In the study unit, not all aspects of father involvement were universally valued and at times fathers were the subjects of disparaging comments; this was recognised by one nurse as problematic:

> "No member of staff will object or comment on [a] mother having skin-to-skin kangaroo care, in fact this is encouraged, but a father doing the same evokes responses of disgust and opens the father to ridicule by some of the staff."

This situation is not entirely unique: the observation that some staff express negative views around supporting kangaroo care are reported elsewhere in other contexts[29]. Nevertheless this behaviour is saddening especially as kangaroo care is known to help a father develop parenting confidence[30,31], feel emotionally close to his infant and help establish a secure attachment[30-32]. Reasons behind this negativity are unclear. One explanation might be a reflection of ignorance of the positive effects of kangaroo care on parent and infant outcomes. However more likely, given the widespread dissemination of evidence about the beneficial effects of kangaroo care, it reflects a lack of confidence both in facilitating kangaroo care and relating to individual fathers.

Goffman suggested that making deprecating comments about others can promote and maintain team cohesiveness and solidarity[23]. However this does not seem to be the case here; this revelation is more akin to an 'inside dark secret'[23], (a fact concealed) the disclosure of which would bring discredit by conveying an incompatible team image, specifically in this case with the values espoused in family-centredness. The comment by the respondent above reveals internal team tensions about what is and what is not deemed appropriate for fathers to do. Individual beliefs about men and fatherhood reflect wider social and cultural influences and norms and as such these beliefs are likely to be influential on how staff and fathers relate to one another[10,33,34].

Moving between front- and backstage

In reality the situation is more complex than the dichotomy suggested above. Indeed many staff who were initially critical (in backstage areas) of individual fathers staying on the unit and getting involved with their infant, shifted their opinion over time. This might have been in response to getting to know the father better and establishing relationships based on greater shared understandings. As one nurse reflected:

> "I find talking to some fathers a lot more difficult than talking to mothers. With the mothers, there is more in common and they open up more than fathers do. With the really tiny ones [very preterm infants] you get to know the family much better and then it gets easier."

Fathers value the support provided by staff at the cot side[35] so the nature and security of their relationships with staff is likely to be important in their overall experiences.

Delivering care involved nurses frequently moving between cot side and

areas of the unit not accessible to parents. Two nurses were observed while preparing intravenous medications for administration to an infant in an adjacent room:

Nurse 1: "Will you come in with me to give this [medication]?"

Nurse 2: "Yes."

Nurse 1: "I don't like this dad; he gives me the creeps, he looks at you funny."

As the nurses went to the cot side where the father was sitting they carried out the usual checks prior to administering the medication to the infant. They spoke with the father about what they were doing and why and it appeared from their speech and smiling facial expressions that the prior conversation had never happened. A later conversation with this particular father was revealing:

"When we were in [another hospital] and [partner] wasn't very well, she had this drip in and she kept complaining about it, but they kept on saying it was alright and using it. When the consultant came round he wasn't happy with it and said take it out right away. She still has the mark on her arm… she doesn't want to complain about it."

There is scope for multiple interpretations of these two conversations but one explanation for this father's unsettling behaviour and hyper-vigilance was that he looked at the staff 'funny' because his previous experiences had led him to mistrust staff reassurances. In this study, appraising the behaviours and motivations of others was not solely confined to staff; fathers were also often simultaneously making judgements about those around them. With few exceptions staff presented a professional face when dealing with parents and consequently fathers seemed largely oblivious that, at times, they were subjected to covert censure.

Front of stage messages and judgments

Staff seemed to be more aware of the potential to be judged by others and some sought to manipulate that to achieve particular goals, one example from observational field notes illustrates this point. A nurse, recently promoted to a unit leadership role is wearing a neatly pressed new uniform; this was in contrast to her usual outfit of theatre scrubs. She is receiving comments about her appearance from her colleagues as they gather around the central staff desk prior to shift commencement, she replies to these comments laughing and says:

"Well you've got to show them who is boss, don't you?"

Later I asked her about who 'them' were, she replied:

"It's everyone. Junior doctors like to feel that they can go to the person in charge, staff [nurses] need to be informed about my change in status but also parents like to be able to identify the nurse looking after their baby and who is in command of the unit."

One of the fathers who had spent several weeks visiting came to his own conclusions about staff hierarchy in the neonatal unit:

"You've got the nurses looking after the babies, you've got the doctors who are on if the nurses have got any complicated questions that they are not too sure about. You got the higher nurses, higher doctors. You can tell who's who. I can just tell by the way they act and how they are in themselves, you know really mega-confident and that. You can tell that they are some big doctor or nurse. Nurses like to have a tiny bit of banter with [them], they are nice and happy."

Interestingly, whereas the nurse in the earlier example placed emphasis on her appearance to convey seniority, this father's interpretation and explanations of the staffing hierarchy placed greater emphasis on how individuals behaved, regardless of what they were wearing.

The fathers clearly paid attention to what was going on around them but on the whole tended to be less overtly judgmental of health professionals and more circumspect in their criticisms. This reticence might reflect perceptions of vulnerability, power imbalances while their infant was on the unit or a lack of emotional distance. During conversation they were invariably more forthcoming with their opinions when they contrasted the neonatal unit with other departments they had previously encountered:

"I was a bit disappointed with upstairs [postnatal inpatient ward], it made her [his wife] very low at the time."

"The hygiene is very good, very clean, that's a good thing.… compared to the other parts of the hospital this is very, very clean [laughs]." [At the time the organisation was receiving public criticism about its cleanliness.]

Opinions about other fathers on the unit were sometimes not complimentary, as this data extract from one father in his early thirties illustrates:

"The young lad next door [teenage father in an adjacent room of the unit] doesn't do much, I don't know why he bothers to come, it seems he has no idea or isn't interested."

Questioning the motivations and behaviours of this teenage father with no more information than how he appears to behave when he is clearly under scrutiny and feeling vulnerable, is somewhat akin to the way the staff behaved on the ward round in the earlier section. It seems that health professionals and fathers alike are capable of making ill-informed judgments about others based on partialities and preexisting prejudices. Consequently staff need to be aware of the effects of such behaviours when seeking to support and communicate with fathers and how this affects the quality of a father's neonatal unit experience.

Conclusion

Clearly the findings from a single study restricted to one neonatal unit and one point in time, limit generalisations. However the intention of this article was to prompt readers to think more deeply and critically reflect about taken for granted areas of their practice. In particular, how they judge and are judged by fathers, what is the dominant view of fatherhood in their unit and whether this is desirable and supportive of men's efforts and fatherhood aspirations.

From a practice perspective, we need to reflect upon how our past experiences, beliefs and attitudes concerning fathers and fatherhood affect our judgments (which are necessarily incomplete and sometimes plain wrong) and influence our interactions with fathers and how these in turn affect the quality of a father's experiences of care in our neonatal units; doing this will help to ensure that we can deliver on our vision for care[36,37].

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