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TRANSITION TO FATHERHOOD IN THE CONTEXT OF CESAREAN BIRTH

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ABSTRACT

Transition to the role of parent can be a stressful event under the best of circumstances. Negative experiences that surround the delivery of the child can make this transition more difficult, and births resulting in cesarean sections (C-sections) have been associated with decreased satisfaction with the birth process itself. Numerous studies have assessed the maternal experience, but there is a lack of knowledge about paternal experiences and how they may affect the transition to fatherhood. This study examined the experiences of first time fathers and their transition to fatherhood in the perinatal and postpartum period after a cesarean section delivery.

Participants were recruited from a major university hospital. Data were collected by audio-taped non-structured interviews which occurred approximately one month after delivery. Data analysis was based on the interpretative phenomenological analysis method by Smith, Flowers, and Larkin (2009) which is grounded in the hermeneutic phenomenological work of Heidegger. Findings included the following over-arching themes that dominated most of the fathers' experiences as they transitioned from stage to stage of the process: Expecting a Natural Childbirth; Ongoing Communication Breakdowns; Riding an Emotional Roller Coaster; Moving to a Sense of Relief and Peace; Awakening to the Challenges of Being a Father; and Resolving the Memory and Moving On. The comments shared with the most emotional and emphatic tones by the fathers related to reports of "communication breakdowns" during the pre-delivery period. Overall, the positive or negative communication skills of the staff had a similarly

polarizing effect on all the fathers' positive or negative perception of the birthing experience.

These findings are significant for the increased understanding they provide of the experience of fathers of children delivered by cesarean section. Insights into the critical role of effective staff communication at key points of time clearly suggest areas for improvement in perinatal and post-partum nursing care, nursing education and research. Recommendations based on findings include: Enhance efforts to improve education of fathers to limit knowledge deficits and potential fears related to cesarean section delivery; redouble efforts to ensure that nursing educational programs support development of graduates prepared to approach perinatal and post-partum care holistically by including fathers as part of the care delivery team; and expanding nursing research to further define the needs of fathers at this early phase of transition to fatherhood. The enhanced understanding of the cesarean delivery experiences of these fathers provides a base for similar studies that expand understanding of commonalities and differences of their birthing experience in other settings and under other conditions. Findings also suggest the need for future research focused on the implementation and testing of quality improvement strategies designed to limit or eliminate the healthcare problem areas identified in this study.

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CHAPTER I

INTRODUCTION

The participation of fathers in child-rearing has expanded recently from the traditional role of breadwinner to a more significant involvement in the daily childcare and early upbringing of their children (Chandler & Field, 1997). Fathers have increased their presence during antenatal classes, become more active participants at the time of labor and delivery, and become routine caregivers in the direct day to day care of their children (Buist, Morse, & Durkin, 2002; Goodman, 2005; Hall, 1991; Nyström & Öhrling, 2004). Federal surveys of childcare arrangements for employed mothers show that fathers now provide a source of childcare equal to that of day care centers and childcare homes (Pruett, 1998).

The addition of an infant to a family can be challenging in the perinatal and postpartum period, especially for fathers that experience difficulty during the transition to fatherhood. Experiences of fathers in the postpartum period that decrease their satisfaction with the transition to becoming a parent can have life-long implications for the infant's welfare and negatively impact the family unit itself (Mercer & Ferketich, 1990). Delivery by cesarean section (C-section) has been associated with more dissatisfaction with the birth experience, and can have a negative impact on the father's support of his spouse and the development of a strong relationship with his infant (Ceronio, Dorfling, & Nolte, 1995).

Anderson (1996) noted that parental feelings towards the infant were slower to develop when birth was by C-section. Furthermore it has been found that fathers used significantly more negative adjectives to describe their infant when birth was by C-section, and the way in which men experience childbirth may affect their subsequent emotional well-being and attitudes towards the infant (Greenhalgh, Slade, & Spiby, 2000).

Nurses in settings that care for the family during the perinatal period are ideally positioned to offer support and mitigate potential problems for fathers during the birth experience and in the immediate postpartum period. Additional knowledge of how fathers assimilate the birth experience can be used to plan more effective interventions, and to assist fathers who are experiencing a C-section for the first time in the development of their role as a parent, their assumption of a successful early paternal-infant relationship, and their overall acceptance of the birth experience. Fathers experiencing their child's birth by C-section seem likely candidates for enhanced nursing interventions, however little is actually known about what father's need most at this time.

The perinatal period generally starts at the 28th week of gestation and ends at one week after birth, and the postpartum period includes the first 6 weeks after birth (US Dept of Health & Human Services, 2008). Research during this time period specifically looking at the experiences of fathers following their first cesarean birth is sparse and contradictory. Most of the past research and literature has focused on mothers and infants in the perinatal and postpartum period, and far less is known about the needs of the fathers or their overall satisfaction with the experiences surrounding and following birth (Anderson, 1996; Fletcher, Silberberg, & Galloway, 2004). There is a growing

recognition that paternal involvement may significantly affect childhood development and the overall sense of well-being as the child develops into an adolescent and adult (Baker, 2007; Lamb, 2002; Tobey, 2001). Fathers provide critical support to their families and contribute to the development of their children which makes it important to more fully investigate the impact of cesarean birth on the transition to fatherhood in the perinatal and postpartum time period. The added stress associated with cesarean births makes it critical to better understand how the event is experienced and what would be needed to support the successful transition to the role of parent. Results from a large postal survey showed that mothers still reported negative experiences 14 years after their initial C-section (Porter, van Teijlingen, Yip, & Bhattacharya, 2007). Most of the distress was caused by lack of preparation and communication, the feeling on missing out on an important life event (vaginal delivery), and delayed meeting and bonding with the infant (Porter et al.). It is natural to expect that these negative experiences would also affect the father. Due to the limited research on the effect of cesarean birth on men during their transition to fatherhood, a study that employs an inductive method of inquiry is needed to gain a better understanding of the actual paternal experience during this time of change and adjustment.

Statement of the Problem

The birth of an infant is traditionally considered to be a joyous occasion: however, the birth event for parents experiencing their first C-section includes fear of the unknown that can place added strains upon the new father and mother (Anderson, 1996;

Greenhalgh et al., 2000, Knauth, 2000). Research has confirmed that the first several weeks after birth are an important time for the development of the mother-infant relationship (Pollock, Amankwaa, & Amankwaa, 2005); however, little is known about the experiences of fathers during this period. Fathers experiencing their first C-section may have very different expectations and experiences than mothers. Problems encountered by fathers may negatively color the birth experience and negatively influence the level of parental involvement by the father, which may adversely affect the long-term paternal-infant relationship (Pollock et al.). The father's experience following birth by C-section may influence the development of the paternal-infant relationship and the overall welfare of the family (Anderson, 1996; Frascarolo, 2004; Knauth, 2000), however the limited amount of research regarding the paternal experience in the postpartum period makes interpretation of the existing data difficult, and based upon the current evidence there is conflicting research that makes planning a quality improvement intervention problematic. In addition, paternal studies are somewhat dated, and may only provide a limited understanding of the experiences of fathers in current times given constant socio-cultural changes (St. John, Cameron, & McVeigh, 2005). The contradictory findings of the available literature also support the need for further study of fathers across the perinatal and postpartum period, to better illuminate the experiences of fathers following their first cesarean birth.

The development of the paternal-infant relationship is an important part of the transition to parenthood for the father, and the outcome of this developmental milestone has implications for the father, the infant, and the family (Frascarolo, 2004). Some fathers have reported an immediate bond with their infant after delivery, while other

fathers have reported that feelings of love and attachment developed slowly and gradually over the first several months, possibly as a result of their experiences during and after the birth (Anderson, 1996). Important factors that may affect the paternal-infant relationship include lack of confidence and competence in childcare skills, inadequate preparation in parenting, disruption of social and sexual life, general fatigue from routine infant care, and feelings of exclusion by the mother especially during breastfeeding (Anderson).

The marital relationship is also an important source of support for the development of parenting skills during the transition to parenthood (Knauth, 2000). The quality of the marital relationship may affect family functioning and subsequently the behaviors of the father, the mother, and eventually the infant (Buist et al., 2003; Knauth, 2000; Lamb, 2002). When fathers have a highly engaged relationship with their partner they are consistently more involved in interactions with their infants and are more sensitive to the needs of their infants (Frascarolo, 2004; Lamb, 2002). Marital relationship quality may predict the amount of paternal stimulation of the infant (Lamb), which has been associated with improved family functioning as well as higher levels of cognitive and behavioral functioning for the infant (Frascarolo, 2004; Knauth, 2000). Fathers in close and confiding relationships with their partner have more positive attitudes in relation to their infants than do fathers from couples experiencing marital distress (Buist et al., 2003; Lamb, 2002). A few studies have reported a decline in the marital relationship following the birth of an infant (Knauth, 2000; Mercer & Ferketich, 1990). Potential threats to the marital relationship during the transition to parenthood may be uncovered by studying the experiences of fathers during the first month after

cesarean birth, and may lead to improved attention to needs and potential nursing interventions.

As stated earlier, it is suspected that the type of delivery may affect the paternal experience and the transition into the role of becoming a father. The birth process can positively or negatively affect assumption of the paternal role, and any experiences that are perceived as negative can accentuate marital discord and negatively influence paternal attachment and family relationships (Anderson, 1996; Greenhalgh et al., 2000). Fathers who are satisfied with the birth experience have been found to have earlier and improved attachment with their infants, which forms the foundation upon which future childhood and adult relationships are based (Anderson, 1996; Goulet, Bell, Tribble, Paul, & Lang, 1998; Melnyk, Feinstein, & Fairbanks, 2002). Fathers who are not satisfied are often less supportive, in general have more stress, are more affected by maternal depression, and have reported decreased family functioning (Knauth, 2000). In one study fathers reported less positive parental affect towards their infants when the birth was by C-section (Greenhalgh et al., 2000), and in another study reported more difficulty focusing on their feelings for the infant when their energy was consumed by thoughts of safety for the mother and child after delivery by C-section (Anderson, 1996). In addition some fathers expressed disappointment with the birth experience when the infant was born by C-section (Ceronio et al., 1995).

The few studies that have investigated fathers during the perinatal and postpartum time periods report that their needs are relatively unmet (Buckelew, Pierrie, & Chabra, 2006; Fletcher et al., 2004). Antenatal classes focus on the mother and infant or towards preparation for labor and delivery, and rarely include information for fathers regarding

effects on the marital relationship after birth such as communication, division of household labor, maternal limitations and post-delivery care, when to resume sexual relations, or how to assist in care of the infant (Fletcher et al.). Interventions that address paternal needs and provide education about the realities of the perinatal and postpartum period for the father are necessary to better prepare them for the upcoming changes in their life. However quality improvement efforts need to be developed and built upon a foundation of evidence that is derived from current research. The creation of effective programs to support the father's transition into parenthood depends on acquiring more knowledge of the actual experience as it is lived. Therefore, this study will focus on improving the understanding of the paternal experience across the perinatal and postpartum time periods to determine possible concerns of fathers at this time that may need to be considered to improve the outcomes for fathers experiencing delivery of their infant by C-section.

Theoretical Perspective

In order to provide greater assistance to patients it is first necessary to accurately understand their perspectives and their needs (Cohen, Kahn, & Steeves, 2000). Each individual is unique and only that person can reveal the meanings that they attribute to their experiences. These meanings help create the patient's needs, and may be helpful in determining how their needs can best be met. While it is important to understand the meanings of individual patients, it is also helpful to understand common themes that extend across patients or cases. Knowledge of common themes may allow nurses to

become more alert to patient issues that may otherwise remain unclear. Phenomenology is ideally suited for nursing research as it seeks to understand the patient's experiences. Nurses have long sought to understand a patient's perceived needs in an attempt to better meet those needs. It is therefore essential to discover the meanings that patients attribute to their experiences as these experiences help create the needs of each individual patient (Cohen et al.).

The phenomenological philosophy and method approach is credited as being first presented by Husserl (1950/1970) who developed its inception from his mathematical and logical studies. Husserl was interested in learning about the lived experience or the structure of life and the world, through the study of the appearance, manner of presentation, and intuited structure of objects as they actually presented themselves in the real world. His main premise about phenomenology was that it was an approach that presumed study could be accomplished in a state free of presuppositions, analyzing data without speculation and free of world view hypotheses. In Husserl's approach to phenomenology the emphasis is on in depth description that leads to specific and cumulative results without making inferences or leading to metaphysical theories. In Husserl's view, phenomenology as a discipline is *a priori* as it leads to certainty, and as a scientific enterprise is not restricted by the presuppositions of science and does not suffer its limitations (Husserl, 1950/1970).

Heidegger expanded on Husserl's view, proposing three main differences (1975/1988). The first component added the process of phenomenological reduction where basic structures of being are discovered and how we attempt to understand phenomena as they are presented to us is emphasized. Heidegger's second expanded

component included the process of phenomenological construction or emphasis on how we attempt to understand (or interpret) the world as it is presented to us. The final component he identified involved a process of de-construction where the traditional concepts were de-constructed down to the sources from which they were drawn in an attempt to understand the genuine character of the concepts (Heidegger, 1975/1988). The essential outcome of application of these components is to determine how people interpret their lives and how they make meaning of what they experience (Cohen et al., 2000). This includes written communication but more importantly verbal interaction and the symbolic activities in which humans engage. In Heideggerian phenomenology, language is extremely important and language expressions are considered to be the common element that binds our experiences with the world in which we live. Thus an object of Heideggerian phenomenological research is language and the individual user of the language. Meaning occurs when a tradition (such as language) is interpreted by a speaker, and phenomenology considers both the individual and the tradition. In Heidegger's view, phenomenology when correctly understood is hermeneutic or interpretative and therefore the interpretative phenomenological research method, that incorporates the hermeneutic circle process for analysis, allows something hidden to be revealed in a way that improves our understanding of it (Dreyfus, 1991). Interpretative phenomenologists contend that consciousness and physical existence are not separable, that there is always consciousness of something, and that it is more important to study and describe experiences (where consciousness exists) rather than emotions or thoughts in abstract (Cohen et al.).

The Lived Experiences of Fathers

Although there is a growing interest in the involvement of fathers in early childcare, the vast majority of the past and current research has been predominantly about the mothers or infants (Cashin, Small, & Solberg, 2008). There have been studies that have looked at the effects of cesarean birth (Ceronio et al., 1995; Padawer, Fagan, Janoff-Bulman, Strickland, & Chorowski, 1988; Porter et al., 2007), but these have usually been about the mother and very few studies have been found that specifically focus on the experiences of fathers in the perinatal and postpartum periods following a cesarean delivery (Chan & Paterson-Brown, 2002; Fortier, 1988; Greenhalgh et al., 2000). No phenomenological studies were found that focused on the experiences of fathers during the first month after a cesarean birth.

Purpose of the Study

The purpose of this study will be to explore the actual experiences of fathers living through the birth of their child by C-section. The focus is on understanding the meaning of this experience for the fathers at the time of birth, during the delivery process and in the month following their first cesarean birth. The goal will be to capture and explore the meanings that the participants assign to their experiences through an interpretative analysis that is transparent and includes components that are idiographic (individuals studied as a unique case) and nomothetic (generalizations about themes upon which individuals in a participant group may vary) (Smith, 2008; Smith, Flowers, & Larkin, 2009).

Research Question(s)

1. What are the experiences of fathers in the month following their first cesarean birth?
2. How does cesarean birth impact the transition to parenthood for fathers in the early postpartum period?
3. How does cesarean birth impact the transition to fatherhood?
4. What experiences do fathers report that involve the mother of the child during and after cesarean birth that may impact the relationship of the couple?

Definitions

Father

The father is defined as the biological parent of the fetus/infant who has also lived with the expectant mother during the entire pregnancy and has not experienced a live cesarean birth with his current or any other partner (Chandler & Field, 1997).

Family

There are many definitions available for family; however, for the purpose of this study the definition of family will be limited to the biological father, the mother, and the infant. Merriam-Webster (2008) defines a family as a group of individuals living under one roof and usually under one head of the family. The family is viewed in this study as

the basic unit in society traditionally consisting of a mother and father rearing their children, or any of the variations differing from but regarded as equivalent to the traditional family such as a single-parent family (Merriam-Webster). Families are a hierarchy of systems in dynamic interaction that include complex individual systems, subsystems (such as dyadic relationships between the husband – wife and parent – child), and various larger supra-systems such as neighborhoods or work and school environments (Segaric & Hall, 2005). It is unknown if the father – infant and mother – infant relationship affect each other or combine to affect child development because of a lack of studies that focus on the father (Segaric & Hall).

Perinatal Period

The perinatal period is defined as beginning after 28 weeks of gestation and lasting to the 7th day after birth (US Dept of Health and Human Services, 2008).

Postpartum Period

The period immediately following birth up to and including the 6th week of life (US Dept of Health and Human Services, 2008). The proposed in-depth interview will be conducted at approximately 4 weeks postpartum.

Assumptions

It is assumed that fathers want to be involved in the care and upbringing of their infant. It is also assumed that there will be changes in family dynamics as the family transitions from a dyadic to a triadic form or experiences the addition of another child. Knowledge gained from exploring the experiences of fathers can serve as a tool to identify fathers' views of the labor and delivery process and the parenting experience in the perinatal and postpartum period. A better understanding of the paternal experience may facilitate development of strategies that improve the marital relationship and the early paternal-infant relationship with the infant. It is recognized that paternal involvement with their infant is important for the development of stable relationships throughout the rest of the infant's life (Pruett, 1998).

The Need for Interpretative Phenomenological Research

When performing qualitative research it is important to be able to defend one's choices, and this can be accomplished by grounding one's works within a methodological discipline (Maggs-Rapport, 2001). Qualitative research encompasses a diverse set of techniques and philosophies that underpin the research practice and an inductive approach to research that may be adopted if it is appropriate for the research question being asked (Maggs-Rapport). Interpretative phenomenological research, grounded in Heideggerian philosophy, provides a philosophy and research approach ideally suited to exploration of a phenomenon with little research background. Interpretative phenomenological analysis (IPA) is a method of qualitative inquiry that is appropriate

for this research grounded in hermeneutic Heideggerian phenomenology as it is designed to examine how people make sense of their major life experiences and includes Heideggerian principles in the methodology (Smith, Flowers, & Larkin, 2009). IPA facilitates exploring the experience in its own terms without attempting to place the experience in predefined or overly abstract categories. At the elemental level people are unconsciously caught up in the everyday flow of experience, but when a person becomes aware of what is happening in a specific situation it is the beginning of what can be described as 'an experience'. The IPA method is especially useful for revealing the everyday flow of lived experience which can take on particular significance for an individual when something important has happened in a that person's life. When a person becomes enveloped in a significant life event they begin to reflect upon what is happening and IPA helps the researcher engage with these reflections. The attempt of the participant to make sense of what is happening to them leads to the second major theoretical axis of IPA. This is an interpretative endeavor informed by hermeneutics, or the theory of interpretation. Human beings are sense-making creatures and the accounts of participants will reflect their attempts to make sense of their experience. Access to experiences is dependent upon what the participant tells the researcher, who must then interpret the account in order to understand the experience. It is in essence a double hermeneutic, with the researcher trying to make sense of the participant as they try to make sense of what is happening to them. IPA makes it possible to examine in detail what the experience is like for the individual participant and how this participant is making sense of what is happening to them. This method is congruent with the Heideggerian phenomenology in the view that human beings are viewed as thrown into

the world of experiences, and their “being-in-the-world” is always in relation to something and that the interpretation of the individual’s activities in context is central to phenomenological inquiry (Smith, Flowers, & Larkin).

Significance

Significance for Research

Very few investigations have examined the experience of fathers during the perinatal and postpartum periods. Evaluation of fathers at this time may increase the understanding of how fathers change during their transition to parenthood (Knauth, 2000). Exploring the experiences of fathers at the time of and in the month following their first cesarean birth may provide a basis for identifying issues that can be remedied through family-based interventions (Knauth). The few studies and literature reviews that have addressed the parental experience are primarily quantitative and are becoming dated, in some cases using data that was gathered during the 1980’s (Knauth, 2000; Mercer & Ferketich, 1990). The findings from these studies may no longer be applicable due to the socio-cultural changes that have occurred since the original data were collected. The findings from the original data are also contradictory, with some authors reporting no change in issues such as paternal satisfaction while others report a decrease in paternal satisfaction with family functioning (Knauth, 2000, Mercer & Ferketich, 1990). If examining paternal experiences does reveal common themes such as a decrease in marital or parent-infant relationships, then interventional programs aimed at improving

paternal-infant interactions should be developed and implemented as early as possible because children with involved fathers have been shown to have better self-esteem and developmental outcomes (Melnik et al., 2002). Most current interventions and programs are designed with the mother in mind, often without the inclusion of the father as an equal partner (Henderson & Brouse, 1991). This may be due to the fact that many past research studies on fathers have been as an adjunct to mother-focused studies or compared fathers to mothers or to other family members (St. John et al., 2005). There needs to be increased recognition of the unique contributions that the father makes to the family during the early postpartum period, and consideration of the multidimensional needs of the father to meet the challenge of new fatherhood (St. John et al.).

Significance for Practice

The early period of an infant's life forms the building blocks for childhood cognitive and emotional development and functioning, and the quality of early parent-infant relationships is essential to this development (Melnik et al., 2002). Poor parental coping skills and decreased comfort with the parenting experience may have adverse effects on parent-infant interactions and child developmental outcomes (Melnik et al.). Sensitive parenting plays an important role in the appropriate development of complex behavioral and physiological responses in infants even as early as 6 months of age, and positively affects the underlying physiological mechanisms that contribute to positive infant behaviors (Propper et al., 2008). Effective early interventions may ameliorate the development of negative parent-infant interaction patterns as well as adverse child

developmental outcomes (Bosmans, Braet, Van Leeuwen, & Beyers, 2006; Melnyk et al., 2002). Interventions to improve parental-child relationships are more effective if applied to parents when their children are young. Interventions to improve parenting skills that are initiated when children are adolescents often fail because parenting styles have lost their most important influence by the time children have reached that age (Bosmans et al., 2006), and behavioral and physiological responses have already been established earlier in infancy (Propper et al., 2008). It is hoped that this research will provide current information that will enable nurses and other healthcare professionals to “foster an environment that will encourage men to engage more fully in their fathering role” and encourage new fathers to successfully support their partners and develop a positive relationship with their new infant (St. John et al., p. 188).

Significance for Education

The paternal experience post-delivery including issues such as changing marital relationships and parental satisfaction with the birth process may be further complicated when the baby is born by C-section. Besides having to care for the newborn infant, the father must also provide care to the mother who has just undergone major abdominal surgery. Although fathers have expressed a high level of comfort in sharing the experience of labor and delivery, some fathers have also reported higher levels of anxiety with cesarean delivery and described them as significantly more traumatic than vaginal delivery (Chan & Paterson-Brown, 2002). In one study fathers with children born by C-section used considerably more negative adjectives to describe their infant at 6 weeks

postpartum when compared to fathers with infants delivered by vaginal birth (Greenhalgh et al., 2000). In an older study first-time fathers revealed that they felt they were totally unprepared for delivery by C-section, coerced into the situation without adequate preparation, and expressed disappointment as the most intense emotion related to the experience (Ceronio et al., 1995). Lack of understanding of paternal experiences surrounding and following birth including the mode of delivery may preclude nurses and other healthcare professionals from providing appropriate counseling and services to fathers in the event of a C-section, which could lead to decreased paternal satisfaction with the birth experience and decreased satisfaction with family relationships in the initial postpartum period. If cesarean birth does affect the paternal post-delivery experience and issues such as the marital relationship or parent-infant relationship, then information from this study could be used to develop nursing curricula and continuing educational programs that address the needs of fathers when their infant is to be delivered by C-section. Nurses and other providers could use the information from this study to develop prenatal educational programs that include the father as an equal partner and prepare parents for the possibility of cesarean birth. Interventions could also be developed for use in the maternity ward, to facilitate better management and crisis prevention during a C-section and to promote a more satisfying experience (Ceronio et al., 1995).

Summary

There is limited research that has explored the father's experiences in the perinatal and postpartum periods. Most research and literature reviews at this point have focused

on the mother, the infant, or the mother-infant dyad. Numerous studies describe the maternal experience in the time surrounding birth including maternal stress in the prenatal period (Engler, 2005), methods of coping with stress and nursing interventions designed to reduce stress (Melnik, 2000), maternal expectations and experiences of childbirth (Gibbons & Thomson, 2001), maternal satisfaction with childbirth (Melender, 2006), and maternal-infant attachment (Schenk, Kelley, & Schenk, 2005). Of the research that has centered on fathers, there is a lack of current literature that adequately describes the paternal experience following delivery by cesarean birth. Specifically lacking is in-depth knowledge of lived experiences of fathers in the immediate postpartum time period.

Interpretative phenomenological research is a qualitative approach that focuses on examining the experiences that are of particular importance to participants, in order to understand the meaning of the experience from the participant's perspective and are valuable for offering detailed and nuanced details about particular instances of a lived experience (Gadamer, 1960/1975; Heidegger, 1975/1988). Good case studies that include insightful analysis of a sensitively conducted interview on a topic that is of particular importance to a participant can make significant contributions to nursing research, practice, and education. The IPA method is congruent with hermeneutic phenomenology and provides a method to explicate the complexity of the human experience (Smith, Flowers, & Larkin, 2009)).

Because fathers provide a significant amount of support to mothers and infants during this critical time, it is important to improve understanding of the impact of cesarean birth of a child from the father's perspective. A negative birthing and early

postpartum experience may affect the father's desire to spend time with and support the mother, and may affect the fathers' involvement with the infant and their desire to be active participants in childcare (Bialoskurski, Cox, & Hayes, 1999; Condon, Boyce, & Corkindale, 2004; Gamble & Morse, 1993; Goulet et al., 1998; Hall, 1991; Melnyk et al., 2002). Nurses have access to fathers in the prenatal clinics, the hospital settings, and through community-based practice, and are in an optimal position to use information from this study to develop interventions that may increase paternal satisfaction with their experiences following cesarean birth to optimize outcomes for the entire family.

CHAPTER 2

REVIEW OF LITERATURE

There have been numerous studies and integrated literature reviews on maternal experiences surrounding childbirth as well as the infant in the months following birth. While there is an increased interest in the experiences of fathers there is still a void of in-depth knowledge of the paternal experience compared to what is known about mothers and their infants. The purpose of this review is to provide a background on the current knowledge base of the paternal experience in the month following a cesarean birth, and what is reported concerning the transition to fatherhood during this critical period. A history of Phenomenology is first reviewed, followed by the reason for choosing IPA as the methodology for this research study. A brief review of studies concerning family perinatal and postpartum care, the transition to parenthood, family relationships, and mode of delivery is also included.

Search Methods

Standard search methods were used to identify relevant articles and multiple databases were explored including CINAHL from January 1982 to present, MEDLINE from January 1982 to present, PROQUEST, PSYCHINFO, and Dissertations Direct. Language limitations were imposed to limit articles to those published in English. Keywords included ‘father(s)’, ‘cesarean section’, ‘men’, ‘paternal satisfaction’, ‘attachment’, ‘childbirth’, ‘family functioning’, ‘satisfaction with perinatal care’, and ‘satisfaction with postpartum care’. The Cochrane database was searched for systematic

research reviews by keyword, title, and abstract using the topics ‘cesarean section’, ‘fathers’, ‘paternal satisfaction’, ‘first-time fathers’, ‘family functioning’, ‘paternal attachment’, and ‘paternal bonding’. Unpublished dissertations were also evaluated and the bibliographies and reference lists of the retrieved articles were manually reviewed to identify additional potential sources. From the search criteria 115 articles and 5 dissertations were identified and reviewed. There were 81 articles used in the final literature review.

History of Phenomenology

Phenomenology is both a philosophy and a research method, and as a research methodology it is a philosophical approach to the study of experiences (van Manen, 1997). There are varying stances regarding ideals and interests depending on the specific phenomenological base for the method, however the overarching emphases involve examining the experience of what it is like being human, especially what things matter to us and what constitutes our lived world. A good phenomenological text can enable us to suddenly see something in an experience that enriches our understanding of that everyday life experience. Phenomenological methodology focuses on the substantive, conceptual, or thematic understandings that the text can offer to the researcher (van Manen). One of the key values of phenomenology as a philosophy is that it can provide a rich source of ideas for examining and comprehending the lived human experience of any phenomenon (Smith, Flowers, & Larkin, 2009). As a method phenomenology helps to explicate the essence of the lived experience of a phenomenon, searching for a unity of meaning and

the identification of the essence of the phenomenon through accurate descriptions and interpretations of the everyday lived experience of the participants (Speziale & Carpenter, 2007; van Manen, 1997). It must be remembered that the point of the method is to ascertain the truth or the true meaning of an experience, but just as there is no one uncontested truth there is no one superior or correct mode of inquiry (van Manen). Phenomenology seeks to discover the “historical approaches and suppositions that may hold promise in rendering human experience interpretable and understandable in our present time and place” (van Manen, 1997, p.346).

The history of phenomenology began in the early part of the 20th century and consisted of three distinct phases including the Preparatory phase, the German phase, and the French phase (Speziale & Carpenter, 2007). The Preparatory phase was punctuated by Franz Brentano (1838-1917) and Carl Stumpf (1848-1936) who was a prominent student of Brentano. The work of this period demonstrated the scientific rigor of phenomenology with a focus on intentionality, with intentionality meaning that consciousness is always consciousness of something. In other words one cannot see without seeing something, hear without hearing something, or believe without believing something (Speziale & Carpenter).

The German phase of phenomenology was dominated by the work of Edmund Husserl (1857-1938) and Martin Heidegger (1889-1976), who developed the concepts of essences, intuiting, and phenomenological reduction during this time period (Speziale & Carpenter, 2007). Husserl proposed that phenomenology could become the foundation of all philosophy and science, and be rigorous enough to restore contact with deeper human concerns. Heidegger followed closely in the steps of Husserl and his work is often

thought of as an outcome of ideas that are slightly different from but initiated by Husserl (Speziale & Carpenter).

The predominant leaders of the third or French phase of the phenomenological movement were Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980), and Maurice Merleau-Ponty (1905-1980), who developed the primary concepts of ‘embodiment’ and ‘being in the world’ (Speziale & Carpenter, 2007). Marcel, Sartre and Merleau –Ponty essentially contended that all acts are based upon foundations of perception or original awareness of some phenomenon, and lived experiences in the perceived world must be described. The primary tenets of this stage were that through consciousness a person is aware of being-in-the-world, and through the body a person gains access to this world. According to this view, it was important to note that at any point in time a particular perspective or consciousness exists for each individual and that this may vary for individuals based upon their history, knowledge of the world, and their openness to events as they occur in the world (Speziale & Carpenter).

Phenomenology According to Husserl, Heidegger, and Gadamer

As a research method phenomenology is rigorous, critical, and a systematic investigation designed to explicate the structure of the lived experience of a phenomenon, to determine the meaning or essence that the everyday lived experience holds for a person (Speziale & Carpenter, 2007). The procedural interpretations of the phenomenological method are based upon the works of different phenomenological philosophers and

associated schools of thought that provide a guideline when an investigator is considering this research approach.

Edmund Husserl and Phenomenology

Edmund Husserl (1859-1938) is credited with the founding of the phenomenological movement and is often referred to as the father of phenomenology (Husserl, 1913/1982, 1950/1970; Lavery, 2003; Maggs-Rapport, 2001). Husserl's initial work was in mathematics; however his interest in philosophy influenced his decision to complete formal education in philosophy under Franz Brentano (Husserl, 1950/1970; Lavery). Husserl saw phenomenology as a universal foundation for philosophy and science, and criticized psychology for attempting to apply methods of the natural sciences to human issues. He proposed these pursuits to be folly in that living subjects do not just react automatically to external stimuli, but respond to their own perception of what the stimuli mean. In Husserl's view, researchers that study only external physical stimuli that can be isolated and correlated with other isolated responses, may miss important variables and ignore context to create a highly artificial situation. Husserl was attracted to phenomenology because of its promise as a new science of being, and as a way of reaching true meaning by penetrating deeper into reality. Disclosure of a realm of being that presented itself with absolute certainty and was based upon experience now seemed possible (Husserl, 1950/1970; Lavery).

Husserl explored the way in which subjects 'know' objects or how they comprehended the existence of all things in their world, and questioned the possibility

that objects can have a separate existence from us (Husserl, 1913/1982, 1950/1970; Maggs-Rapport, 2001). He argued that it was not the existential existence of objects that was important, but rather that objects exist as objects of consciousness for us and that consciousness is unavoidable. Whether or not consciousness is acknowledged its presence is felt, and consciousness is implicit in everything that is written or spoken about. This included facts and feelings, dreams, sensations and fantasies, and referential objects. An object is anything that presents itself to consciousness, and should be described exactly as they are interpreted by the person to whom the object was presented. Objects can transcend the act in which they appear to the person, however they are not themselves consciousness and therefore are not independent of the subjective act of awareness (Husserl, 1913/1982, 1950/1970; Maggs-Rapport). Real objects or phenomena were experienced exactly as they presented to the participant, through a process guided by human intention and not mechanistic causation. Intentionality directed the act of consciousness to the object that transcended it, and this conscious awareness was what facilitated development of a participant's knowledge of reality (Husserl, 1913/1982, 1950/1970; Laverty, 2003; Maggs-Rapport).

Phenomenology according to Husserl involved careful examination of human experience, to find a means for a person to accurately know their own experience of a particular phenomenon (Smith, Flowers, & Larkin, 2009). The goal was to develop adequate depth and rigor to allow the identification of the essential features of that experience, and to determine if these essential features transcended the particular circumstance of their appearance and could illuminate a given experience for others as well. Husserl developed a phenomenological method for identifying the core features of

human experience. He described the idea of first needing to “bracket” or put to one side the everyday world in order to concentrate on the perceptions of that world. The researcher then proceeds through a series of reductions intended to separate the researcher from their own assumptions and preconceptions and back towards the essence of the experience of a given phenomenon. The task for Husserl therefore was to try and establish the core of the subjective experience and the central idea or essence or *eidos* through eidetic reduction. This was accomplished through various techniques such as free imaginative variation or considering the different possible instances of the phenomenon. Finally Husserl suggested going through a process of transcendental reduction by focusing on the experience and describing its essential features, to try and look at the nature of consciousness itself in an attempt to get at the content of the conscious experience (Smith, Flowers, & Larkin).

Aspects of Husserl’s work influenced the development of phenomenological psychology and specifically descriptive phenomenology and descriptive psychology followed by Giorgi and colleagues (1985). The purpose of phenomenological research methods grounded in Husserl is do justice to the lived aspects of human experience and to describe how someone has actually experienced what has been lived. To do this requires in-depth evaluation of the experience through direct exploration, analysis, and description of the particular phenomenon to integrate and synthesize the insight into a description of the experience (Giorgi, 1985; Speziale & Carpenter, 2007).

Interpretative phenomenological analysis moves beyond the emphasis on description of the experience focused on by Husserl and his followers to the interpretation of the meaning and understanding of the experience as it is lived in the

world. The turn to an emphasis on interpretation of the experience is a change based upon the work in hermeneutic phenomenology led by Martin Heidegger and Hans-Georg Gadamer (Cohen et al., 2000).

Martin Heidegger and Hermeneutic Phenomenology

Martin Heidegger (1889-1976) was born in Germany like Husserl, and trained with Husserl to learn the processes of phenomenological intentionality and reduction (Lavery, 2003). Heidegger's hermeneutic phenomenology was concerned with the life world or lived human experience, with a focus on illuminating details and aspects within the experience that may be taken for granted to create meaning and achieve a sense of understanding (Heidegger, 1975/1988; Lavery, 2003). Heidegger disagreed with Husserl on how the exploration of the lived experience should proceed. Husserl focused on understanding beings or phenomena, and was interested in acts of perceiving, recalling, and thinking about the world where human beings were the principle knowers. Heidegger was more interested in what he called 'Dasein' or the mode of being and the situated meaning of humans in the world, and he viewed human beings as creatures concerned with their fate in the world. Heidegger contended that consciousness could not be separated from the world and was a formation of a person's historically lived experience. He called this *historicality*, and a person's background and history including the culture that a person was born into and handed down presented ways in which the person understood the world. According to Heidegger, people determine what is real through their understanding of their world, and pre-understanding is a structure for being

in the world. Pre-understanding is the meanings or organization of a culture that is present before it becomes understood or the historicity of an individual. Pre-understanding cannot be separated from an individual, and Heidegger claimed that nothing could be encountered without reference to a person's background understanding. In this view people are being influenced by the world at the same time they are constructing the world based upon their own backgrounds and experiences, and this is how understanding and meaning is found. Interpretation is the key to this process of understanding, and Heidegger contended that every encounter involved interpretation that was influenced by the person's historicity. In his view understanding occurs through a set of fore-structures, including historicity, as one becomes aware of and accounts for these interpretative influences. Therefore, prior experiences are considered impossible to separate, or 'bracket', from the here and now and are part of the process of coming to understand everyday life. Heidegger emphasized that the interpretative process occurs through a *hermeneutic circle* of analysis that moves through parts of the experience to the whole of the experience and back and forth, increasing in depth of engagement and understanding, until a place of sensible meaning has been reached that is free of inner contradictions (Heidegger, 1975/1988; Lavery).

Heidegger stated that people relate to things as an integral element of external reality and that humans are inseparable from their world of being (Maggs-Rapport, 2001). He referred to this as "being-in-the-world", and saw this fundamental ontology as the foundation for constructing the human sciences. 'Being-in-the-world' was evidence of the world in which we interact and how we make sense of the world *through* our existence in the world, rather than in any other detached manner. Heidegger focused on

understanding rather than description alone, and considered both phenomena and the interpretation of those phenomena. Language and speech were key elements that were essential for 'being-in-the-world' to be both manifest and understood (Maggs-Rapport).

Hans-Georg Gadamer and Hermeneutic Phenomenology

Hans-Georg Gadamer was born in 1900 and studied philosophy at Marburg and Freiburg in Germany in the 1920s (Lavery, 2003). He was influenced by the work of both Husserl and Heidegger and extended Heidegger's work into more practical applications. Gadamer believed the work of Hermeneutics was to further clarify the conditions in which understanding takes place, and was not just a procedure for understanding (Gadamer, 1960/1975). Gadamer agreed with Heidegger that language and understanding were inseparably linked structural aspects of 'being-in-the-world', and that language was the universal medium in which understanding and interpretation takes place. Interpretation was seen by Gadamer as a *fusion of horizons* and a dialectic interaction between understanding of the subjective meaning of the text and the expectations of the person interpreting the text (Gadamer, 1960/1975). A horizon in this context means the range of vision including everything seen from a particular vantage point, and Gadamer contended that individuals with limited horizons did not see far enough and were unable to look beyond what was close at hand (Gadamer, 1960/1975; Lavery, 2003). It was important to have a questioning attitude, which was an essential aspect of the interpretative process that could help to illuminate new horizons and made obtaining understanding possible. Gadamer also contended that understanding and

interpretation were inseparable and that interpretation is a continually evolving process, therefore a static or definitive interpretation is likely never possible. He was not opposed to methods that could increase our level of understanding or overcome limited perspectives; however he was emphatic that methods are not totally objective or value free from the investigator. In this vein he viewed bracketing as manifestly absurd because our understanding of an experience is based upon our historicity and therefore inherently prejudiced as a condition of what we find intelligible in any given situation. He rejected the idea that a knower could separate him or herself from the immediate situation in the present by merely adopting an attitude, and he worked to extend the ideal that these perspectives gained by past experiences of the researcher played an essential role of enhancing understanding gained by the research process (Gadamer, 1960/1975; Lavery).

Interpretative Phenomenological Analysis

Interpretative phenomenological nursing research is often based upon hermeneutic phenomenology, where interpretative frameworks are used to unveil the relationships and meanings that knowledge and context have for each other (Denzin & Lincoln, 2000; Speziale & Carpenter, 2007). Interpretative phenomenological analysis (IPA) is a phenomenological research method that has evolved from the school of philosophy grounded by the work of Heidegger and Gadamer, and focuses on interpretation and understanding of experiences rather than the description of the experience that is espoused by Husserl and his followers. IPA is an approach to

qualitative experiential research that has its origins in psychology but has been used increasingly in the human, social, and health sciences (Smith, Flowers, & Larkin, 2009). IPA is committed to examining how people make sense of their major life experiences, and it is phenomenologic in that it is concerned with exploring those experiences in their own terms and contexts. IPA researchers are interested in what happens when something important occurs in life, and the everyday flow of lived experiences takes on a particular significance for a participant. Researchers using IPA are concerned with the details of each individual case, wanting to know what sense each individual person is making of what is specifically happening to them. The aim is to reveal themes in the narrative accounts of each individual and to uncover any connections between the themes. IPA then moves across cases in an attempt to establish super-ordinate (overarching) themes. A dynamic form of bracketing is used within and between the individual cases that is congruent with the views of Heidegger and Gadamer, to allow the themes of each individual case to develop fully without the influence of themes from previous cases. Exploring the similarities and differences between each case is then used to help the researcher develop an understanding of the meaning that the experience has for each of the individual research participants. The outcome of IPA research is usually a narrative account that presents the elicited themes, which are supported by verbatim extracts from the individual accounts of the research participants (Smith, Flowers, & Larkin).

Interpretative phenomenological analysis was chosen as a methodology for this study because it allows for an increasingly sensitive awareness of humans and their ways of being-in-the-world (Speziale & Carpenter, 2007). One of the philosophical questions for nursing research is what kinds of knowledge are helpful for the discipline and how

should nursing go about obtaining this knowledge (Allen & Jensen, 1990). The value of knowledge for nursing can be determined by its relevance to and significance for understanding the human experience. Nursing requires modes of inquiry that allow for freedom to explore the richness of the human experience in order to accomplish this task (Allen & Jensen). IPA offers such a mode of inquiry, allowing for arrival of a deeper comprehension of human existence through attention to the nature and meaning of phenomena and then further interpretation of the meaning and its contexts to enhance understanding of the experience. It enables nurses to unveil otherwise concealed meanings in the phenomena, and helps to bridge the gap between what is familiar in our worlds and what is unfamiliar (Speziale & Carpenter, 2007).

Family Perinatal and Postpartum Care

The experiences of labor and delivery and early parenthood holds a special place in the lives of many parents and it is natural to assume that this stage of life has been thoroughly investigated (Wilson, Rholes, Simpson, & Tran, 2007). Surprisingly, little is known about parents' perceptions of and reactions towards each other during labor and delivery and how this may affect their feelings towards their new infant. The perinatal and postpartum period can be fraught with stressors such as fatigue, uncertainty, financial concerns, and work-family conflict that must be addressed while caring for and developing a relationship with the new infant (Wilson et al).

The early parent-child relationship that begins to develop in the perinatal and postpartum period has important long-term effects on the infant from both a

psychological and physiological perspective (Propper et al., 2008). Early involvement of both parents and provision of sensitive care is essential for the optimal development of the infant during the critical first year of life (Propper et al.). However some fathers have reported that they felt their relationship with their infant was slower to develop than the mother-infant relationship, and that their partner held a privileged position because of circumstances such as maternal-fetal bonding and attachment during pregnancy and breastfeeding (Gamble & Morse, 1993). Other fathers have expressed feeling alienated from and jealous of the strong mother-infant relationship, and of being more of a bystander that is excluded from providing care to the infant. Sometimes new fathers may feel alone with no one to talk to about their experiences (Gamble and Morse). The circumstances surrounding birth such as a cesarean delivery can bring about feelings of anxiety, relief (that the labor is finally over), anger (lack of preparation or rapidity of the procedure), and helplessness which may negatively influence the father's feelings and response towards their infant (Anderson, 1996). The lack of early instrumental and emotional support to become involved and emotionally attached to their infant may also negatively affect the father's transition to the role of parent and delay the development of the paternal-infant relationship (Gamble & Morse). Interventions to promote quality improvement of infant and family outcomes during the transition to parenthood have a greater potential for success if the early involvement of the father is recognized, and made an integral part of efforts to improve successful parenting during perinatal and postpartum care (Hawkins, Lovejoy, Holmes, Blanchard, & Fawcett, 2008).

Perinatal Care, Postpartum Care and Parenthood

The perinatal and postpartum periods are times of enormous change for families and especially first-time parents. Parents frequently bear complete responsibility for a new life and must often change their own way of living compared to what they knew and experienced before the birth of their infant (Pollock et al., 2005). There are studies that have examined parental concerns in the perinatal period (Gamble & Morse, 1993; Matthey & Barnett, 1999) but there needs to be a better understanding of the events surrounding labor and delivery and how this may affect parents and their relationship to their infant. Adequate preparation of parents as they transition to their new role in the perinatal period should address the possible stressful experiences that may be encountered (Pollock et al.). It is very important that nurses and other perinatal educators who provide care understand the experiences of fathers as well as mothers in order to plan care interventions and educational programs that are based on evidence of potential stressors experienced by the entire family unit (Pollock et al.).

According to Pollock, Amankwaa and Amankwaa (2005) common daily annoyances can become significant stressors. Financial strain, anxiety, and depression in fathers may become stressors that affect the marital and parent-infant relationship as well as the overall health status of the family. All members of the family influence and are influenced by the addition of an infant which may cause joy and stress, but there remains an inadequate understanding of paternal postpartum stressors and how they may affect family relationships. In their study, primiparous fathers with children under 1 year of age revealed that four of the top five most bothersome postnatal stressors were related to role

function including ‘not enough time to do the things you want to do’, ‘having too many responsibilities’, ‘concerns about your child’s health’, and ‘concerns about the health of family members’. The sixth highest ranked stressor was ‘difficulties with your child’s mother’. The results of this study provide a preliminary examination of everyday stressors that new fathers have in their first year of fatherhood including role conflict and role overload that can directly affect a couple’s relationship and their attainment of effective parenting skills (Pollock et al.).

Sensitive parenting plays an important role in the appropriate development of complex behavioral and physiological responses in infants even as early as 6 months of age, and the way in which parents respond to the needs of their infants may determine how the infant will respond to physiological stress later in life (Propper et al., 2008). Genes have also been shown to be a key influence on how children react to stress, and Propper and colleagues conducted a study to compare the effect of genes versus maternal sensitivity on infant stress response. Infants were separated from their mothers and their heart rates were monitored to determine cardiac vagal tone as a measure of stress response at 3, 6, and 12 months of age. The mothers were videotaped playing with their infants at 6 months of age to determine if maternal sensitivity was high or low. DNA was collected from the infants to determine if they carried a specific dopamine receptor gene that has been linked to risky behaviors in adolescence and adulthood including aggression and substance abuse. At 3 and 6 months of age those infants with the at-risk gene were found to have a blunted cardiac response to the stressful situation while infants without the gene had an appropriate elevation in heart rate when stressed. Mother sensitivity did not seem to alter infant response at 3 and 6 months. However by 12 months of age

infants with the at-risk gene and sensitive mothers showed an appropriate cardiac response to the stressor while infants with the at-risk gene and an insensitive mother continued to show an ineffective cardiac response to the stressor. The findings demonstrate that while genes contribute to the development of physiological responses, environmental experience including parental sensitivity can have a strong enough influence to change the effect that genes have on physiology very early in life. This study highlights the importance of effective parenting for appropriate development of children's behaviors and the underlying physiological mechanism that support this behavior, especially when children have inherited a genetic vulnerability to problematic behaviors (Propper et al., 2008). Assessment in the perinatal period would help identify individual family needs that can be addressed to support sensitive parenting.

Paternal Needs in Perinatal and Postpartum Care

The needs of fathers in the perinatal and postpartum time periods has often been neglected or trivialized when compared to the needs of the mother and the newborn. The failure to include the father may lead to inconsistencies in positive reinforcement of appropriate parenting behaviors, which may leave fathers feeling inadequate when they attempt to provide infant care. One method of education that has been utilized to improve the experiences and parent-infant relationships in the postpartum period has been prenatal parent-infant classes. Most prenatal classes have traditionally focused on the childbirth experience and are designed for the maternal aspect of birth (Matthey & Barnett, 1999). In a study to assess the effectiveness of perinatal education on couples

who attended prenatal education, approximately one third of the fathers would have liked to have had more education regarding infant care, and at 6 months postpartum three quarters stated they would have attended an educational class with their infant in the early postpartum period to improve their care. Rates for the mothers in the study were found to be similar (Matthey & Barnett).

More men are now attending childbirth classes than in previous decades with attendance rates as high as 80 to 90% (Fletcher et al., 2004; Kaila-Behm & Vehvilainen-Julkunen, 2000). However few programs provide support that is specifically designed for fathers, a critical need given the growing awareness of the benefits that positive father involvement has on child development (Fletcher et al., 2004). This has led to a greater recognition of the support needs of men during their transition to fatherhood, but also to a realization that fathers are not currently accessing existing family-related services. The evidence on how to best meet the needs of fathers during their transition to fatherhood is far from clear. To attempt to address this issue, new Australian fathers were asked to indicate how antenatal classes had prepared them for labor and delivery and life after the birth, to assess how well antenatal classes were meeting the needs of new fathers, and to assess new fathers' awareness and use of family support services. Couples who had attended at least 50% of their antenatal classes were recruited for the study, and the responses showed that 88.3% of the new fathers felt that the antenatal classes helped them feel more confident during labor and 87.2% reported feeling confident in their role as a support person. Only 29.8% of the new fathers felt that the classes prepared them for lifestyle changes and only 27.8% felt the classes prepared them for relationship changes. Greater than half of the fathers indicated they would have attended postnatal classes if

they were offered after business hours. When asked about whom they queried for information about fatherhood 91.8% turned to the mother primarily, although 34.6 % turned to fellow fathers as a secondary source of information. The fathers were asked to rate their awareness of 11 support services that were available in the community. Except for the general practitioner, early child clinic, and poison center greater than 50% of the fathers were unfamiliar with all other services. Frequency of use of these unfamiliar services was accordingly low. From this study it appears that antenatal classes can be successful on several issues such as preparation for labor and role as support person. However the study researchers contend that classes can clearly be improved and the curriculum should be updated to address lifestyle and marital relationship changes. It was found that over one third of the fathers in the study turned to fellow fathers for parenting advice. Approximately 60% of the fathers indicated an interest in attending postnatal classes if they were at more convenient times such as after business hours or on the weekends. Findings were reported that fathers were very unfamiliar with the available community support services, and infrequently used the ones they were familiar with. Authors of this study emphasize that improved paternal involvement with children will depend on increased education aimed directly at the needs of fathers (Fletcher et al., 2004).

The Transition to Parenthood

Various roles have been described for fathers during the perinatal and postpartum period including breadwinner, helpmate, teammate, witness, and coach (Kaila-Behm &

Vehvilainen-Julkunen, 2000). These differing perceptions about the paternal role may lead to role conflict and role strain for first-time fathers during the transition to parenthood, which can increase stress and cause dissatisfaction with family relationships (Anderson, 1996; Gamble & Morse, 1993; Hall, 1991). The changing role of the father and the increasing involvement of fathers in childcare and housework necessitate a better understanding of how fathers view their transition to parenthood during the perinatal and postpartum period (Kaila-Behm & Vehvilainen-Julkunen). It will also be important to understand how they redefine their roles as workers, spouses, and fathers to minimize negative effects on family relationships (Hall).

The Couple and the Transition to the Role of Parent

Alleviating stress and providing support during the transition to parenthood has been identified as an important role for the male partner (Somers-Smith, 1999). A relationship with the male partner in which support expectations are met correlate with positive outcomes for new mothers. If expectations of support are not confirmed or met, feelings of loss of control may arise and the mother is at higher risk for depression. Sometimes fathers may not know how to best help and support their partner during childbirth, which can cause marital distress. A prospective design using a qualitative approach was used to explore the expectations that primagravidae have concerning the support they hoped to receive from their partners during labor and delivery. A secondary aim was to identify the thoughts and feelings of the male partners concerning their role as a support person and how well they felt they performed that role. First-time parents were

recruited from antenatal clinics using purposive sampling, and 8 of the 13 couples approached agreed to participate. Ages of the participants ranged from 25 to 32 years for women and 24 to 36 years for men. Data were collected by individual interviews in the participants' homes approximately 6 weeks before confinement and again between 10 to 16 weeks following childbirth. Interviews were then transcribed and themes and concepts were identified. Mothers had quite specific expectations for their partners during labor. Fathers exceeded expectations in three areas including just being there, holding hands, and providing moral support. Fathers fell below the mother's expectations when it came to massaging her back, helping make decisions, helping with breathing, helping to change positions, and entertaining or distracting her. Some mothers had other expectations such as wiping of the forehead or walking with their spouse, but more important to them was psychosocial support from the father including expressing empathy and caring, having eye-to-eye contact, and actively providing verbal encouragement. Most men felt confident they could fulfill these expectations; however some did express concerns or fears that they might panic, faint, or fail to respond to the needs of their spouse. Some of the men kept these fears to themselves, partially so as not to worry their spouses but also due to socio-cultural norms that discourage men from having public displays of emotion. The reasons for this are unclear, but could be due in part to unrealistic expectations in the first place or fathers feeling inhibited about moving around the birthing suite, embracing in public, or giving their spouse a massage in front of healthcare personnel. Men also felt that their expectations of childbirth were more negative than the actual experience. Fathers reported feeling less distressed about their partner's pain, less frightened and more excited and fulfilled than expected. The mere

presence of the father made the mother feel valued and cared for during delivery, and high levels of perceived support generally led to a more satisfying birth experience for women. The perception of childbirth varied from father to father and birth evoked both pleasant and unpleasant emotions. Many fathers described it as an emotionally uplifting experience with reports of crying at the moment of birth; however a number of the men found the birth experience to be distressing as well as exciting. Many fathers did recall certain manifestations of distress surrounding labor and birth. Some noted that their anxiety levels increased if labor was prolonged, excessively painful for their partner, or plagued by complications. The most common feeling was a sense of helplessness, and not knowing what to do for their partner, especially when the mother was in pain. The father's needs should be regularly assessed during childbirth and the laboring couple should not be left alone for more than a short period of time. Fathers and especially first-time fathers may need support and guidance to help them effectively cope if they have feelings of helplessness, and relief should be readily available if necessary. Fathers should be encouraged to provide active emotional and practical support to mothers during labor and delivery to allow them feel more involved and appreciated by their partner (Somers-Smith).

The transition to parenthood is an appropriate time to introduce father involvement interventions (Hawkins et al., 2008). To improve marital satisfaction an intervention was introduced to a group of first-time parents that consisted of an informational video and guidebook emphasizing qualities that lay the foundation of a loving and lasting marriage. The primary goal was to prevent couple relationship deterioration and support more effective parenting and infant well-being during the

transition to parenthood. Couples were divided into a control group, a comparison group, and a treatment group. The control group consisted of couples who were interested in the study but not in the home visits that were part of the intervention. A comparison group consisted of couples who received a standardized monthly home visitation program during the first year after birth to increase parental awareness of infant development and available resources. The intervention group received the standardized monthly home visitation program as well as the marital improvement intervention at 3 months after birth. The groups were assessed at three time periods using measures included in the intervention guidebook. Analysis of the data showed no effect of the intervention on marital relationship outcomes, however there was a modest increase of father involvement in daily infant care of the treatment group compared to the control group (Hawkins et al.). This study demonstrates why it is important to utilize the quality improvement process and carefully plan an interventional program based upon assessed needs. Couples in this study were asked about changes in their relationships and then given an intervention which generally emphasized qualities to improve marital relations, versus an intervention based upon the couple's answers regarding changes in their relationship since the birth of their child. It would have been better to conduct an in-depth assessment of changes in the couple's relationship after the birth of their child and to develop an interventional program based upon the couple's answers. There would be a better chance of strengthening a couple's relationship outcomes by addressing each couple's individual needs.

The Father and the Transition to the Role of Parent

The paternal experience of becoming a parent has been largely understudied (Barclay & Lupton, 1999). In a review of the nursing research that has been published, some common themes were evident (Bartlett, 2004). Fathers may be ambivalent during the early phases of pregnancy until the pregnancy becomes “real” during the third trimester. Men may then become more involved with concerns about financial security, changes in the sexual and marital relationship, and their adequacies as fathers. Pregnancy evokes a wide range of emotions, from pride and euphoria to anxiety over expanded financial responsibilities, and documented physical effects experienced by fathers during pregnancy include loss of appetite, nausea, and vomiting (Bartlett). Most of the emphasis in nursing research has been on the mother’s transition to parenthood, and the focus of the family-dynamic literature has been on the role of the mother (Kaila-Behm & Vehvilainen-Julkunen, 2000). There has been a lack of interventions including fathers and there is a need to better understand the process of becoming a father, to promote the desired level of involvement and to support the father in his transition to the role of father so he can optimally interact with his family.

The transition to parenthood can be stressful, especially for first-time fathers and mothers (Henderson & Brouse, 1991). The transition for most new fathers is not perceived as a crisis, but it is a difficult time of adjustment. There is a paucity of research regarding the paternal transition to parenthood, with most of the past research and parenting education programs focused on the maternal-infant relationship. This matricentric viewpoint has created a significant gap in nursing research and theory which

is problematic for effectively addressing the needs of fathers (Henderson & Brouse).

Twenty-two first-time couples were interviewed three weeks after birth to clarify the understanding of the experience of new fathers during this critical period of family development. A phenomenological approach was used to uncover the meanings that the experiences held for the fathers, and the mothers were included so as not to reveal that the fathers' experiences were the main focus of the research. The interviews were transcribed and analyzed and themes were identified. A significant theme was the intense emotions experienced by new fathers. They frequently felt anger and frustration when they had to make decisions based on conflicting information. They pointed out inconsistencies throughout the birth experience such as prenatal classes that either left them unnecessarily frightened or inadequately prepared for the actual labor. The postpartum period was equally filled with conflicting information as it seemed that every healthcare provider had a different opinion about postpartum care. Fathers felt upset on behalf of their wives because of the conflicting information, but were hesitant to clarify the information because of the perceptions that the nurses were too busy to be bothered. Parents felt guilty about asking questions, and were often torn between the wish to go home and the fear about their ability to care for the infant once they were discharged. Further analysis of the data revealed three main categories for fathers during their transition to parenthood: expectations, reality, and transition to mastery. Expectations were the father's vision before birth developed from conversations with friends and families, previous experiences with other newborns and formal insight gained from prenatal classes and reading. Most fathers acknowledged that their expectations were of limited value when the birth actually occurred. Reality set in after the baby was born and

came home, and fathers realized their expectations were not based on fact. Some fathers expressed feelings of disruption, exclusion especially if the baby was breastfeeding, and the overwhelming feeling that they needed to become more involved. The third main category was transition to mastery, when the fathers began to feel more comfortable.

They described a conscious and deliberate appraisal of what was happening to them and a decision to master their new role. They began to derive satisfaction from their efforts and mentioned the joy they received in seeing the infant laugh or giggle. The last theme that arose from the data was the lonely decision that the fathers made to become more involved with their infants. They cited lack of services that were specifically designed for new fathers and the desire for more information and support in the perinatal period. It is unfortunate that these fathers felt this way, but this study does reveal the inequality in provision of perinatal care as all of the families in this study were visited by community health nurses (Henderson & Brouse).

To be able to provide appropriate and relevant care and education to fathers there must be a basic understanding of the experiences, processes and life changes from the father's perspective (St. John et al., 2005). To explore this issue 18 first-time or subsequent fathers were interviewed 6 to 12 weeks after the birth of their infant. A grounded theory approach was used to analyze in-depth interviews conducted on fathers recruited from the maternity wards of a large public hospital in Australia. Eighteen fathers completed the study, which included in-depth audio-taped interviews that lasted approximately 1 hour. The majority of the interviews were conducted in the subject's home but 2 of the interviews were conducted at the university affiliated with the hospital. Half of the subjects were first-time fathers. To guide the interviews a script was utilized

that was refined as the study progressed. Topics included experiences during the perinatal and postpartum period, daily activities, healthcare and support, changes in relationships or lives, and views on being a father. Themes were developed and refined from the data as the study progressed. Six major themes based upon the fathers' perspectives were identified: making a commitment, negotiating responsibilities, developing and maintaining relationships, maintaining family integrity, balancing activities, and perceiving themselves as fathers. Making a commitment entailed recognition that new fatherhood brought on new responsibilities and commitment to the new infant, the spouse, and the role of father. The fathers made sacrifices where necessary to accommodate the changes required in fathering a newborn. Negotiating responsibilities of parenting with the spouse was accomplished by helping partners to manage in the care of the infant and with household tasks. Some of the participants noted the demands brought on by a new infant made them feel frantic at times while others described just doing what needed to be done. Developing a relationship with the newborn was usually related to the amount of time spent in day to day care of the infant. Those fathers with more time invested were excited and surprised to find that they were enjoying interaction with their newborn in the early weeks. Some of the other fathers postponed forming a deep relationship and stated that they were waiting for the infants to become older and a little more responsive to their care. Maintaining a relationship with their spouse was also a process of negotiating new roles that affected the couples' relationships. Household tasks and values, beliefs and ideas about how the infant should be cared for were all open to negotiation and sometimes caused stress, disagreements, and tension. Other participants felt that the shared parenting strengthened their

relationship as a couple, gave them a new appreciation of each other, and they were able to see their spouse in a different role. In maintaining the family integrity fathers balanced the demands at home with those at work. While mothers were enmeshed in the care of the infant the fathers' roles often straddled the home world and the outside world.

Balancing activities for the fathers included juggling the competing demands of family, work, relationships, and personal activities and often required making choices and trade-offs. The fathers reprioritized what was important in life which enabled them to spend more time with their family and cope with everyday living. Development of the self as a father occurred over time for participants as they reflected what it meant to be a father, how they had been fathered, what was important in their lives, and what type of father they wanted to be. All of the participants wanted to be the best father possible and some wanted to be like their fathers while others did not want to make the same mistakes.

Fathers in this study revealed that the transition to fatherhood is complex and that fathers engage in a balancing act between the role of provider and the developing role of father.

The early weeks of new or expanding fatherhood were challenging and sometimes stressful. The postpartum period was also rewarding for most men and most fathers were committed to their families, wanted to become good fathers, and worked to reprioritize their lives to share responsibilities with their partners and develop new routines and life patterns. A range of competing demands affected the ability of fathers in this study to participate in the home and with their newborn in the postpartum period. Further investigation should be performed on the marital relationship and how men negotiate roles with their partner and what factors affect paternal involvement in routine care of the newborn (St. John et al.). This study involved uncomplicated vaginal delivery

experiences outside the United States (Australia), limiting the utility of findings for fathers experiencing a cesarean birth of a first child in the United States.

Family Relationships

Commitments of time and energy are necessary to build family relationships and maintain effective family functioning and parental competence (Knauth, 2000). The development of positive family relationships in couples can be determined by the importance they place on interpersonal relationships. Couples that place a low importance on family relationships usually expend less time and energy nurturing those relationships, which often results in less satisfaction, decreased family functioning, and a decreased sense of parental efficacy and competence after the birth of a child (Knauth). To understand how to better promote family relationships it is essential to be able to describe how couples respond to the birth of a child, and to examine the early postnatal experiences of fathers to identify factors that may lead to or interfere with a successful transition to parenthood.

The Marital Relationship

The quality of the marital relationship may affect family functioning and subsequently the behaviors of the father, the mother, and eventually the infant (Knauth, 2000). The marital relationship is an important source of support for the development of parenting skills (Knauth). When fathers have a highly engaged relationship with their

partner they are consistently more involved in interactions with their infants and are more sensitive to the needs of their infants (Frascarolo, 2004). Marital quality may predict the amount of paternal stimulation of the infant which has been associated with increased family functioning as well as higher levels of cognitive functioning for the infant (Frascarolo).

Parents must be able to provide a secure, safe, and loving environment in order for children to develop normally (Elek, Hudson, & Bouffard, 2003). First-time parents are faced with multiple changes including the increase in childcare related tasks that must be mastered. Fathers may differ from mothers in the rates at which they obtain and become comfortable with parenting tasks, and may feel less confident in their skills in the immediate postpartum period. Fathers usually report feeling more comfortable with childcare as the year progresses, and are more likely to engage in childcare task at an earlier point if the mother returns to employment. Parents must also maintain a satisfactory relationship with their partner while at the same time forming a satisfactory relationship with the new infant (Elek et al.). Some studies have shown that marital satisfaction declines for both men and women in the first postpartum year (Elek et al.; Knauth, 2000; Mercer & Ferketich, 1990). In contrast, another study by Hudson, Elek, & Fleck showed that marital satisfaction scores remained stable after birth and even demonstrated a small but significant increase in marital satisfaction between the prenatal period and the 4th month postpartum (2001). A longitudinal non-experimental design was used to determine if reports of infant care self-efficacy and marital satisfaction scores change from 4 to 12 months after birth of a child. The sample consisted of 32 of the couples from the 2001 study by Hudson, Elek, and Fleck (Elek et al.). The couples were

contacted when their infant was nearly one year old and asked to complete questionnaires on infant care, parenting satisfaction, and marital satisfaction. Infant care self-efficacy scores increased significantly between 4 to 12 months postpartum, with mothers scoring higher than the fathers. Parenting satisfaction scores did not significantly increase from 4 to 12 months for either mothers or fathers, however marital satisfaction scores did decrease for both parents during the time period. The reports of marital satisfaction by both parents were strongly related to each other. This suggests that parents view their relationships in similar ways and that the relationship between parenting satisfaction and marital satisfaction may affect the parent's relationship with their infant. Fathers continued to complain about general lack of education and support they received from healthcare providers in regards to infant care and what to expect in the postpartum period. The results of this study show that the parenting satisfaction and skills of the parents are not necessarily related, and that nurses should schedule well child visits when both parents can attend so their interactions can be assessed (Elek et al., 2003). Informational deficits can be addressed at this time, and the goal of maintaining the prenatal level of marital satisfaction should be a high priority.

The dynamic interactions between the marital and parenting systems are highly enmeshed, and the mother-father relationships influence and are influenced by the parent-child relationships (Cox & Paley, 2003). The level of emotional support and the level of conflict and hostility in a marriage may relate to different qualities of parenting by fathers and mothers (Barnett, Deng, Mills-Koonce, Willoughby, & Cox, 2008). The parenting behaviors of 97 co-resident mothers and fathers was studied to determine if marital quality was associated with similarity between maternal and paternal parenting behaviors.

Participants were a subset of a larger longitudinal investigation of early child development, and were recruited by phone within the first 3 months after birth of the child. Data were collected when the child was 6 months of age. Parents were filmed separately in their home during a semi-structured 10 minute dyadic free-play interaction with their infant. A diverse team of seven coders scored the videotapes for caregiver behavior and negative and sensitive parenting. A separate team of coders scored the interactions of child behavior. To measure partner relationship each parent filled out separate self-report questionnaires while the other parent participated in the free play interaction. Analysis of the results showed consistent interdependence of parenting by fathers and mothers. Negative and sensitive parenting interactions were both evident. Negative parenting in each parent-infant dyad was associated with negative parenting in the other parent-infant dyad. Interdependence of sensitive parenting behaviors for both parent-infant interactions was also found with high perceived marital quality associated with more sensitive parenting behavior. Positive marital processes are associated with positive child outcomes, and this study showed that this may be because high quality marriages support sensitive parenting by both partners. This study lends support to the evidence that family interventions must consider both the father and the mother to be effective. Enhancing marital quality by reducing conflict and promoting intimacy may support positive and sensitive parenting from one parent-child dyad to the other and lead to improvements in positive child development (Barnett et al.). The increased potential for a C-section delivery to negatively affect the marital relationship makes it important to improve understanding of this experience.

The Parent-Child Relationship

The Parent-Infant Relationship

Pruett (1998) contends that infants develop in a complex social system to which the fathers make unique contributions. Part of this complex system can be explained by attachment theory, which states that when infants signal their needs and parents respond appropriately, a secure parent-infant attachment ensues. This should hold true for fathers as well as mothers, as no biologically-based sex differences in responsiveness to infants has been substantiated. Fathers are just as anxious as mothers about leaving their infants in the care of others, and a father's ability to identify their infant is equal to that of the mother. Fathers are equally responsive to infant cues regarding hunger, satiation, burping, and soothing, although paternal responsiveness has been shown to vary in correlation with the amount of infant care that the father assumes. Satisfaction with the marital relationship is also a factor that affects paternal engagement. Fathers with a warm and confiding marital relationship report more optimistic attitudes towards their young infants. Fathers who are affectionate with positive attitudes that take time to be involved with their infant are more likely to have secure attachment relationships with their child at 12 months of age. The quality of care versus quantity of care matters most, with the quality of the father's involvement being a much more potent predictor of a secure attachment relationship. Fathers provide another source of attachment stimulation in opposition to the mothers because of their innate physical differences. Larger physical size, deeper voice, coarser skin and smell all combine to offer a distinctly different basis for potential attachment behaviors. This variation may aid the infant in earlier and

improved recognition of the mother and father, creating an early paradigm for appreciating the unique attributes of others and predisposing the infant to have a heightened awareness of different social styles and possibly enhanced social competence (Pruett).

Involving parents early in their infant's care and developing secure attachment relationships has been positively related to early language development, and early development of the infant brain (Bronte-Tinkew, Carrano, Horowitz, & Kinukawa, 2008; Tobey, 2001). "The infant's brain develops from the bottom up with the brain stem developing first followed by the midbrain, limbic system, and cortex" (Tobey, p. 19). The role of the parent and early attachment is critical to neurological development in significant areas of the brain, with major implications for development and regulation of affect and the origin of self. Although the brain stem is almost fully functional at birth, the limbic forebrain develops more slowly and requires significantly more social, emotional, perceptual, and cognitive stimulation during the first several months and years of life. The limbic forebrain is responsible for emotions such as pleasure, rage, joy, and fear. Infants raised in an abnormal or deprived or socially isolated environment can lose billions to trillions of synapses as limbic system nuclei atrophy, and random or abnormal neural pathways and interconnections develop. Because the limbic system provides the foundation for all social and emotional behaviors, it is critical that fathers and mothers recognize their contribution to their infant's brain development. Social competence, empathy, and attachment across the lifespan are all influenced by the early experiences of the infant. Early attachment relationships influence later social competence by serving as the foundation for the child's expectation about future relationships. As infants develop

expectations arise that social partners will respond to them and that they are worthy of positive responses. Anxious infants often develop as a result of inconsistent treatment or rejection by their social partners. Social competence is learned as the infant is taught about behavioral and communication synchrony, and how they should respond to social partners and how social partners should respond to them. As the infant moves from toddlerhood into childhood, children with more secure histories form friendships more competently, are more readily accepted into groups, and are more likely to follow group norms than those with anxious histories. Children with secure histories acquire a more empathetic foundation than children with anxious histories. They are more sensitive to another person's emotional cues, whereas children with anxious histories often express more anger, hostility, and aggressive behavior towards both parents and peers.

Successful adolescent development and relationships are based on stable parent-child relationships from earlier in life. These early relationships are seen as a secure base for future explorations, and for developing future peer attachment relationships necessary for successful adolescent development. While parental attachment cannot be used as a predictor for onset of adolescent sexuality, it is influential in the expression of certain other behaviors. These influences included the correlation of low levels of attachment with use of alcohol or drugs prior to sexual intercourse, increased numbers of sexual partners over a six month period for those adolescents using drugs or alcohol, and acknowledgement of sexual abuse in adolescent girls including the feeling of being used sexually. Paternal abandonment or low maternal attachment also correlates with higher numbers of reported traumatic events such as parental incarceration or divorce, physical or sexual abuse, and learning disabilities or failure of a grade in school (Tobey).

Decreased paternal attachment may also lead to insecurity and coercive sexual behavior later in life (Smallbone & Dadds, 2001). The role of the father is again often overlooked, and may be significant in the development of coercive patterns of male sexual behavior. It has been noted in the developmental psychopathology and criminology literature that adolescent and adult sexual offenders often report the influence of family factors on their behaviors, including harsh and inconsistent discipline, marital discord, parental separation, and parental rejection. It appears that both sexual and nonsexual aggression may be linked to insecure and avoidant orientations to close adult relationships and childhood attachment insecurity may predict aggression, anti-sociality, and coercive sexual behavior. In a comparison of incarcerated adult offenders, sexual offenders often reported poorer relationships with their parents and significantly less childhood maternal and paternal attachment than did property offenders, and deviant sexual offenders experienced particularly problematic relationships with their fathers. In fact, stranger rapists were more likely than any other group to recall fathers who were abusive, uncaring, unsympathetic, and violent towards them (Smallbone & Dadds).

The Paternal-Infant Relationship

The importance of the father-infant relationship has been receiving increasing attention over the last decade as more mothers enter the workforce and fathers take on more of a role as a primary caregiver. Many aspects of how fathers interact with their infants remained unexplored as much of the past research has focused on deficits of children in father-absent families (Bronte-Tinkew et al., 2008). There is no single overarching theory of fatherhood, however it is agreed that successful fatherhood starts

with the development of bonding and attachment that occurs during the first year of the child's life (Ferketich & Mercer, 1995). The characteristics of both the father and his infant can affect the developing bond and attachment relationship. The developing father-infant relationship can be influenced by past experiences including bonding and attachment relationships with the father's own parents and previous experiences with other children. In this manner fathers are thought to be similar to mothers. The marital relationship, events surrounding childbirth and a supportive environment are all thought to be factors that can affect paternal bonding and attachment (Ferketich & Mercer).

To further investigate the factors that influence paternal-infant relationships from the father's perspective a grounded theory approach involving 14 first-time fathers was used to describe a theoretical analysis of the experiences and development of the initial father-infant relationship during the first 2 months following birth (Anderson, 1996). The qualitative interviews allowed fathers to describe and interpret their own view of the father-infant relationship and provided new understanding of factors that were a substantial influence. The fathers in this study were either married to or living in a common-law arrangement with the mother, present in the household, and first-time fathers of healthy infants with no congenital anomalies. Fathers were interviewed using open-ended questions, and fathers were encouraged to talk in-depth about their experiences. Four general areas of interest were focused upon: the father's perceptions of his infant, the relationship with his infant, his self as a father, and spousal support. The factors that had the most influence on the father-infant relationship fell into three major categories: Making Room for the Baby, Father-Father Relationship, and Wife's Support. In making room for the baby, fathers connected with their babies by adjusting their lives

to make physical and psychological room for the infant. Fathers adjusted their work schedule and worked more efficiently so they could have as more time at home with the ones they loved. Some fathers admitted to being resentful that work took time away from being with their family. Fathers made adjustments in their personal and social time, mostly by changing their priorities or seeking pleasurable moments with the family. The fathers realized that their relationship with their wife was also changing as they facilitated the relational connection with the infant and moved from a dyadic to a triadic relationship. Most fathers felt the infant helped the husband and wife to become closer to each other, although one did mention resenting the intrusion of the infant on the close marital bond. The fathers in this study stated that it was important to be physically and emotionally available for the infant and to provide love and protection, and that they felt more in touch with their nurturing abilities. Many of the fathers described the relationship with their own fathers as distant, detached, or problematic. They reported that their own mothers played the lead role in their families and was who they turned to discuss emotional or intimate problems. They felt that they did not know their own fathers as a person, but more of as a provider or teacher of specific activities. It was clear that the fathers in this study wanted to be more emotionally connected with their children. The wives provided valuable informational and emotional support to the fathers which aided in the development of the initial father-infant relationship. All but one of the mothers planned to return to work so it was necessary for fathers to become involved with infant caretaking tasks. Some fathers expressed that it took longer for them to develop a relationship with their infant, but recognized the intense communication and closeness associated with breastfeeding and that the mothers spent more time caring for

the infant. Wives helped their husbands to get to know their infant by giving general advice for infant care, and by sharing daily events about the infant while the father was at work. The fathers also reported that their wives provided emotional support and encouraged them to become involved with their infant. This gave the fathers confidence in their nurturing abilities and contributed to their self-esteem. It was recognized that the mothers had a powerful influence on encouraging or discouraging the father's involvement with the infant. When mothers willingly shared information about the infant and encouraged participation with infant care the fathers were more likely to develop an emotional relationship with the infant. This informative study showed that fathers felt the desire to be sensitive to the needs of their infant and emotionally involved at an early stage of their infants' lives. They did not emphasize subscribing to the stereotypical paternal role of provider and disciplinarian. They disclosed that they had conflicting relationships with their fathers and that they wished to be more emotionally involved their own infants. Spousal support including emotional and informational support was a significant help in the development of the paternal-infant relationship, and encouraged these fathers to become more involved in their infant's lives. Future questions that need to be answered include what fathers find that is non-supportive during the initial development of the father-infant relationship, including the effect of a non-supportive spousal environment. Other questions that need to be answered are the effects of the joint influence of mothering and fathering and the way in which the marital relationship influences the development of the father-infant relationship (Anderson).

Mode of Delivery and Family Relationships

Cesarean birth rates continue to rise throughout the developed world (Porter et al., 2007), and in 2005 accounted for 30% of the live births in the United States and for more than 25% of the births in many other industrialized nations (Notzon, 2008). The continued rise in cesarean births is due to the increasing rate of primary cesarean delivery and the decline of vaginal births after cesarean delivery (Centers for Disease Control and Prevention, 2007). The National Institutes of Health has recommended against C-sections unless medically necessary in women desiring to have subsequent children and for pregnancies less than 39 weeks gestation (CDC). The effect of delivery by C-section versus vaginal birth on the perinatal experiences of fathers has not been widely studied. The available literature shows that some fathers are distressed by the experience (Chan & Paterson-Brown, 2002; Greenhalgh et al., 2000) while others are satisfied with the experience or have no significant difference when compared to families whose infant was born by vaginal delivery (Porter et al., 2007). Approximately 31% of fathers attend the birth when by planned or emergent C-section, as compared to the almost 96% of fathers that attend vaginal deliveries (Dellmann, 2004). This may have negative implications for families as decreased satisfaction with the birth experience may negatively impact family relationships.

Fathers' coping styles and antenatal preparation in relation to their labor and postpartum experiences were investigated by Greenhalgh, Slade, and Spiby in the perinatal and postpartum period (2000). Fathers had to be present for at least part of the labor and the mother and infant had to well post-delivery to be included in the study.

Parents also had to have attended at least 1 or more antenatal classes. Participants were visited on the postnatal wards and asked to participate. After consent they were given questionnaires on the experience of childbirth, a behavioral style scale, and a postnatal depression scale. At 6 weeks postpartum the participants were mailed a second questionnaire booklet that included the depression scale and a questionnaire regarding the description of the baby. From analysis of the questionnaires it was determined that fathers who attended antenatal preparation classes did not significantly differ from non-attending fathers in regards to reported experiences of birth, emotional status after birth, or in attachment to their infant. Fathers' reports of satisfaction with the experience of attending childbirth were related to lower levels of depressive symptoms at 6 weeks postpartum. Fathers' description of their baby at 6 weeks postpartum was unrelated to their experiences of *attending* childbirth, however fathers used significantly more negative adjectives to describe their infants at 6 weeks postpartum when birth was *by* C-section. Those fathers whose partner had an emergency C-section were more distressed than fathers of vaginal deliveries, and were much less likely to find the birth exciting or wonderful. Implications for this study include the finding that birth by C-section may affect a father's relationship with his infant. The authors did point out that the measures used for the study were all developed for women as no equivalent measures have been validated for men (Greenhalgh et al.).

To determine how fathers felt after accompanying their partner to labor and delivery, Chan and Paterson-Brown studied couples in the immediate postpartum period (2002). Couples were recruited from the postnatal ward of a hospital in London after delivery but before discharge and asked to rate their feelings. All couples were eligible if

the father attended delivery however couples with planned pre-labor C-sections were not included. There were no demographic differences between couples for type of delivery other than operative delivery was more common for first-time parents. Fathers' labor experiences were generally more positive than their partner's perception of them, and the mothers stated that fathers were very helpful regardless of mode of delivery. Fathers were significantly more nervous with C-sections compared to normal or instrument deliveries. Fathers also found instrumental and C-sections much more traumatic than vaginal delivery. Generally fathers found the delivery to be an enjoyable and rewarding experience, although fathers found vaginal deliveries to be more rewarding than C-sections. When asked about future deliveries 100% of the fathers who attended vaginal and C-sections would choose to stay again, while 97% of fathers who attended instrumental deliveries would choose to stay. The fathers in this study who chose to attend childbirth had a very positive experience overall regardless of mode of delivery. Fathers attending vaginal deliveries felt they were more helpful, less anxious, and felt the experience more rewarding and less traumatic than fathers attending an operative delivery. A few fathers did find the experience unrewarding and un-enjoyable. One of these fathers was reluctant to attend and stay for the delivery and two were unprepared to stay for the entire delivery. Although most men in this study gained from the labor and delivery experience, it is important to be sensitive to those who are reluctant to attend or unprepared to stay for delivery and to maximize their experience if they choose to stay (Chan & Paterson-Brown).

A study of mothers post C-section showed that families who have their first baby by C-section are less likely to have subsequent children than families who deliver

vaginally, and those who do have subsequent children usually have fewer children with longer gaps between births (Porter et al., 2007). The trauma or dissatisfaction associated with the experience of birth has been suggested as reasons for the delay. To determine what factors women considered distressing a large postal questionnaire study was conducted on 1661 women who had delivered their first infant by caesarean section in Scotland between 1980 and 1995. None of the women had given birth to another infant in the subsequent 5 years. Many did find some aspect of the experience distressing, and 42% provided written descriptions of these aspects. The reasons were transcribed from the questionnaires and coded into 5 major categories using content analysis: prepartum, intrapartum, postpartum, psychological/general, and overall. Negative experiences in the prepartum period focused on the length of labor women had to endure before the C-section was performed, or being told the infant was in distress and an emergency cesarean had to be performed. Lack of preparation, not knowing what to expect, the rapidity of the events, and staff not keeping them informed were the greatest sources of distress. During the delivery the greatest sources of distress were mainly related to anesthesia issues such as the epidural didn't work and they felt the surgeon cutting, staff attitudes or behaviors and the impersonal nature of the process, and being shocked at the speed and urgency by which the operation was completed. After cesarean delivery the largest areas of concern arose from medical problems and complications such as blood loss, intensive care unit stays, wound healing issues, and the general length and difficulty of recovery. Other major causes of distress included not being able to see the baby or being separated from the baby, pain relief issues, and decreased mobility and not being able to completely care for the baby. General and psychological sources of distress that

affected the women's mental well-being related to their lack of information about what was happening to them. Not being informed and the feeling of shock and panic as well as being separated from their husbands were major concerns, as was being asleep or too sedated to remember the birth. Perception of satisfaction with healthcare has been related to issues that revolve around the patient-provider relationship and the importance of sharing of information. Most of the distress found in this study was caused by lack of preparation and communication, the speed and urgency with which the operation was carried out, the feeling of missing out on an important life experience (vaginal delivery), and delayed meeting or bonding with their infant. Satisfaction with the birth experience may be increased and stress reduced by keeping women informed during the labor and delivery process and adequately preparing them for the possibility of a C-section (Porter et al.). It is not known if findings would be similar for fathers since they were not included in the study.

Summary

Several noticeable gaps are evident after reviewing the available literature. There is a general lack of knowledge of the expanding role of the father and a lack of inclusion of fathers in perinatal education and preparation for birth (Wilson et al., 2008). Many men express that attending the birth of their infant is an emotionally uplifting experience however they admit they often lack sufficient information to support their partners as much as they perceive they should (Wilson et al.). The needs of the father and the paternal-infant relationship in the postpartum period often take on a secondary

importance when compared to the needs of the mother and the maternal-infant relationship, and fathers are seldom given guidance or education about how to interact with their infant or how to provide routine care (Anderson, 1996; Buckelew et al., 2006)). Fathers are often thought of as just a support person for the mother rather than a capable caregiver in their own right.

There is mounting evidence that infants with involved parents who provide sensitive care have improved developmental outcomes (Propper et al., 2008). Early involvement of both parents in providing infant care is necessary if the infant is to develop secure attachment relationships, and secure parental attachment has been positively related to early language and cognitive development (Tobey, 2001). Infants with parents that are insensitive or uninvolved are at risk for developing childhood psychosocial problems and cognitive delay, and aggression and antisocial behavior when they become adults (Blanchard, Gurka, & Blackman, 2006).

There is an overall lack of professional support for fathers and especially new fathers in the perinatal and postpartum period. While the support that a wife gives to her husband has been found to have a significant effect on the stress and health of fathers (Anderson, 1996), there is almost a universal absence of available programs or services designed to assist fathers in their transition to parenthood (Henderson & Brouse, 1991).

The effect of cesarean birth on the perinatal and postpartum experiences of fathers has not been fully investigated. The current literature is conflicting with reports of the paternal experience being either positive (Chan & Paterson-Brown, 2002) or negative (Greenhalgh et al., 2000). This could be particularly important with the current rate of C-sections being over 30% of all live births in the United States, (Notzon, 2008). Updated

information on the impact of cesarean delivery on family relationships may also be important, given the fact that there is a decreased rate of subsequent pregnancies and increased length of time between pregnancies when a couple's primiparous birth is by C-section (Porter et al., 2007). Further research is needed to improve understanding of how fathers are affected during the transition to fatherhood and whether this transition is influenced by a cesarean birth experience.

CHAPTER 3

METHODOLOGY AND RESEARCH APPROACH

The purpose of this study was to explore how men describe the experience of the transition to parenthood in the context of a cesarean delivery. This study will contribute to the body of knowledge regarding how fathers react and behave in the first month following a cesarean birth as they transition to the role of a new parent. The findings are expected to increase awareness of the potential gender and cultural differences in the interpretation of the experience for the father at the time of the birth and in the immediate postpartum period.

Qualitative Research

The lack of prior research on how cesarean birth is actually experienced or the meaning of that experience to fathers supports the use of a qualitative research method for this study. Qualitative research has been developed and can trace its roots through disciplines such as sociology, anthropology, psychology and philosophy (Speziale & Carpenter, 2007). There are multiple qualitative research approaches and each one is grounded in a specific philosophical perspective that provides a base for the study design. In general, qualitative research is a form of social inquiry that can uncover the meaning of how people experience phenomena, and various qualitative methodologies have been used widely in nursing, medicine, education, and political science as well as other disciplines to enhance understanding of human experiences (Speziale & Carpenter). In phenomenology the underlying premise is that a particular experience is unique to each

individual, and each individual's concerns regarding that experience may be qualitatively different (Smith, Flowers, & Larkin, 2009). Experiences are shaped by language, culture, history, and value placed on the experience, and the individual interprets the experience for the researcher who in turn interprets the explanation from the informant. The information gained from an interpretative phenomenological study incorporates the perceptions of both the informant and the researcher and although not generalized in the same manner as quantitative studies, works to provide a broader understanding of the phenomenon under investigation (Smith, Flowers, & Larkin).

Rationale for Choice of Method

The rationale for the selection of this research method was based upon the need to better understand the actual lived experiences of fathers in the perinatal and postpartum periods following the birth of their infant by C-section. Interest in this topic is supported by the author's personal experience with the birth of a first child by C-section. The procedure itself was not an emergent situation but it was unplanned, and there was no education or consideration provided in the prenatal period, and little time for discussion once the decision was made to proceed with the C-section. The rapidity with which the procedure occurred was surprising, as was the lack of postpartum information regarding infant and postoperative care.

Further interest developed after interactions with other fathers who presented with their children for care in the family practice office setting and reported a lack of preparation for the C-Section experience. They expressed concern regarding a general

lack of information about the postoperative period, and how to provide care for their infant or occasionally their partner. A review of literature at this point showed a there was a gap in the research literature on fathers and specifically on those who had experienced a C-section. Very few studies were found documenting how C-sections affected fathers or their assumption of the father role in the context of a C-Section delivery. Since it has been documented that negative experiences around the time of birth may have negative consequences on the process of infant bonding, transition to the role of parent and future paternal-child attachment relationships (Fortier, 1988; St. John, Cameron, & McVeigh, 2005) it was logical to expect that negative experiences at this point could affect the father-child relationship and/or the mother-father relationship or parenting after birth. The focus of this study is on improved understanding of the actual experiences of fathers to gain insight into what the experience is like for new fathers and consider how nursing interventions might improve the quality of this experience.

Phenomenology was chosen as a method for the study because phenomenology seeks to uncover meaning in the experiences of participants by carefully examining and listening to the stories of those who have "lived the experience" (Speziale & Carpenter, 2007). Phenomenology is an examination of how these individuals make sense of their major life experiences, and is especially suited to the detailed examination of an individual's experience (a particular case) to determine in detail what the experience was like for that person. In this instance there is a question of the conditions of the transition to fatherhood in the context of C-section delivery. Phenomenology is the method of choice as it seeks to determine how the experience of cesarean birth is perceived by each individual. Phenomenology recognizes that there are multiple realities, and how we

perceive and make sense of an experience has a great impact on how we behave and the actions we take following that experience (in this case the assumption of the role of a parent and the transition to fatherhood). Prior experience of the researcher with the experience is not considered a limitation, rather a possible source for added insights that can be contrasted with findings from study participants (Smith et al, 2009).

Phenomenology

The object of phenomenology is to describe the essence or experience of a phenomenon with the purpose of promoting human understanding (Morse & Field, 1995). Phenomenological studies seek to understand the lived experiences of participants and their intentions in their 'life-world', and thus develop an accurate description of the experience of the phenomenon (Morse & Field). Phenomenology is both a philosophy and a method, and several schools have been developed based upon the type of phenomenological approach (van Manen, 1997). Two of the more common approaches to phenomenology are descriptive phenomenology based upon the work of Edmund Husserl (1913/1982, 1950/1970) and interpretive phenomenology based upon the work of Martin Heidegger (1975/1988). There are several primary differences between these two approaches, including how the research findings are generated and how the findings are used to further professional knowledge of a subject (Lopez & Willis, 2004). An important component of the descriptive approach by Husserl is that all prior personal knowledge of the topic is shed by the researcher in order to grasp the essential lived experience of the participants (1913/1982, 1950/1970). This involves bracketing or

holding preconceptions, ideas, and personal knowledge in abeyance when interviewing and reflecting on the experiences of participants. There is also a belief that there are universal essences or common features to any lived experience for all those who have had the experience, and that these essences can be extracted regardless of context or the impact of culture, society, politics, or the environment (Husserl, 1913/1982, 1950/1970; Lopez & Willis). The hermeneutic or interpretive approach of Heidegger differs from descriptive phenomenology in that presuppositions or prior knowledge of the researcher can be valuable guides to inquiry and thus make the research project a more meaningful undertaking (1975/1988). Interpretative phenomenologists contend that it is impossible and even counterproductive to attempt to rid the mind of the background of knowledge and understanding that has led the researcher to deem that a topic is worthy of further inquiry. Interpretive phenomenology also goes beyond a mere description of the core concepts and essences of an experience to uncover meanings embedded in common life practices. These meanings may not be apparent to the research participants but can be discovered in the narratives that they produce, and the focus of hermeneutic inquiry should be on what humans experience versus what they consciously know. The pure content of human subjectivity is not the focus, but rather what the participant's narrative implies about their experiences on a daily basis. Human beings are embedded in their world and their subjective experiences are linked with cultural, societal, political and environmental contexts (Heidegger, 1975/1988). This is the concept of situated freedom where individuals are free to make choices, but their freedom is linked to the specific conditions of their daily life and therefore not absolute (Lopez & Willis). For interpretive phenomenology the analysis of the narratives in relation to these various contexts is

important in determining how these meanings influence the choices that participants make in their daily lives (Heidegger, 1975/1988; Lopez & Willis).

Professional nursing practice is enmeshed in the life experiences of clients in specific contexts; therefore interpretative phenomenology is a research approach that is particularly appropriate for the investigation of phenomena that are of importance to nursing (Speziale & Carpenter, 2007). Interpretative phenomenological analysis is particularly suited for nursing research in areas that have been understudied or where a theoretical pretext may be lacking, to provide meaningful and unexpected analysis of psychosocial issues (Reid, Flowers, & Larkin, 2005; Smith, Flowers, & Larkin, 2009). Understanding human experience is central to interpretative phenomenological analysis, and IPA offers researchers the ability to gain insights from the research participants themselves. IPA enables us to understand the decisions that people make regarding a diverse range of issues. The lived experience of the research participant is coupled with a subjective and reflective process of interpretation where the researcher is explicitly engaged in the research process with the participant. Inferences are then made cautiously, with a conscious awareness of the contextual and cultural backgrounds of the researcher, participant and the characteristics of the environment in which the data are generated. Interpretations that reveal meaning, cognition, affect and actions can be drawn from a range of theoretical perspectives developed around a central account of the participants' experiences and their phenomenological worlds (Reid, Flowers, & Larkin; Smith, Flowers, & Larkin).

Participants

A purposive sample of fathers who experienced the first birth of a child by C-section was obtained from a list of couples who presented to give birth at a major university hospital in central Pennsylvania or referred from one of the family practice offices. Inclusion criteria included fathers who were over the age of 18 and had a partner (mother of infant) who was also over the age of 18. The father needed to be able to write and speak in English. Recruitment of research participants depended upon their ability to understand the principles of their involvement in the research process, engage with the researcher, and express a willingness to share their experiences and opinions (Reid, Flowers, & Larkin, 2005; Smith, Flowers, & Larkin, 2009). Sample sizes are relatively small (N=3-6) in interpretative phenomenology research in comparison to other research methods, reflecting the idiographic (individual case study) nature of the research (Smith, Flowers, & Larkin, 2009, p. 106). Idiography is concerned with the particular, rather than being nomothetic or making claims at the group or population level or establishing laws of general human behavior. The informants for this study were relatively homogeneous to enhance insight towards the impact of cesarean birth on the transition to fatherhood in the perinatal and postpartum periods. Recruitment of study participants continued until saturation of the data occurred, or to the point at which the addition of further informants revealed repetition and confirmation of previously collected data. It was found that adequate sampling was reached at 4 participants, which is also considered adequate for the method (Smith, Flowers, & Larkin).

Exclusion criteria included fathers of infants born before 36 weeks gestation or with significant health problems or who had experienced death of the infant. Significant health problems included but was not limited to birth trauma including subdural hematoma, intracerebral or intraventricular hemorrhage, spinal-cord injury, basal skull fracture, peripheral-nerve injury present at hospital discharge, clinically significant genital injury, seizures occurring during the first month of age, Apgar score of less than 4 at 5 minutes, coma, intubation and ventilation, tube feeding, or any problem that required admission of the infant to the neonatal intensive care unit.

Setting

The setting for data collection was a mutually agreed upon meeting place or the participants' homes at their request. Privacy during the interview was maintained to assure the confidentiality and anonymity of the participants. Names of potential participants were obtained from the daily census lists of couples experiencing the first C-section at a local university hospital or in referral from one of the family practice clinics. Potential participants were approached while their infant was still in the hospital during the immediate postpartum period, or fathers who expressed interest in the study were contacted by phone via a contact number they provided. The researcher explained the nature and purpose of the study on initial contact and asked the father to read the informed consent and sign the document if willing to participate. Participants were contacted later to establish a meeting time and place for an in-depth interview in the month following the C-section, and they were given a copy of the informed consent

document. Interviews lasted at least one hour but not more than two hours for each participant. Participants were allowed to inform their partner of participation in the study, but a private interview location was used so they could openly discuss their experiences.

Protection of Human Subjects

Approval from the Human Subjects Protection Office of the university hospital was obtained before commencement of the study. To protect the privacy of the informants a code number was placed on the interview forms and audiotapes. The code number was used to link the participants with their transcribed interviews. The researcher was the only one conducting and recording the interviews, and no identifiers were placed on the audiotapes other than the code numbers. Interviews were transcribed verbatim by the researcher or a paid transcriptionist who had taken the University-approved course on protection of human subjects. The researcher was the only one with access to the code numbers and participant identification, and this information was kept strictly confidential on a password-protected computer accessible only to this researcher. The informants were told that there were no known risks or immediate benefits to participate in this study; however information gained from this study may be useful in helping other fathers in similar situations in the future. Informants were told that they could stop their involvement at any time during the study period without penalty, and that there was a \$20 grocery gift certificate as remuneration for participation. They were also informed that while the information they shared would be kept strictly confidential, the

researcher was obligated to refer them to the appropriate healthcare professionals should there be any indication of safety issues for themselves or their families. Further referrals would have been made for any informants requiring immediate medical or psychological treatment or interventions, including directions to the local Walk-In health clinics and emergency departments as well as telephone numbers for the Crisis Hotline and Intervention services. No evidence was found that necessitated referral of any of the participants during this study for any issues.

Procedure and Data Collection

Data collection was completed through audio-taped direct face-to-face or phone interviews with the participants based on an interview schedule of open-ended questions designed to enable the participants to share their experiences in depth. This was an idiographic approach in that there was a commitment to a sense of detail and a depth of analysis of individual cases that was thorough and systematic to support determination of how the C-section experience was understood from the perspective of a the individual before look at the group of first time fathers (Smith, Flowers, & Larkin, 2009). Data collection was conducted through interviews, and it was recognized that interviews are not a neutral means of data collection (Reid, Flowers, & Larkin, 2005; Smith, Flowers, & Larkin), therefore the process involved in-depth analysis of the respondent's interviews to assure that interpretation centered on the relevant meanings of the participants. The analysis of each individual participant was completed in its entirety before moving on to the next case.

Interview Process

The general nature of interview process in interpretative phenomenology includes in-depth interviews that are unstructured or semi-structured and make use of open-ended questions (Smith, Flowers, & Larkin, 2009). The specific purpose of data collection in this study was to elicit detailed stories, thoughts and feelings from the participant and allow the participant to tell their story in his own words, to speak freely and reflectively and express their concerns and develop their ideas at length (Smith, Flowers, & Larkin). The overall interview schedule included the following topical areas and related probes to encourage a full description of the experience:

- Tell me about a time, one that you will never forget, that is an example of an experience that really illustrates what it was like to experience the birth of your child by C-section.
- What are some examples of what you experienced before the delivery process?
- What are some examples of what you experienced during the delivery process?
- What are some examples of what you experienced immediately after the delivery process?
- What experiences do you recall sharing with your spouse/wife/the infant's mother during this time?
- What interactions or concerns do you recall related to your spouse/wife/the infant's mother during this time?
- What are some things that you remember went through your mind before the delivery process?

- What are some things that you remember went through your mind during the delivery process?
- What are some things that you remember went through your mind after the delivery process?
- What discussion about the birth experience do you recall having after the delivery...and with whom?
- What are some examples of experiences you had that stand out for you during the first month after delivery?

The dialogue during the interview was enhanced by probes as necessary to allow the informant to elaborate on their responses. Probes facilitated exploration of the details of each memory of an event or time within the overall experience. Probes included phrases such as:

- Could you clarify that for me?
- Please elaborate on that point/experience for me.
- Please give an example of what you were feeling. Experiencing.
- Could you describe that more fully for me?

Stages of the Analysis Process

The analysis process was based upon the method of interpretative phenomenological analysis as described by Smith, Flowers, & Larkin (2009). The general stages for the analysis included:

1. *Verbatim transcription* of each audio-taped interview was completed and the text was line-numbered.
2. Initial *reading* of the written transcript was performed for immersion in the data.
3. *Re-reading* of the data and *initial noting* of anything of interest in the interview: There are no definitive or prescriptive rules or requirements for this process, however the research had the following goals:
 - a. produce a comprehensive and detailed set of notes and comments.
 - b. develop a descriptive core of comments that stayed close to the participant's explicit meaning.
 - c. emphasize notes that described things that mattered to the participants: Relationship, processes, places, events, values and principles.
4. Initial noting involved three distinct processes with differing focuses that made up the initial noting level of analysis:
 - a. Descriptive Comments were used to describe the content and the subject of the talk (in this case a participant's interview).
 - i. These were key words, phrases, or explanations.
 - ii. They took things at face value.
 - iii. Highlighted objects which affected the participant's thoughts and experiences.
 - iv. Here the researcher placed thoughts about the participant's experiences in relationship to important things that made up their world.

- b. Linguistic Comments explored the specific use of language.
 - i. How was the meaning and content of the talk (interview) presented?
 - ii. How did the participant use elements of speech such as pronouns, laughter, pauses, tone, repetition, degree of fluency (is he articulate or hesitant?), and metaphors (i.e. shell shocked).
- c. Conceptual Comments began to focus on a more conceptual level and moved away from the specific.
 - i. Each interesting feature of the participant's account was considered for development of further questions.
 - ii. This level of coding involved a shift in focus towards the participant's overarching understanding of what they were discussing.
 - iii. This included a movement away from focusing on the meaning of specific instances and towards an overarching element or theme that was common to them all.
 - iv. Often included were elements of personal reflection as the researcher drew on his own experiential and professional knowledge (Gadamerian).
 - v. Other phrases that referred to a critical sense of a time frame: i.e. such as "...at the time"; "...in the early days" were noted:
 - 1. Were these experiences embedded in time?

2. Were there clear differences between the “early days, the present, or even the imagined future?”
3. Did the participant come to terms with his situation and how was this achieved?
5. From this interpretative notes were considered for the *development of emergent themes* to better understand how and why the participant had a concern. Emergent theme development included:
 - a. looking at the language the participant used,
 - b. thinking about the context of the participant’s world (their lived world), and
 - c. Identifying more abstract concepts, which helped make sense of the patterns of meaning in their account.
6. The emergent themes were then considered individually, grouped in various configurations and organized into a structure for the *identification of super-ordinate themes*, which were further organized by focus areas to relate the sequence of the experience for participants.

A narrative summary with related actual quotes was developed for each participant. After full analysis of the individual experiences, a *comparative analysis of cases* process was employed to identify commonalities and differences across cases and the stability of the super-ordinate themes for all fathers.

Data analysis and interpretation of data from this study was developed from verbatim transcripts of the interviews (Reid, Flowers, & Larkin, 2005; Smith, Flowers, & Larkin) and author field notes. Typed transcripts were line-numbered and checked

against the audiotapes to ensure accuracy, and to allow for initial impressions to be noted in the transcript margins. Then a line-by-line analysis of the transcripts was conducted to gain knowledge of the experiential concerns and understanding of each participant (Smith, Flowers, & Larkin). This first phase of active engagement with the data started the process of entering the world of the participant. Initial noting was accomplished by detailed analysis of the transcript to examine semantic content and language on an exploratory level. Identification of emergent themes in the initial case was accomplished by reading and re-reading the data (transcripts in this study) to ensure that the participant was the full focus of analysis. In this process the researcher worked to develop an initial insider's perspective on the topic through inductive and iterative procedures, documenting progress by using verbatim examples from the interviews for illustration and support. This process included identifying and pulling out phrases, sentences, or even entire paragraphs that appeared to have meaning and could stand alone as examples of key points or main ideas. Through this process the researcher identified *emergent patterns or themes* within the transcripts looking for convergence and divergence, and commonalities and nuances of the single case/participant. This was accomplished by a process of coding, organizing, integration and interpretation of data from the transcripts of the participants. The moving from the individual comment to the overall context and back, inherent in the hermeneutic circle approach, was employed throughout the analysis process. The set of emergent themes were then organized into a structured overview of *super-ordinate themes* which provided the topics and focus sequence for analytic commentary. Findings were organized in a table format to allow for transparency, so that the analysis could be traced from initial comments on the transcripts to final development

and structure of themes (Smith, Flowers, & Larkin). The analysis process was accomplished in collaboration with an expert in phenomenological research who also had experience with application of this research method. The collaborative process helped assure the accuracy, coherence and plausibility of the interpretation.

The analysis is supported by detailed commentary of the data extracts and reflections of the researcher's own perceptions and conceptions of the process (Smith, Flowers, & Larkin, 2009). The themes are translated into an expansive narrative account where the themes are explained, illustrated and nuanced, with care taken to distinguish between the respondent's commentary and the researcher's interpretation of the account (Smith, Flowers, & Larkin).

The Hermeneutic Circle

The dynamic relationship between individual words and the full text, the single interview and the overall context of the experience provided a base for exploration of the meaning of words stated by participants and the meaning within the context of the experience. After transcription of the audio-taped interviews and completion of initial exploratory comments and development of emergent themes, the interviews and interpretations were shared with an expert in phenomenological research and application of the interpretative phenomenological method by Smith et al, 2009. Dialogue regarding the emergent themes facilitated development and expansion to achieve the final interpretations. The approach to analysis in hermeneutics is not linear in nature, but depends on moving back and forth through varied ways of looking at the data and

moving through levels of analysis by considering how each relate to the other. This process provided an additional lens through which to view the participants and their stories, and allowed initial thoughts to mature and evolve to an enhanced understanding of the experiences of these new fathers.

Rigor and Trustworthiness of Findings

The naturalistic paradigm has been used to enhance understanding of many problems pertinent to nursing practice and education. Methodological rigor within a qualitative study is validated by standardized measures that assure the trustworthiness of the findings. Although the testing for validity, reliability, and generalizability does not apply in qualitative study, the robustness of qualitative inquiry is judged by a systematic process to assure the study does enhance and advance our knowledge about a topic (Guba, 1981; Tobin & Begley, 2004). Criteria for judging the trustworthiness of inquiries within the naturalistic paradigm have evolved and moved away from those traditionally used by the positivist paradigm (Guba). Guba proposed the terms credibility, transferability, dependability, and confirmability to be applied to naturalistic inquiries to replace the positivistic terms internal validity, external validity, reliability, and objectivity (1981). For credibility naturalistic researchers attempt to take into account the array of factor patterns that are presented to them and interpret them to develop an explanation that is credible and leads to findings that are plausible. Generalizability is often eschewed by naturalistic researchers, although transferability can be enhanced by collecting descriptive data that is thick and allows for comparison of the

studied context to other possible contexts in the future. Dependability is concerned with the stability of the study data, while at the same time allowing for instability that arises from different realities that become evident or that stem from developing insights on the part of the investigator-as-an-instrument. Finally confirmability was developed as naturalistic researchers moved away from the concept of investigator objectivity and moved towards the concept of data and interpretational confirmability (Guba). For this study, the findings were considered in relation to the measures proposed by Smith, Flowers, and Larkin when using interpretative analysis to assure congruence with the research method (2009). These included: sensitivity to context; rigor or thoroughness; transparency and coherence; and impact or importance (Smith, Flowers, & Larkin).

Sensitivity to Context

Sensitivity to context included understanding the socio-cultural milieu in which the study was situated and demonstrating a grasp of the existing literature on the topic (Smith, Flowers, & Larkin, 2009). Sensitivity to context was also used to describe the interpretations that were made in the research study to assure that claims were made were appropriate for the sample being analyzed (Smith, Flowers, & Larkin). Credibility, another term that has been used to describe this aspect of the research process, was considered to assure fit between the respondent's views and the researcher's interpretation of them (Tobin & Begley, 2004). Credibility (comparable to internal validity) asks if the explanation fits the description and whether the description is

credible (Guba, 1981; Tobin & Begley). Text analysis samples are provided to allow the reader to judge credibility of finding for this study.

Rigor or Thoroughness

Rigor or thoroughness of the study considered appropriateness of the sample to the question at hand and the quality and completeness of the interview process and the subsequent analysis (Smith, Flowers, & Larkin, 2009). For this study the sample was carefully and purposively selected to match the research question, and the sample was relatively homogenous to enhance insight towards a particular perspective (first time fathers) of the phenomenon (delivery of child by C-section) being studied (Smith, Flowers, & Larkin). Dependability, a term also applied to this portion of the study was considered to and ensures that the research process was logical, traceable, and clearly documented (Guba, 1981; Tobin & Begley, 2004). Dependability has been compared to reliability, and was demonstrated by an adequate audit trail, reinforced in the style of this research report and the review of a researcher familiar with the research method. In general this written report allows for examination of the researcher's methods, documentation of data, decisions and final analysis (Guba; Tobin & Begley).

Transparency and Coherence

Transparency and coherence of the study was accomplished by clearly reporting the stages of the research process, and enhanced by carefully describing selection of

participants, explaining the interview process and how the interviews were conducted, and describing the steps used in analysis of the data (Smith, Flowers, & Larkin, 2009). Based on the principles of a good IPA study a coherent argument with themes that logically fit together was provided. The hermeneutic and phenomenological sensibility is apparent in the report based on the focal topic discussion of the fathers' transitions to fatherhood that illuminates the significant experiential domain of C-section delivery for the research participants (Smith, Flowers, & Larkin).

Impact and Importance

The final measure of trustworthiness for a qualitative research project considered in this study was the impact and importance of the inquiry (Smith, Flowers, & Larkin, 2009). This study demonstrates research that is interesting, important, and useful to nursing education and practice, by helping clarify the needs of first time fathers who experienced a C-section delivery.

Summary

Interpretive phenomenology grounded in the philosophy of Heidegger (1975/1988) and Gadamer (1960/1975) was used as the philosophical underpinning for this qualitative research study. The interpretative phenomenological analysis method utilized was appropriate for this research study because the study was concerned with exploring the experience (in this case cesarean delivery) without attempting to place the

experience in predetermined categories (Smith, Flowers, & Larkin, 2009). IPA is especially suited for determining how the everyday flow of lived experience takes on a particular significance for a group of people, by examining in detail what the experience is like for each individual participant and how the participant is making sense of what is happening to them (Smith, Flowers, & Larkin). The purpose of this study was to better understand the experiences that occurred for fathers during their transition to parenthood following delivery by C-section. It is understood that this micro-level analysis is focused on confirming the existence of actual patterns within a particular experience , not with actual incidence. However, as is congruent with this method, the patterns revealed at this micro level were also used to suggest a theoretical view and subsequent studies for theoretical model development on a larger scale (Smith, Flowers & Larkin).

CHAPTER 4

ANALYSIS OF DATA AND REPORT OF FINDINGS

As stated in Chapter 3, the process of developing emergent themes and super-ordinate themes was accomplished first for each participant, by following the non-linear steps of the interpretative phenomenological analysis (IPA) process. Individual case analysis was completed to ensure that the interpretations for each participant were isolated before moving to a comparison of cases. During the process of exploring patterns and connections within the text to identify emergent themes, a conscious effort to examine preconceptions was an ongoing cyclical process (bracketing), to focus on what was new and actually contained in the text. Based on Heidegger's approach to phenomenology, it is recognized, as part of the hermeneutic phenomenological method, that some influence of prior experiences on development of emergent themes is inevitable, therefore interpretation priority was given to uncovering how things actually appeared then reflecting back to examine preconceptions or fore-structure in light of what appears. In this process it is to be expected that fore-structures change during (and as a result of) the interview and analysis process (Smith et al., 2009).

These participants most assuredly had circuitous and poignant experiences as they ran through the gamut of emotions ranging from the excitement of impending birth, the fear or surprise involved with the necessity for an unplanned operation, to the pride and joy of new fatherhood. In the end, the dynamic relationships between the parts and the whole of the experiences of the participants, and conscious reflection of personal experiences of the researcher following the birth of a child by C-section several years

earlier, revealed six overarching super-ordinate themes and commonalities and differences for study participants as they lived through the experience of becoming a father in the context of a cesarean birth.

Synopsis of Theme Development

The process of developing the emergent themes for each case and subsequently the super-ordinate themes followed the methods described by Smith, et al. (2009). The audio-taped interviews were transcribed verbatim. Each text was numbered line by line to facilitate marking of sample text related to themes identified. Following an initial reading of the text, the text was re-read and highlighted for content. Field notes that were collected at the time of each interview were added in the margin to the right of the body of the text for tonal quality. The exploratory comments (initial reflections of the researcher) were then developed from the highlighted text and the field notes, and also placed in the right margin of the verbatim transcript table. These exploratory comments and the tone of the interview were then analyzed, and the emergent themes that developed were placed in the left margin of the transcript table. The initial emergent themes were further condensed, combined, and collapsed or expanded after a process of re-analysis of the content of the highlighted text in conjunction with the exploratory comments.

As stated previously, the process of developing emergent teams was completed one case at a time to allow each case to maintain its individuality. The data set from each original transcript was expanded with highlighted text, exploratory comments and field

notes, and initial emergent themes before progressing to the next transcript. Table 4-1 summarizes the emergent themes identified for each participant individually. At each step care was taken to reflect on personal experiences to assure that the findings truly reflected those of the participant.

Super-ordinate themes were then developed for each case by listing the emergent themes in tabular form. The process of the hermeneutic circle was ongoing and is evident here as this researcher traversed between the parts and the whole of the interviews, re-analyzing initial impressions and final emergent themes for each case, and finally progressing from the emergent themes and super-ordinate themes for each case to looking for patterns of themes that crossed cases. Table 4-2 summarizes the super-ordinate themes identified by collapsing emergent themes for each individual case. A return to the original cases for additional comparative analysis and confirmation of emergent themes and super-ordinate themes in each case and across cases is described in detail in Chapter 5.

Table 4-1: Emergent Themes for Each Participant

| <u>Chris</u> | <u>Alex</u> | <u>Nick</u> | <u>Mike</u> |
|---|---|--|---|
| Birth as a planned partnership. | Birth as a Natural Delivery | Rushed (Urgent) Decision. | Birth as a Natural Delivery/Planned Partnership |
| Overwhelmed by the unexpected. | Emotional Roller Coaster | Elation versus Fear & Concern. | Concern for Wife |
| Lack of Communication. | Rushed Decision | Concern (Loss of Control) for Wife and Baby. | Lack of communication |
| Loss of Trust. | Lack Of Communication | Waiting without Knowing. | Loss of Trust |
| Loss of Control (helplessness). | Loss of Control. | Relief after Delivery. | Loss of Control |
| Acceptance driven by Fear. | Unexpected Outcomes. | Trust in Staff. | Emotional Upheaval |
| Waiting without Knowing. | Waiting without Knowing. | Working Through Differences. | Rushed Decision |
| Elation Amidst Concern | Relief after Delivery. | Resolving the Memory. | Waiting without Knowing |
| Guilt over not "being there" (for his wife). | Lack of Knowledge, Preparation (Uninformed Decision). | Moving On. | Relief after Delivery |
| Relieved and Back in Control. | Resolving the Memory. | Need for Support. | Feeling of Guilt |
| Awareness of New Challenges. | Guilt he let down his wife. | Feelings of Guilt. | Resolving the Memory |
| Working to accept Differences. | Trust in Staff/Loss of Trust. | Challenges of New Parenthood/Responsibilities. | Challenges of New Parenthood |
| Acceptance of the Need for Support (Need family; can't go alone). | Realized Need for Family Support. | Reflections and Recommendations. | Moving On |
| Reflections and Recommendations. | Expectations, Challenges of New Parenthood. | | Transition to the Role of Parent |
| | Emerging as a New Family. | | Adjusting to Differences |
| | Retrospect and Evolution. | | Need for Support |
| | | | Reflections and Recommendations |

Table 4-2: Super-Ordinate Themes & Nested Emergent Themes

| Super-Ordinate Theme (Dominant) | Chris | Alex | Nick | Mike |
|--|---|--|--|--|
| Expecting a Natural Childbirth | Birthing as a planned partnership Overwhelmed by the unexpected. | Birth as a Natural Delivery | *N/A | Birthing as a Planned Delivery, Planned Partnership |
| Ongoing Communication Breakdowns | Lack of Communication Waiting without Knowing. | Lack of Communication Unexpected Outcomes | **N/A | Lack of Communication Lack of Trust |
| Riding an Emotional Roller Coaster | Loss of Control (helplessness). Elation Amidst Concern Emotional Upheaval | Emotional Roller Coaster Loss of Control | Rushed (Urgent) Decision Elation versus Fear & Concern Concern (Loss of Control) for wife & Baby | Loss of Control Emotional Upheaval Rushed Decision |
| Moving to a Sense of Relief and Peace | Relieved and Back in Control | Relief after Delivery | Relief after Delivery | Relief after Delivery |
| Awakening to the Challenges of Being a Father | Awareness of New Challenges | Realized Need for Family Support Expectations, Challenges of New Parenthood | Working Through the Differences Need for Support Challenges of New Parenthood & Responsibilities | Challenges of New Parenthood Transition to the Role of Parent |
| Resolving the Memory and Moving On | Reflections and Recommendations | Resolving the Memory Retrospect and Evolution | Resolving the Memory Moving On Reflections & Recommendations | Resolving the Memory Moving On Reflections & Recommendations |

* Had planned natural child birth, attended first prenatal class, however cesarean section was performed by choice to reduce maternal and fetal risk related to undetermined source of vaginal bleeding.

**Experience was actually the polar opposite. Thorough/effective communication from staff shed a positive light on a potentially traumatizing experience.

Summary

The researcher found that conducting a study that involved fathers during their first postpartum month can be especially challenging. Participation was constrained by the father's time constraints, family care needs, and often issues that surround their recent return to work. Some fathers in the study were the sole source of support for their partner, and often expressed feeling guilty about leaving her with the new infant for even a short period of time. The fathers recruited for this study experienced all of the above issues, yet took time out of their busy schedules to complete the interviews, and one even brought his newborn with him so that his wife would have her first day to herself since the delivery. These participants were extremely gracious and giving, but most importantly they all expressed a desire to be supportive to and provide insight for other father's who are about to undergo a similar experience.

General review shows that two of the super-ordinate theme areas suggest the potential for quality improvement initiatives due to their pervasiveness and their potential impingement on every other aspect of the perinatal and postpartum experience. The general breakdown in communication at many different levels and at many different points in time had wide-sweeping ramifications for all of these new families, both before and after the birth. Also prevalent was the emotional roller coaster and unanticipated upheaval that both of the parents experienced throughout the birthing process by C-section that could have been tempered by focused interventions. The stories of some participants reveal many opportunities where the experience could have been improved and emphasize the need to determine the prevalence of similar negative experiences.

CHAPTER 5

ANALYSIS AND INTREPRETATION OF FINDINGS

Comparative analysis of individual case findings was accomplished by returning to the original stories to compare themes for each participant and the super-ordinate themes identified in each case. Focus points were used to re-order the text and provide a parallel organization and enhance the ability to look at similarities and differences for the participants. Each of the cases is presented individually, with a brief demographic description followed by a vignette that is a précis of the participant's interview to give the reader a flavor of their entire story.

The organization of sample emergent themes nested within their over-arching super-ordinate themes is illustrated for each participant in corresponding Tables 5-1 through 5-4 in this report of findings. Table 5-5 illustrates a sample of emergent themes across cases at particular focus points in the experience, with examples of descriptive verbatim comments of the participants to support the emergent themes identified. A comparison of recurrent super-ordinate themes across all of the participants is displayed in Table 5-6.

Summary of the Experience for Each Participant

The following are brief summaries of the stories shared by each of the participants, using assigned names. They are presented in a chronological order from first to last participant, and from the time of initial presentation to the healthcare facility

for labor and delivery until the time of the interview which was conducted at approximately 4 weeks postpartum. The stories are organized along shared focus points for this experience for all participants. Further details of the analysis are available in Chapter 4, Analysis of Data and Report of Findings.

Chris' Story

Chris was a gentleman in his early 20's who worked in the computer field outside of the medical community. His wife of similar age was expectant with their first child. The pregnancy had progressed to 40 weeks gestation at which time they presented to the hospital for delivery. There were no complicating factors. This interview was conducted at 4 weeks post-delivery, and starts after the point where they have been admitted to Labor and Delivery.

Pre-delivery Expectations

Chris and his wife wanted to have a natural (vaginal) delivery of their first child. They had a birth plan and Chris emphasized that the plan never even considered cesarean section as a potential possibility. Chris' wife was adamant about having a "natural delivery", and did not want any sort of medications or epidural anesthesia. They had taken prenatal classes at the same university hospital where they presented for delivery. Chris begins to relate his story at the point where his wife has gone through 22 hours of labor. He was massaging her and they were trying different positions to get labor to progress but were having little success. It got to the point where the nursing staff insisted that she get an intravenous (IV) line inserted and receive medication for pain. The reason

for the interventions was not communicated to Chris or his wife. His wife still did not want to be medicated and Chris was unhappy about his wife having to resort to these measures, but they acquiesced to the insistence of the hospital staff. This is where he began to feel like he was becoming overwhelmed by these unexpected turns of events, and he also began to lose his trust in the staff. After multiple unsuccessful attempts, the first nurse was unable to place the IV needle and a second nurse had to be summoned to place the catheter.

They were also becoming disappointed with the stressful environment they encountered at the hospital during this period. They wanted to have a tranquil and serene setting for the delivery of their first child. Instead they were greeted with the sound of drills going off beneath them and the floor vibrating, as the hospital was undergoing construction for an expansion project at this time. The unexpected environment seemed to add to Chris's view that the birthing experience was not as expected.

Imminent Delivery

As the labor wore on and progression waned, frustration began to wear on the couple as nursing shift changes occurred. This further eroded their trust in the staff as they were constantly meeting somebody new. Chris related that he began to feel like he was losing control of the situation, especially after the staff announced that his wife would have to get an epidural immediately or go for a cesarean section. No one explained why a caesarean section was being considered.

Active Delivery Process

The epidural was placed by a resident physician, despite the request by Chris for the attending physician to perform the procedure. Chris related frustration that the attending physician did not seem to understand the concerns he had or his strong wish that the attending himself complete this procedure. The attending physician told Chris that the resident had plenty of experience in these procedures, and would be the one placing the epidural catheter. There were some difficulties however, and the epidural provided only partial anesthesia for Chris' wife. The failure of complete anesthesia reinforced that the attending should have listened to him and resulted in a decrease in his trust in physician staff.

As the couple surpassed the 20 hour mark since rupture of membranes (water breaking), they were told they would need to have a cesarean section because of the potential risk of infection to the baby or possible birth complications. They requested and were given another hour to try natural labor, but Chris reported that the pain became too great for his wife without analgesia and she was prepared for the cesarean section. Chris was given OR scrubs and told he could join his wife shortly, so he got his camera, donned the scrubs and waited patiently in the hall. One of the staff returned after quite awhile and told Chris his wife would need general anesthesia because of the failed epidural, and that he wouldn't be able to join her or see the birth of his first child.

Initial Post-Delivery

Chris stated he was very upset with the whole delivery experience up to this point, and waiting for his baby to be delivered without any knowledge of the progress was

extremely trying for him. His image of a perfect natural birth was initially shattered, however after the birth of his son he became ecstatic and felt his experience began to change for the better. Yet he still feared for the welfare of his wife and kept going back and forth between feelings of concern and joy as he waited to see her. The single most important thing he identified at this time was improved communication from the hospital staff, and he felt that the hallmark of his post-delivery course was just a better explanation of all that occurred from then until the time of his discharge.

Establishing the Family Unit

His transition to home was initially difficult. He described himself as a self-starter when it came to infant care but he also had to take care of his wife during her post-operative recovery, a factor that they had not been informed about nor considered when planning for the baby. This was most noticeable in provision of simple care to his wife such as activities of daily living and performing chores around the house, but also included activities such as carrying the infant in his car seat to physician appointments (which exceeded her lifting restrictions). He needed to rely upon the help of family members when the young couple's emotional and physical resources became strained, especially as the baby became more responsive and was harder to console at night. He believed this period was harder for his wife because she was still in considerable pain from her incision.

Chris found this period to be very, very rewarding as well. Despite the fact that the baby was crying more frequently and that it was easy for he and his wife to become frustrated, he described this transition to a family as a beautiful, beautiful thing. Chris

stated he felt that it was necessary to have a good team, and that is where he came in – to take some of the responsibilities “off her plate” and to make life a little easier for his wife. His goal was to try and make the whole “life after the baby” thing work out and to move on with their lives.

Conclusion

Chris noted that the circumstances leading up to the delivery of their infant could have been better explained and “extremely more polished” as the whole labor process was rough. The lack of communication from the staff did not instill confidence, and he said that although the people were very nice, sometimes being nice doesn’t make up for a lack of knowledge (of the staff or provided by the staff).

The biggest recommendations that Chris had for couples experiencing a cesarean section was to make sure that a support system was in place for when they return home. Either the husband or family members need to be available to help support the wife, as she will be unable to do many things on her own. He encouraged fathers to keep a positive attitude and try to keep smiling and maintain a level head when dealing with the baby and your wife. Finally he suggested that it is important to avoid taking things too, too seriously, and that everyone should be open-minded and remember that things will improve over time.

Table 5-1: Chris

| <u>*Super-Ordinate & Related +Emergent Themes</u> | Line #'s | Sample Quote |
|--|-----------------|--|
| <u>*Expecting a Natural Childbirth:</u> | | |
| +Birthing as a Planned Partnership | 45 | We had a birth plan and the plan was not to have one (a cesarean section). |
| +Overwhelmed by the Unexpected | 101 | Drills going off beneath you, floor vibrating. |
| | 103 | Wasn't what we expected. |
| <u>*Ongoing Communication Breakdowns:</u> | | |
| +Lack of Communication | 404 | Nobody explained that to me. |
| | 415 | No one explained why I wasn't allowed in the OR. |
| +Waiting without Knowing | 261 | I put on everything and I'm waiting, and waiting... |
| | 350 | It seemed like forever...a very trying thing to get over (waiting for the delivery). |
| <u>*Riding an Emotional Roller Coaster:</u> | | |
| +Loss of Control | 180 | We didn't want it (epidural), but were told we had to get it. |
| +Emotional highs and lows | 394 | Many different thoughts and emotions going through you. |
| | 374 | Everything at times is a blur. Everything was surreal. |

| | | |
|---|------|--|
| <u>*Moving to a Sense of Relief and Peace:</u> | | |
| +Relieved and Back in Control | 471 | After – everything – after the delivery – things were good. Um... for the simple fact that things were <u>explained</u> . |
| <u>*Awakening to the Challenges of Being a Father:</u> | | |
| +Awareness of New Challenges | 851 | A ton has changed for me.... it would be good to know about those little things right.....after the c-section. |
| | 860 | Its way more challenging than her and I both initially thought. Because of the c-section. |
| <u>Resolving the Memory and Moving On</u> | | |
| Reflections and Recommendations | 1265 | Make sure there is a support system in place. |
| | 1273 | Keep saying “yes”, try to, not to create any conflict. |

Alex’s Story

Alex and his wife were in their mid to late 20s. He was working as a semi-professional, and his work afforded him the opportunity to be finished by mid-afternoon. His wife was expectant with their first child. They were in their 40th week of gestation at

the time of rupture of membranes, which occurred at home. They called the obstetrician who instructed them to present to the hospital for evaluation. Their arrival on the labor and delivery floor was delayed for several hours because they were in the process of selling their house and had meetings with persons involved. There were no complicating factors with the pregnancy and they fully expected an uncomplicated vaginal delivery birthing process. This interview was conducted within the fourth week of the post delivery period.

Pre-delivery Expectations

Alex and his wife had made the decision to have a natural (vaginal) delivery. Partial rupture of membranes occurred at approximately 3 o'clock in the morning and precipitated their decision to go to the hospital. Her contractions were initially sporadic but by 10 AM the pain and contractions became more intense and they presented to the hospital for evaluation at that time. Both Alex and his wife were under the impression they would evaluate her and send her home, but by 2 PM she had a complete rupture of membranes and was admitted for active labor.

Alex related that their prenatal education consisted of material they had read during their obstetric visits, and a brief video course that his wife had found online. Alex said it described everything involved in the labor and delivery process, but he was unsure of how good it was when compared to other formal classes. He stated they watched "it real quick", and that they did not discuss the delivery process further because they did not think she would have any problems with the delivery. Alex felt that the video course adequately prepared them for natural delivery, and they knew a little bit about cesarean

delivery from what they read. However he stated that he and his wife would have been better prepared for a cesarean delivery if they had discussed that possibility as more than just a remote option. He expressed he thought they would have been better off if they had time to talk about it amongst themselves, because his wife was scared going into the cesarean delivery because she didn't know what to expect with the procedure. He also found that although the hospital environment was pleasant and quiet, that the hospital staff was not very forthcoming with their communication. They did not provide any additional information regarding what to expect during the cesarean section, other than a very cursory explanation.

Imminent Delivery

As his wife's labor approached 24 hours since rupture of membranes and there was little progression, the hospital staff eventually gave them an ultimatum that they would have to perform a cesarean section if natural delivery did not occur within the next 20 minutes. Alex says there still was no real discussion between he or his wife or with the staff regarding the cesarean section and eventually the nursing staff came in and stated that they needed to get her to the OR right away and "get this done".

Alex was extremely distraught that the staff seemed to be rushing this process, entangling his wife in the IV lines and monitor chords as they hastened to reposition her and move her to the stretcher for the operating room. Because of his training as a part-time firefighter, Alex stated he felt that the staff conducted a very poor primary assessment of the scene and that this could have been handled with much less excitement and drama.

Active Delivery Process

Alex was given a set of OR scrubs to put on after his wife was taken to the operating room. He was told by the staff that they would be right back to get him, and that he could join his wife after she was prepped for the procedure and an epidural catheter was placed for anesthesia. He was told this would take approximately 15 minutes so he waited patiently. He stated that 15 minutes came and went by, and after another 20 minutes he became concerned and began to wonder about the delay as nobody came to explain what was happening to his wife.

When the staff finally came to get him they explained that there had been some trouble placing the epidural, and he expressed that “this would have been nice to know a little while ago”. He was shaken up by this experience, but when he got to the birthing suite he saw that his wife was scared so he sat down next to her and tried to comfort her. He states he was just worried at that time and wanted all of it to end. His wife continued to be scared throughout the procedure and asked about the baby frequently. He did the best he could to comfort her.

Initial Post-Delivery

After the baby was delivered and they heard her cry for the first time, they both kind of relaxed and calmed down. Alex stated that everything seemed to be fine after that, and expressed that he felt like a weight was lifted off of his shoulders. Immediately afterward the nursing staff asked Alex if he wanted to come over and take a look at his daughter and take pictures. His wife was greatly relieved the whole process was over and that the baby was healthy. The couple felt that everything kind of turned around after

that point and they transitioned into what was described as “a lighter mood”. After the delivery of their daughter Alex also stated that he and his wife felt that the post-operative course became a more positive experience and that the tensions eased up. He stated he felt that they definitely weren't prepared (for a caesarian section) and that they should have talked more about the possibility of a cesarean delivery. He stated on numerous occasions throughout the interview that he thought there should have been more prenatal education regarding cesarean sections even if the plan was to have a natural (vaginal) delivery.

One distressing point did occur in regards to holding the baby. Alex held the baby immediately after birth but then the new family was separated as the infant was taken to the nursery and his wife had her abdominal incision closed in the operative suite. Alex left his wife and went to let his family know about the birth of his daughter. When he arrived outside the waiting room he found his in-laws holding his new infant. He was extremely distressed as his wife had yet to hold their infant, and she became really disappointed after learning about this. He has not brought this up again as he does not want to cause additional distress, and the couple has not discussed this further.

Establishing the Family Unit

Their transition to home was marked by a sharing of responsibilities. Alex stated that there was information provided to him by the hospital staff, but this was very basic and only included some brief instructions about wound care and a few lifting restrictions for his wife. Other than breast feeding instructions from a breast feeding coach there was very little information regarding infant care was provided by the hospital. They did rely

upon family support in the initial weeks following delivery, with his wife's mother staying with them for the first week to help provide care while he was at work. He then took off from work during the second week post-delivery, so that his wife was able to have help with care of the infant for the first two weeks after the delivery.

At this point Alex stated that both he and his wife get up in the morning at approximately the same time. They take turns caring for their daughter, getting her fed and dressed while they take turns getting ready for the day. After work he takes over care of the infant while his wife cooks dinner and then relaxes. He states they help each other out, and split up chores as best they can. He states that both he and his wife have expressed becoming frustrated with infant care at times, especially when they cannot figure out why the infant is crying or how to console her. In regards to his wife's postoperative recovery, he does feel that she would have been able to move a lot faster and had a shorter recovery time if they would have had a natural delivery. He stated that he does feel that they are getting back to their old routine and that they're closer because now they actually have a family. He states it feels different and that they feel tighter as a couple with an extra person that actually ties them together a little more. He's come to appreciate time, wanting to spend more with his wife and daughter. He tries to set more time aside specifically for his family, and has a greater amount of respect for his wife because of all that she went through during the delivery process.

Conclusion

When asked to describe his overall experience during the last several weeks since birth, Alex immediately stated that he would describe it as a “roller coaster” of frequent

emotional changes. He stated with everything going on, their emotions were up and down constantly. He states that with all of the concurrent events (selling their house, moving to a new house, delivery of their infant) they were extremely stretched and it was good that their family was able to help them out.

Alex's recommendation to improve the overall delivery experience was to read more about the entire process including the different possible outcomes and modes of delivery. He states a little more knowledge about the entire process would have helped them out immensely. He states the (perinatal) staff should help to keep parents informed about what is transpiring along the way. He also stated that he thinks there needs to be more thorough information provided to parents who have planned a natural delivery but end up requiring a cesarean section, and this should include both postoperative and the infant care instructions.

Table 5-2: Alex

| *Super-Ordinate & +Related Emergent Themes | Line #-s | Sample Quote |
|---|-----------------|---|
| <u>*Expecting a Natural Childbirth:</u> | | |
| +Birth as a Natural Delivery | 17 | She was trying to do it natural. |
| | 47 | We were wanting to do it natural. |
| <u>*Ongoing Communication Breakdowns:</u> | | |
| +Lack of Communication | 89 | They were rushing and rushing and then they were like “do you have any questions?” They were just going so quick. There was |

| | | |
|--|----------------------|---|
| <p>+Unexpected Outcomes</p> | <p>66</p> <p>144</p> | <p>not time to really.....</p> <p>She had the impression they she would look at her and send her home and we had no idea.</p> <p>She was scared going into it. Because she really didn't know what to expect.</p> |
| <p><u>*Awakening to the Challenges of Being a Father:</u></p> | | |
| <p>+Realized Need for Family Support</p> | <p>515</p> | <p>We kind of had it planned, because her mom really wanted to stay down here.</p> |
| <p>+Expectations, Challenges of New Parenthood</p> | <p>520</p> | <p>I expected it would be rough at first. A lot of changes.</p> |
| | <p>583</p> | <p>My wife needed the help, so I had to help her.</p> |
| | <p>585</p> | <p>I had to help her a little bit more than if it would have been the other way (Natural Delivery).</p> |
| <p><u>*Resolving the Memory and Moving On:</u></p> | | |
| <p>+Resolving the Memory</p> | <p>287</p> | <p>I don't see anything anywhere at the doctor's offices.</p> |
| <p>+Retrospect and Evolution</p> | <p>660</p> | <p>A roller coaster (describes the past several weeks since birth).</p> |
| | <p>700</p> | <p>I think there needs to be a better heads up for people that plan on doing it natural and it turns out to be a cesarean.</p> |

Nick's Story

Nick was a 33 year-old gentleman whose profession was that of a school teacher in grade 10. His wife was slightly younger and pregnant with their first child. The pregnancy was at 36 weeks gestation when she developed some vaginal bleeding and they presented to the Emergency Department for further evaluation. They had no other complicating factors during this pregnancy, although it was discovered much later during the interview that they had experienced two previous miscarriages. This interview was conducted over the telephone during the fourth post-delivery week. Nick begins his story right at the moment of delivery which he states was amazing to watch, and then begins to retell his story right from the moment when he and his wife arrived at the Emergency Department.

Pre-delivery Expectations

Nick and his wife had planned on a natural (vaginal) delivery. They had not really entertained the thought of a cesarean section. Their prenatal education consisted of a single class held two days before their presentation for delivery. Nick was unsure why their prenatal education was scheduled so late in the pregnancy. The first class was very informative and mainly went over what labor would be like, breathing and relaxation techniques, and reviewing the three stages of labor. Nick felt that more time was spent on "meet and greet" than on provision of actual information or active learning.

Imminent Delivery

When they presented to the emergency department Nick was very nervous, however a fetal ultrasound soon revealed that the baby was okay. No source of the

bleeding could be found and the obstetrician felt it would be necessary to admit his wife. The couple was told that the risk of continued bleeding or complications to the infant were great, and they were presented with two options: the obstetrician could induce labor which could take up to 24 hours for delivery and carried the same amount of risks towards the mother and infant; or they could perform a cesarean section which would take approximately 30 minutes and carried reduced risks. The couple had no aversion to a cesarean section at this time, so they chose this option and when they asked how long it would be before the staff performed the operation they were told, "We are going to do it right now."

Active Delivery Process

The excitement of new fatherhood initiated an up and down surge of emotions for Nick as he realized his baby was about to be delivered. He made a couple of phone calls to friends and family to alert them, and then the staff assisted him in joining his wife who had already been taken to the operative suite. Nick became nervous and concerned for his wife. When he entered the operative suite he saw that his wife also looked very nervous and worried. He sat next to her and talked to her and tried to keep her calm. He could see nothing of the procedure as it was cloaked behind a sterile curtain. At the appropriate time he was instructed to stand up and was able to observe his infant being delivered from his wife. He described this event as remarkable to watch. He thought that the hospital staff did an excellent job of keeping him informed of what was occurring, and involving him to the extent possible. He seemed excited and elated over the birth of his infant until he noticed blood rushing from his wife like a "waterfall". His voice then

became shaky and he was obviously emotionally disturbed by this scene. He thought it looked like there was a ton of bleeding coming from the wound and he became very concerned for his wife. Nick made sure that his son was okay and then walked over to be with his wife. After the placenta was delivered and the bleeding subsided the nurses brought the infant over so that the couple could share their first family moments together before the infant was taken to the nursery. Nick then accompanied his son to the recovery area and nursery while his wife remained in the operative suite to have her incision closed.

Initial Post-Delivery

Nick relates at this time that no source for the vaginal bleeding was ever discovered. He also relates that this all transpired very quickly and he wishes they had more time for preparation. While in the recovery area Nick was told that his wife would be joining them in approximately 10 minutes. As time wore on Nick became very concerned for his wife and he asked several nurses to check on her. He was still unsure of her condition when he heard a trauma call, which he thought was especially unnerving. His baby also experienced some respiratory grunting, which he was told could be a sign of respiratory distress. The nursing staff stated it was most likely due to the fact that his wife had not experienced labor and that the baby was simply trying to expel amniotic fluid from his lungs. Although Nick still had no information about his wife, he found the nurse to be very informational and she made him feel relaxed as she talked to him. He was not exactly sure how much time had passed when an x-ray was ordered for the infant and his wife was finally brought by the nursery so she could see their child. She was then

taken up to her post delivery suite and he stayed with the infant to try some skin to skin contact to see if that would stop the grunting. Nick thought that this "kangaroo care" was a "really cool thing" to do and he was very pleased to sit in a "very comfortable recliner" while holding the infant. After the infant had a chest x-ray performed he spontaneously stopped grunting and the x-ray returned negative. Nick was greatly relieved when he finally knew that everything was okay and he and his infant joined his wife at approximately 2:30 in the morning.

Nick felt that most of his interactions with the staff were great and that they kept him very informed. He states that the nursing staff provided him with a lot of useful information especially after the delivery. They made him feel very relaxed during the whole time he was in the nursery and his infant was experiencing the respiratory grunting. His only negative experience with the staff involved the very first nurse they encountered. He states that although she was very knowledgeable she didn't seem to be very people savvy, and that she seemed to be lacking the gregarious interpersonal skills possessed by the rest of the staff.

Establishing the Family Unit

Nick stated that his home life currently is punctuated by a lack of sleep. He states he and his wife are trying to figure out a system that will benefit the both of them, where the infant can feed and Nick can help out so that his wife can sleep at night. He states that even though they are experiencing the current problem, that life is terrific in general and he wouldn't change anything. Nick further states that he couldn't be happier now with his family, his son and his wife. He was able to take the past three weeks off for maternity

leave. He did have to work during the first week after delivery of the infant until a substitute teacher could take over. During that first week his mother-in-law came out to help with infant care and his father-in-law came out to help with home improvements. He states he performed split shifts for infant care with his wife and mother-in-law, and that he was grateful to his father-in-law for aiding him in completion of the home improvements.

Conclusion

Nick actually experienced the opposite of communication breakdowns that occurred with several of the other participants. Except for a couple of minor instances, he was extremely pleased with the open communication and helpful explanations provided to him by the hospital staff. He believed this provided relief for most of his concerns during his more stressful moments. However, Nick did experience what could be considered an emotional roller coaster during the delivery process and early postpartum period. His emotional swings included worry about their early delivery, excitement and pride of being a new father, concern for his wife when she was bleeding and for the baby when he was grunting, joy and the feeling of affection at holding his infant's hand and just being with him, irritability during the early transition to home, and finally complete happiness with his new family.

Nick reflects that each person's experience is unique to that person, and relates that the journey of creation and birth is an amazing one. He really stresses the importance of spousal communication and working together as a team. Teamwork was mentioned several times, including "trading off" when one person becomes frustrated with infant

care. He suggests talking through the differences of opinion, and discussing ground rules for treating one another with respect. He also recommends supporting each other in providing care for the infant and when dividing and performing household chores

He and his wife have had to make some adjustments. There was some irritability initially between him and his wife after they first arrived home, and they were able to talk it out and work through their differences of opinion. He states they are now open to joke about this and bring it up later for discussion if necessary. His wife also has restrictions that she must follow as a result of a cesarean section. He states that normally he is a very caring and helpful husband, that he already helped his wife in their household responsibilities, and therefore he did not consider the additional workload of having a wife with restrictions and a new infant to be a burden on his transition to the role of parent.

Table 5-3: Nick

| *Super-Ordinate & +Related Emergent Themes | Line #-s | Sample Quote |
|---|----------|--|
| <u>*Riding on an Emotional Roller Coaster:</u> | | |
| +Rushed (Urgent) Decision | 70 | It all happened really fast. I asked how long before they wanted to do it (Cesarean section), "Well we're going to do it right now." |
| +Elation versus Fear & Concern | 192 | I was really excited to be a father until I saw all that blood, then I was just worried that she's going to be okay. |
| +Concern (Loss of Control) for Wife and Baby | 56 | My initial emotion was one of concern and worried-ness for her safety and the baby's safety. |
| <u>*Moving to a Sense of Relief and Peace:</u> | | |
| +Relief after Delivery | 265 | At that point I knew everything was okay, and he (the baby) came up at about 2:30 in the morning. |
| <u>*Awakening to the Challenges of Being a Father:</u> | | |
| +Working Through Differences | 415 | Well right now would be lack of sleep...We're trying to figure out a system. |
| +Need for Support | 536 | We live away from everyone we're immediately family with, so there is just not that immediate presence of anybody. |

| | | |
|--|-----|--|
| +Challenges of New Parenthood/Responsibilities | 416 | We're trying to figure out a system, where he can feed and I can help out, where she can sleep at night. |
| <u>*Resolving the Memory and Moving On:</u> | | |
| +Resolving the Memory | 756 | Just amazing how it all happened, earlier than expected but I couldn't be happier now than any other time in my life. It's all really cool! |
| +Moving On | 443 | So satisfying to know that all that (Nursery, renovations, etc.) is completed as well too. I'm pretty much just ready to move on with his life, our lives. |

Mike's Story

Mike was a 33 -year-old professional whose wife was approximately the same age. This was their first child and the pregnancy had progressed to 40 weeks +2 days gestation. They presented directly to the labor and delivery ward of a University hospital where they both were employed after spontaneous rupture of membranes. There were no complicating factors during pregnancy. The timing of the interview is four weeks to the

day post delivery of their infant. Mike began telling his story at the point where they presented to the Labor and Delivery unit.

Pre-delivery Expectations

Mike and his wife had planned on a natural or vaginal delivery. As with many couples they did not consider the possibility of having or needing a cesarean section. Also cesarean delivery was not their intended goal, even though that is how Mike's mother-in-law delivered his wife. Their only discussion of cesarean delivery revolved around the fact that they would accept it if it occurred. Their preparation for birth included taking almost every prenatal class available to them. Mike and his wife attended at least five sessions but he became very frustrated with the simplistic education that was provided. When asked Mike noticed that very little information on cesarean deliveries was provided, and he was rather shocked by the lack of information provided by the prenatal staff. In retrospect he states that they did not have nearly enough preparation in regards to a cesarean section, and feels that more information and devotion of time to the subject would be warranted.

Mike states their labor experience began with a spontaneous rupture of membranes (water breaking). He states that at 3:45 a.m. his wife jumped up from bed and ran to the bathroom. He could hear her water breaking, and describe a sound as if someone had poured a bucket of water onto the floor. After calling they presented to the labor and delivery unit, where they were told there was no evidence of her rupture of membranes, which caused a lot of anguish for Mike and his wife. Her contractions started approximately one to two hours after the present to labor and delivery and so they were

told to walk in the halls. They were essentially there 12 hours when his wife stopped dilating. The obstetric staff was still not convinced that she was in true labor until they tried to artificially rupture her membranes. When the staff realized that she had spontaneously ruptured her membranes almost 24 hours earlier, they stated she would have to either deliver naturally very soon or have a cesarean section to decrease the risk of infection in the baby.

Imminent Delivery

Mike states that his wife eventually received an epidural for anesthesia around 3:00 in the afternoon. His wife seemed to be fine until about six or seven in the evening when her pain started getting worse. It became clear to Mike from the frequency of physician visits that she wasn't progressing as they had hoped. He knew that something was wrong when several doctors came in during a 5 to 10 minute time frame and this is when the obstetrics staff started talking actively about needing a cesarean section. Mike and his wife were still under the impression that they were going to have a natural delivery until about 11 PM, when the staff said that they were going to take her for a cesarean section.

Active Delivery Process

Mike states that they had very little warning before this occurred. The resident who had seen them initially almost 20 hours ago had gone home and returned. Seeing they still had not delivered, the resident reviewed their case with the attending that had been on call all day. This resident was one who explained the need for a cesarean section to them, and when he left their room the attending obstetrician returned within five

minutes and essentially repeated what he had said. Mike describes this as a very hectic period in time and that the staff "flew through" the information regarding the cesarean delivery procedure. Mike states that he was told "this is how it's going to go", and "basically you can do whatever you like, just stay out of the way". His wife was prepped and taken to the operating room, and he was given OR garb and told to wait until he was summoned. He states neither he nor his wife were able to take in very much of this information, and that the staff was in such a rush that there was little time for discussion between he or his wife. He was told by one staff members that the obstetrician had already performed five cesarean sections that day, that two more were ready to go on the unit, and that they would need to perform her cesarean quickly. Mike felt that due to the circumstances that he and his wife had no control over the situation and that the staff actually made the decision to perform the cesarean section.

The actual procedure itself did not take long. Mike eventually was brought in and told to sit next to his wife. He was behind an operative sterile screen and attempted to keep his wife calm as best he could. Her epidural wasn't working well so this made for a very rough cesarean section. After the delivery there were some operative complications, and one of the residents mentioned the possibility of his wife needing a hysterectomy. Mike is still unsure what occurred and they are having ongoing discussions with the obstetric and anesthesiology staff to clear up this matter. Mike feels that this pervasive lack of communication by the obstetric and neonatal staff, combined with the lack of appropriate analgesia during the cesarean section, made for a very unpleasant experience for both he and his wife.

Initial Post-Delivery

After the baby was born she was taken across the room for her Apgar and basic postnatal checks. Mike took some pictures and showed them to his wife as she was demanding to see her infant. His wife was unable to hold her child and she expressed that she was deeply disappointed about this fact. Mike felt very bad for her in this regards especially since he was able to hold the baby immediately after delivery. The baby was then taken to the nursery while Mike waited with his wife to have her incision closed. This was again difficult because of the lack of analgesia.

After period of time they were taken to their post delivery suite where they asked about their infant. It'd been about 4 1/2 hours since the baby was taken from them and they began to become concerned. When the nurse returned told Mike and his wife that their baby had received an IV and IV antibiotics because of the fever his wife had experienced during her labor process. Mike and his wife were both very upset as they had no previous knowledge about this fact, and feel they would have liked to have known if something could have potentially been happening to their infant. This was another added stressor for Mike on top of the fact that he had approximately 20 family members present and waiting for news about the infant. Mike wanted to go answer their questions; however his wife did not want him to leave the room because she stated she was “afraid of the doctors” at this point. She was completely stressed out and emotionally distraught, and Mike himself likens the whole procedure to torture. During the next three days that they were admitted to the hospital he felt that his wife improved substantially and regained most of her composure.

Establishing the Family Unit

The couple returned home on a Sunday evening. When his wife awoke the next morning she was in significant pain and unable to move. Mike had to call off work and spend the entire day with his wife and child because his wife was unable to do anything including get out of bed. This continued for several days until her pain began to ease and she was able to ambulate with assistance. Mike had only planned for two days off from work and states he feels very fortunate that his work was flexible enough to allow him more time off. Because of his wife's pain Mike had to provide care to his wife as well as to his new infant. He states that other than feeding he provided total care of both his infant and wife. He noted again a lack of preparation and information. He states the post natal education that occurred while they were in the hospital include a single video that was shown in the post delivery waiting area for all interested fathers. He states that this was mostly a joke and offered common sense information such as "don't shake your baby" and "don't beat your wife". He states he was shown very little infant care techniques from the staff and was never shown how to change a diaper or provide appropriate wound care to his wife.

Transition to the role of parent occurred rapidly for Mike, as he was forced to provide immediate care to both his infant and spouse. He did have the help of his mother- and father- in -law in the immediate postpartum period. His mother-in-law provided help with infant care and caring for his wife, and his father-in-law helped with completing some home improvements as well. As his wife began to improve, she began to share in the responsibilities for infant care. At this point Mike feels he has successfully transitioned to the role of a father. He has shown successful bonding to his

infant and the beginning of an attachment relationship is evident by use of phrases such as "this is my child; she is precious; I feel connected to her; and yes, she is definitely mine." Mike finally states when asked to look back on the whole experience that even though it was a rough start he feels that he is extremely happy at this point. He felt immediate love for his infant and given the four weeks since delivery they have turned the corner as a family and transitioned into an acceptable routine. He states they are much happier as a family at this point in their life.

Conclusion

Mike stated he feels that their experience of having a cesarean section was rough at best. They evolved from a chaos state with overwhelming stress and system overload to being able to look back on the experience in retrospect, and realize that they have survived and emerged at a point where they're very happy with their new family. Mike's overwhelming and recurring complaint during this whole experience was the pervasive lack of information and breakdown in communication from the neonatal staff. He stated that communication is the key and all of the negative experiences he ties to lack of communication from the staff. His earlier comments suggest (even though nursing is clearly part of this issue) that he finds most of the fault with medical staff [i.e. changes in attitudes and care with each different resident; a lack of direction from the attending (i.e. simply parrots the resident assessment and decision); failure of the epidural and anesthesia; negative and unexplained comments and issues that arose during the cesarean section; and lack of follow-up medical evaluation and care for his wife)].

Mike further related that fathers should be involved in all of the decision-making processes across the board, and that there needs to be a better understanding of requirements for time off to care for the infant and partner following the cesarean delivery. His final recommendation is that dads need to be educated early on in the pregnancy about post-delivery expectations and care needs as well as possible complications, so that they can plan accordingly,

Table 5-4: Mike

| *Super-Ordinate & +Related Emergent Themes | Line #'s | Sample Quote |
|---|-----------------|--|
| <u>*Expecting a Natural Childbirth:</u> | | |
| +Birthing as a Natural Delivery/Planned Partnership | 38 | We were planning on a natural or vaginal delivery. |
| | 42 | We kept (cesarean birth) in our mind but that was not the intended goal, at all. |
| <u>*Ongoing Communication Breakdowns:</u> | | |
| +Lack of Communication | 90 | I find it a little shocking that there wasn't more information given. |
| +Loss of Trust | 768 | She didn't want me to leave the room at all because she was afraid of the doctors at this point. |
| <u>*Riding an Emotional Roller Coaster:</u> | | |
| +Loss of Control | 770 | I was being pulled in many different directions is what it came down to. |

| | | |
|--|------|---|
| +Emotional turmoil | 703 | (The previous doctor) had cut out for the day...so another doctor says her water didn't break and said, "well you're not in labor." |
| +Rushed Decision | 369 | They were in a rush to get the C-section done, they had two more going to give birth within the next two hours. |
| <u>Awakening to the Challenges of Being a Father:</u> | | |
| Challenges of New Parenthood | 793 | She had trouble getting up, getting out of bed, any of those things she needed help with so, it all fell on me (to care for the baby?). |
| Transition to the Role of Parent | 1128 | When you take her home, in the car driving her, and that's like really, "this is my child." And very protective of her, of my child. |

Comparative Analysis

After completion of analysis of individual cases, a comparative analysis was performed to look for patterns across the cases. This was accomplished by placing all of the emergent themes from each case in a comparison table and looking for similarities

and differences amongst the various themes. Emergent themes were expanded and collapsed, reconfigured or relabeled, and developed or discarded in a creative endeavor to move to a more theoretical level as recognition of more common themes that crossed cases and eventually super-ordinate themes that were present across cases became apparent.

As predicted by Smith and colleagues (2009), emergent themes from one case often illuminated aspects of another case, and it became apparent that some themes thought to initially be individualistic indeed represented instances of higher order concepts shared amongst the cases. In this manner the super-ordinate themes eventually evolved, and were themselves refined through the hermeneutic process and after multiple discussions with an adviser with expertise in the method. The super-ordinate themes identified that were common to more than one member of the group were as follows:

Super-Ordinate Themes Shared by Participants

1. Expecting a Natural Childbirth.
2. Ongoing Communication Breakdowns.
3. Riding an Emotional Roller Coaster.
4. Moving to a Sense of Relief and Peace.
5. Awakening to the Challenges of Being a Father.
6. Resolving the Memory and Moving On

Super-Ordinate Themes in Relation to the Participants.

All of the participants shared some expectation of having a Natural Childbirth. Each one of them prepared for the labor and delivery process by either attending or viewing a prenatal educational program. None of these participants prepared for the possibility of cesarean birth, and except for Nick, all of the participants fully expected to have a natural delivery until approximately 30 minutes before the cesarean section. Nick was the only one who related some potential for C-section, based on his wife's pre-delivery status.

Most of the fathers in this study expressed experiences with significant Ongoing Breakdowns in Communication with the staff. The period leading up to and immediately preceding the cesarean delivery is where the most pervasive lack of communication occurred. The participants echoed the sentiment that they would have felt less stress and less rushed if they had been given the opportunity to discuss the necessity of a cesarean delivery with their partner. Being rushed into the decision to have a cesarean delivery, and the rapidity with which the operation was carried out following the decision all added to the feeling and sense of a loss of control of the situation for participants. The only exception to the theme of a communication breakdown was reflected by the experience of Nick, whose labor and delivery occurred at a different healthcare facility. Nick's experience was actually the polar opposite of the other participants, and he related that his experience was enhanced by the effective communication from the staff of that facility.

The expressed feeling of Riding an Emotional Roller Coaster was very prevalent in all of these stories. Emotions for these participants varied greatly, from the apogee of the impending birth of their first child and the feeling that they are about to become a new father to the anger and then concern of waiting without knowing, or fear for the safety of their unborn child and wife. Many of these emotional ups and downs seemed to be complicated by the lack of communication and explanation of what was happening.

These gentlemen related a feeling of Moving to a Sense of Relief and Peace after the birth of their child and the resolution of the operative procedure. They expressed their feelings with verbiage such as: "after the delivery everything was good"; "things were better explained"; "the nurse reminded us of a grandma, warm and relaxing". Some of the men described feeling warmed by their emotion of love for their new infant, a deepened respect for their wife, and their pride at being a new father. Several also alluded to the bond that had formed between themselves and their new child immediately after birth, and a burgeoning attachment relationship that was evident in their narratives.

Returning home and to home life presented a new Awakening to the Challenges of being a Father and all that entailed. First and foremost was the issue of child care for the new infant, compounded by the fact that the planned primary caregiver (the mother) was now herself a postoperative patient also in need of support and care. Instead of having a partner to help meet the feeding and care schedule of their new infant, the participants in this study performed double duty and were required to help with not only the caring and feeding of the infant but also with wound care for the mother, coupled with general assistance in the activities of daily living and household chores. Their descriptions revealed that they performed these duties admirably, meeting the challenges

head on, and taking pride in their abilities to care, comfort, and soothe their infants and the needs of their spouse. Participants related a variance in their understanding of a need for help with care of wife and infant due to the C-section and participants who realized the need and were able to get help related more satisfaction overall with the return to home.

Resolving the Memory and Moving On emerged as a recurrent theme as these fathers reflected upon the birth of their child by cesarean section and came to terms with their experiences. They all related that there needed to be an improved educational process for preparing families for the possibility of a cesarean delivery. When questioned, several of the fathers did not recall that any educational material on cesarean deliveries was either readily available or offered during their prenatal office visits. They stated that this omission in planning greatly hampered their transition to the role of parent and increased their stress during the postpartum period. That being said, they all echoed the sentiment that they could not be happier at this point in their life because of their new family. They expressed a closeness that they had not felt before, and they all felt that they had transitioned to either a more comfortable or an acceptable routine. Some actually stated they were ready to move on with their lives, and the necessity for teamwork was mentioned by others. Multiple participants mentioned that they would "trade off" the infant when either they or their spouse became frustrated with infant care, and it was emphasized that fathers should try to keep a positive attitude when dealing with the infant and their spouse. Final recommendations from the fathers for other fathers included avoiding taking things too seriously, being open-minded and treating one

another with respect, and keeping open lines of communication with their spouse with the understanding that things will improve over time.

Table 5-5: Sample of Themes across Participants

| Focus of Theme | Line # |
|---|--------|
| I. Pre-delivery Expectations. | |
| A. Birthing as a Planned Partnership. | |
| i. Chris: We had a birth plan and the plan was not to have (a cesarean section. | 45 |
| ii. Alex: We were wanting to do it Natural. | 47 |
| iii. Nick: N/A | |
| iv. Mike: We were planning on a Natural or Vaginal Delivery. | 38 |
| II. Imminent Delivery. | |
| A. Loss of Control | |
| i. Chris: We didn't want (an epidural) but were told we had to get it. | 180 |
| ii. Alex: They just came in and started doing. They just asked me to step back and that was it. | 96 |
| iii. Nick: My initial emotion was one of concern and worry for her (my wife) and the baby's safety. | 56 |
| iv. Mike: I was being pulled in many different directions is what it came down to. | 770 |
| B. Emotional Roller Coaster | |
| i. Chris: There were many different thought and emotions going through you. | 394 |
| ii. Alex: A roller coaster (is how he would describe the whole experience). | 660 |
| iii. Nick: I was really excited to be a father until I saw all that blood, then I was just worried that she was going to be okay. | 192 |
| iv. Mike: (The previous doctor) had cut out for the day...so another doctor says her water didn't break and said, "Well you're not in labor." | 703 |
| III. Active Delivery Process. | |
| A. Waiting without Knowing | |
| i. Chris: It seemed like forever (waiting for delivery), a very trying thing to get over. | 350 |
| ii. Alex: I just kept waiting and waiting and nobody came over to explain anything to me. | 174 |
| iii. Nick: I think that about 15 or 20 minutes later my wife still wasn't out which was some cause of concern for me. | 209 |
| iv. Mike: (We asked) after she (the baby) was taken from us for 4 1/2 hours. You know, you didn't realize that that could have even been a situation? | 406 |
| B. Trust in Staff | |
| i. Chris: It was hard because once you gained trust with somebody they throw someone else at you. | 120 |
| ii. Alex: (After shift change) there was a completely different mood change. Everything just kind of changed. | 414 |

| | |
|---|------|
| iii. Nick: N/A | |
| iv. Mike: She didn't want me to leave the room at all because <u>she was afraid of the doctors at this point.</u> | 768 |
| IV. Initial Post-Delivery. | |
| A. Relief after Delivery | |
| i. Chris: After delivery things were good for the simple fact that things were explained. | 471 |
| ii. Alex: Yes, yes (a weight lifted off of my shoulders). | 238 |
| iii. Nick: At that point I knew everything was okay, and he (the baby) came up at about 2:30 in the morning. | 265 |
| iv. Mike: It was after they had cleaned her up, probably took five minutes, and then showing my wife. | 614 |
| B. Need for Support | |
| i. Chris: Oh yeah, you've got to (have support). Families quite often. | 943 |
| ii. Alex: We kind of had it planned, because her mom really wanted to stay down here. | 515 |
| iii. Nick: We live away from everyone we're immediately family with, so there is just not that immediate presence of anybody. | 536 |
| iv. Mike: We've had quite a bit of support from her family since my wife can't get up; her mom came down and helped. | 907 |
| V. Establishing the Family Unit | |
| A. Accepting the Differences | |
| i. . Chris: There are a lot of things that I still have to do because of the c-section that weren't explained. | 586 |
| ii. Alex: N/A | |
| iii. Nick: Well right now would be lack of sleep...We're trying to figure out a system. | 415 |
| iv. Mike: I pretty much did everything. I also had to try and figure out how to work out my job in the meantime. | 811 |
| B. Resolving the Memory and Moving On | |
| i. Chris: Just keep a level head with everything; don't take things too, too seriously as far as letting things get out of control. | 1280 |
| ii. Alex: I think there needs to be a better heads up for people that plan on doing it natural and it turns out to be a cesarean. | 700 |
| iii. Nick: Just amazing how it all happened, earlier than expected but I couldn't be happier now than any other time in my life. It's all really cool! | 756 |
| iv. Mike: Hopefully in the future we're going to get back to what we were expecting, so there was an expected pattern, and we are kind of starting to see evidence of that now. | 877 |

Table 5-6: Comparison of Recurrent Super-Ordinate Themes

| Super-Ordinate Themes | Chris | Alex | Nick | Mike | Present in over half of sample? |
|--|--------------|-------------|-------------|-------------|--|
| Expecting a Natural Childbirth | Yes | Yes | Yes/No* | Yes | Yes |
| Ongoing Communication Breakdowns | Yes | Yes | Yes** | Yes | Yes |
| Riding an Emotional Roller Coaster | Yes | Yes | Yes | Yes | Yes |
| Moving to a Sense of Relief and Peace | Yes | Yes | Yes | Yes | Yes |
| Awakening to the Challenges of Being a Father | Yes | Yes | Yes | Yes | Yes |
| Resolving the Memory and Moving On | Yes | Yes | Yes | Yes | Yes |

* Had planned natural child birth, attended first prenatal class, however C-section was performed by choice to reduce maternal and fetal risk related to undetermined source of vaginal bleeding.

**Experience was actually the polar opposite. Thorough/effective communication from staff shed a positive light on a potentially traumatizing experience.

Summary

Many avenues for action can be discovered by review of this data, including the realization that at least 2 of the super-ordinate themes are particularly ripe for quality improvement initiatives due to their pervasiveness and their potential impingement on every other aspect of the perinatal and postpartum experience. The Ongoing Breakdown in Communication at many different levels and at many different points in time had wide-sweeping ramifications for all of these new families, both before and after the birth. Also prevalent was the Emotional Roller Coaster and unanticipated upheaval that both of the parents experienced during their ordeals; and some of these stories can truly be labeled ordeals and there is much to improve upon if these experiences are more common than not.

There were numerous transition points where nursing interventions could have been initiated to improve outcomes. The prenatal education was sporadic for these fathers, and ranged from watching a web-based video on natural labor to attending multiple prenatal courses available at the university-based prenatal clinics. Notably lacking was an adequate preparation for a possible cesarean birth, even though the C-section rate is currently over 30% in the United States (Notzon, 2008). A breakdown in communication plagued the labor and delivery process and period, and contributed to their reported feelings of fear of the unknown and loss of control, as well as left the fathers feeling excluded from the decision-making process or like they were part of the care-delivery team. The fathers in this study expressed feeling a sense of relief in the post-delivery period, yet they all agreed the transition was hampered by a lack of

adequate education about life after delivery including infant and spousal post-operative care needs, and a lack of preparation and information regarding realistic expectations of what would be required during the transition to the role of parent.

Conducting research on fathers during their first postpartum month can be especially challenging. There are time constraints, family care needs, and often issues that surround their recent return to work. They are sometimes the sole source of support for their partner, and often feel guilty about leaving her with the new infant for even a short period of time. The fathers recruited for this study experienced all of the above issues, yet took time out of their busy schedules to complete the interviews, and one even brought his newborn with him so that his wife would have her first day to herself since the delivery. These participants were extremely gracious and giving, but most importantly they all expressed a desire to be supportive to and provide insight for other father's who are about to undergo a similar experience.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

This research project has underscored the concept that the birth of a child (especially a first child) can be looked upon as a series of transitions for fathers: transition from pregnancy to birth; transition to the role of fatherhood; transition from status as a couple (dyad) to that of a family (triadic relationship); and transitions through focus points in time, such as during the actual labor and delivery process (e.g., from excitement to fear and then back again to joy) or during the early postpartum period (i.e. learning to competently and effectively care for the infant).

It is hoped that the findings of this study have led to the development of a better understanding of the experiences of fathers during this critical time period, and has helped to identify potentially high-risk situations or deficits in the care needs for fathers and their families experiencing C-section delivery. A secondary benefit of the findings is the potential for the knowledge gained to be used in the development of improved interventional programs for fathers and families, needed to help justify the allocation of resources to improve the quality of care and support of fathers and families during this high risk period of time.

Family Perinatal and Postpartum Care

Most fathers participating in this study stated they developed an immediate bond with their infant and even had the opportunity to experience bonding before the mother.

This is in contrast to a prior study that reported fathers often found their relationship with their infant was slower to develop than the mother-infant relationship, or that their partner held a privileged position because of maternal-fetal bonding during pregnancy or from breast-feeding (Gamble & Morse, 1993). While fathers from this study did express feeling some exclusion because of the mothers breast-feeding, one of the fathers actually stated that his wife sometimes expressed jealousy of his close father-infant relationship that she related was due to him being the first one to hold their infant. The alienation from participation in care and jealousy of the strong mother-infant relationship reported by Gamble and Morse was also not reported by fathers from this study. In contrast the care needs of the mothers caused the fathers to be more directly involved with infant care as soon as they arrived home from the hospital. This was similar to the findings of Ceronio and colleagues who noted that paternal-infant bonding was possible at a very early stage when fathers were present at birth and were able to hold and partake in the care of their infant directly after birth (1995).

The circumstances surrounding the birth by C-section brought about feelings of anxiety, relief (e.g. that the labor was finally over), and occasionally anger for the fathers in this study. These issues were similar to those found by Anderson (1996); however, unlike some of the previous research this study revealed that the causative agent for most of the problems including anger and anxiety was the pervasive lack of communication by the perinatal staff. When discussing their sense of relief that the labor was over, these fathers defined relief as the end to their wife's suffering, as several participants noted a lack of appropriate or effective analgesia for their partner during labor and even during the operative procedure.

Perinatal Care, Postpartum Care and Parenthood

All of the fathers in this study expected to help with infant care and participate in household chores, and admitted they knew there would be changes in the postpartum period. What was not expected by the participant fathers was that they had to take on the responsibility for both the postoperative care of their wives as well as care for their new infants in the immediate postpartum period. While they described themselves as self-starters or the type of husband that already willingly helped out with household chores, they all expressed frustration at the lack of appropriate information and preparation that they received in the prenatal period. They mentioned that most of the prenatal classes they attended were more like "meet and greet" sessions and lacked any depth or substantial information. None of the classes adequately addressed the possibility of cesarean birth, how to prepare for it, or the significant amount of vacation (time off from work) that would be required to care for their wife and new infant. These findings are similar to those of Pollock et al. who noted that common daily annoyances could become significant sources of stress, including 'concerns about the health of family members', 'having too many responsibilities', and 'not having enough time to do the things you want to do' (2005).

Paternal Needs in Perinatal and Postpartum Care

Fathers from this study reported a great variation in their preparation for infant care prior to discharge from the labor and delivery ward. Some of the fathers stated that the staff taught them "everything", while others were upset that information about even

the most basic care (such as changing diapers) was never conveyed. The needs of fathers in the perinatal and postpartum time periods have often been neglected compared to mothers and the newborn, which may lead to inconsistencies in appropriate parenting behaviors (Matthey & Barnett, 1999). As previously noted, most of the fathers from this dissertation study expressed that they were feeling inadequately prepared to provide infant care in the early postpartum period despite recalling a feeling of confidence before the labor and delivery process.

These participants all attended or accessed some form of childbirth preparation in the prenatal period, which they found superficial as stated above. However, another educational opportunity was missed as they received very limited or no information about postnatal education or father-focused classes that were available in the post-partum period, and they denied being alerted to any paternally-oriented support or networking groups post-delivery. Even though it is recognized that more men are now attending childbirth classes than in previous decades (Fletcher et al., 2004; Kaila-Behm & Vehvilainen-Julkunen, 2000), there must also be a realization that information still appears to be maternally-focused and as a result fathers may not be benefitting from the existing “family” related services in the prenatal or postpartum period.

The Transition to Parenthood

The transition to the role of fatherhood was more difficult than anticipated by the fathers in this study. Various roles have been described for fathers during the perinatal and postpartum period including breadwinner, teammate, and coach which may lead to

role conflict, role confusion or role strain (Kaila-Behm & Vehvilainen-Julkunen, 2000). Fathers in this study did not display role confusion, although they were surprised by the necessity of taking on the role of a primary caregiver for their infant and wife. None of them planned to be off work for more than a few days, and all stated that the transition would have been easier if they had better information about the possibility of cesarean birth and could have planned accordingly. It was pointed out that it is easier to give back vacation time than to request additional time off.

The Father and the Transition to the Role of Parent

The transition to parenthood was also more stressful for these first-time fathers, and they noted that the postpartum period was filled with conflicting information, heightened emotions, and very limited professional support. Henderson and Brouse (1991) cited a lack of services that were specifically designed for new fathers that provided information or offered support in the perinatal period. The conclusions from this current study are consistent with some of the past findings in that there continues to be a lack of paternal support services or networking. While some fathers were able to rely upon the support of extended family members, others had to make do with very little help and lamented the fact that they had to “go it alone”. They found that they were ill-prepared to care for their wife and infant. They were unaware how many tasks needed to be accomplished, and how much help their wives would need including “little things” such as helping their wives bathe and shower. Some of the new mothers remained in bed for the first week because of their pain, and had difficulty even moving around. The lack

of planning could have caused serious family dysfunction post-delivery, strained spousal relationships, jeopardized employment status and caused financial hardships, or led to decreased bonding and ineffective or dysfunctional attachment relationships for the fathers and their infant. These fathers confirmed the fact that in the 19 years since the study by Henderson and Brouse, little has changed and there has been minimal forward progress despite the call for improvement.

Interestingly despite all of the above-mentioned issues, the fathers in this dissertation study admitted to feeling immediate love for their infant and used verbiage such as "He's mine", "She is my daughter", and "This is my child" that demonstrated a burgeoning parental bond and a successful early attachment process. This differed from St. John and colleagues (2005) who noted that some fathers postponed developing a father-infant relationship until their infant became older and a little more responsive towards their care.

St. John and colleagues (2005) also found that fathers had to balance activities in the postpartum period and juggle competing demands of family, work, relationships, and personal activities which required making choices and trade-offs. Several of the fathers from the current study found they were unable to immediately return to work because of the post operative requirements of their wives. They pointed out that this result of a C-section delivery was totally unexpected and that they were fortunate in having flexibility in their work schedules to request additional time-off. They also questioned why there was a complete absence of information regarding the possible outcome of a C-section and pointed out that this could have adversely affected their post delivery course had they not been able to accommodate this issue.

Family Relationships

The fathers in this study had what they described as open, communicative, and supportive relationships with their wives. They all agreed this was an essential part of their successful transition from a dyadic to a triadic relationship and eventually a family unit. They admitted to feelings of frustration with infant care occasionally and that they relied upon their spouses for relief when they felt over-burdened. The quality of the marital relationship affected the behaviors of the father, the mother, and eventually the infant, and the marital relationship was an important source of support for the development of parenting skills, which is similar to what was found by Knauth (2000). It was mentioned by several of the fathers that couples need to openly and effectively communicate with each other and act as a team, as infant care was more challenging than many of the fathers expected. These fathers also mentioned that a vaginal delivery probably would have been less stressful on their relationship, because of having a partner who could have actively participated in household tasks and infant care during the initial postpartum period. It was suggested by several fathers that couples should be better educated about the relationship changes that may occur after a C-section.

Several of the participating fathers mentioned they were never asked about their educational needs nor had the opportunity to ask for information and help regarding learning how to properly care for their infant or spouse. These fathers were disappointed with the lack of availability and quality of the post delivery education and felt it impacted their spousal relationships and caused unnecessary strain. Because of their wives disabilities these fathers learned very quickly how to provide basic infant care. Their

experiences varied however; one father credited the staff with showing him “everything”, while another pointed out that education about even the most basic care such as changing diapers or infant bathing was neglected and he learned how to “do it on his own”. All of these fathers found that after a “rough start” and some frank discussions with their spouses regarding “rules of engagement” that their marital bond had grown deeper. They noted that they were more satisfied with their marital relationship, had more in-depth conversations with their spouse, or expressed “feeling more like a family”. As previously stated, they were able to talk things out with their spouses and eventually came to an understanding regarding their interactions, provision of infant care and division of housework. First-time parents are often faced with the numerous changes in their routines following birth, and fathers may differ from mothers in the rates at which they obtain and feel confident in their parenting skills (Elec, Hudson, & Bouffard, 2003). The sporadic educational efforts of the perinatal staff towards the fathers in this study demonstrated an ongoing lack of understanding of their needs and possibly a lack of guidance or commitment to address the fathers’ concerns.

It has been found that positive marital processes are associated with positive parent-child relationships and outcomes (Barnett et al., 2008). While the current study did not specifically address the level of marital quality, it did inquiry about marital relationships and interactions. As stated previously these participants acknowledged that they had a positive and an openly-communicative relationship with their spouses. They expressed that they developed an early sense of love and adoration for their infant and this study lends credence to the position that high quality marriage-relationships support sensitive parenting. As a part of the sampling design this study included a group of

fathers that had secure and loving relationships with their spouse which enabled them to eventually share the burden of child care responsibilities, although initially they performed the bulk of the tasks secondary to their wives' operative deliveries. Some had the help and encouragement of nearby relatives who added to their supportive environment in the post-operative period, while other fathers would have liked more involvement of family members to provide occasional relief. All stated that the events surrounding childbirth detracted from the birth experience and were extremely stressful. However, all of these fathers were able to overcome this stressor and move on towards bonding and formation of a successful attachment relationship with their infant. Delivery by C-section was seen as a major stressor and a complicating factor that was unforeseen and unexpected, yet it was temporary and resolved eventually possibly in part due to a supportive and open marital relationship. The ingenuity and perseverance of the fathers in the study group may have been another factor.

Mode of Delivery and Family Relationships

The effect of delivery by C-section versus vaginal birth on the perinatal experiences of fathers has not been widely studied. Seventy- five percent (three out of four) of the fathers in the current study were able to attend the delivery of their child, and while they found it to be a harrowing experience, they all agreed that the moment of birth was exciting and a joyous occasion. The other father felt very differently. The father who was not able to attend the C-section complained of how disappointed he was at being unable to witness the birth of his first child. He also expressed anger and

resentment toward the medical staff for not honoring his request for the attending anesthesiologist to place the epidural catheter for anesthesia. These feelings of anger only increased after the resident physician failed to properly place the catheter or get it to provide appropriate anesthesia for his wife. This father also stated his wife expressed disappointment at missing out on a major life event (i.e. the vaginal delivery and birth of her first child), and that she was unable to hold her infant until hours after the delivery. It is evident that the emergent C-sections were traumatic experiences for both the fathers and mothers, and produced fear and negative emotions for the fathers in this study. This is similar to some of the past research that has been completed, which revealed that some fathers were distressed by the experience (Chan & Paterson-Brown, 2002; Greenhalgh et al., 2000) while others were satisfied or ambivalent about the experience (Porter et al., 2007).

This study sought to investigate the reflected experiences of fathers surrounding birth and in the month following their first cesarean birth, to enhance understanding of their transition to parenthood in the early postpartum period. Careful analysis of the data shows that there are several dominant themes that were recurrent amongst the study participant. The two most poignant themes that stood out included a persistent lack or breakdown in communication from the health care staff and a constant emotional upheaval during the labor and delivery process that was likened by some to being caught on an emotional roller coaster. The emotional highs and lows extended into the postpartum period as fathers experienced the pride and joy of fatherhood contrasted with the expressed feeling of not being adequately prepared for provision of care to their new infant or shown how to adequately take care of their post-operative spouse. Frustration

from lack of information regarding infant and post-delivery care was mentioned by several participants, and the implications reflected by this data highlighted opportunities where the care delivery process could possibly be improved by implementation of nursing interventions.

Limitations

The number of participants in this study was small as dictated by the phenomenological research design. All of the participants were from a university hospital, of similar age, college educated, and experiencing the birth of their first child by C-section. This could be considered a limitation in other methodologies; however, the homogenous sample ensured that they all had experience with the phenomenon of interest, a condition required for phenomenological research. All of the transcripts very richly tell the story offered by each of the participants from their personal perspective of the experience of having a child born by C-section.

Other than the father's accounts no information was available as to whether or not there was any maternal or fetal distress that would warrant an emergent C-section since a chart review of the participants' spouses was not part of this protocol. No information was obtained on whether or not the same obstetrician was performing the C-sections for the fathers in this study or if there were numerous attending obstetricians or resident physicians following the aforementioned "24 hour time limit" since rupture of membranes.

Although saturation of the data occurred for this study, it is possible that carrying out the study at several other facilities may yield additional or differing information. This being said, it must be remembered that in phenomenology interpretation of the findings is never complete, but an ongoing process and though the results may be similar, some of the aspects will be unique based upon the participants, the context and the setting as well as the interpretations of the researcher. The results of this study can only be considered applicable to the participants, although the findings can suggest areas for action or future research.

Strengths

A purposeful sampling strategy was used for this study to ensure that the sample was theoretically consistent with the qualitative paradigm and IPA's orientation towards selecting a sample of subjects that can provide meaningful insight into a particular experience (Smith et al., 2009). This ensured that all the participants in the study had experience with the phenomenon being studied, and all of the participants described their experience in their own words and were allowed to express their unique perceptions during the interview process. This sample size and population was faithful to the ideographic approach of IPA, which is concerned with understanding a particular phenomenon in a specific context (Smith et al.).

The study's findings were derived from the participants' accounts of their experiences, and imparted constructive information that may be used to impact nursing practice, education, and future research. The study used the interpretative

phenomenological analysis (IPA) approach, described by Smith and his colleagues (2009), to carefully evaluate the data and then offer an interpretative report based upon this evaluation. The data obtained was rich in detail, provided with minimal prompting from the participants, presented a complete picture of their journey from labor into the post-delivery period, and concisely expressed their issues and concerns. In keeping with the context of hermeneutic and interpretative phenomenological methods the interpretation of the data was discussed in length with an expert in phenomenological research who also had experience with application of this research method. This collaborative process further helped to assure the accuracy, coherence and plausibility of the interpretation of the data.

Implications for Practice

Opportunities that exist to improve care (whether perceived or actual care deficits) may occur at many places along the trajectory from labor and delivery to birth, and may have wide-sweeping ramifications on the experiences that occur in the early postpartum period. Devotees of quality improvement initiatives will look at methods such as path analysis to detect areas of breakdown in the care delivery process and to develop or plot pathways for streamlining and improving care. Although path analysis was not used in this study, the concept is useful here to draw attention to areas that stand out from analysis of the data and highlight transition points – places along the trajectory of care where change, whether incremental or comprehensive, can have long-lasting positive effects on the perceived and actual care provided.

The first step is to focus on the process of care delivery itself and to determine where the care deficit occurred. For three out of the four participants in this study, the focus on the process of labor revealed that the diverting point from the planned outcome of natural birth to the necessity of a(n) (emergent) cesarean delivery was reported as a lack of progression to a natural delivery within 24 hours of rupture of membranes. The fourth participant and his wife, through a choice of their own to minimize unknown maternal and fetal risks, chose to have a C-section as well, and once the decision was made they were hurried along in the process as well.

Rupture of membranes (ROM) in and of itself is not a sentinel event for the mother or the fetus, especially if there is an absence of complicating factors (Manuck, Maclean, Silver, & Varner, 2009). In fact even with preterm premature rupture of membranes (PPROM), generally accepted management strategies include administration of corticosteroids and antibiotics in conjunction with hospitalization for careful monitoring to prolong the period of latency (the time between ROM and labor) (Manuck et al.). This standard of care was confirmed for this study in discussions with 2 separate obstetric providers at the study institution, one who is a nurse midwife and one who is a family practice physician, both of which have obstetric privileges at local hospitals (K. Curci; G. Henning, personal communication, May 10th, 2010). The literature did reveal that increased signs of newborn asphyxia have been associated with prolonged labor when the expulsion efforts have been longer than one hour (Le Ray, Audibert, Goffinet, & Fraser, 2009). However, no signs of maternal or neonatal distress were reported and some of these participants' wives never progressed to the point of expulsion during the

labor process, so for the fathers in this study it remains unclear as to why there was such a “Rushed Decision” to progress rapidly to a C-section.

One of the obvious implications for practice learned from this study would therefore be an improvement in the communication pathways between all of the neonatal staff and the expectant parents. The dichotomy was clearly evident from this study: the fathers who complained the most about the lack of communication had a more emotionally trying experience with greater expressed anger towards and lack of trust in staff; the father who reported effective communication from the neonatal staff actually stated that parts of his experience were enhanced because of the excellent communication skills of the staff. This helped to keep him informed and enabled him to partially relax during some of the more stressful points of the labor and delivery process. The lack of preparation and communication that generated a negative experience for these fathers closely echoes a report of the maternal experiences following a C-section in a study conducted by Porter et al., (2007), and many of the other emergent themes (Waiting without Knowing, Lack of Trust, Lack of Knowledge) would logically improve or at least be partially mitigated following an enhancement in the communication practices of the perinatal staff.

Another implication for practice that could become part of an improvement initiative should be adequate preparation for Transition to the Role of Parent. It was mentioned numerous times by the participants that they felt inadequately prepared: unprepared for the decision to have a C-section; unprepared for the procedure itself; unprepared for the post-operative care required by their wife; unprepared for infant care; and unprepared for the significant time required and support needed in the post-partum

period. Several participants recommended that fathers should be alerted early on in the pregnancy to the possibilities of a C-section (one third will deliver by this method) during the prenatal period, and that a much greater amount of time be devoted towards the explanation and preparation for the procedure should the need arise. This would go a long way towards alleviating the fear of the unknown and decreasing their sense of a Loss of Control.

Finally the significant time commitments required to care for the post-operative mother and the newborn infant in the early postpartum period should be addressed. All of the participants in this study were fortunate enough to be employed in positions that allowed them to be flexible in their schedules or arrange for an additional amount of vacation time to care for their new family. None of these participants expected or planned to be off from work for more than a few days. They also pointed out that financial constraints could have become an issue and that financial planning needs to be considered early on in the course of pregnancy - just because the Family Medical Leave Act guarantees time off for paternity leave, it does not require or guarantee that this leave will be paid time off. Fathers need to have improved knowledge of the possible outcomes of pregnancy and the delivery alternatives so that they can adequately prepare, and nursing must effectively provide the education required early on in the pregnancy to allow fathers time to make the necessary and appropriate arrangements for post-delivery care, family support, and time off from work.

Implications for Education

The Implications for Nursing Education flow logically from the Implications for Practice. Using the Focus Points of Pre-Delivery Expectations and the Imminent and Active Delivery processes, one can look at the transition points to determine where educational initiatives are necessary. Starting with the Focus Point of Pre-Delivery Expectations, initiatives should be considered to educate the nursing staff on how to improve prenatal programs for expectant fathers as well as mothers. This would include consideration of fathers as part of the care delivery team. It would also focus on keeping fathers informed regarding progression of the pregnancy and including them in the decision-making process during the imminent and active delivery period.

Nursing education that stresses the importance of involving fathers in the provision of care for their new infant and post operative spouse must be a requirement, and should include components detailing the expectations of parenthood following delivery. This would ideally also include discussions of anticipated time off from work for paternity leave and making possible arrangements for family support, should it become necessary.

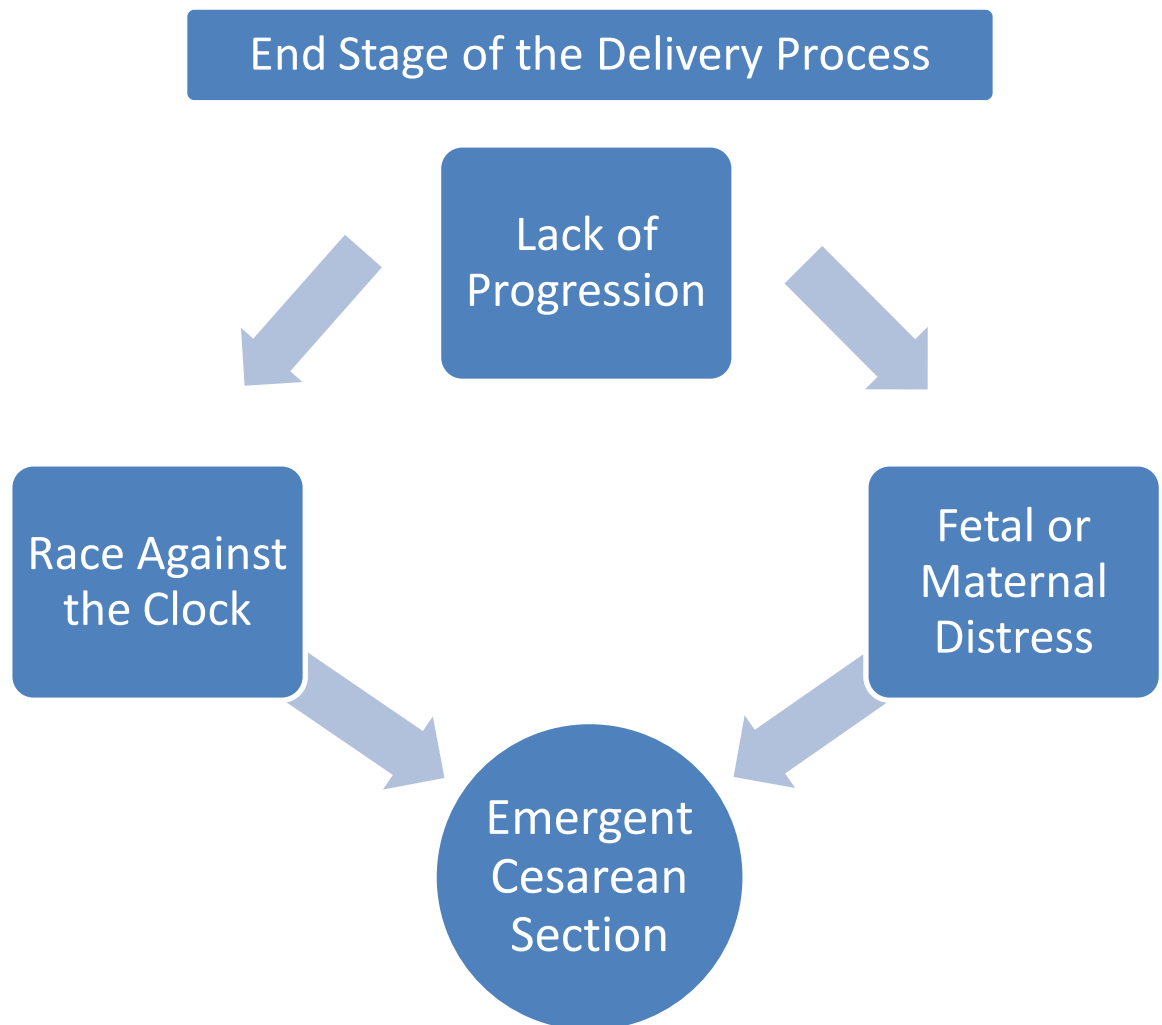
It is imperative to educate perinatal nursing personnel on the importance of constant communication with the expectant parents during the admission to the labor and delivery unit. Nurses must also continually update their own knowledge of the processes that the birthing couple is experiencing, as one father expressed, “being nice does not always make up for a lack of knowledge”. To better visualize and understand the decisions in the delivery process that may lead up to a C-section and to aid as a teaching

tool a graphic representation has been provided. Figure 1 is listed below and shows the phases of the end stages of the delivery process. The initial process steps that may lead to the decision tree and result in an unplanned C-section are listed above the figure:

Phases of the Delivery Process that may lead to an Unplanned Cesarean Section

1. Admission to Labor and Delivery Unit after Rupture of Membranes (ROM).
2. Expectations of Natural Delivery (mindset of fathers & what they expect).
3. Labor progresses to active expulsion of fetus by spontaneous vaginal delivery.
4. Lack of Progression (failure to deliver within 24 hours of ROM).

Figure 6-1: Pathway to an Emergent Cesarean Section



Finally, it is essential that nursing educational initiatives embrace the importance of involving fathers early on in the post delivery period, to make sure they feel confident and competent as providers of care to their infants before they are discharged to home.

Implications for Research

Several implications for research became evident and could be considered for future studies. It would be interesting to note whether or not the same attending obstetrician performed these “emergent” C-sections at the one facility and to discern the reasoning behind the rush to the operating room. It was communicated that although there is no current protocol requiring delivery within 24 hours of rupture of membranes, many attending staff reportedly stick by this guideline for litigious reasons (K. Curci; G. Henning, personal communication, May 10, 2010). It is unknown if there were any complicating factors that these fathers were unaware about, which is plausible due to the pervasive lack of communication about many other things. This could have been a factor, and a chart review of the nursing and attending notes from the delivery may be beneficial in future studies if those fathers are unsure of the answer to this and other questions.

In the few studies that have investigated fathers during the perinatal and postpartum time periods, it was noted that their needs were relatively unmet (Buckelew, Pierrie, & Chabra, 2006; Fletcher et al., 2004). From this study it is clear that prenatal classes have continued to focus on preparation for natural/vaginal labor and delivery for the mother and infant to the exclusion of the father, and rarely included information for

fathers about what to expect in the postpartum period. In the future it would be beneficial to do a more longitudinal study that looks at the effects of C-sections on the marital relationship in the year following birth, and includes topics for inquiry such as spousal communication, division of household labor, maternal limitations and post-delivery care, when to resume sexual relations, or how the father assisted in care of the infant.

An interventional study could be used to test a more efficacious method of improving perinatal communication with expectant fathers. Developing and testing a simple interventional treatment like an educational brochure or a poster to be displayed in the delivery suites and explaining the necessity for and the steps involved in a C-section may improve understanding of the procedure and help to alleviate some of the fear of the unknown, allowing fathers to be more participative and supportive of their spouse.

Finally, expansion of the original study methodology to a different (e.g. an underserved population) may generate further information. In addition to increasing the sample size and number of study facilities, an attempt to recruit participant groups from different socio-economic backgrounds and ethnicities may expand insights for consideration.

Conclusions: What do Fathers Need Most?

After listening to these fathers eloquently and at times emotionally share their stories it is clear that there is a need for improved educational processes and preparation for fathers in the prenatal, perinatal, and post-partum periods. All of these fathers became primary caregivers to their respective infants and spouses, yet they expressed that

they felt “left out” or like they were in the way, and would have liked to have had more inclusion in the decision-making processes especially during the events that led up to the C-section. An improved communication effort from the staff was requested by several of the fathers to “keep them in the loop”, and all of these fathers mentioned that better communication from the staff would have greatly decreased their stress during and after the C-section. The last issue that all of the fathers mentioned was the lack of (or need for better access to) help and support in the post-partum period. They stated that there was a general absence of information about available community resources, and no referrals or information about support groups designed to help new fathers with the transition to parenthood.

Recommendations

The findings from this study indicate that it is essential for prenatal nursing personnel to educate fathers early on in the perinatal period about the possibility of delivery by C-section, as one-in-three will deliver by this method. Part of this educational process should be encouragement of adequate preparation and planning for appropriate time-off following delivery and return home, to help with infant care and possibly care of their spouse if the mother has just gone through a major abdominal surgery. Fathers should also be made aware of the processes that may lead to a C-section, to decrease the anxiety that may arise if vaginal delivery is no longer a viable option. A brief educational class or informational brochure should be developed and provided to fathers in the immediate post-operative period, before the mother and infant are discharged from the hospital. There are numerous resources available in-print and online, such as “the Expectant Father” and the National Fatherhood Initiative. Finally education of nursing

personnel must become a high priority, with focus on: Improving and encouraging constant communication to expectant fathers; providing emotionally supportive care; ensuring that fathers are comfortable with infant care prior to discharge; identifying issues that may need intervention from Care Coordination or Social Services; and making sure that fathers are comfortable with providing post-operative care to their partners.

Future Research Plans

Further avenues for extending this research may include extending it to other facilities or to other participant groups (based on demographics or locations). This may include underserved populations such as economically disadvantaged families, minority fathers, non-resident fathers, and non-English speaking fathers. A chart review of the mothers and infants may also be beneficial and yield information about extenuating circumstances that necessitated the C-section. An observational component or mixed-method study that observes the obstetric staff may be helpful in uncovering unwritten rules or unspoken cultural norms that directly or indirectly affect the decision to have a delivery by C-section. If these well-educated and articulate fathers had this many questions and concerns during the perinatal and post-partum periods, it would be interesting to delineate the experiences of fathers with lower levels of education, less available family and social support, and possibly issues with or components of dysfunctionality in their families.

Summary

A key tenet of the nursing profession is to improve the health and well-being of all those we care for. This ideally includes the partner of those under our charge, or the family unit as a whole in many different settings. It is often important and frequently

necessary to look beyond the moment at hand and to grasp the larger reality of the situation. Nursing as a profession and nurses as professional practitioners must be aware that their care and the actions of their care often affect individuals other than just the intended care recipient.

As was uncovered by the experiences of the fathers in this study, simple adjustments in the provision of care such as improved communication may vastly alter the experience, including instilling an increased sense of trust in the staff, improved ability to overcome unexpected outcomes and decreased fear of the unknown, improved sense of control and mastery of the situation, decreased emotional upheaval and an improved sense of knowledge and preparation. Family Centered Care is now more than just an aspiring goal on the horizon, and it is an important aspect of the provision of quality care that will allow the profession of nursing to adhere to its commitment of caring in a holistic manner by considering all parties during transitions in care.

Information from this study can be used to increase understanding of how fathers change during their transition to fatherhood and to provide a basis for identifying issues that can be remedied through family-based interventions (Knauth, 2000). It has provided current and updated information that may enable nurses and other healthcare professionals to: provide enhanced prenatal education to fathers; communicate more effectively with expectant fathers during the labor and delivery process and to mitigate their emotional upheaval; provide fathers who are post-delivery with appropriate information and demonstrate the necessary parenting skills that encourages men to become more fully engaged in their parenting role; and discuss the post-operative changes and restrictions of their spouse that will allow them to successfully support their

partners and develop a positive and healthy relationship with their new infant and family(St. John et al., 2005).

This information may be used to develop appropriate educational and supportive programs that may promote early paternal-infant involvement and improvement in parenting, and possibly lead to improved family relationships for the father and mother and possibly life-long benefits for the infant. Improving the experience and satisfaction in the early postnatal period should be a goal of the entire healthcare team, especially for fathers as their importance in the role of a supportive partner and primary care-giver is unquestionable. It is important to give all parties involved the same degree of attention when it comes towards improving outcomes in child-bearing families. Fathers as well as mothers and their infant should all be considered when developing a plan of care with the goal of improving the experiences in the perinatal and postpartum period. Once informed with accurate and up to date knowledge, nurses can develop and implement appropriate interventions or provide assistance and care when necessary. Nursing's emphasis on health promotion, and provision of anticipatory guidance during predictable health-related events, would seem to be uniquely suited to meet the needs of new fathers during this critical transition (Henderson & Brouse, 1991).

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Appendix A: Informed Consent Document

CONSENT FOR RESEARCH Penn State College of Medicine The Milton S. Hershey Medical Center

Title of Project: The Transition to Fatherhood in the Context of the Cesarean Birth Experience.

Principal Investigator: Eric R. Messner, MS, CRNP.

Other Investigators: None.

Participant's Printed Name: _____

This is a research study. Research studies include only people who want to take part. This form gives you information about this research, which will be discussed with you. It may contain words or procedures that you don't understand. Please ask questions about anything that is unclear to you. Discuss it with your family and friends and take your time to make your decision.

1. **Purpose of the Research:** This study will utilize in-depth interviews to focus on improving the understanding of the paternal experience across the perinatal and postpartum time periods, and to determine possible concerns of fathers at this time that may need to be considered to improve the outcomes for fathers experiencing delivery of their infant by cesarean section. Fathers provide critical support to their families and contribute to the development of their children, which makes it important to more fully investigate the impact of cesarean birth on the transition to fatherhood in the perinatal and postpartum time period.
2. **Procedures to be Followed:**
 - After Informed Consent has been explained and all questions answered, a contact phone number will be requested for the purpose of setting up an interview date, time and place to occur approximately 30 days after the birth of your infant.
 - Data collection will occur by audio-taping the interviews, which will last approximately 1 hour.
 - No hospitalizations or outpatient clinic visits will be required.

3. Discomforts and Risks:

- There are no known discomforts or risks to the study participants.

4. Possible Benefits:

a. Possible benefits to the participant: There is no guarantee that you will benefit from being in this research.

b. Possible benefits to others: The results of this research may be used to guide the future treatment of fathers who have children born by cesarean section, by providing a more thorough understanding of their experiences in the month following birth.

5. Other Options that Could be Used Instead of this Research:

- You may decline to participate in the research, and you may stop your participation in this research study at any time during the study period without penalty.

6. Time Duration of the Procedures and Study:

- There is one interview to complete and it is expected to last approximately one hour.
- The interview will be conducted approximately 30 days after the birth of your infant.

7. Statement of Confidentiality:

a. Privacy and confidentiality measures

- Your records that are used in the research at The Milton S. Hershey Medical Center (HMC) and Penn State College of Medicine (PSU) will include your name linked by a code number to the phone number that you provide for the purpose of arranging the interview. The code number will also be placed on your audio-taped interview and any transcribed information from the audiotapes. All records, audio-taped or written, will be kept in a locked safe in a secured area in the primary investigator's residence.
- In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared. We will keep your participation in this research study confidential to the extent permitted by law. However, it is possible that other people may become aware of your participation in this study. For example, the following people/groups may inspect and copy records pertaining to this research.
 - The Office of Human Research Protections in the U. S. Department of Health and Human Services.

- The HMC/PSU Institutional Review Board (a committee that reviews and approves research studies).
- The HMC/PSU Human Subjects Protection Office.
- Some of these records could contain information that personally identifies you. Reasonable efforts will be made to keep the personal information in your research record private and confidential but absolute confidentiality cannot be guaranteed.

8. Costs for Participation:

- a. Costs:** There will be no expected costs for the research participant.
- b.** You will not lose any legal rights by signing this form.

9. Compensation for Participation:

You will not receive any compensation for being in this research study.

10. Research Funding:

The institution and investigators are not receiving any funds to support this research study.

11. Voluntary Participation:

- Taking part in this research study is voluntary. If you choose to take part in this research, your major responsibilities will include completing an in-depth interview at a scheduled date approximately 30 days after the birth of your infant. The interview will be audio-taped. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time. If you decide not to participate or if you decide to stop taking part in the research at a later date, there will be no penalty or loss of benefits to which you are entitled.
- There are no adverse consequences (physical, social, economic, legal, or psychological) of a participant's decision to withdraw from the research.

12. Contact Information for Questions or Concerns:

- You have the right to ask any questions you may have about this research. If you have questions, complaints or concerns or believe you may have developed an injury related to this research, contact Eric R. Messner at 717-531-4660.
- If you have questions regarding your rights as a research participant or you have concerns or general questions about the research, contact the research protection advocate in the HMC Human Subjects Protection Office at 717-531-5687. You may also call this

number if you cannot reach the research team or wish to talk to someone else.

- For more information about participation in a research study and about the Institutional Review Board (IRB), a group of people who review the research to protect your rights, please visit the HMC IRB's Web site at <http://pennstatehershey.org/web/irb>. Included on this web site, under the heading "Participant Info", you can access federal regulations and information about the protection of human research participants. If you do not have access to the internet, copies of these federal regulations are available by calling the HSPO at (717) 531-5687.

Signature and Consent/Permission to be in the Research

Before making the decision regarding enrollment in this research you should have:

- Discussed this study with an investigator,
- Reviewed the information in this form, and
- Had the opportunity to ask any questions you may have.

Your signature below means that you have received this information, have asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference.

Participant: By signing this consent form, you indicate that you are voluntarily choosing to take part in this research.

| | | |
|------|--------------------------|------|
| | Signature of Participant | Date |
| Time | Printed Name | |

Person Explaining the Research: Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the research.

| | | |
|---|------|------|
| | Date | Time |
| Signature of person who explained this research Printed Name | | |

(Only approved investigators for this research may explain the research and obtain informed consent.)

Appendix B: Institutional Review Board Approval Letter

PENNSTATE HERSEY



Milton S. Hershey
Medical Center

PENNSTATE HERSEY



College of Medicine

DATE: January 05, 2010
TO: Eric Messner, CRNP, Nursing
FROM: Kevin Gleeson, M.D., Executive Chair
Institutional Review Board
RE: IRB Protocol No. 32746EP - The Transition to Fatherhood in the Context of Cesarean Birth

Thank you for your application to the Institutional Review Board (IRB). The above IRB protocol number was assigned for the research and should be included on all future correspondence and documentation. In accordance with Federal guidelines and institutional policy, the proposed research was determined to qualify for expedited review and was reviewed accordingly.

Official approval: Official approval was granted for this research effective December 20, 2009 through November 30, 2010, at which time IRB reconsideration will be required. This approval includes the following:

- Research Protocol - Protocol summary (dated 12/30/09)
- Total entry – 20 subjects. This research may not involve prisoners. If an individual becomes incarcerated after enrollment contact the IRB to address specific regulatory requirements in order to continue participation.
- Informed Consent - Consent form (version date 12/30/09). **Use of the attached, stamped form is required.**
- Authorization to use protected health information (PHI) - Inapplicable, as PHI is not accessed for this research.
- Advertisement – Invitation to Participate (rec'd 12/28/09) • Questionnaire – Interview Questions (rec'd 12/7/09)
- IRB member exclusions from this review: No investigators for this research serve on the IRB.

Informed consent and Authorization: Only approved investigators may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form.

- Medical record - For clinical treatment protocols, include a copy of the consent form and the protocol summary in the patient's HMC medical record to inform other medical caregivers about this research.
- Originals – Original consent forms/authorizations should be filed in a secure place and retained after termination of the research for a period of 6 years if the research accesses protected health information (PHI), or 2 years if no PHI is accessed. Other FDA or sponsor requirements may apply.

Clinical Trials Registration: Not required

Required Reports and Modification Requests: To submit reports for this research or requests for modifications, use the instructions and forms available on IRB web site, <http://www.hmc.psu.edu/irb>, under Forms & Instructions, Ongoing Studies.



January 05, 2010
IRB Protocol No. 32746EP

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- Problem Reporting: Investigators are required to promptly report any events that may represent unanticipated problems involving risks to subjects or others. See the web for the IRB policy "Reporting of Unanticipated Problems Involving Risk to Participants or Others" and the applicable report form and tracking log.
- Proposing Changes: Federal regulations require prompt reporting to the IRB of any proposed changes in a research activity and prior approval before changes are initiated, except where necessary to eliminate apparent immediate hazards to the subject. Submit the 'Modification Request Form' to change an existing investigation.
- Continuing Review: A progress report will be required for reapproval of this research. You will receive an e-mail reminder and the necessary form 8 weeks before the current approval expires.

The Institutional Review Board appreciates your efforts to conduct research in compliance with the institutional policies and federal regulations that have been established to ensure the protection of human subjects. Please feel free to communicate any future questions or concerns regarding this research to the IRB via its administrative arm, the Human Subjects Protection Office.

KG\js

VITA

Eric Robert Messner

7186 Union Deposit Road
Hummelstown, PA 17036
(717) 579-5653 (H)

Academic Background

Ph.D.: The Pennsylvania State University - August 2010
Minor in Health Care Administration
GPA: 3.73

Master of Science in Nursing (M.S.): The Pennsylvania State University – December 1997
Family Nurse Practitioner
Grade Point Average — 3.56

Bachelor of Science in Nursing (B.S.N.): York College of Pennsylvania – July 1994
Grade Point Average — 3.76
National Honor Society — Gamma Phi Sigma Chapter of Alpha Sigma Lambda
International Honor Society — Sigma Theta Tau

Bachelor of Science in Management (B.S.): The Pennsylvania State University – December 1988
Grade Point Average — 3.07
Honors—Dean's List; December 1988

Faculty Appointments and Instruction

Faculty Appointments to The Milton S. Hershey Medical Center, College of Medicine: Instructor of Medicine, Dept. of Family and Community Medicine; Instructor of Emergency Medicine, Dept. of Emergency Medicine.

Adjunct Faculty or Clinical Preceptor for Nurse Practitioner students from the following academic institutions:

• The Pennsylvania State University • Drexel University • Duquesne University • University of Maryland • Millersville University • University of Pennsylvania • Widener University.

Scholarly Activities

Hoffman, B.L., Rapp, M.A., **Messner, E.R.**, Artley, P. Penn State Hershey Faculty Restraint Initiative. Developed PowerPoint/CME program to improve patient safety and reduce patient restraints. Posted to the Medical Staff Service's website December 2008.

Too Many Pills, Polypharmacy in the Elderly. Podium Presentation at the quarterly Geriatric Update forum at The Milton S. Hershey Medical Center. July 2007.

Hatfield, L., **Messner, E.R.**, Lingg, K. (2006). Evidence-based strategies for the pharmacological management of pediatric pain during minor procedures in the emergency department. *Topics in Emergency Medicine* 28(2), 129-137.

Guest Editor and featured Author for Fall 2005 - *Topics in Emergency Medicine*. Foreword p.249-250.

Curci, K., **Messner, E.R.**, Reck, D. (2005). The effectiveness of a patient educational brochure in the emergency department. *Topics in Emergency Medicine* 27(4), 251-255.

Messner, E.R. (2005). Quality of care and patient satisfaction: The improvement efforts of one emergency department. *Topics in Emergency Medicine* 27(2), 132-141.

Phase II Pilot, Randomized, Open-Label, Multi-center Study to Evaluate the Safety and Efficacy of Dalbavancin (V-Glycopeptide) versus Investigator/Physician Designated Comparator in Skin and Soft Tissue Infection. Investigators: Chris DeFlitch, MD (PI), **Eric R. Messner, CRNP**. Status: Closed. Amount: \$154,325.