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FATHERS' SENSE OF SECURITY DURING THE FIRST POSTNATAL WEEK - – a qualitative interview study in Sweden

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Abstract

Background: Father's sense of security in the early postnatal period is important for the whole family. An instrument which measures Parents' Postnatal Sense of Security (the PPSS instrument) is under development.

Objective: to explore and describe factors which influence fathers' sense of security during the first postnatal week.

Methods: An explorative design with a qualitative approach was used. Thirteen fathers from three hospital uptake areas in Southern Sweden were interviewed using focus group discussions and individual interviews. Analysis was carried out using qualitative content analysis.

Findings: *Participation in the processes of pregnancy, birth and early parenthood* emerged as the main category for fathers' postnatal sense of security. The emergent categories were; *"willingness to participate and take responsibility"*, *"being given the opportunity to take responsibility"*, *"being assured about mother's and baby's wellbeing"*, *"having someone to turn to – knowing who to ask"*, *"being met as an individual"* and *"being met by competent and supporting staff"*.

Key conclusions and implications for practice: New and specific items of importance when investigating fathers' sense of security during the early postnatal period have been pinpointed. Fathers' sense of early postnatal security may be enhanced by giving them a genuine opportunity to participate in the birth process and by giving them the opportunity to stay overnight at the hospital after the birth. Midwives and care organizations need to give clear information about where competent help and advice can be obtained at all hours. Midwives should strengthen the fathering role by acknowledging and listening to the father as an individual person.

Keywords: Father, Participation, Postnatal, Sense of security

Introduction

In recent decades, research from Sweden and Australia has shown that both parents expect and demand increased involvement of the father during pregnancy, birth and early parenthood (Plantin et al., 2003; Ny, 2007; McKellar et al., 2008; SFOG, 2008; Ellberg et al. 2010). Sense of security is important for fathers' experiences of the first postnatal week (Persson and Dykes, 2002; Fredriksson et al., 2003; Persson et al., 2007; Persson and Dykes 2009). Feelings of security or insecurity are individual experiences, which must be seen in relation to their specific contexts (Andersson, 1984). The context of our study is the first postnatal week and our definition of sense of security (in Swedish "trygghet") includes confidence and adjustment which is close to the definition developed by Andersson-Segesten (Andersson-Segesten, 1991). In order to enable critical appraisal of early postnatal care, an instrument which measures Parents' Postnatal Sense of Security (the PPSS instrument) is under development (Persson et al., 2007). The PPSS instrument will be used for measuring quality of postnatal care. Midwives/nurses empowering behaviour, the father's own general wellbeing, wellbeing of the mother (Persson et al., 2007) as well as a sense of participation during pregnancy (Persson and Dykes, 2009) is shown to be important for fathers' sense of postnatal security. Other variables which particularly influence fathers' sense of security during this period need to be elucidated.

Becoming a father for the first time is, for most men, a time of change in self identity and also in partner relationships (Barclay and Lupton, 1999). Scandinavian studies have also shown that some fathers do not feel happy in the early postnatal period and may report psychological distress (Skari et al., 2002; Ryden, 2004).

It has also been suggested that fathers' experiences during the childbirth period influence their subsequent wellbeing (Greenhalgh et al., 2000; de Montigny Lacharite, 2004) the couple's relationship (Persson and Dykes, 2002; de Montigny Lacharite, 2004), and may also affect the child (Ramchandani et al., 2005). Studies in the western world have indicated that fathers would like to be involved from early pregnancy and onwards into the postnatal period (Finnbogadottir et al., 2003; Singh and Newburn, 2003; de Montigny Lacharite, 2004; Hildingsson, 2007; Ellberg et al., 2010). Hildingsson (Hildingsson, 2007) showed that both parents' satisfaction with early postnatal care was enhanced when fathers were given the opportunity to stay overnight at the postnatal ward and were involved in care of the newborn child. An increased understanding of fathers' perspectives is essential for the future development of postnatal care and therefore fathers should be included in research concerning the childbirth period (Brown et al., 2002).

The PPSS instrument exists in two versions, one for mothers and one for fathers (Persson et al., 2007). The theoretical standpoint for the PPSS instrument was based on a qualitative study which was carried out in the context of voluntary early postnatal discharge (Persson and Dykes, 2002). Further development of the PPSS instrument requires elucidation of factors which, irrespective of the timing of hospital discharge, may influence the father's sense of security in the early postnatal period. The aim of the present study was therefore to explore and describe factors which influence fathers' sense of security during the first postnatal week.

Swedish maternity care

In Sweden, midwives are primary care providers for the perinatal care of women not at risk. Antenatal care for low risk mothers is community based and continuity of carer (midwives)

during pregnancy is generally high. According to official recommendations in Sweden (SFOG, 2008), the father should be invited to participate and to be supported in his participation during pregnancy, birth and early parenthood. Siblings are not specifically invited but the recommendations are to strengthen the family. In the postnatal period, women not at risk are often cared for in a form of care referred to as “hotel care” or “family suites”, which allows the father and siblings to stay overnight to a greater extent than earlier (Fredriksson et al., 2003; Ellberg et al., 2010). Thus, their participation is encouraged (Fredriksson et al., 2003). The mean length of postnatal hospital stay in Sweden for healthy women experiencing a normal birth is approximately 2 days (Socialstyrelsen, 2008). Women who experience risk pregnancies and births are cared for on traditional wards and the hospital stay is usually more than three days. In this form of care, fathers and siblings do not usually stay overnight. In Sweden most families are offered a home visit by a child health nurse after hospital discharge and fathers have the right to 10 days parental leave in connection with the birth of their child (Socialstyrelsen, 2008).

Methods

Design and ethical considerations

The study had an explorative design with a qualitative approach. The ethical principles in the Declaration of Helsinki (2004) were used in the planning and implementation of the study. The Local Research Ethics Committee and the managers responsible for the departments at the hospitals involved gave permission for the study to be carried out (Protocol number: 607/2007).

Settings and participants

The study took place in southern Sweden. It was set in three hospital uptake areas and five different postnatal wards were included. Two of these were hotel-like wards with family rooms, one of which was not staffed during the night but staff from the nearby postnatal (risk) ward were on-call to the parents. One ward was a combined delivery suite and postnatal ward and the remaining two were traditional postnatal wards. Presumptive participants were recruited from preparation for parenthood classes and from postnatal wards. In total 20 fathers were asked to participate (14 in focus group discussions and 6 in individual interviews). At recruitment, presumptive participants were given verbal and written information about this study, their freedom to take part and that they were fully entitled to withdraw their participation at any time. For the focus group discussions fathers were asked to give written consent to be contacted two to three weeks after the birth. Eleven of the 14 fathers gave their written consent to be contacted but three fathers declined to participate when they were contacted. The fathers from the postnatal ward who were asked were six individuals who were available at the postnatal ward on one single day. One father declined to participate. Inclusion criteria were that their partner had given birth to a live full term child (≥ 37 gestational week) and that they could speak and understand the Swedish language. Four of the fathers had children previously and all of them were born in Sweden.

Table 1. Sociodemographic variables and form of interview regarding the 13 participating fathers

Interviews	Participants	Age	Education	Age of the child	Number of children	Type of ward
Interview 1 focus group interview	I:1 R1	28	Upper secondary	Between 4 and 8 weeks	1	2*
	R2	34	Upper secondary		3	1*
	R3	33	University/college		1	2*
	R4	30	University/college		1	2*
Interview 2 focus group interview	I:2 R5	36	Upper secondary	9 weeks	1	3*
	R6	29	University/college	weeks	1	4*
Interview 3 focus group interview	I:3 R7	25	Upper secondary	7 weeks	1	1* (2 days) and 2* 2 (days)
	R8	34	University/college	3 weeks	1	5*
Interview 4 individual interview	I:4 R9	33	University/college	4 weeks	2	1*
Interview 5 individual interview	I:5 R10	33	University/college	4 weeks	2	1*
Interview 6 individual interview	I:6 R11	31	Comprehensive school	4 weeks	1	1*
Interview 7 individual interview	I:7 R12	26	Upper secondary	4 weeks	1	2*
Interview 8 individual interview	I:8 R13	37	Upper secondary	5 weeks	3	1*

* 1= traditional ward hospital 1, 2= family unit hospital 1, 3= traditional ward hospital 2, 4= family unit, hospital 2, 5= combined unit

Data collection

Data were collected 3-9 weeks after childbirth in April to June 2008 and May to June 2009.

Three of the interviews were focus group discussions (8 fathers, interviews 1 to 3) and five were individual interviews (interviews 4 to 8) (Table 1). The first focus group discussions were conducted by two of the authors (EP and A-KD). The remaining discussions/interviews were carried out by EP alone. None of the interviewers were involved in care of the participating families. The focus group discussions took between 90 and 120 minutes and the individual interviews took between 30 and 60 minutes.

According to the narrative interview method (Kvale and Brinkmann, 2009) the fathers were asked to talk freely and to give as much detail as possible. Each discussion/interview which started with an open question "*Please tell me what was important for your sense of security during the first postnatal week*" was in the form of a conversation where the role of the interviewer was that of an active listener (Krag Jacobsen, 1993). Each interview was audio tape-recorded and transcribed verbatim.

Data analysis

The transcribed texts were analysed using qualitative content analysis as described by Burnard (1991). According to Burnard this method has been adapted from a grounded theory approach (Glaser and Strauss, 1967) and from other research on content analysis (Berg, 1989). Initially each interview was read carefully and notes about the character of the text were taken. Everything said in the interviews which related to the aim of the study was worked into a coherent text. Open coding was performed and when ideas occurred to the researchers, these were written down as

memos. The transcripts were re-read several times and the process of open coding resulted in many sub-categories. These were later collapsed in order to limit the number of categories. One main category emerged from the analysis. Quotations were chosen from every interview and every category to increase trustworthiness. In order to enhance validation, all co-authors were involved in the process of analysis.

Findings

One main category, six categories and 17 subcategories emerged. Sub-categories are not given separate sub-headings but are included in the text (Table 2).

Participation in the processes of pregnancy, birth and early parenthood

The main category which emerged from the analysis was “*participation in the processes of pregnancy, birth and early parenthood*”. The fathers wished to be involved participants from the first day of pregnancy for the sake of their partners’, their baby’s and their own wellbeing. This participation could increase security for the mother and thus for the father himself (Table 2).

Table 2. The process of the categorisation regarding fathers' sense of security the first postnatal week

Main category	Categories	Subcategories	Quotations
P A R T I C I P A T I O N	Willingness to participate and take responsibility	Being involved during pregnancy	<i>R13: ...being there for the mother...from the first day you know about it(the pregnancy)... and then...do the shopping, cleaning, maybe take care of the children...the other two...a bit more. Lift things when necessary and so on...(I:8)</i>
		Being prepared before birth	<i>R9: ...books about pregnancy...and then there's parenthood classes, it was up to myself if I really wanted to get some information....the midwife didn't do anything active at the meetings ...not for me at any rate (I:4)</i>
		Taking responsibility for the mother and baby after birth	<i>R7:I wanted to be there and help because it was a cesarean so she couldn't look after the baby herself... (I:3)</i>
T H E P R O C E S S	Being given the opportunity to take responsibility	Sharing responsibility for the baby with the mother	<i>R7: Needing each other's support...it's about security for my wife too .. (I:3)</i>
		Being given the opportunity to be together with the family at hospital	<i>R11: It felt awful, going home and sitting there alone. It would have meant security for me, being allowed to be there...definitely...it felt very insecure not being there, it really did...(I:6)</i>

E S S E S O F P R E G N A N C Y B I R T H A N D	<p>Having the possibility to be together with the family at home</p> <p>Being assured of mother's and baby's wellbeing</p> <p>Feeling assured of the mother's and baby's overall wellbeing after childbirth</p> <p>Being given confirmation about the normality of the situation</p> <p>Having someone to turn to – knowing who to ask</p> <p>Having staff to call and to ask from home</p> <p>Having a social network</p>	<p><i>R5: I felt that it was great having paternity leave. And my wife thought it was nice too. (I:2)</i></p> <p><i>R12: But then I was frightened that something might happen to my wife...the purely medical bit, if something should happen....the security of it (being at the hospital)... (I:7)</i></p> <p><i>R9: Security for me after the birth....the most important was that both of them were alright, doing well, both of them...just as important... (I:4)</i></p> <p><i>R6: ...being told what was going on ... and that it was normal. (I:2).</i></p> <p><i>R8: That there has to be someone to ask, since it's all so new...that you have staff or someone who can help you, that they're there, close by. You feel calm if there was someone there... (I:3)</i></p> <p><i>R2: When there's been a question, one has always been able to ring, and been given an answer to all the questions. (I:1)</i></p> <p><i>R11:..we have friends and we have relatives on both</i></p>
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E		with close relatives to call and to ask	<i>sides...that's an enormous feeling of security, we can ask for help at any time. (I:6).</i>
A			
R	Being met as an	Being listened to and	<i>R10: Yes and being taken seriously with things... in a</i>
L	individual	taken seriously	<i>subjective sort of worry that wasn't really medically</i>
Y			<i>sound. I think that process has to start a long, long</i>
			<i>time before the time after the birth...(I:5)</i>
P			
A		Being cared about and	<i>R13: ...the care...that they show that they care about</i>
R		being given attention	<i>you by coming into the room and asking how things are</i>
E			<i>going...if there was anything they could do for you...</i>
N			<i>(I:8)</i>
T			
H	Being met by	Being given relevant,	<i>R10: ...there was one of the staff who had some extra</i>
O	competent and	consistent information	<i>education and you could see a big difference in how</i>
O	supporting staff	and explanations	<i>she dealt with things as compared to the others. There</i>
D			<i>were less tips and tricks. (I:5)</i>
		Experiencing a calm	<i>R5: ... and they didn't just come running in... (I:2)</i>
		demeanour and body	
		language	
		Being given practical	<i>R7: You need help with all the other things, so that you</i>
		service	<i>can concentrate on the baby. That gives you security.</i>
			<i>(I:3)</i>

Willingness to participate and take responsibility

The fathers wanted what was best for the mothers-to-be and for the children and they wished to take their responsibility by showing their interest and by participating from early pregnancy. The fathers expressed a desire to *be involved in pregnancy* and “be there” in every phase, participating in antenatal visits and in a physical capacity by helping the mothers-to-be towards the end of pregnancy. Participation in antenatal visits meant that they could get direct answers to their own questions which increased feelings of security after the birth. The fathers felt that the more they participated, the better were their prospects of good contact with the child later on.

“You imagine that otherwise children are only attached to their mother.” (R4; I:1)

Being prepared before the birth was experienced as an important factor for security after the birth. If the father was well prepared, he was able to support the mother after the birth and through this, he felt himself to be secure. Preparation for the time after the birth was dependent on both the father’s own resources and on the midwife’s attitude to his participation. Father’s own resources included having thought through events and being mentally prepared and also reading and actively searching for information.

“...it’s about preparing mentally....that has been a major part of security for me.” (R13; I:8)

“...actually, the first time she spoke to us (antenatal midwife) she said that I should try to “be there” for the mother.” (R5; I:2)

After birth, by the time of the interviews the fathers could understand that parenthood classes had not included information about the time after birth and that there had been too much focus on the birth itself. The fathers felt that the word “parenthood classes” suggested that the time after birth would be included. They stated that they would have been glad to listen to information of that kind. There were fathers who had attended a special lecture for fathers-to-be which focused on the time after birth and in particular on the father’s perspective and this had provided some security for the post-birth period.

“ Yes, I got a lot out of it (special lecture for fathers-to-be). I got nothing like that out of the usual parenthood classes.” (R12; I:7)

The fathers wanted to *take responsibility for the mother and the baby* in the early postnatal period. They felt secure if they could take care of both the mother and the child. Since the mother was breastfeeding, the father took responsibility for practical things and showed his responsibility for breastfeeding by giving the mother positive support in her striving to feed the child. It was also important for the fathers to be able to take responsibility for economical considerations in the early postnatal period.

*“ New roles; shopping for food and that...
I get the shopping, I call it ground service.” (R1 and R3; I:1)*

*“Money is definitely a thing that made me feel insecure...that we haven’t enough money. In just that feeling of taking care of the family... in some way.”
(R11; I:6)*

In cases of operative delivery, as Cesarean section, where the mother could not take care of her newborn, the father took responsibility and acted as a surrogate for the mother.

The baby is close and all that. That's when you participate, most definitely...if you hold your own child – near the mother who can't hold it just then..."

(R5; I:2)

The baby's wellbeing and health were central to the father's sense of security and it was therefore important for him to be able to *share responsibility for the baby with the mother*. Participation in the care of the baby was important both at the hospital and at home. Parents felt secure in being at home but nevertheless they shared some anxieties with each other.

"...if my wife has a check on him (the baby) that makes me secure...if she's having difficulty with all that then I feel insecure too, that's how it is."

(R12; I:7)

Being given the opportunity to take responsibility

Enabling to take and share responsibility was important and was strengthened if fathers were given the opportunity to *be together with the family at hospital* during the first days. The family needed a chance to get to know one another in peace and quiet and allowing the father to stay with the mother at the hospital and to be given help was seen as incontrovertible. Care services which did not give the father the opportunity to be with the family 24 hours a day were considered as old-fashioned. If the couple were given the impression that fathers were not welcome to stay overnight, this could motivate them to choose another hospital for the birth.

"...and I wasn't allowed to go with them. That I didn't have that possibility, just

like that... the new little family is split up. That influences feelings of security a great deal.” (R10; I:5)

Returning home to everyday life felt secure and this security was enhanced by the father’s *possibility to be together with the family at home* which in turn was strengthened by the 10 days paternity leave. The fathers wanted to have as much contact with the baby as the mothers had, from the very start, so that the child would also bond with him.

“You really want to be there...it’s that you can be at home with the baby, both of you. That’s security, that the family can find its way back again...back to the everyday. I thought those ten days just disappeared.” (R2; I:1).

Being assured of mother’s and baby’s wellbeing

Fathers’ security during the first postnatal week was affected by what transpired on the delivery ward. If all went well with the birth, a sense of security followed on to the week after. *Available medical resources* were important for feelings of security. Fathers wanted the mother and baby to be given medical check-ups.

“...that there are no medical risks, no risk that something bad might happen to the baby.” (R10; I:5)

Feeling assured of the mother’s and baby’s overall wellbeing after childbirth was also of great importance for fathers’ postnatal sense of security. This was evident even after discharge from hospital.

“Then I thought it was good to have a home visit from the well children’s clinic.

They came home and checked things. It felt very good. I could almost wish that there were more of those check-ups.” (R9; 1:4)

Feelings of security could be enhanced by *being given confirmation about the normality of the situation*. Even if the father was well prepared and well informed it was nevertheless important that staff confirmed that all was as it should be and that the parents were doing things right. This allowed the father to concentrate on the child.

“It was that third day thing...it was also nice that someone could say that it was normal... especially to do with breastfeeding...what’s normal and what’s not” (R7; I:3)

Having someone to turn to – knowing who to ask

On the postnatal ward, having staff close at hand at all times in case questions arose about the mother or the baby affected fathers’ sense of security. By virtue of staying at the hospital the father had access to the same information as the mothers and this strengthened his role as giver of security.

“It’s good at the ”hotel” because there is a midwife the whole time in case there should be something...then you could just, whenever, go out or give them a call...and you got a direct answer. Actually that gave good security.” (R1; I:1)

When questions arose *at home* about the mother’s and the baby’s health and wellbeing it was vital that *staff were available to call and ask*. Fathers felt secure when they could ring to the hospital 24 hours a day or could contact the child health clinic whenever necessary after

discharge. Since fathers considered breastfeeding to be an important question it was also a matter of security to be able to make contact with the breastfeeding clinic.

“They said, like, that if there’s anything at all when you get home just give us a call. You could ring around the clock.” (R8; I:3)

“Secure...that’s how I feel about the breastfeeding clinic.” (R6; I:2)

Having a social network with close relatives to call and ask about the mother and the baby was an adjunct to or a replacement for health care staff. When it was a father’s first child but his partner had given birth before, the woman’s experiences and knowledge gave him security.

“You feel secure when you know that there are people that you can...Grandma or Nanna ...who can come, who have a bit of...” (R2; I:1)

“I felt that there was always someone to turn to since my partner had a child previously...so she had everything under control. It felt like that.” (R8; I:3)

Being met as an individual

Being *listened to and taken seriously*, having their individual needs and experiences taken into account by the midwives increased fathers’ feelings of security. They felt that midwives should exert themselves in order to understand the uniqueness of each father’s situation and it was important that his worries were acknowledged. Allowing fathers to stay at the hospital with the

new family after the birth was a way in which staff could show that they listened to and took the fathers seriously.

“... if there’s that kind of warmth in the contact. I believe that that kind of warmth starts with a genuine feeling of empathy and a way of showing that empathy... a good listener, and what I mean by that is that if you don’t start with yourself and your own experiences when you give advice but that you instead genuinely try to listen and want to understand, that’s the first step.” (R10; I:5).

Fathers’ security was affected by the way in which midwives *cared about and gave attention to them* before, under and after the birth. Midwives could give care and attention by actively making contact with the family, looking in on them whilst at the hospital and by making a phone call to them when they had returned home. These contacts gave the feeling that a professional had checked things out. A midwife who cared about also how the father was feeling gave him an increased sense of security and in reverse, being met by a midwife in a nonchalant way could lead to feelings of insecurity.

“...she showed that it was important for her that everything was alright with all of us...it mattered.” (R9; I:4)

“Yes, I thought it was quite hard work. They were quite nonchalant in the way they treated us and I didn’t feel that they gave us what we needed at all, quite simply, not at all.” (R11; I:6)

Being met by competent and supporting staff

The situation during the first days was in most cases described as chaotic and the fathers felt a need to constantly be told what was going on. If this information was forthcoming the mother also benefited from it. *Being given relevant and consistent information and explanations*, preferably before problems arose, was particularly important when it was a first child and fathers wanted the information they were given to be uniquely adjusted to the needs of the family.

“Being able to get some information...in the beginning you didn’t know at all what to do. It’s good to get information and straight away too.” (R7; I:3)

Receiving ambiguous information and explanations caused insecurity. The level of midwives’ knowledge was especially noticeable when it came to breastfeeding information. The baby’s wellbeing was generally related to functioning breastfeeding and the “food situation”. If breastfeeding support was satisfactory (whether or not it later led to successful breastfeeding) security was increased both at hospital and at home. After discharge home the level of knowledge of the midwives at the breastfeeding clinic was important.

“ It’s like, even though you’re somewhere where everyone’s supposed to be an expert on breastfeeding they all say different things about what to do when things get difficult.” (R10; I:5)

It was not only what the midwives said but how they said it that affected fathers’ sense of security. *A calm demeanour* in combination with *body language* gave signs about competence. If midwives were calm in what they did they were also presumed to be knowledgeable and if they seemed unsure the fathers felt unsure. It was felt that staff should be available rather than obtrusive.

“...you notice that they know what they are doing...feel calm and secure in what they’re doing....you notice quite quickly if they are unsure what they’re doing. That makes me unsure and I think: Do they not know about this? But if they’re calm and they know what they’re doing, one feels calm also and secure, that’s what I think.

That’s it...body language...” (R1 and R2; I:1)

Support could also be given *by practical services* at hospital in the form of provision of meals and having someone to clean the room was important for fathers’ sense of security since this allowed them to focus just on mother and baby.

“...that one could feel relaxed...go and have some food without having to make it yourself... they see to your room and you can just concentrate on the new baby. That was a very good ground for feelings of security.” (R10; I:5)

Discussion

This is not a large scale study but it is founded on earlier research and the intention is to use the results to further develop the already existing PPSS-instrument. In the present study new items could be identified which were in alignment with the dimensions in the first version of the PPSS instrument (Persson et al., 2007). However the first study only identified items which covered aspects of the postnatal period. Our present results also point to the importance of antenatal care, showing that fathers did not consider the postnatal period as a separate entity from the rest of the

childbirth process. They indicated that their sense of security was dependent on experiences during the processes of pregnancy, birth and early parenthood and participation in these processes emerged as the main category for fathers' postnatal sense of security. The idea of paternal participation in childbirth was initiated in the industrialised world during the 1970s when men were given the opportunity to be present at the birth. Our study shows that fathers are prepared and willing to take part in the processes of pregnancy, birth and early parenthood and are keen to take their responsibility in the early postnatal period which confirms results from other recent studies (St John et al., 2005; Erlandsson et al., 2008). A sense of security may strengthen the fathers' confidence and therefore enable adjustment to fatherhood. The concept sense of security (the Swedish word "trygghet") emerged from a grounded theory analysis in an earlier study (Persson and Dykes, 2002) and translation from Swedish to English is not problem-free. In Grounded theory it is important to remain "close" to the data and for this reason we, in this study, have retained the original translation. More than 25 years ago, Andersson (Andersson, 1984) suggested that the taking of responsibility was a way in which a sense of security may be attained. Taking responsibility for the family is closely related to protecting the family, which was described more recently by Finnbogardottir et al. (2003) and Danerek & Dykes (2008). Staff should not only permit but actively encourage fathers to share responsibility and to be involved in the whole process since it has been shown that a father's involvement in care has positive effects on his attachment to the child (Pruett, 1998; Sullivan, 1999; Goodman, 2005).

It is important that those fathers who have worries during the antenatal period are taken seriously by the midwife and that they are given the opportunity to voice their feelings. One option might be to have a specific "antenatal listening visit" for the father-to-be alone (Finnbogardottir, 2003).

The fathers in our study had in general expected more preparation for fatherhood and parenthood in the antenatal classes; a finding which has been discussed before (Deave, 2006). This highlights the importance of having a gender perspective in antenatal education which has also been shown in Australian research (Condon, 2006).

As in our previous studies (Persson and Dykes, 2002; Persson et al., 2007; Persson and Dykes, 2009) we found that relationships with staff were important for fathers' sense of security. Earlier Swedish research has shown lack of support from staff to be the most important factor for fathers' dissatisfaction with early postnatal care (Hildingsson et al., 2009). Health care staff may facilitate the father's participation and responsibility by establishing a relationship based on his individual needs. The midwives ability to listen, to take both parents seriously and to care about them in their unique situation are construed as genuine empathy which in turn gives the father a sense of security. Being listened to and taken seriously are needs that probably are not specific to the birthing situation but are rather basic conditions for communication as a whole. Genuine empathetic listening may induce a sense of security and it is a challenge for all health care staff to gain insight into the importance of this capacity. Training in listening skills both for in-service staff and in midwifery education may be a way to increase parents' sense of security.

Wellbeing of the mother and child signifies wellbeing and security for the father. Therefore, confirmation of mother's and baby's health and normality is essential for father's sense of security. Having someone to turn to – knowing who to ask highlights the importance of a clear structure for the availability of advice and support both at hospital and at home after discharge. Fathers brought up the problem of inconsistent advice particularly regarding breastfeeding and

that post-discharge help from a breastfeeding clinic was essential. This shows the importance of this type of resource and it may be false economy to limit services of this kind.

The importance given to fathers' possibility to stay overnight at the postnatal ward probably reflects the expectations in our society regarding fathers' equal participation in family life. This identified need may not be apparent in international settings. However, care routines which separate the family unit into small parts may violate some aspects of natural family building. The importance of early postnatal care which strengthens the whole family has been pointed out by many researchers (Fredriksson et al., 2003; McKellar et al., 2006; Waldenström et al., 2006; Hildingsson, 2007; Forster et al., 2008; Ellberg et al., 2010). A question which may be posed is why fathers, despite research results, still experience that health care staffs do not consider their parenting role as equally important as the mothers (Hildingsson et al., 2009; Ellberg et al., 2010). The answer maybe multi-factorial; an organization can be dependent on its economical resources but also on its specific caring culture and philosophy. Planners of future maternity services must be aware of the need to plan postnatal care to also include the father. In Sweden, women who have had a complicated pregnancy and/or birth are cared for on traditional postnatal wards. On these wards, their partners do not automatically have the opportunity to stay overnight (Ellberg et al., 2005). It seems paradoxical that when there is concern for the mother's wellbeing, the father is excluded. This paradox must be addressed.

Methodological considerations

To increase trustworthiness data collection was carried out by two of the authors and quotations were chosen from every interview and category. In order to strengthen credibility all the co-authors were involved in the process, analyzing parts of the data separately and then discussing the analysis together until consensus was reached. The sample included both first time and experienced fathers, fathers with differing educational backgrounds and fathers from both rural and urban settings, with the aim of collecting a diversified range of data. However a limitation

may be that the participants were able to speak and understand the Swedish language and that all the fathers were born in Sweden. Focus group discussion is a suitable method for qualitative research (Morgan, 1998) and according to Morgan “focus groups are useful when it comes to investigating what participants think” (p. 25). The use of focus groups and individual interviews and recruitment from both preparation for parenthood classes and postnatal wards broadened the data collection in this study. Recruiting from postnatal wards gave the advantage of including experienced fathers, since at preparation for parenthood classes most are first time fathers. A limitation of studies of this kind is that it can be assumed that those who agree to participate are already interested in the area under investigation and are therefore to some extent self-selected. This is difficult to avoid. A further limitation of the study may be the variation in time span for conducting the interviews (3-9 weeks after birth) which may have influenced the findings. Transferability was strengthened by the fact that results from this study showed similarities to the dimensions identified in our earlier studies (Persson and Dykes, 2002; Persson et al., 2007; Persson and Dykes, 2009). The PPSS instrument will be further developed by amalgamation of new items from the present study (Table 3) into the instrument after they have been psychometrically evaluated.

Table 3. New items specific to fathers’ postnatal sense of security which will be further psychometrically evaluated

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- being invited to participate early in pregnancy
 - being able to take responsibility
 - being involved during pregnancy
 - being prepared during pregnancy
 - being given the opportunity to be together with the family in hospital
 - being given the opportunity to be together with the family at home
-

-
- being given confirmation about doing things right
 - feeling secure with available medical resources during delivery
 - feeling secure with available medical resources after birth
 - being given confirmation about the normality of the situation
 - having someone to call and ask (about the mothers and the baby's health and well-being)
when at home
 - being met as an individual in the meaning of being listened to
 - being cared about.
 - experiencing a calm demeanour and body language
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Conclusions and implications for practice

New and specific items of importance when investigating fathers' postnatal sense of security have been pinpointed. After testing, these may be amalgamated into the PPSS instrument.

Fathers' sense of early postnatal security may be enhanced by giving them a genuine opportunity to participate in the whole process and thereby take responsibility for the family's wellbeing.

Giving them the opportunity to stay overnight at the hospital after the birth is also important.

Midwives and care organizations need to give clear information about where competent help and advice can be obtained at all hours. Midwives may strengthen the fathering role by

acknowledging and listening to the father as an individual person. Being listened to gives a sense of participation which in turn gives a sense of security. Future development of pre- and postnatal services should take fathers' desire to be part of the family from the very start into consideration.

A specific "antenatal listening visit" for fathers-to-be only, can be one option. Training in listening skills both for in-service staff and in midwifery education may be a way to increase both parents' sense of security.

References

Andersson, K., 1984. Patienters upplevelse av trygghet och otrygghet (Patients experience of security and insecurity). PhD thesis. Stockholm University, Esselte Studium, Stockholm.

Andersson-Segesten, K., 1991. Patients' experience of uncertainty in illness in two intensive coronary care units. *Scandinavian Journal of Caring Sciences* 5, 43-47.

Barclay, L., Lupton, D., 1999. The experiences of the new fatherhood: a sociocultural analysis. *Journal of Advanced Nursing* 29, 1013-1020.

Berg, B.L., 1989. *Qualitative research methods for the social sciences*. Allyn and Bacon, New York.

Brown, S., Small, R., Faber, B., Krastev, A., Davis, P., 2002. Early postnatal discharge from hospital for healthy mothers and term infants. *Cochrane Database Systematic Review* 3, CD002958.

Burnard, Ph., 1991. A method of analysing interview transcripts in qualitative research. *Nurse Education Today* 11, 461-466.

Condon, J., 2006. What about dad? Psychosocial and mental health issues for new fathers. *Australian Family Physician* 35, 690-692.

Danerek, M., Dykes, A-K., 2008. A theoretical model of parents' experiences of threat of preterm birth in Sweden. *Midwifery* 24, 416-424.

Deave, T., Johnson, D., Ingram, J., 2008. Transition to parenthood: the needs of parents in pregnancy and early parenthood. *BMC Pregnancy and Childbirth* 29, 8, 30.

Ellberg, L., Lundman, B., Persson, M.E.K., Högberg, U., 2005. Comparison of Health Care Utilization of Postnatal Programs in Sweden. *Journal of Obstetrical, Gynecological and Neonatal Nursing* 1, 55-62

Ellberg, L., Högberg, U., Lindh, V., 2010. "We feel like one, they see us as two": new parents' discontent with postnatal care. *Midwifery* 26, 463-468.

Erlandsson, K., Christensson, K., Fagerberg, I., 2008. Fathers' lived experiences of getting to know their baby while acting as primary caregivers immediately following birth. *Journal of Perinatal Education* 17, 28-36.

Finnbogadottir, H., Crang Svalenius, E., Persson, E., 2003. Expectant first-time father's experiences of pregnancy. *Midwifery* 19, 96-105.

Forster, D.A., McLachlan, H.L., Rayner, J., Yelland, J., Gold, L., Rayner, S., 2008. The early postnatal period: exploring women's views, expectations and experiences of care using focus groups in Victoria, Australia. *BMC Pregnancy and Childbirth* 22, 8, 27.

Fredriksson, G., Högberg, U., Lundman, B., 2003. Postpartum care should provide alternatives to meet parents' need for safety, active participation and "bonding". *Midwifery* 19, 267-276.

Glaser, B.G., Strauss, A.L., 1967. *The discovery of grounded theory*. Aldine, New York.

Goodman, J.H., 2005. 2005. Becoming an involved father of an infant. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 34, 190-200.

Greenhalgh, R., Slade, P., Spiby, H., 2000. Fathers' coping style, antenatal preparation and experiences of labour and the postpartum. *Birth* 27, 177-184.

Hildingsson, I.M., 2007. New parents' experiences of postnatal care in Sweden. *Women and Birth*, 20, 105-113.

Hildingsson, I., Thomas, J., Olofsson, R.E., Nystedt, A., 2009. Still behind the glass wall? Swedish fathers' satisfaction with postnatal care. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 38, 280-289.

Krag Jacobsen, J., 1993. *Konsten att lyssna och fråga. (Interview - the art of listening and asking)*. Studentlitteratur, Lund.

Kvale, S., Brinkmann, S., 2009. Den kvalitativa forskningsintervjun (The Qualitative Research Interview). Studentlitteratur, Lund.

Ny, P., 2007. Swedish maternal health care in a multiethnic society – including the fathers. PhD thesis. Malmö University, Faculty of Health and Society, Malmö.

McKellar, L.V., Pincombe, J.I., Henderson, A.M., 2006. Insight from Australian parents into educational experiences in the early postnatal period. *Midwifery* 22, 356-364.

McKellar, L., Pincombe, J., Henderson, A., 2008. Enhancing Fathers' Educational Experiences During the Early Postnatal Period. *Journal of Perinatal Education* 17, 12-20.

de Montigny Lacharite, C., 2004. Fathers' perceptions of the immediate postpartal period. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 33, 328-339.

Morgan, D.L., 1998. Planning Focus groups. Focus group kit 2. Sage Publications Ltd, Thousand Oaks, California.

Persson, E.K., Dykes, A-K., 2002. Parents' experience of early discharge from hospital after birth in Sweden. *Midwifery* 18, 53-60.

Persson, E.K., Fridlund, B., Dykes, A-K., 2007. Parent's Postnatal Sense of Security (PPSS): development of the PPSS instrument. *Scandinavian Journal of Caring Sciences* 21, 118-125.

Persson, E.K., Dykes, A-K., 2009. Important variables for parent's postnatal sense of security: evaluating a new Swedish instrument (the PPSS instrument). *Midwifery* 25, 449-460.

Plantin, L., Månsson, SE., Kearney, J., 2003. Talking and doing fatherhood: on fatherhood and masculinity in Sweden and Britain. *Fathering* 1, 23-26.

Pruett, K.D., 1998. Role of the father. *Pediatrics* 102, (5 Suppl E): 1253-1261.

Ramchandani, P., Stein, A., Evans, J., O'Connor, T.G., 2005. ALSPAC study team: Paternal depression in the postnatal period and child development: a prospective population study. *Lancet* 365, 2201-2205.

Rydén, B., 2004. När kvinnor och män får barn. Ett psykologiskt och könsspecifikt betraktande av psykisk hälsa och ohälsa (When Women and Men Expect and Have a Child - Psychological and Gender Specific Views of Mental Health and Wellbeing). PhD thesis. Lund University, Department of Psychology, Lund.

SFOG [Swedish Association for Obstetric and Gynaecology] Intressegruppen för mödrahälsovård inom SFOG och samordningsbarnmorskorna inom SBF i samarbete med MödraBarnhälsovårdpsykologernas Förening. 2008. Mödrahälsovård, Sexuell och

Reproduktiv hälsa (Maternity health care, Sexual and Reproductive health) Rapport nr 59.
Stockholm.

Singh, D., Newburn, M., 2003. What men think of midwives. RCM Midwives 6, 70-74.

Skari, H., Skreden, M., Malt, U.F., Dalholt, M., Ostensen, A., Egeland, T., Emblem, R., 2002.
Comparative levels of psychological distress, stress symptoms, depression and anxiety after
childbirth - a prospective population-based study of mothers and fathers. BJOG 109, 1154-
1163.

Socialstyrelsen [The National Board of Health and Welfare]. Medicinska födelseregistret.
Sveriges officiella statistik 2008:5. Graviditet, förlossning och nyfödda barn (Pregnancy,
birth and newborn children). Stockholm.

St. John, W., Cameron, C., McVeigh, C., 2005. Meeting the challenge of new fatherhood
during the early weeks. Journal of Obstetric, Gynecologic and Neonatal Nursing 34,180-189.

Sullivan, J.R., 1999. Development of father-infant attachment in fathers of preterm infants.
Neonatal Network 18, 33-39.

Waldenström, U., Rudman, A., Hildingsson. I., 2006. Intrapartum and postpartum care in Sweden: women's opinions and risk factors for not being satisfied. *Acta Obstetrica et Gynecologica Scandinavica* 85, 551-560.

World Medical Association, the Declaration of Helsinki. 2004. Ethical Principles for medical Research Involving Human subjects.

[<http://www.wma.net/en/30publications/10policies/b3/index.html>]

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