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Parents' experiences of the significance of interpersonal interactions for becoming parents and a family during neonatal intensive care

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ABSTRACT

Purpose: To describe parents' experiences of the significance of interpersonal interactions for becoming parents and a family during neonatal intensive care.
Design and Methods: We employed a qualitative descriptive design with semi-structured family interviews. Ten families were included from four neonatal intensive care units (NICU) in Sweden. Results were evaluated using thematic analysis.
Results: The results were presented as two themes: 1) Interactions within the family, and 2) Interactions between parents and staff. Analyses revealed that interpersonal interactions could both facilitate and hinder development in becoming a parent and a family.
Conclusion: Interactions within the family and with the staff have an important function in the process of becoming a parent and a family. This process would benefit from a systemic approach, focusing on the family as a unit, as unique individuals, and as parents with unique needs and experiences.
Practice implications: Our findings can facilitate changes to reduce the separation between family members (mother-father-newborn-siblings) during their stay in NICU; guiding parents to take care of their child, while being sensitive and balancing their situation as to where they are in their process; supporting the family through joint conversations by listening to the parents and their expectations and experiences both in the NICU and at home; and encouraging parents to do everyday things together outside NICU like an ordinary family.

Introduction

Transition to parenthood begins as early as pregnancy, with an increased sensitivity for both mothers and fathers. At this stage, they begin to process their self-images, perceptions, and expectations of their unborn child, such as when feeling a little kick or seeing an ultrasound image of their child (Bakermans-Kranenburg et al., 2019; Zdolska-Wawrzkiewicz et al., 2020). Notably, the self-image of a mother may affect how strong their bond to the child becomes (Zdolska-Wawrzkiewicz et al., 2020). However, this process to parenthood could be interrupted abruptly if a healthy full-term child does not arrive as imagined (Epifanio et al., 2015). Mothers with premature children often have difficulties with transition to motherhood (Heydarpour et al., 2017), as they may experience feelings of guilt and failure for not carrying the infant to term, or realizing that they might not be able to protect their child from painful procedures (Medina et al., 2018; Spinelli et al., 2016). A systematic review also revealed that fathers could have difficulties with transition to fatherhood due to the unexpected start of child care, in addition to their minimal physical contact and participation in the daily care of their preterm child (Provenzi & Santoro, 2015).

Mothers and fathers who have experienced complicated pregnancy or birth have to face this unexpected experience, possibly involving highly specialized care and hospitalization in the neonatal intensive care unit (NICU). This experience can leave both mothers and fathers in a sense of powerlessness, stress, and fear regarding their child's survival, which delays their transition into secure roles as mothers and fathers (Al Maghaireh et al., 2016). Mothers and fathers often experience symptoms of anxiety and depression when they are in the NICU, which is a risk factor for developing difficulties in child bonding and negatively

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impacting childhood outcomes (Huhtala et al., 2014; Nordahl et al., 2020; Roque et al., 2017). In fact, a study conducted in 2017 showed that more mothers than fathers experienced high levels of stress (e.g., 60% of mothers and 47% of fathers experienced post-traumatic stress disorder [PTSD]) as a consequence of a child hospitalization in the NICU (Aftyka et al., 2017). Thus, parents' ability to manage their transition and interactions with their child during a time of high stress can be a complex psychological process with several personal and familial changes, such as shifting in responsibilities and parental roles, which can affect their future relationships and well-being in the family (Al Maghaireh et al., 2016).

In summary, the transition to become a mother or father has been shown to be difficult when having a child in need of neonatal intensive care. In order to address this, the NICU staff have been trained to be actively engaged as facilitators to supportive parents using tools to identify their individual needs during and after the NICU experience, including any emotional distress (Roque et al., 2017; van Veenendaal et al., 2019). Neonatal intensive care has therefore been organized to facilitate transition and bonding in the families of many countries under the services of family centered care (FCC), which offers both mothers and fathers the opportunity to be with their child in the NICU. Participating in the care of their child contributes to a sense of competence and has been found to increase self-confidence in mothers and fathers (Baylis et al., 2014; Craig et al., 2015). Early and close physical contact has also been found to stimulate mother-father-child interactions and bonding, which has led to the conventional use of the Kangaroo Mother Care (KMC) model (Maastrup et al., 2018; Norén et al., 2018). In addition, support from healthcare professionals and regular communication are important in helping mothers and fathers to interact and create bonds with their children, as well as facilitate an easier transition to parenthood when being in the NICU (Lundqvist et al., 2019; Mäkelä et al., 2018).

Despite all these findings, there is still a lack of knowledge regarding the significance of interpersonal interactions (conceptualized here as relational and mutual processes between the parents, staff, and child) in the NICU for the transition to become parents and family. Moreover, few studies have included both mothers and fathers, most of which had individual perspectives from either the mother or father, rather than taking a joint parental perspective. Thus, this study evaluated this joint parental perspective, focusing on the verbal and nonverbal communication interactions in the NICU context.

Purpose

This study aimed to describe parents' experiences of the significance of interpersonal interactions for becoming parents and a family during neonatal intensive care.

Design and Methods

Context

This study was conducted at four NICUs with different levels (Barfield et al., 2012): one specialized unit (level I) in Northern Sweden caring for newborns from 22 weeks of gestation, and two units (level II) in Southern Sweden caring for newborns from 27 weeks of gestation (one unit) and 30 weeks of gestation (one unit). All units received the standard care based on the concept of FCC, with the possibility for parents to stay with their child along with KMC, Neonatal Individualized Developmental Care and Assessment Program, (NIDCAP), and possible neonatal home care. In cases of overcrowding in a local neonatal unit, some of the participating parents had the experience of being transferred to specialized intensive care units at a regional university hospital or to a another NICU.

Participants and Recruitment

This study is part of a larger project, in which the Family Health Conversation Model (FamHCM), was evaluated as an intervention in the context of neonatal care. Thus, recruitment and sample selection in the current study largely coincided with sampling in the larger project (Åberg Petersson et al., 2021). For the project, parents whose newborn infants needed neonatal intensive care with a respirator or Continuous Positive Airway Pressure (CPAP) were recruited. The contact nurses at the four NICUs provided oral and written information to the parents who met the inclusion criteria. Parents who wanted to participate provided their written consent and were thereafter randomly assigned to either the intervention or the control group. Parents in the intervention group participated in a series of Family Health Conversations and parents in the control group received standard care.

For this current study, a consecutive sampling strategy was used by inviting the first ten families that were assigned to the project control group to participate. The first author (MÅP) contacted the families via phone approximately 8–10 months after the parents were assigned to the control group to confirm their interest in participating in an interview. They were then updated regarding the study, and after agreeing to participate, the time and place of the interviews were determined. The sample consisted of six families who were first-time parents, three families who already had one to two children, and four families who had experienced losing a child. The ages of the participants varied between 25 and 41 years and all, but one participant was Swedish. The amount of care received at the hospital and at the home varied from 1 week to 10 months, and the children were born with a gestational age of 22–40 weeks.

Data collection

Interviews were conducted between May 2017 and September 2018. Parents were interviewed together in all of the cases, with the exception of one case where only one of the parents could participate. The interviews were audio-taped and conducted in a secluded room at the hospital ($n = 3$), at the participants' homes ($n = 1$), or by phone ($n = 6$), lasting between 45 and 90 min. The joint interviews (e.g., mother and father together) (Eggenberger & Nelms, 2007) followed a semi-structured method using a guide that was based on the systems theory assumption of the family as a unit. The first question invited the parents to talk about their experiences of having a child in need of neonatal intensive care, which was followed up with circular questions, for example, beginning with “what” or “how” (Benzein et al., 2008; Shajani & Snell, 2019). Both parents' experiences were also examined using reflecting and clarifying questions in different areas, such as how their experiences of a child in need of neonatal intensive care had affected them and their family relationships.

Data Analysis

All interviews were transcribed verbatim and analyzed using reflexive thematic analysis, which is a theoretical flexible method developed by Braun and Clarke (Braun & Clarke, 2019). An inductive and semantic way of coding was used, according to this method. Analysis was performed from describing to a careful interpretation process by implementing six phases (Braun & Clarke, 2006, 2019). First, the researchers were familiarized with the data by transcribing, reading, and rereading the text several times while noting ideas. Second, words and phrases were placed in a document, and initial codes were generated. Third, the themes were examined by evaluating the codes and categorizing them into possible themes. Fourth, the themes were reviewed to provide distinctions between them and in relation to the codes. Fifth, each theme was named and defined after correlating to the specific overall story of the analysis. Lastly, the report was written using these data that were analyzed in the previous phases. During this whole process, there was a movement between the various steps, mostly between steps 3, 4, and 6, to define and distinguish the themes. Although the first author was primarily responsible for the analysis, the identified themes were regularly discussed and revised within the research group.

Ethical considerations

The study was performed in accordance with the Declaration of Helsinki (Association, 2014) and was approved by the Regional Ethical Review Board in Linköping, Sweden (D-nr: 2015/83–31, 2017/248–32). The researchers were aware of the ethical challenges when conducting joint interviews with the parents and thereby sought to build a respectful atmosphere during the conversation with them (Voltelen et al., 2018).

Results

Overall, analysis showed that the interpersonal interactions could both facilitate and hinder parents' process in becoming a parent and a family. The result was presented in form of two themes: 1) Interactions within the family, and 2) Interactions between parents and staff.

Interactions Within the Family

When a child requires intensive care outside the delivery room, it could prevent the family from being together, as most hospitals do not have the necessary medical equipment in the delivery room. The participants recounted on how the fathers were invited to come with the medical staff and the child to the emergency room, allowing them be near the child while the mother remained in the delivery room. In this situation, the fathers expressed that it was difficult to leave their partner, with whom they had a deeper relation to than with the newborn child, whereas the mothers stated how it was frustrating to be separated from their children, since they had no physical contact with the child and were worried about the child's survival. Both parents also reported that this "unexpected start" (e.g., to be separated from the child and each other) hindered possible mutual interactions and proper transition to the role of parents.

"It was very hard, I was not aware of what was happening the first days and couldn't sort things out, and I felt I could not live up to the expectations, you are supposed to be happy that the babies were born. You should want to go and see them and sit there and watch them all day and night, but I couldn't cope with it, I did not want to, I just wouldn't acknowledge I had become a parent, there were many feelings I could not manage." (Mother, Family 5)

At the beginning of the care period, when families were often separated, the fathers were able to spend a long time with the child alone due to the mothers' condition. This provided an opportunity for the fathers to create a closer interaction with their children, which was something the mothers did not experience to the same extent. Although the fathers expressed that they were not fully ready to feel like a father in this situation, interacting with their children through early skin-to-skin contact helped them feel important and allowed their feelings of being a father to rise. Furthermore, the fathers were able to see their important role as a parent, which is advantageous compared to fathers with full-term and healthy babies.

"I have been a dad a little more than other dads. For almost the first whole week it was me who had, or at least over the first four days, it was me who had contact with the children, was there watching them and holding them, putting my hand into the incubator, so I almost had feelings of being a father before my wife had feelings of being a mother." (Father, Family 1)

Parents also needed time to emotionally process and take on the different parental roles. They struggled in several ways to interact with their child and to feel like a parent, rather than just becoming one. They further expressed that the medical equipment often made the bonding more difficult for both of them, such as when they were not able to see their child's face or easily have physical contact. In addition, parents also recounted that the fragile appearance of their premature child affected them.

"Tubes everywhere. In the beginning, it was just like this, I mean, I felt that it wasn't even a baby at first, well you sit there and hold her because that is my role, that's what someone's told me to do." (Mother, Family 4)

An even greater challenge was noted when the mothers sometimes needed intensive care and could not be near their child for a few hours or weeks. This hampered their opportunity to interact with their child and their partner, which could delay the experience of becoming parents and a joint family. The need for intensive care for the child and mother also made the situation difficult for the fathers, as they expressed high levels of stress and feelings of being torn between wanting to be with their child or their partner.

"This feeling of being forced to leave him (the infant) all the time to be able to take care of her (the mother) too created a rather great fragmentation, which I felt was tough too during the period of care." (Father, Family 8)

For parents who had already experienced losing child before or during the present pregnancy, it was found to be especially difficult for them to dare to interact and bond with their newborn child and a challenge to see themselves as parents. Parents, with multiple children, who had lost one of them also found it difficult to be happy for the child that survived, while simultaneously mourning for the child they lost. Within the couple dynamic, each parent handled this scenario in different ways, making it difficult for them to communicate their feelings with each other, as they experienced a feeling of not having shared the same journey.

"*I think I would have felt better if I had had the opportunity to share my thoughts more with my husband. I think it would have been easier to live, to have a common experience and not parallel journeys."* (Mother, Family 1)

Another kind of separation within the family that was very difficult was the separation from other family members, including older children, grandparents, and friends. This was especially seen in parents who were separated from their other children, as they struggle in prioritizing the needs between their other children and their new child. For example, when one couple were home a night for a visit, the partner had to be home with the siblings, or they had to go to work, they had a bad conscience for not being in the NICU with their new child. Some of the families had the choice to have the siblings with them in the family rooms in the NICU, which often was appreciated but sometimes also complicated. Nevertheless, parents recounted that aside from supporting the family as a whole, having the choice of staying in family rooms could support interactions between their new child and the siblings.

"We will always carry this with us, I suppose it's something that is just between us. But it's been tough too, we haven't had time for each other. It would have been a bit different if (sibling's name) had not been with us, so we had to take turns all the time, so one of us took care of one of the children and vice versa*, so we've basically not been able to see each other so it feels like you drift apart during that period and then it's a challenge to find your way back when you come home, that is how it feels."(*Mother, Family 7)

However, as time passed, parents spoke of "flashes of light" and "turning points" that they clearly remembered as being related to the growing feeling of being a parent. Such moments included when parents had an enriching interaction with their child, when they developed a deeper emotional relationship upon seeing that their child felt well in their arms, or when they realized that their child had the strength to fight and managed so much more than they thought. When children were transferred from the incubator to a regular bed, parents expressed that this accessibility made physical and psychological interactions easier, thereby facilitating the development of their emotional bond.

"One thing I thought was very or was kind of a big thing with the baby was that when we came to (city's name) and we took off the roof of the incubator, I thought it was a big thing because then I felt that God so much more access you got to her, you could smell or breath on her, you could kiss her." (Mother, Family 4)

When families came home, the parents also mentioned new insights and challenges that made them feel a deeper family cohesion after spending a long time together in the NICU. In developing new routines and creating an everyday life together, the interplay between parents is integral for prioritizing, taking the day as it comes, and deciding what is the most important given the new situation. Furthermore, parents

expressed that they learned to trust their own and their partner's feelings in similar situations, and that they were able to take care of their child when the staff were no longer around. Being able to take care and provide an assessment of the child's condition strengthened their emotional bonds, which was described as a feeling of being capable as a couple and as a joint family (e.g., ability to do probe-feeding, performing life-sustaining interventions in the event of respiratory arrest or foreign body aspiration).

"These emotional bonds had actually developed at first when we were home again and they have increased more and more … when you come home, then you can take care of him for real and when he cries you pick him up and no one else comes running." (Father, Family 8)

Interactions Between Parents and Staff

Parents' experiences of interactions with the staff varied during the care period. In the beginning, parents were dependent on the staff's experiences and knowledge on childcare, which they described as akin to a trustful relationship. After some time, parents were left to become independent, which was challenging as they were unaware what was expected of them and what they were allowed to do without asking the staff. Having a child but not really being able to take responsibility could actually cause frustration, as some expressed that they felt like visitors in the care room rather than parents. Many parents also expressed a lack of communication with the staff and sometimes disappointment when the staff did not wake them up, or make it possible for them to, for example, change diapers, perform tube feeding, or join hospital rounds. These parents argued that this behavior had an inhibitive and a negative impact on their process to find their parental roles.

To be able to feel like a parent, the parents mentioned that it was important that the staff involved them in their child's care. This would prepare them for the transition from the intensive care unit to discharge as they would become more prepared with their parental roles. Moreover, the sensitivity of the staff was important to support the parents with coaching and minimal guidance through pushing.

"*We had fantastic personnel around us, and I am sure they did exactly what they could do, but the situation is so complex, and the way you treat each other is not straight on, but my feeling is that they actually had a very nice way of making us understand … I think most of them got to know us well and enough to know how to meet us where we were.*" (Mother, Family 1)

In cases where the staff were unresponsive or insensitive, the relationship and interplay between the parents and the staff could delay or hinder their ambition to act as a parent, such as when they receive difficult information regarding their child's health. Parents expressed that they wanted the staff to take their time by staying and waiting for their questions to be answered and reactions to be noted. For those parents who had to change their hospital/care unit due to their children needing more specialized care or due to overcrowding, they often experienced additional challenges. Changing their care unit was associated with having mixed feelings, as parents leave a sense of security with the relationships they built with the previous staff and their familiar routines, which was described as taking a lot of energy and consequently hindering their realization to become parents. Similar to their experiences during their child's first admission, the parents also wished that the new staff showed trust in their competence to participate in the care of their child, such as when managing a pulse drop, providing position corrections, and fixing respiratory aids. They argued that these caring activities were an important part of becoming a parent.

"*Then it was the same with the transition when you, like us who came from (city's name), and they told us to do like this, like this and like this, then you already have a routine and of course we understand it will be other routines when you meet new staff and things, new wards and everything, that maybe they are sensitive and take in interest in how we did things where we were before.*" (Father, Family 4)

Moreover, the parents described that the process of becoming and feeling like a family started in the care unit, such as when they could openly talk with the staff about what they perceived as difficult and about everyday events outside the unit. When the staff acted and supported the parents in doing something for themselves, like going out for a walk or to eat dinner, the parents appreciated this gesture, which was helpful in normalizing difficult situations. It was during these moments that they began to realize that their life as a family was developing.

"When we really were out for the count, a few times, the staff understood, they really threw us out once… they forced us to go to the cinema, and once they forced us just to go downtown to have a cup of coffee, yes, to get out of the hospital." (Father, Family 1)

When the families had settled down at home, they also had time to look back at their stay at the hospital, expressing that this was the first time they could articulate their experience of the care they received. They described that the time in the NICU gave them the opportunity to get to know their child with help from the staff, and to really feel like parents and a family when they came home. In addition to showing appreciation for the professional and qualified care that was provided, the parents also suggested some improvements that could have facilitated their journey towards becoming a family. For example, they mentioned that professionals should meet the parents as a unique family and listen to their expectations and experiences. While the parents acknowledged that their child needed most of the focus during these times, they felt that their journey would have been facilitated even better if the staff had acknowledged them as a family, seen them both as individuals with their own needs, as well as a couple with needs to see each other. For example, while the parents acknowledged that the child needed 100% focusing during the care situation, they felt it would have facilitated their journey if the staff had acknowledged them as a family, that is, seen them both as individuals with their own needs, as well as a couple with needs to see each other.

Furthermore, the parents recounted experiences of being offered to participate in conversational support with counselors, psychologists, midwives, nurses, or doctors during the care period. Many of the parents denied invitations to these conversations, since they had difficulties in deciding what conversations would benefit them the most. Others realized that they were protecting themselves by avoiding conversations regarding their difficult situations. It was only the time when they had some distance from their hospital stay that they realized these joint conversations would have probably helped in their journey towards being a family. They also suggested that conversational support should be offered as a routine procedure during and after NICU care, as they thought it would have supported family interplay and functioning.

"*But it is not like you need a conversation on one occasion, this is something you need the whole time.*" (Mother, Family 3)

Discussion

The theme "interaction within the family" described parents' experiences of an unexpected start, which challenged the mutual interpersonal interactions between mother, father, newborn child, and other family members. These experiences were also found to both facilitate and hinder the process of becoming a parent and a family. Conversely, the second theme "interactions between parents and staff" described parents' experiences of how interpersonal interactions between parents and staff could similarly facilitate and hinder the process of becoming a parent and a family.

Our study showed that the unexpected start of parenthood with multiple separations between family members generated difficulties in the process of becoming a parent and a family. In Swedish NICU care, FFC and KMC have been used to reduce physical separation and make mothers and fathers feel involved to facilitate their transition to their parental roles. Therefore, suggestions have been made to improve parents' experiences during and after NICU care, including the Family-Integrated Care model (Bracht et al., 2013; Patel et al., 2018) and home care before discharge (Flacking et al., 2019). Although new care models have been developed, parents in our study described their

physical separation from their child and each other at the start of their NICU stay as a challenge that limited opportunities to be close to and interact with their child, hindering the feeling of being a parent and a family. This made most parents live with emotional distress, making it more difficult for them to understand that they had become parents and to develop interpersonal interactions within the family. Parents also described that this physical separation made it more difficult to become new parents when they could not take care of their child, which was difficult to express for each other. This has been similarly described by parents in other studies as a feeling of not being a good mother and father due to their inability take care of their child (Roque et al., 2017; Spinelli et al., 2016). The parents in our study further described that this affected their initial bonding to the child, aside from their affecting their journey to parenthood.

An important finding of our study is that the fathers often had a greater opportunity to be involved and be more responsible for their child's care at the start of the care period. This facilitated a close interaction and early bonding to the child. However, there could also be differences between different units and parents' experiences.

In a previous study, fathers with a premature child experienced delays in bonding with their premature child and a sense of insufficiency in their role, possibly because they focused on practical matters and spoke little about of their emotions (Lundqvist et al., 2019). However, in another study, fathers described that having a newborn child with health issues helped them to boost their confidence and develop closeness with the child (Clarkson & Hearn, 2021). FCC has yet to be practiced worldwide (Provenzi & Santoro, 2015), and there are different challenges based on cultural values and practices. For example, in a study from the Middle East, it was shown that traditional attitudes and the cultural-religious backgrounds contributed to limited participation in the child's care based on the father's secondary role in FCC (Valizadeh et al., 2018). As such, fathers need to be offered opportunities to be engaged in child care without any pressure (Provenzi & Santoro, 2015), given that each father has individual needs that should be recognized and supported (Merritt, Maxwell, & Urbanosky, 2022).

This study also showed that unlike the fathers, mothers did not have the same opportunities to form early and close interpersonal interactions with their child due to their own medical condition. Mothers in a previous study described that seeing pictures of their child helped in coping with physical separation and their child's medical situation (Haward et al., 2020). In our study, the mothers could see some “turning points” when they started to develop a deeper emotional relationship with their child, as well as a growing feeling of being a parent. Such situations included when they saw that their child felt well in their arms or was transitioned from the incubator to a regular bed, as both situations facilitated physical and psychological interactions. In another study, mothers' inital separation from their premature child was described as a challenge in their process to motherhood. This process could however be facilitated if the child was cared for in the same room where the parents slept (Lundqvist et al., 2019).

Most families in our study had problems staying together in the NICU, since it depended on their situations with other children at home and need to go to work. The mothers often spent the most time in the NICU, which was a long time of separation from the siblings and family. Resultantly, this separation made the parents feel that they had not shared the same journey and had not enough time for their partner. For some families, this was associated as a challenge towards embracing parenthood, but at the same time, it can contribute to stronger interactions in the family by spending a lot of time together and going through these difficult situations. Our study also showed the importance of the interplay between the parents for developing new routines and creating an everyday life together, since this enhanced their capabilities as a couple and as a joint family. This is comparable with a study by Loewenstein et al. (2021), which showed that the time in NICU helped parents to put their relationship into perspective (Loewenstein et al., 2021). However, the opposite has also been described in a study by Manning (2012), which showed that NICU care was a risk for relationship dissolution (Manning, 2012). Overall, these studies describe the range of parents' different experiences, as all families are unique.

Furthermore, this study showed the importance of interpersonal interactions between staff and parents for facilitating family bonding, transition to parenthood, and family development. Due to a lack of communication with the staff, some parents recounted that not knowing what the staff was expecting from them and what they were allowed to do hindered in their transition to become a parent a family. This was consistent with a previous study where parents described that the staff had a lack of communication and interest in listening to their experiences in the NICU, which increased the burden of an already difficult situation (Wigert et al., 2014). The parents in our study recounted that they had different needs over time, which made it challenging for them to express these needs, especially after the end of the care period. Therefore, sensitive nonverbal and verbal communication between staff and parents is important for facilitating their process to parenthood and becoming a family, such as instructing staff members to listen and note what the parents perceived as difficult and to wait for questions and reactions from the parents after the conversation. In another interview study, the importance staff-parent relationships were highlighted, showing that trust and physical interactions can facilitate transition to parenthood in the NICU and can highlight the sense of being involved in child care (Gallagher et al., 2018). This may be especially important for families who needed to be transferred to another health institution, as they had to build new relationships and trust with the new staff members. Overall, difficulties in transition can be alleviated if the NICU staff met parents where they are and listened to their experiences (Neonatalvården i fokus: trygg hela vägen - före, under och efter graviditet, 2018).

Practice implications

These study findings have implications for healthcare professionals working with families in NICU. Our findings suggest a systemic approach in NICU focusing on interpersonal interactions within the family and between the family and the professionals. To facilitate the transition to parenthood and the sense of being a family, it seems essential for the professionals to find ways to reduce the time of separation between family members (mother-father-child-siblings) and to facilitate interactions with the child during their stay in NICU. Professionals' interactions should guide, encourage and support parents to take care of their child, while being sensitive to their specific needs and balancing their situation as to where they are in their processes. By inviting parents to take part in joint conversations focusing on communication of their individual and shared expectations and experiences their transition into becoming parents and family could be facilitated. Professionals can also encourage the parents to do everyday things together outside the NICU, such as going out for lunch or taking a walk, to better facilitate their process of being a couple and feeling like an ordinary family.

Limitations

This study has both methodological strengths and limitations. One strength is that both parents were included, and that they were interviewed together, which contributed to a nuanced result based on the parents' experiences of individual but also joint processes in their transition, becoming parents and a family. We are however aware of the potential bias in parents of not being comfortable disclosing everything to each other in joint interviews (Voltelen et al., 2018). There is a potential limitation for diversity and plurality, as parents who could not write and speak Swedish were excluded. This could have affected the transferability to other populations. To improve comprehensibility and provide sound interpretation of data one of the researchers was responsible for the analysis but all researchers discussed divergent options concerning themes to reach consensus (Braun & Clarke, 2006).

Conclusions

Our results show that the interactions of parents within the family and with the staff have an important function in the process for becoming parents and a family. This process would benefit from a systemic approach, which focuses on the family as a unit, as well as unique individuals with different needs and experiences. Further research on how the staff can support parents through interpersonal interactions and reflective communication is warranted for make it easier to become parents and family when have children that require neonatal intensive care.

Author contributions

Marie Åberg Petersson collected the data, concepted the design, and the analysis and drafting the manuscript. All authors made substantial contributions to conception and design, and also to the analysis and in drafting the manuscript.

Data availability statement

Data are available on reasonable request, with deidentified participant data. Contacting PhD student Marie Åberg Petersson, (marie.petersson3@regionkalmar.se).

Credit statement

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Declaration of Competing Interest

The authors have no conflicts of interest to report regarding this study.

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