RESEARCH ARTICLE

A qualitative study of recorded telephone support calls with mothers of preterm infants: Expressing both positive and negative feelings

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Abstract

Aim: To describe the structure and content of telephone support calls between mothers of preterm infants and support team members after hospital discharge.

Design: This is a qualitative study.

Methods: Data consisted of 19 recordings of telephone calls that occurred between March 2013 and December 2015. The calls were made by support team members to mothers within two weeks of discharge from the neonatal unit. Analyses were performed using content analysis.

Results: One category referred to what the support team members said that facilitated or did not facilitate the conversation. It was found that the support team members managed to have conversations that were tailored to the mother's current needs and conversations where the focus was on what the support team members thought was important. A second category referred to the topics the mothers talked about and that the mothers expressed both negative and positive feelings.

KEYWORDS
nursing, paediatric care, parenting, person-centred care, preterm infants, telephone support calls

1 | INTRODUCTION

Every year, many infants are born preterm (<37 weeks of gestational age) worldwide, with a large proportion needing care in a neonatal unit (World Health Organisation, 2012). Hospitalization time for preterm infants may be lengthy, and mothers may experience feelings of anxiety about what life will be like once they leave the hospital for home. Leaving the secure environment of the neonatal unit, where help is always available, to go home may therefore represent a daunting transition for the mothers (Lundqvist et al., 2019; Murdoch & Franck, 2012). Mothers' experiences of the transition from the neonatal unit to home vary, and it has been reported that mothers would like to have more continuity in the support offered (Premji et al., 2017).

Since communication is the basis of support and care, it is of great importance that it is adapted to suit the individual (Rider et al., 2014). A person-centred approach is an important component (McCormack & McCance, 2016). Person-centred care is based on therapeutic relationships between healthcare workers, people who need care and others who are significant in these people's lives. Such relationships are based on mutual trust, understanding and the sharing of accumulated knowledge (McCormack

& McCance, 2016). In this study, person-centred care means that the care provider engages with and has a sympathetic presence with the person, provides supportive care and builds a trusting and understanding relationship. Person-centred care through telephone-based support is of great importance to patients but can be more complex than face-to-face care and is not always easy to provide (Gambling & Long, 2009).

2 | BACKGROUND

Previous data published from a randomized controlled trial (RCT) (Ericson et al., 2018) showed that proactive telephone support (i.e. when a support team member makes the call) after discharge from the neonatal unit decreased the mothers' parental stress levels and increased their feeling of empowerment. Furthermore, the mothers felt stronger as parents and felt supported and safe when they were called and offered support (Ericson et al., ,2017, 2018). In addition, telephone support calls after discharge from the neonatal unit have been shown to be a cost-effective method of contacting mothers and strengthening their parenting role, leading to lower rates of re-admission (Akbarian et al., 2017).

Preterm infants and their mothers are a vulnerable group that may need support from the healthcare sector. Mothers of infants born preterm are at higher risk for depression, anxiety and post-traumatic stress, which may impact infant bonding (Hoffman et al., 2017; Rogers et al., 2013). Furthermore, preterm infants are at greater risk for hospitalizations, outpatient visits and societal costs after discharge. Care for mothers and their preterm infants after discharge is often fragmented. Improved delivery of care may result in improved health and development for both the mother and the infant (Kuo et al., 2017). Understanding and addressing the support needs of mothers of preterm infants is important, not only to alleviate each mother's concerns immediately after discharge, but also to contribute to the best possible long-term outcome for both infant and mother. There are some earlier studies examining mothers' experiences of various support interventions during and after neonatal care, especially about breastfeeding (Dellenmark Blom & Wigert, 2014; Ericson et al., 2017; Ikonen et al., 2015; Lundkvist et al., 2019). In those studies, the data were collected retrospectively. To our knowledge, there is no previous evidence about the structure of support calls and its influence on conversations in this context. Thus, there are knowledge gaps in how to structure conversations to meet mother's needs and what topics mothers want to talk about in support calls after being discharged from a neonatal unit. The earlier mentioned RCT (Ericson et al., 2018) on proactive telephone support recorded a number of the support calls made. This trial provided an opportunity to investigate how the real-life telephone support calls were structured and what was discussed. The research questions of this study were "How does the staff structure support calls?" and "What do mothers of preterm infants talk about in support calls during the two first weeks after discharge from the neonatal unit?" Thus, the aim of the study was to describe the structure and content of support telephone calls between mothers of preterm infants and support team members after hospital discharge.

3 | THE STUDY

3.1 | Design

The study employed a qualitative design and involved the analysis of recordings of telephone support calls conducted during a RCT (Ericson et al., 2018) investigating proactive telephone support calls to mothers of preterm infants, conducted after discharge from six neonatal units in Sweden. The RCT had an embedded mixed-method design (Creswell & Plano Clark, 2017) involving collection of both qualitative and quantitative data during the study period and at all follow-ups. The RCT included 493 mothers of preterm infants (intervention group, 231; and control group, 262) and was conducted between March 2013 and December 2015. The intervention group received daily proactive telephone support calls from a support team for their first two weeks at home after discharge. The calls were intended to be person-centred. The control group was given a number that they could call for support when needed. The inclusion criteria were breastfeeding mothers at discharge and who had been admitted to the neonatal unit for at least 48 hr. The exclusion criteria were mothers who had serious medical or psychiatric problems, had language difficulties that could not be resolved, had infants who were transferred to another hospital or unit or had infants who were terminally ill. Members of the support team, that is nurses and assistant nurses, at each site received two days of training before the initiation of the study. Training covered topics such as breastfeeding support, person-centred care and a description of the study's design (Ericson et al., 2013).

3.2 | Methods

In total, 19 support calls were recorded by the support team members between March 2013 and December 2015. The recorded calls varied in length, ranging from 42 s to 19.5 min (mean 7 min). Participating mothers were informed in the consent form that some calls would be recorded. Before the support team member started to record the call, the mother was again asked for permission to record it. It was not predetermined which calls would be recorded, and there were no criteria dictating which calls would be recorded; the decision to record a call was made by the support team member making the call. Thus, convenience sampling (Patton, 2015) was applied of study participants subsampled from the trial. No predetermined questions were asked in the support calls. The only instruction given to the support team from the research group was to ask an open question such as "How are things going?"

The calls were anonymous; no information was included about the mothers' identities except that they had been included in the RCT. Thus, no background information can be presented on the

study participants. Nine of the recorded support calls were made by Registered Nurses, and ten were made by assistant nurses. Two support team members recorded three calls each, two recorded two calls each and the reminder of the calls were recorded by different team members. All support team members were relatively experienced in their profession, which was a requirement to be part of the support team. Information on whether the calls were proactive or reactive was not included, but it could be concluded from the recordings that only proactive calls were recorded.

3.2.1 | Rigour

To ensure transparency, the reporting of this study follows the Standards for Reporting Qualitative Research (SRQR). This checklist was selected based on its suitability for data collected from genuine, recorded telephone support calls (O'Brien et al., 2014).

According to Guba (1981), rigour requires credibility, dependability, confirmability and transferability. In this study, credibility was attained by recording data directly from real life, making the data believable and true, and quotations from the interviews were used to further strengthen credibility. Dependability was achieved through a detailed description of the method. To ensure confirmability, the analyses were conducted by AJ and MJ independently, and the results were compatible. The results were discussed and reflected on with JE, who was responsible for the RCT study and who had good insight into the process of the recording of the support calls and their content. In the final support call, no new information was gained, and data saturation was reached, which strengthened the study's transferability to similar contexts.

The authors have backgrounds in different nursing specialties and therefore have diverse pre-understandings. AJ is a public health nurse working with community health with prior experience in palliative care and support conversations. MJ is a public health nurse with experience in psychiatric care and support conversations. JE's research area is primarily within neonatal care. She is a paediatric nurse with extensive experience in neonatal care. The research process was based on having an open approach to the data, and the interpretations were questioned, problematized and reflected upon to ensure validity.

3.3 | Analysis

The recorded support calls were transcribed verbatim by a research assistant and JE, prior to analysis. The support calls were coded as T1-T19. The analysis was performed with a content analysis approach inspired by Elo and Kyngäs (2008). To gain an overall understanding of the content, the complete transcripts of the included support calls were read individually by all authors several times. The next step was to code the material, and the codes were then grouped into subcategories. These subcategories were then compiled into categories, which were condensed into two main categories. The

authors performed their analyses individually and obtained similar results. The final step was to reflect on and discuss all the written text material and categories until consensus was reached among all authors. To make valid scientific interpretations, the authors made every effort to bridle our pre-understandings to be truthful to the data. Quotations were used to provide authenticity to the data and were coded with the identifier of the corresponding telephone support call (T1-T19). The last conversation did not add any new information to the analysis; thus, the data were deemed to have reached saturation (Fusch & Ness, 2015). Table 1 is presented to provide authenticity to the analysis process and shows the text, categories and main categories.

3.4 | Ethics

This study was part of a larger RCT study. The RCT, including the recordings of the telephone support calls, was approved by the regional ethical review board in Uppsala Dnr 2012/292 and 2012/292/2. Participation was voluntary, and all participants signed a written consent form and gave their permission to have their support calls recorded. Data are presented without any personal details to protect participants' anonymity.

4 | RESULTS

The results of the analysis of the 19 transcribed support calls are presented below by two main categories and each of their subcategories.

4.1 | The structure of telephone support calls

This main category focussed on how the call was structured, what the support team member said that facilitated the call, and what they said that did not.

4.1.1 | A structure that facilitated the conversation

The support team members who asked open questions often received detailed answers and more information from mothers that they could follow up on with further questions. *"So, I'm curious, how are things are going?" (T11)* was a question that got a detailed answer. The question *"Yes, so what should we try now, do you think?" (T11)* also resulted in longer answers, as the mother herself was given the chance to reflect on what could be done about the problem being discussed. A short summary also helped mothers continue telling their stories. Another facilitating factor was when support team members showed that they were listening by making supportive sounds such as *"mmm."* Support team members also helped the mothers put their feelings into words. Validation was a large part of the conversations;

TABLE 1 Example of the analysis process of the 19 transcribed telephone support calls

Telephone call	Original statement	Category	Main category
T17	Mother: *"No, he vomits during the daytime as well. However, it feels like he is easier to calm then. It feels a little more troubled at nighttime."*	*Expressing negative feelings*	Support calls as an opportunity to express feelings
T8	Mother: *"Absolutely, he is so calm and kind, eats really well and gains weight, so I'm so satisfied/pleased."*	*Expressing positive feelings*	Support calls as an opportunity to express feelings
T6	STM[a]: *"Mm, then he sleeps a little more at night then?"* Mother: *"Yes, although still a little worried, but last night he slept quite well, I think."* STM: *"Mm, how nice … but now when he gets a little extra [formula], how do you think he eats it then?"* Mother: *"He gets more satisfied; he will not be satisfied until he gets what he wants. He does not give up."* STM: *"He doesn't give up, no."* Mother: *"No, he doesn't; he does not become calm until he has received more."* STM: *"No, OK."* Mother: *"Even though you try to distract in other ways, he does not fall for it."* STM: *"No … what about the stomach today then?"* Mother: *"It's like before, no poop yet, he hasn't pooped since Sunday."* STM: *"No (pause) he gets…"* [interrupt each other] *STM: "Do you give him formula often?"*	*A structure with difficulties*	The structure of telephone support calls
T3	Mother: *"We usually give 60 [ml] in the morning when he has slept a long time."* STM[a]: *"Yes"* Mother: *"and it usually goes well."* STM: *"It sounds like you just came up with a great idea for how this works."* Mother: *"Yes, yes"* STM: *"Yes, how do you feel?"* Mother: *"Yes, well but I think it works very well."*	*A structure that facilitated the conversation*	The structure of telephone support calls

[a]STM, support team member.

mothers asked for and received validation. Encouragement was also something that the support team members gave the mothers.

> Support team member: "But you are doing that. You are giving him food, being there for him. You are changing his diaper. You are there for him. Even if it is really hard."(T18)

Repeated calls between the same support team member and the mother facilitated the conversation and made it easier to follow up on what had happened earlier, and the support team member could be more supportive of the mother's situation.

4.1.2 | A structure with difficulties

Other conversations revealed the difficulties in conducting a support conversation. Support team members occasionally did not seem to know who the mother was or what her history was. In one conversation, the support team member spent a considerable amount of time trying to determine who the mother and infant were, and it became obvious that the mother was disturbed by this.

> Support team member: *"I do not know if I met you at the department."*
> Mother: *"It feels like your voice sounds familiar anyway."*
> Support team member: *"Yes, okay, but what week is he born in or is he full term?"*
> Mother: *"Yes, he was born in week 35."*
> Support team member: *"Yes, I'm sure I met you, but I can't place you right now, but…"*
> Mother: *"But we met anyway."* (T19)

In other conversations, the support team member asked mainly closed questions that only received short answers. Occasionally, the support team member started with a closed question and then continued with closed questions. Questions were also occasionally phrased as statements.

> Support team member: *"(…) how it's going with breastfeeding and so on."*

Mother: "Yes, it's fine."

Support team member: "And the child healthcare worker was at your place yesterday, right?"

Mother: "The day before yesterday."

Support team member: "That was your first home visit, right?"

Mother: "Yes, it was."

Support team member: "Great, so you are enjoying being at home in any case."

Mother: "Yes."

(T19)

In some conversations, the support team member spoke much more than the mother, gave information on areas that the mother said she had already received information on earlier or gave information that she had not asked for in the conversation. On some occasions, the support team member also changed the subject by asking a question on another topic without confirming that the mother was finished talking about the previous topic.

Mother: "Yes, we do stomach massage a couple of times a day. We've also started with drops for the stomach to see if it helps, these drops. It has been better tonight anyway."

Support team member: "Good. Have you tried anything to get him to latch without the nipple shield?"

Mother: "Yes, we're trying a little, but it's really hard."

...

Support team member: "But keep trying anyway and practice a little each time like that. You can also trick him a little by expressing some milk, so that he feels that it is there, when he is there to suck. But otherwise, it actually tends to get a little easier and easier the bigger they gets."

Mother: "Yes, exactly."

Support team member: "But trying to get him to burp, how is that going?" (T12)

4.2 | Support calls as an opportunity to express feelings

This main category concerned what the mothers brought up in the conversations and what topics the mothers talked about. Mothers expressed negative feelings, such as anxiety and frustration, and/or positive feelings, such as joy and pride.

4.2.1 | Expressing negative feelings

This category was clearly evidenced by the recorded conversations. The mothers expressed negative feelings such as frustration, anxiety and defeat; they also sometimes expressed powerlessness in their situations.

Mother: "And it feels so frustrating, when you see that he can't get peace to eat properly, and he can't get peace to sleep properly. He tenses up like a violin string and turns completely red. You see him snort and growl and it is so hard for him.

... Yeah, I feel powerless." (T6)

The mothers' negative feelings could involve frustration over not being able to help their infant when he/she was struggling, and they asked for advice and support for this situation. They expressed difficulty enjoying being a parent when their child was having a difficult time.

Mother: "Sometimes I almost feel, when it is really bad, 'No! Now we're going to the hospital. Now we need help'. I feel like that sometimes. Who do we turn to? What should we do?" (T10)

The conversations covered various stomach difficulties, which caused a large portion of the anxiety and frustration that the mothers spoke about, as it was hard to see their child in pain and not be able to do anything to help. The mothers asked for support, reassurance and advice about their infants' stomach problems. Infants with stomach difficulties slept badly or could awaken during the night, which could disturb their mother's sleep even if they managed to sleep. Mothers who had infants who frequently awoke during the night expressed that their lack of sleep negatively affected them. They expressed frustration about not being able to find a solution that would let their infant sleep better, and stomach problems could be experienced as more difficult to deal with than they were previously due to lack of sleep. The mothers also expressed how the transition from the neonatal unit to the child healthcare centre increased their anxiety and frustration because the advice given to them on stomach problems at the child healthcare centre did not calm them or reduce their anxiety.

Breastfeeding could also be the cause of anxiety and frustration, and the mothers looked for support, information, advice and reassurance with breastfeeding. Topics of concern included whether the baby was getting enough food, how the mothers could increase their milk production, whether the baby was latching on properly, supplement feeding, the use of a nipple shield, the baby swallowing a large amount of air and breastfeeding taking a large amount of time. It was also mentioned that it was frustrating not being able to measure how much milk was consumed during breastfeeding. Breastfeeding during the night could be experienced as hard work when the infant wanted to feed frequently. Some mothers had been given conflicting information on breastfeeding from different support team members who had made the support calls. They had also received conflicting information and advice from the child healthcare centres and neonatal care about weight gain, which could lead to anxiety and the need for reassurance from the support team members, whom the mothers felt they could trust.

4.2.2 | Expressing positive feelings

The mothers also expressed positive experiences and feelings. Some mothers mentioned that it was nice to be home, that the whole family was doing well and that everyone was helping. One mother expressed these sentiments as follows:

> "It's going well; we have just got into our routines here at home. I don't get much done. I spend most of my time sitting with him (laugh), but that is how it should be." (T5)

Watching their child's development was an important factor in giving mothers positive feelings, and they described their child's development in conversations with the support team members. It was apparent that mothers were very proud of the development steps made and that they were happy that their infants were more alert and awake. They also talked about experiences of sleeping well both during the day and at night. The mothers thought things were going smoothly if their child woke up, was breastfed and then fell asleep again. Positive feelings and experiences about the support calls were expressed. One mother said that she experienced a feeling of security that was associated with the support team member with whom she had the conversation. Other expressed that it was nice to be called even on days when there was not anything specific to discuss and they gained a sense of security from knowing that they were going to be contacted.

> Mother: "I feel that I have had much better support than I had last time I had a baby. It was much harder then and I was mentally much lower as well. Now I feel strong." (T11)

In the conversations, breastfeeding was also mentioned as something positive, something that worked well, something that led to the infant gaining weight and/or something that gave mothers joy. Breastfeeding was something that mothers strived for, and they invested a lot of time into ensuring that it worked. Positive feelings associated with an infant's weight gain were something that all the mothers mentioned in the conversations. Weight gain was expressed as a calming factor amid the anxiety caused by breastfeeding and stomach problems, and it gave the mothers a sense that they were doing something right. It also came up in the conversations that when breastfeeding worked, this was positive for the mothers; they had more energy and felt better.

> Mother: "I am happy that … yes, that I can breastfeed every day. And I can see that they get the milk going and that they drink it and so on." (T11)

5 | DISCUSSION

The results in the present study provided a picture of how support calls were structured and what kinds of topics mothers of preterm infants wanted to talk about after discharge.

In the analysis, the structure emerged as important for the conversations. When a support team member asked open questions, acknowledged the mother's story and helped her put her feelings into words, this resulted in more person-centred conversations, as defined in McCormack's and McCance's (2016) theory of person-centred care. In less person-centred conversations, it is possible that the support team member missed some areas where the mother might have needed more support, as the focus was on the areas that the support team member thought were important. The ability of support team members to use a structure conducive to person-centred conversations seemed to vary. Practising person-centred care can be challenging, according to McCormack and McCance (2016), and requires the support of the organization and individual healthcare workers. There was no information indicating that person-centred care was an approach that the support team members were used to, beyond their having completed the short training course at the start of the RCT study. It is possible that some support team members did not have the necessary experience and tools to structure and conduct person-centred support calls and that the short course was insufficient for learning how to provide person-centred care in the long term. Speculatively, the support team members who used a more person-centred approach might have had past experience of this or personalities that were better suited for person-centred care. McCormack has claimed that one's personality is an important aspect in provision of person-centred care (McCormack & McCance, 2016). Another study showed that few meetings were person-centred, even when nurses were supposed to adopt a person-centred approach (Siouta et al., 2019). These findings demonstrate that it is important that care organizations create the conditions their workers need to practice person-centred care. Person-centred care has been shown to increase support satisfaction and mothers want person-centred support, making this particularly important in the study context (McCormack & McCance, 2016; Schmied et al., 2011). Proactive, individually adapted, sensitive, and responsive person-centred communication and support has been suggested as a strategy to support parents. This would require education of staff, to improve communication strategies and interventions. A review by Hall et al., (2015) has shown that educating staff to enhance psychosocial support can facilitate the communication process and improve parents' functioning and parent–child relationships. Lundqvist et al., (2019) have suggested that integrating a person-centred approach, such as supportive person-centred dialogues focussed on parents' individual needs, might be one way to support parents.

The results also gave a picture of the topics the mothers of preterm infants talk about in support calls and indicated that calls provide an opportunity to express both positive and negative feelings. This finding is consistent with other studies showing that mothers experienced worry and anxiety after being discharged from the neonatal unit (Kynø et al., 2013; Murdoch & Franck, 2012). In the support calls in the present study, it was most common for a mother's anxiety to be associated with their infant's stomach problems. Landgren and Hallström (2011) examined the lives of parents of

infants with colic and found that it consumed the parents' existence. All focus was placed on the suffering infant and on surviving the situation. The parents felt both anxious and helpless. About breastfeeding, mothers in the present study were looking for both support and reassurance from support team members. Breastfeeding support has in previous studies been described as a balancing act, and support may be experienced as either empowering or disempowering (Palmer & Ericson, 2019). Leeming et al., (2015) claimed that it was important that the support was person-centred and based on each mother's wishes and needs. Child healthcare centre nurses were found to be a source of increased anxiety in both our study and previous ones. Studies have found that getting conflicting advice increases dissatisfaction with child healthcare services (Kynø et al., 2013; Premji et al., 2017). Taken together, the present study and earlier studies show the importance of designing and adapting support to this particular target group and our study contributes to understanding of how conversations should be structured to promote the person-centred care that mothers have been shown to want and of which topics mothers want to talk about.

This study also showed that the mothers shared their positive experiences and feelings with the support team members during the conversations. Furthermore, mothers who said that everything was going well had the opportunity to put their positive feelings into words or to focus on the positive areas. Being encouraged to talk about positive experiences and feelings may be a way of increasing well-being; this approach is used in positive psychology and in some other areas (Fredrickson & Joiner, 2016, 2018). This aspect was not specifically included in this study or in the original RCT, and it is not known whether and how the mothers benefitted from expressing their positive feelings. Additional research is needed to evaluate whether and how a positive psychological approach is associated with maternal well-being.

5.1 | Limitations

Only breastfeeding mothers were included in the present study, and only proactive calls were included in the data. The results could have been different if the study had included mothers who did not breastfeed and/or reactive calls, that is when the mothers made the phone calls themselves when they needed to ask a question or obtain support. However, the aim of the study was not just to support breastfeeding women; rather, the mothers were asked to talk about what was important for them at the time of the call. Thus, the results may be transferable to other contexts; it is feasible that preterm infants have similar behaviour in other contexts and that mothers in other contexts still have the need to talk about their anxiety related to breastfeeding or their infant's stomach problems or to obtain other advice from healthcare workers. The study sample could have been a limitation. It was not specified why these 19 support calls were recorded, but the sample was most likely a random sample based on the support team members who were prepared to record their conversations. Despite the small number of calls, the study managed

to capture a broad range of calls of varying quality, which most likely made the selection representative of all the calls made and possibly even illustrated what the structure of the calls would have been if the study had been conducted at other neonatal units. The material was also deemed to have reached saturation, given that the last conversation did not add any new information to the analysis, but rather confirmed what was found in earlier calls, which gives the study authenticity. The recorded telephone conversations provided important information despite the mothers' anonymity. It seems unlikely that our results were affected by the time aspect; there should not be any major differences in the structure or contents of support calls made today, as these aspects probably depend more on staff education and context. A strength of the study is that the conversations were taken directly from the reality that the participating mothers were living in when the calls were recorded, which allowed analysis of their reality.

6 | CONCLUSION

Telephone support calls to mothers of preterm infants after discharge from the neonatal unit gave the mothers the opportunity to express both positive and negative feelings and/or ask for support and reassurance from support team members. The conversation structure was of importance. Specifically, support team members who based their conversations on the mothers' stories had deeper and more intimate conversations than those who did not take this approach. This knowledge can be applied by healthcare workers who meet with this group of mothers but can also be used as a foundation for further studies assessing how support can be optimized, especially for the transition from the neonatal unit to the child healthcare centre.

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