

Assuring the integrity of the family: being the father of a very low birth weight infant

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Abstract:

Aim. The purpose of this study was to explore the paternal role of fathers of very low birth weight infants during their first year of life.

Background. Following birth, very low birth weight infants often require extended hospitalisation and long-term care. The birth experience and the infant's hospitalisation often overwhelm parents and may hinder the development of their parental roles. The father is known to be an important supporting figure for the mother, but most studies in Taiwan have focused on mothers.

Design. A qualitative design using a grounded theory approach was employed in this study.

Methods. In-depth interviews were conducted with a purposive sample of fathers during home visits. Each father was interviewed twice at one to three months and seven to nine months after his very low birth weight infant's discharge from the hospital. Data were analysed using constant comparison and repeated verification.

Results. Twelve fathers were included in the study. During the first year of life of their very low birth weight infants, the fathers experienced 'protecting the wife-baby dyad', 'concentrating on the child's health and growth', and 'possessing a complete family'. Subcategories within each major category also emerged.

Conclusion. In this study, Taiwanese fathers of very low birth weight infants learned different and broader dimensions of the paternal role and continually made adjustments to assure their family's integrity.

Relevance to clinical practice. These findings can help nurses understand paternal perceptions and behaviours related to having a very low birth weight infant and in turn help fathers adjust to their role.

Keywords: children | fathers | low birth weight | midwifery | nurses | nursing

Article:

Introduction

The transition to parenthood can be both stressful and exciting for parents (Hwu & Yang 2002, Kerstin & Kerstin 2004, Goodman 2005). The premature birth of an infant can complicate this process (Miles & Holditch-Davis 1997), because many premature infants are born weighing less than 1500 gm (i.e. very low birth weight, VLBW) and these infants are often hospitalised for a long time after birth. In the neonatal intensive care unit (NICU), parents experience stress from their altered parental roles and the unit environment (Lau & Morse 2003, Lee *et al.* 2005). This newborn's premature birth and hospitalisation may traumatise parents and the trauma symptoms can last for a long period (Holditch-Davis *et al.* 2003). Most studies with these infants have focussed on the mother's role and few have examined the father's role. As the paternal relationship with an infant during the first year of life is very important for the child's future development (Lamb 1997), it is crucial for healthcare professionals to understand how fathers of VLBW infants perceive their parental roles in the earliest stages after the birth, so that when needed, appropriate interventions might be made.

Traditionally, fathers played, primarily, the bread-winner role in families; however, in recent decades, the role of the father has changed with changes in social values (Tiedje & Darling-Fisher 1996, Wang & Yu 1997). In present-day Western society, fathers are expected to be simultaneously provider, guide, household help and nurturer (Barclay & Lupton 1999). Hawkins and Dollahite (1997) consider the paternal role as a developmental process and Tiedje and Darling-Fisher (1996) have noted that fatherhood is no longer a gender role but something created and sustained in day-to-day interactions with family members through role negotiations. However, these studies do not provide clear information about how fathers initially transit to their paternal role, especially fathers who encounter difficult circumstances such as the premature birth of an infant.

The transition to fatherhood begins when pregnancy is confirmed. Fathers of full-term newborns anticipate their paternal role and participate in the processes of labour and delivery. These fathers experience their role changing from 'unconfirmed fatherhood' before the labour to a 'suddenly I am a father' feeling after birth (Chandler & Field 1997). The amount of fathers' involvement during pregnancy is positively related to the level of their participation in child-rearing in the first year of life (Bronte-Tinkew *et al.* 2007). However, for fathers of VLBW infants, the process of role transition may be threatened by an unstable pregnancy and uncertainty about the baby's survival. Few researchers have studied the role transition for fathers of VLBW infants (Jackson *et al.* 2003, Pohlman 2005). In Taiwan, gender roles remain rigid, with men being responsible for outside affairs and women being responsible for activities within the home (Sun & Roopnarine 1996). Although Taiwanese husbands plan to have offspring and expect to participate in normal labour and delivery, it is unclear how the premature birth of a VLBW infant affects the Taiwanese father's perception of his role.

Aim

The purpose of this study was to explore the process of being the father of a VLBW infant in Taiwan. As fathers tend to respond to having a premature infant differently from mothers (Pohlman 2005), we chose to explore the father's transition experiences from the perspective of the father himself.

Methods

Research design

This qualitative study used a grounded theory approach to explore being the father of a VLBW infant. Two in-depth interviews were conducted at one to three months and seven to nine months after the baby's discharge from the hospital. Guidelines were used for the two interviews and questions were revised or added after the first few participants had been interviewed. Based on literature, the transition to fatherhood begins when pregnancy is confirmed (Chandler & Field 1997), and role identity includes an internalised view of the self and an external behavioural component (Mercer 1995). The first interview focussed on how the fathers felt about themselves and what they did from the beginning of the mother's pregnancy, labour and delivery and infant's hospitalisation to one to three months after the baby's hospital discharge. The second interview was an unstructured interview that focussed on how the fathers had felt and what they had done in the few months just past.

Participants

Purposive sampling was used based on the following criteria: (1) first-time fathers had an infant whose birth weight was less than 1500 g, (2) the infant had been hospitalised in a NICU, (3) the father could speak the Mandarin or Taiwanese dialect and (4) the father was living with his baby at the time of the two interviews. Twelve fathers were included in the study. The ages of the fathers ranged from 29–49 years. Their education ranged from a middle school degree to a master's degree. The gestational age of the babies ranged from 25–31 weeks and their birth weights ranged from 620–1480 g. The duration of the baby's first hospitalisation ranged from 58–160 days and only one baby stayed one month. There were two sets of twins but in both sets, only one baby survived. At the time of the second interview, three mothers had returned to work, two full-time and one part-time.

Data collection and analysis

The study was approved by the Institutional Review Boards of the National Taipei College of Nursing and two hospitals located in Northern Taiwan. Potential participants were approached and provided a written explanation of the study while their infants were still hospitalised. Anyone interested in participating left a telephone number for further contact and the investigator called potential participants. If a potential participant agreed, home visits were arranged for the interviews. A signed consent form was obtained at the first home visit prior to the interview.

Interviews lasted from 60–90 minutes. During the interview, fathers were encouraged to describe their experiences and express their feelings. Interviews were audiotaped with the father’s permission and transcribed verbatim immediately after the home visit. In addition, during each home visit, the interviewer recorded the participant’s non-verbal behaviours, any special events that occurred and thoughts derived from the interview.

Interviews were continued until data saturation. Constant comparison was used to analyse the transcripts (Strauss & Corbin 1990, Streubert & Carpenter 1999) and open coding started with the first study. The data were examined line-by-line to construct substantive codes. As the data accumulated, early codes were modified and more codes were added. Then, categories were established by grouping similar codes. Through the process of comparison, the categories were reduced and a core category emerged. A framework was finally constructed by continuous modification and integration. New interview data were continuously and repeatedly fit into the categories with no more new information added after including the tenth father’s interview. To confirm the saturation, two more participants were interviewed and the recruitment stopped after the twelfth father was interviewed. During data analysis, literature related to the paternal role was reviewed to ensure completeness of the description.

Trustworthiness

The investigators ensured trustworthiness of the study by carefully conducting the research process. To maintain consistency, in this study, all the interviews were conducted by the first author, who visited and contacted participants multiple times. The typed transcripts were carefully checked by listening to each tape again to assure their accuracy. During the analysis, if questions occurred to the interviewer, the father was called right away or questioned in the second interview. To ensure the accuracy of the analysis, experts in the qualitative method, a nursing specialist in neonatology and the participants were invited to verify the results.

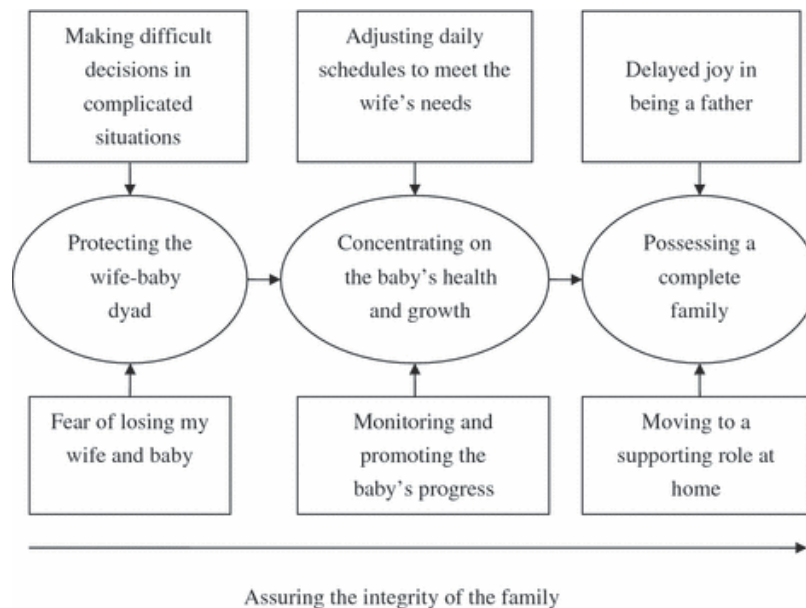


Figure 1. Theoretical framework of the process of being the father of a very low birth weight infant.

Results

A framework of the process of being the father of a VLBW infant developed from the data is depicted in Fig. 1. The core category describing this process was ‘assuring the integrity of the family’. These fathers passed through many stressful experiences in having a VLBW infant before they gained the feeling of possessing a complete family. Fathers experienced stress because of potential loss of the foetus in an early stage of pregnancy. In addition, each baby went through critical periods in the NICU for weeks or months before being finally united with the family in the home.

During the pregnancy, each of these fathers began to provide indirect care to the unborn baby through taking care of the mother. Then the father remained active by visiting the newborn baby in the NICU when the mother was ‘doing the month’, a traditional ritual practiced in the Taiwanese postpartum period. While ‘doing the month’, the mother would not go out of her residence for about one month.¹ Once the mother completed ‘doing the month’ or the baby was discharged from the hospital, the father gradually changed from an active role to a supporting role in caring for the baby. From the unstable pregnancy to the end of the baby’s first year, fathers continually adjusted their attitudes and behaviours in an effort to maintain an integrated family.

In the process of assuring the integrity of the family, three major categories were identified by fathers: ‘protecting the wife–baby dyad’, ‘concentrating on the baby’s health and growth’ and ‘possessing a complete family’. Subcategories within each major category also emerged.

Protecting the wife–baby dyad

Most couples had wanted for a long time to have a baby to inherit their family name. However, shortly after the husband learned that he was to become a father, the mother-to-be began to have an unstable pregnancy. Either one of the twins in the womb was found to have defects upon ultrasound or the mother had abnormal signs or uncomfortable symptoms such as infection, severe vomiting or bleeding. ‘Protecting the mother–baby dyad’ refers to actions taken by the father to take care of the mother and, indirectly, to save the unborn baby. The fathers searched for resources as best as they could. They accompanied their wives to see the best doctors they could find to stabilise the pregnancy. One father whose wife had had a miscarriage before said:

We did prenatal exams in two different hospitals. The prenatal exam took us lots of time and I went with my wife every time.... Both doctors were very famous. We asked one doctor questions and went to the other doctor to double check the answers. We let both

¹ The ‘doing the month’ practice, which is based on the yin-yang concept tracing back to ancient times, is a traditional ritual in the Taiwanese postpartum period (Heh 2004). The purpose of ‘doing the month’ is to help postpartum women recover from delivery. It is believed that the quality of ‘doing the month’ can affect women’s later health (Lin & Chen 1999). In the past, during the first month after the birth of a newborn, postpartum women were encouraged to eat and rest and follow rules (Hung 2001). These rules included consuming Chinese herb soup and sesame oil chicken for body recuperation and to supplement nutrition and avoiding going out and blowing wind so as not to catch a cold. Usually their mothers-in-law or their own mothers were key care providers for these women. Now, a couple can also pay a postpartum centre to assist the mother in completing the ‘doing the month’ practice.

doctors know that we did the double checks. I don't feel that we offended them [the doctors]. We just wanted to be sure that everything was OK.

Most fathers urged their wife, who was on bed-rest, to eat as much as she could so that the foetus might grow bigger. However, premature labour and delivery continuously threatened the paternal role.

Making difficult decisions in complicated situations

The instability of the pregnancy confronted the father with the likelihood that the father-to-be period would be shortened and his plan for participating in the labour process would have to be altered. The father had to make careful decisions in unfamiliar circumstances. These fathers sought information from friends, relatives and health professionals and based on this information, formulated a plan of action that would be the best for the mother and the foetus.

After the premature birth, the fathers felt astonished and they ached when they saw the VLBW newborn's size and the tubing in the baby's body in the NICU. The fathers would try to stay calm and learn unfamiliar medical terminology, to decide what to do. In the meantime, they had to comfort the mother and other family members. Although these fathers mediated between the mother and the neonatologist, almost no fathers revealed to their wife the baby's true health condition at first. One father who decided not to let his wife and the grandparents know that the newborn was undergoing resuscitation immediately after the birth said:

That day was so chaotic. The doctor told me to sign the consent form and explained to me but I could not hear anything. I didn't know what to do... yeah...don't know how to describe...I had no courage to let my family, my in-laws and my wife know the situation.... I just thought it was better not to tell them. You had to play so many roles and make the family feel less worried.

Fear of losing my wife and baby

Despite being informed of the unstable condition of the mother and unborn baby, most fathers did not expect a premature birth to occur. During the wife's hospitalisation for halting early labour signs, the father thought that his wife would undergo procedures to prevent premature birth for a period of time. Thus, when his wife began labour prematurely, the father felt overwhelmed. Fathers were afraid of losing the mother and the baby. Several fathers mentioned that they started prioritising who to save first. One father whose wife had placenta previa said:

I felt so helpless. When my wife suddenly was in labour, my first thought was to save my wife first, if asked by the doctor. Not until my wife went to the recovery room and I made sure that she was OK, then you tried your best to save the baby.... I saw them trying to rescue my baby. I really did not want to watch but I also was afraid I would never have a chance to see him [the baby] again. It was a very strange feeling....You just felt life was so fragile.

During the baby's long stay in the NICU, the fathers still felt uncertain of their baby's survival. Some fathers believed that if the baby was fated to live with them, the baby would overcome the health crisis but otherwise would not survive. When the fathers were at home or at work, they felt fearful and tense when the phone rang, fearing that a phone call from the hospital would give notice of the baby's worsening health.

Concentrating on the baby's health and growth

After giving birth, the mother usually stayed in the hospital for 3–5 days and then was discharged home to 'do the month'. Therefore, during the first month of the baby's hospitalisation, the father was the primary person to visit the baby in the NICU and convey information to the mother. Almost every day, the father came to the hospital and watched the baby's health condition.

Adjusting daily schedule to meet the wife's needs

Fathers scheduled time after work or took hours or days off from work to visit the baby in the hospital. Besides reporting the baby's progress to the mother, fathers were responsible for delivering the mother's breast milk to the NICU. The fathers told of being exhausted by running between office, hospital and home during the baby's hospitalisation but felt this was the least they could do.

After 'doing the month', when the mother went to visit the baby, the father might accompany her. Even after the baby was discharged from the hospital, some fathers would take the baby back to the hospital for check-ups if the mother requested this. During the first few months after the baby went home, almost every father came home immediately after work to take turns with his wife in caring for the baby. Fathers limited their social lives with friends so that they would have more family time. Four babies in our study needed to participate in a rehabilitation programme in their late infancy and in these cases, the father accompanied the mother and the baby to see therapists either voluntarily or at the mother's request.

Monitoring and promoting the baby's progress

The fathers used a variety of ways to care for their babies. When visiting a baby in an incubator, most fathers said they would only 'watch' the baby during the first few visits, either because the baby was so tiny or because they were afraid of passing bacteria to the baby. Some said they were not told by the medical staff when they could hold the baby. One father said: 'I even told my wife not to touch the baby. What if we passed germs to her [baby]? She was already so fragile. I would rather wait until she was bigger and stronger'. Fathers often made connections with their babies by talking, singing and reading to them. Some silently encouraged their baby to keep great spirits. Many fathers would not touch the baby's body or hold the baby until the baby moved out of the incubator. Most continued to practice strict hand-washing procedures before touching the baby at home and asked other family members and guests to follow this rule for months.

The baby's body weight was one of the indicators most frequently tracked by the father, as increasing weight could mean that the baby was 'healthy' and 'closer to discharge'. One father recorded daily in his cellular phone the baby's weight, intake and follow-up exam results for several months after the baby's discharge. Another father wrote the data in a journal that he had prepared for the baby.

Possessing a complete family

Fathers felt 'a sense of family' in finally being able to live together with their wives and babies. The feeling grew when the baby's health status improved and the baby's interactions with the father increased.

Delayed joy in being a father

Fathers experienced 'being a real father' at different time points. Some had the feeling the first time they touched the baby in the hospital. One father whose baby had been hospitalised for four months said, 'In the beginning [of the baby's hospitalisation], I went to the hospital just to see him. Later, every day after work I would rush to the hospital to talk to him, call his name and touch him. I felt differently by touching him everyday'. Other fathers said they did not feel like a father until they could finally hold their baby, usually close to the baby's discharge. Fathers who did not have a chance to hold their babies during the hospitalisation experienced a more delayed feeling of being a real father. When holding the baby, although the father was still worried about his baby, he felt joy at being a father. One father shared his experience in the special care nursery:

If she [baby] was stable, the nurse would let me hold her. I usually held her for 30 minutes to one hour, pretty long...Every time I held her, her blood oxygen level would go up but not when her mom held her. The nurses said she liked her daddy more.

These fathers experienced a hectic lifestyle after the baby's discharge home but figured out ways to bring things under control. Then they had time to enjoy having a 'special and brave' baby who had successfully fought for life and they shared their pride with others. Fathers also shared their child-rearing experiences to comfort other parents who had had a premature baby. In the baby's late infancy, the fathers not only enjoyed seeing the baby's developmental progress, but also looked forward to having more interactions as the baby grew older. Even for infants who had severe morbidities and possible developmental delays, most fathers maintained a positive attitude.

Moving to a supporting role at home

The father gradually re-established his work schedule after the baby went home and he felt responsible to make more money to raise the child. Some fathers supported their wives in quitting their jobs because they did not feel safe having others care for their fragile baby. Three of the 12 mothers went back to work during the baby's late infancy. Fathers often described themselves as assistants to their wives at home. One father said:

My wife read a lot of childrearing books and she would share what she read about how to take care of a baby. I listen to my wife and just do whatever she wants me to do. In general, she [wife] made a plan and I helped her to execute the plan.

Most fathers preferred doing house chores (e.g. buying daily groceries, cleaning bottles) than doing direct physical care activities (e.g. feeding the baby, bathing the baby). The fathers in single-earner families often helped only by holding the baby or occasionally playing with the baby. These fathers acted as short-time caregivers to ‘watch’ the baby when the mother needed to be away temporarily or needed to rest. One father whose wife went back to work in the baby’s late infancy described how he perceived his paternal role:

I probably share one third of the load in taking care of her [the baby]. When her mom needs to do something else, I will take over holding her, play with her or rock her to sleep.... I am not sure how the other fathers function in their role but I believe I have done my ‘father’s duty’ pretty well. I’d give myself 70–80 points if not 100 points.

Discussion

From father-to-be to being the father of a VLBW infant, these fathers went through ‘protecting the wife–baby dyad’, ‘concentrating on the baby’s health and growth’ and finally ‘possessing a complete family’. Commonly, the transition to fatherhood is described as occurring during the wife’s late pregnancy. In our study, premature birth shortened the process of transition to fatherhood in the pregnancy period: fathers had to face an immediate crisis. In addition, the long hospitalisation resulting from the premature birth prolonged the process of transition after the birth. Therefore, the experiences of these fathers of VLBW infants in the transition from their role in the husband–wife dyad to their role in the father–mother–baby triad differed somewhat from those of fathers of full-term infants.

Even with today’s advanced technologies and treatments, the fathers in our study were afraid of losing their wives because of the urgent delivery they underwent. The fathers focussed on the mother’s health condition first and then shifted concern to the newborn after the wife’s health became stable. Some fathers felt that the survival of the VLBW infant was a matter of fate. During the long hospitalisation, most of these Taiwanese fathers chose not to touch or hold the baby until the baby was ready to go home, although doing so provided them with a sense of fatherhood. The father’s fear of passing germs and minimal encouragement by the nursing staff to touch the baby contributed to the touch-avoidance observed in this study.

As in several Western studies (Miles *et al.* 1996, Lee *et al.* 2006), fathers provided significant support to the mothers when the newborn was admitted to the NICU. However, the traditional cultural practice of the mother ‘doing the month’ facilitated early paternal involvement in our study. Whether the mother chose to practice this ritual partially or completely, the father had to take primary responsibility for visiting the baby, making medical decisions, monitoring the baby’s progress and transporting breast milk. Such visiting in the first month of the hospitalisation established a special paternal–infant bond. The father took care of all of his baby’s needs and acted as a messenger between the mother and the baby during this time.

The feeling of having a real family and togetherness, found in studies of fathers with a full-term infant (Anderson 1996, Chandler & Field 1997), was gradually experienced by the fathers in this study. These Taiwanese fathers of VLBW infants readjusted their daily schedules and went home early to enjoy the family atmosphere. But their provision of direct child care activities at home depended on their perceptions of the paternal role. The traditional thought that ‘the mother could do a better job with a child’s physical care’ was still in the minds of these modern Taiwanese fathers. They provided primarily indirect child care with minimal direct child care, yet felt that they had done a lot in their infant’s first year. Most fathers chose to play a ‘secondary child-rearing role’ in the family and expressed willingness to ‘help’ their wives in taking care of the child rather than perceiving themselves as the main child caregiver (Wang & Yu 1997). Even if the fathers were actively involved in child care at the beginning of parenthood (during the pregnancy and the infant’s hospitalisation) and after the baby was discharged from the hospital, the father’s identity was gradually asserted during which time the father took less initiative regarding direct child care. As in Pohlman’s (2005) study, they approached their work with a renewed sense of fervour to provide financially for their families. In addition, like the Pohlman fathers, these fathers felt heavier financial responsibilities than before they had the baby.

Relevance to clinical practice

Because of the unstable pregnancy and the postpartum practice of their spouses, these fathers of VLBW infants actively participated in prenatal care and in infant care during the first month after discharge. A support programme should be provided to fathers in the high-risk prenatal clinic until the postpartum follow-up. Possible consequences of premature birth should be introduced to couples in the high-risk prenatal clinic so that expectant parents are aware of the situation they may encounter in the near future. These fathers of VLBW infants did not feel that they were a father until they touched or held the baby. Nurses in the NICU and special care nursery should assess each father’s readiness for fatherhood and, while giving support, encourage fathers to touch and hold the baby.

Conclusion

Our study supports McBride and Rane (1997) view that the paternal role should not be focussed on nurturing and caregiving aspects to the exclusion of other components. Our fathers learned to play different and broader dimensions of the paternal role and continually make adjustments during the transitional process to assure their family’s integrity.

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Contributions

Study design: TYL, THH; data collection and analysis: THH, CHH, TYL, HRL and manuscript preparation: TYL, HRL, RB.

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