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RESEARCH

EXPERIENCES OF THE FATHER/MAN IN CARE OF THE HOSPITALIZED PREMATURE CHILD

VIVÊNCIAS DO PAI/HOMEM NO CUIDADO AO FILHO PREMATURO HOSPITALIZADO

EXPERIENCIAS DEL PADRE/HOMBRE EN LOS CUIDADOS DEL HIJO PREMATURO HOSPITALIZADO

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ABSTRACT

Objective: to apprehend the representations of the father/man regarding the care of premature and/or very low weight hospitalized children, with the support of a protocol of care directed to the father performed in a neonatal unit of a school hospital in the northern region of Paraná. **Method:** this is a qualitative research with 15 parents interviewed between June and December 2016. For analysis, the theoretical reference of Social Representations was used, following the Collective Subject Discourse (DSC) method. **Results and Discussion:** after analyzing the data, five main ideas emerged: Pleasure in caring; Reinforcement of paternal identity; Overcoming Fear; Appropriation of the caregiver role and the importance of staying in the hospitalization unit. Final **Considerations:** it is necessary that the father figure is more present during the hospital stay of a premature child, and consequently more inserted in the accomplishment of the care.

Keywords: Father-Child Relations; Infant, Premature; Intensive Care Units, Neonatal.

RESUMO

Objetivo: *apreender as representações do pai/homem frente ao cuidado ao filho prematuro e/ou de muito baixo peso hospitalizado, com o apoio de um protocolo de cuidados direcionados para o pai, realizado em uma unidade neonatal de um hospital-escola da região norte do Paraná.* ***Método:*** *trata-se de uma pesquisa de abordagem qualitativa com 15 pais entrevistados entre junho e dezembro de 2016. Para a análise, utilizou-se o referencial teórico das representações sociais, seguindo-se o método do discurso do sujeito coletivo (DSC).* ***Resultados e Discussão:*** *após a análise dos dados emergiram cinco ideias centrais: prazer em cuidar; reforço da identidade paterna; superação do medo; apropriação do papel de cuidador; e a importância da permanência na unidade de internação.* ***Considerações finais:*** *é necessário que a figura paterna esteja mais presente durante a internação hospitalar de um filho prematuro e, consequentemente, mais inserida na realização dos cuidados.*

Palavras-chave: *Relações Pai-Filho; Recém-Nascido Prematuro; Unidades de Terapia Intensiva Neonatal.*

RESUMEN

Objetivo: *entender las representaciones del padre/ hombre ante los cuidados del hijo prematuro o de muy bajo peso internado, con ayuda de un protocolo de atención dirigida al padre. Se trata de un estudio realizado en la unidad neonatal de un hospital escuela del norte de Paraná.* ***Método:*** *Investigación cualitativa llevada a cabo con 15 padres entrevistados entre junio y diciembre de 2016. Para el análisis se utilizó el referente teórico de las representaciones sociales, según el método del discurso del sujeto colectivo (DSC).* ***Resultados y discusión:*** *tras el análisis de datos surgieron cinco ideas centrales: placer en cuidar; fortalecimiento de la identidad paterna; superación del miedo; apropiación del rol de cuidador e importancia de la permanencia en la unidad de internación.* ***Consideraciones finales****: la figura paterna debería estar más presente durante la internación hospitalaria de un hijo prematuro y, consecuentemente, más comprometida con la realización de los cuidados.*

Palabras clave*: Relaciones Padre-Hijo; Recien Nacido Prematuro; Unidades de Cuidado Intensivo Neonatal.*

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INTRODUCTION

After the birth of a premature newborn (NB), a long period of hospitalization begins within a neonatal intensive care unit (NICU), transforming the idealization of parents into bringing a healthy newborn home into a reality with fear and frailties. This event brings sudden social and cultural changes to the whole family, strengthening family ties.[1]

It is common that, after delivery and during the hospitalization process, the health team has the mother as the main reference for care, because it has been historically built the idea that she is the custodian of the child rearing and maintenance of marriage, while the father is responsible for providing and maintaining the home. However, with the social changes experienced in recent times and the new family configurations, these roles are shared, and the father is also seen as the caregiver of the children, the house and the conjugal relationship.[2] However, there are difficulties and resistance in the parents for the newborn (NB), especially the premature infant, and it is important that the health professional responsible for prenatal care, childbirth and NB care encourages the participation and care for the father.[3]

After the birth of a premature newborn, the most common feelings expressed by the parents are fear, insecurity, and impotence, when faced with a child other than expected, often dependent on devices and drugs to survive. Thus, it is common that there is a fragility of the affective bonds between parents and children in the NICU environment, because of these feelings, and also because of the prolonged hospitalization period, the routines of the institution, the clinical instability of the newborn and the fear of death of their son.[4]

The premature NB needs touch, neck, and maternal and paternal care since as a result of factors unfavorable to its intrauterine permanence, it was taken from an environment conducive to its development, where it was comfortable, and abruptly received in another completely different, often away from the family.

The good relationship with the nursing team favors the narrowing of the family bond since the nurse is who invites the family members to perform the first care. The first time the father has his child on his lap is of paramount importance to encourage him to perform other care activities.[5]

The length of stay of the parents in the NICU can clarify some situations and feelings facing the hospitalization of the child. Some parents feel that they are not able to care for their NB in the same way as the health team, and because of this, they are absent from the unit or remain static for hours beside their child's incubator because they feel some kind of guilt situation.[2]

For the parents to feel encouraged to touch and caress the hospitalized child, they need to be encouraged and have confidence in the health team. This trust begins to be built when the family first enters the NICU and must be accompanied by the nurse, who is responsible for hosting the father and/or the person responsible for the NB.

After the parents become familiar with the NICU staff and environment, many of them see the unit as a recovery, life-seeking environment, no longer as something to limit and frighten them. From that moment, they see themselves as an important part of the process of recovery of the child and begin to assume more intensely the responsibility for the care, which is understood not only as an action, but as an act of love, of building paternality.[2]

Therefore, the need and importance of the insertion and participation of the father in the care of the hospitalized premature child is perceived. Therefore, the purpose of this study was to apprehend the father/man representations regarding the care of the premature and/or very low weight hospitalized children, with the support of a protocol of care directed to the father.

METHOD

This study includes a large research project entitled "The father in the care of premature and low birth weight neonates hospitalized in a neonatal intensive care unit", funded by the *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (CNPq).

The qualitative research was used to carry out this study. Qualitative research facilitates understanding of the meaning of a particular problem in the individual's life. It consists of a set of material and interpretative practices that give visibility to the world, transforming it into a series of representations, with the purpose of understanding or interpreting phenomena.[6]

The study scenario was the NICU and the neonatal intermediate care unit (IMCU) of a tertiary university hospital located in the northern region of Paraná. Accredited by the *Sistema Único de Saúde* (SUS-BR), this hospital acts in the provision of health care in practically all medical specialties, human resources training, continuing education, research and technological development and carries out technical and scientific cooperation with the health services network of Londrina by providing services such as laboratory tests, research and treatment of genetic diseases. The structure consists of medical-surgical and pediatric hospitalization units, as well as maternity, center-surgical, emergency room and adult ICU, pediatric and neonatal unit. The neonatal unit has 10 neonatal intensive care beds, 10 neonatal intermediate care beds, and four intermediate neonatal "*kangaroo*" care beds.

Fifteen fathers who had their low birth weight preterm infants admitted to the NICU/IMCU from June to December 2016 participated in the study and performed care proposed in the newborn care protocol directed to the father. This protocol has 14 activities: a) touched/nurtured the NB; b) picked him up on his lap; c) did *kangaroo*; d) did eye hygiene; e) did oral hygiene; f) changed diapers; g) bathed; h) put the NB to sleep or to calm down; i) assisted the mother to breastfeed; j) admin-

istered oral medications; k) offered a prescribed bottle; l) offered prescribed milk in the glass; m) demonstrated knowledge about disengagement maneuvers and danger signs; n) demonstrated knowledge about milking.

After the admission of low birth weight preterm infants in the NICU/IMCU, the father was personally invited by the researchers, informed about the research objectives, data collection procedures, confidentiality of information, possible risks and the possibility of interrupting participation at any time, without prejudice to their activities or hospitalization of their child. With the agreement of the father approached, they were asked to sign the term of free and informed consent, as a way in possession of the researcher. The inclusion criteria were: parents who had preterm children with gestational age of less than 34 weeks and/or weight less than 1,500 grams (n=32). The exclusion criteria adopted were: parents who did not perform the care proposed in the care protocol for the father (n=15) and preterm infants who died during hospitalization (n=02). Therefore, the sample consisted of 15 fathers who effectively participated in the care protocol.

The interviews were scheduled in agreement with the father, occurring at the moment of discharge, performed individually, in a place intended for parents in the physical space of the NICU, guaranteeing the privacy and minimum interruptions.

Data collection was performed from April 2016 to February 2017, through a semi-structured interview with two parts: the first one related to the characterization of the fathers and the second one referring to the objective. The guiding questions used to motivate parents´ speeches were: "What care could you carry out with your child?"; "Tell me about the easiest and most difficult care"; "Do you believe that you could have done some more care that you did not do? Talk about it"; "Is there any care you have performed, but would you like not done? Talk about it".

The average duration of the researchers´ meeting with the fathers was 20 to 40 minutes, considering the initial interaction and the interview.

The interviews were recorded and a field notebook was used to synthesize the researcher. At the end of the interview, the father was asked to listen to the recording of the interview and to read the summary performed, granting him the right to change the information if he thought it was necessary.

The theoretical reference adopted for data analysis was the theory of social representations, considered an interpretation of reality that presupposes that there is no distinction between subject and object of research: once all reality is represented by the individual, all representation is a global and unitary view of an object. For the subject to form this global vision, it uses elements of everyday facts and common-sense knowledge.[7,8]

Then, the methodological reference of the Collective Subject Discourse (CSD) was used, which is a methodology of organization and tabulation of qualitative data of a verbal nature, obtained from testimonials. The purpose of this discourse is basically to analyze the collected verbal material, extracting four methodological figures from the speeches (key, central idea, CSD and anchorage expressions) to organize, present and analyze the data obtained through the testimonies. Thus, the results are presented as one or several speech-synthesis, written in the first person singular, aiming to express the thought of a collectivity, as if this collectivity were the emitter of a discourse.[9,10]

The study was approved by the *Comitê de Ética em Pesquisa* of the *Universidade Estadual de Londrina* – UEL, through CAAE n. 30709814.0.0000.5231, Opinion number 694,303. The name of the interviewed father was replaced by the letter F followed by numerical sequence to protect the identity of participants.

RESULTS AND DISCUSSION

Brief characterization of the fathers indicates age between 21 and 50 years old. One of them had incomplete elementary education, three had completed elementary education, seven had completed high school, one had incomplete secondary education and three had completed higher education; their marital status was, 13 declared as married, one in consensual union (seven years ago) and one single, but in a relationship with the mother; 10 already had other children, and one father had already experienced a premature birth and hospitalization in NICU and five were experiencing paternity for the first time.

From the CSD technique, the collected data were analyzed, obtaining the central ideas and their corresponding key expressions that were grouped according to their similarity, composing the speech-synthesis in the first person singular - the collective discourses, representative of the reality that it is proposed to study.

Therefore, from the analyzed empirical material, five central ideas (CI) emerged: pleasure in caring; reinforcement of paternal identity; overcoming fear; appropriation of the caregiver role; and the importance of staying in the hospitalization unit.

CI 1 –Pleasure in caring

> CSD 1 – *It was a very good feeling, very nice. I felt important, I felt great. It is good to participate in a little of the process, a duty fulfilled. We keep getting love. I felt she felt more comfortable. Being able to help a little, especially when the mother could not be here, helped in her evolution. I advise that every father try to care for their children in the NICU* (F1, F2, F3, F4, F5, F6, F9, F11).

When the fathers began caring for their newborns, they showed feelings of happiness and fulfillment. Touching and

caring for the child made the feeling of paternity possible, enabling to dedicate entirely to the newborn and to be the center of care. This moment also allowed experiencing the reactions that the NB presented during the care provided by the father. Corroborating a study regarding the facilities and barriers of hospitalization of the hospitalized premature child according to the father's perception, it was observed that the father's participation was "more or less" intense and this is due to the child's health status, the individual values of the fathers about the care and environment of the NICU.[11]

The father is an important figure in the birth and follow-up of the child and has relevant feelings, especially in the birth of the premature child and the need for the child to be admitted to a NICU, revealing the need for the professionals of this unit to include the paternal figure in the care of the newborn premature hospitalized, allowing him to fully experience his fatherhood.[4]

It can be seen that at first, the father had no understanding that he could perform care, but when encouraged by the nursing team, this fact awakened him to practice his fatherhood.

CI 2 – Reinforcement of paternal identity

> CSD 2 – *I thought I could not [perform care], it was just the mother, but we see it's ours, it's part of us, it's another piece of us. It is such a small thing and such a big responsibility on our hands. What I dreamed the most was being a father* (F8, F9, F14).

When experiencing the process of caring for the hospitalized premature child, the father realizes the importance of being a father and at that moment, he concretizes the meaning of being a father. The early involvement of parents and family members in the care of premature newborns is fundamental for the promotion of affective bonding.[3]

Life renews and transforms, where the man starts rethinking his values, his attitudes, and thoughts. It is the birth of the new father that breaks with the preconceived stereotypes of the domineering, inseminating and insensitive male. For the new conceptions of gender in which man actively participates in the creation of children, demonstrating their emotional and affective involvement is the concretization of shared responsibility with the woman, new times dictated by the new society.[12]

However, when faced with such a small and fragile child, the father believes that he will not be able to help him, and at that moment feelings such as fear emerge, as observed in the following speech.

CI 3 –Overcoming Fear

> CSD 3 – *At first I was afraid, a little tense, afraid to hurt, to choke, to drop him. We're very rude, right? He is very small, premature, and I have no experience, but I have been improving. It is not difficult, it is really afraid* (F2, F3, F6, F10, F14).

The fragility linked to prematurity arouse a feeling of overprotection of the newborn son for the fathers, making them believe that what is best for their child is not to be touched or manipulated by them, only by the professionals, because they believe that they do not have the delicacy and the skills required to do so. This is due to the lack of knowledge of the causes and consequences of prematurity and also due to the lack of information about the intensive care unit where the newborn is found.[2]

In a study regarding the experience of the father in the discharge of the premature child of the NICU, it was observed that the fathers felt powerless in the situation experienced by the child, as well as in the identification of lack of care for him. Thus, some fathers withdrew from the hospital setting due to limitations in dealing with the suffering caused in them showing feelings like fear and anguish for child care at home and reflections on how to exercise their fatherhood.[13]

Regardless of the complexity of the care that the father performs in the neonatal unit, at first he feels that he will not be able to take care of the child, but after performing the first care, he feels fulfilled despite the difficulties.

The meanings given by the father to the care of the premature child in the NICU revealed that following the recovery of the child, enjoying being with the NB and being recognized as a parent are motivations that lead him to face all the obstacles and difficulties to stay as long as possible in the NICU. However, fathers often feel unable to perform care such as bathing, diapering, and feeding, and taking the infant to their laps, particularly in the case of premature infants.[14]

During the hospitalization, it is noticed that the fathers change their point of view regarding their participation in the care of the hospitalized child, replacing the initial fear for the pleasure to be able to take care, as they occur the improvement of the health picture and the acceptance of the difficulties and the interaction with the health team.

> CSD 4 – *The first kangaroo was the most difficult. He was full of things, everything was beeping. Changing his diaper also made me very nervous, it was not easy, we cannot, we have no ability in the beginning. Difficult even when he has access, manipulating it, put in the incubator, then I took care without difficulty, it was very good. When*

there is a procedure, I run, because if I see him, I get a little mad (F10, F13, F14).

The health situation of the child at the moment of the father's care is decisive for the interpretation of the paternal feelings. The parents of newborns in critical condition and/or need more equipment either for vital signs monitoring or for drug administration show more insecurity and fear for the care, due to the lack of knowledge of the hospital equipment. This situation is mitigated during the hospitalization period, by the opportunities created by the team to insert the father into the routine of the child's care and by the daily learning for the operation of the hospitalization unit, making the father an empowered person of his role, as described in the following speech.

CI 4 – Appropriation of the caregiver role

CSD 5 – *I did all the care from a father and mother, it is our duty. What we could do, we did it. And if I can do it then I have more to help, right?! I felt that it helped in her evolution* (F1, F6, F12, F14).

After the birth of the NB, the fathers were confronted with the separation, the technological devices, the incubator and the recommendations of the health team, which naturally limit the possibilities of care and interactions, thus the importance of the insertion of these fathers into care[15].

For the fathers, caring is action, and it is evidenced by touch, food, hygiene, lap, among other activities that positively influence the recovery of the child, and, unconsciously, the strengthening of the paternal bond, re-meaning his role in the family.

The father often assumes the role of a helper after childbirth by understanding that the woman needs support and assistance in facing the hospitalization of the newborn child, especially when her partner is discharged and the child remains hospitalized.[3]

In this context, the father realizes that his presence is necessary and important for the recovery of his son, as observed in the speech of some fathers.

CI 5 – The importance of staying in the hospitalization unit

CSD 6 – *We stay with him, and that's important. I could have changed him, but someone always came or I had to leave soon enough. I could come more often. I also wish I had slept in the unit, so I could help the mother more at night. We feel that when I can stay longer my son has been improving much faster, we get to know better what he feels, if he is in pain, if his position is not pleased, it is turning red, if the belly is growing and this is not normal* (F4, F6, F8, F14).

As they spend more time with the hospitalized child, the parents make the hospital their home, often staying longer in the institution than any other place.[2] This may be indicative of strengthening the paternal and family identity, especially if this increase in time of permanence is associated to the improvement of the health status of the NB, since the improvement of the general picture allows a range of care and procedures that can be performed and assisted by them. On the other hand, if somehow the parents are feeling excluded by the team or distrustful of the care provided to the child, this also increases the hours spent in the unit.

Besides the discourses evidenced by the research, other details were observed regarding the behavior of the fathers.

Not all fathers had full awareness of care. On several occasions, they failed to name the care they had taken with the child when questioned. This lack of clarity can be interpreted in two ways: fathers were already used to caring frequently, and for that reason they no longer considered them to be relevant to their child's well-being; or they did not know they were taking care when it was done indirectly, such as helping breastfeeding.

Another important fact is that the fathers whose children remained hospitalized for a longer time showed a better appropriation and dexterity of care. Therefore, these parents remained longer within the unit and had a closer link with the health team.

The level of father involvement and participation in the care is closely linked to work, and men who get leave or vacation or have flexible hours of activity are more likely to be present.[3]

More experienced fathers, who already had other children, more often used expressions such as "normal," "not new," "I've done it before," when asked about their feelings of caring for their child. Despite the experience of prematurity, these parents were able to adapt the way they performed daily tasks to the hospital reality, based on previous experiences.

As a limitation of the study, the low participation of the fathers in the care of the hospitalized child due to work difficulties is mentioned. This limited the representations of the fathers regarding care to the premature child, which may represent a study bias.

Final considerations

After analyzing and interpreting the statements obtained, it is considered that the objective of the study was reached since it was possible to identify the feelings and representations experienced by the fathers in the speeches when performing care with the children still hospitalized. It is again emphasized that feelings of fear and insecurity are frequent, especially at

the beginning of hospitalization, when parents are not yet used to the environment, the team, and when the severity of the health status of the newborn is greater.

Knowing that the father is generally the member of the family to have the first contact with the premature child hospitalized in the neonatal ICU, it is extremely important that the team is careful to carry out the first approach in the best possible way, offering clear information about the NB health picture and identifying opportunities to insert the father into the care, even if minimal.

The study showed that fathers wish to participate more in the care of the premature children and the use of the protocol of care directed to the father enabled their insertion in the care, showing their need to perform care to the newborn in the unit and also after discharge.

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