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PATERNAL CARE FOR HOSPITALIZED PREMATURE CHILDREN: MATERNAL REPRESENTATIONS

O CUIDADO PATERNO AO FILHO PREMATURO HOSPITALIZADO: REPRESENTAÇÕES MATERNAS

EL CUIDADO PATERNO AL HIJO PREMATURO HOSPITALIZADO: REPRESENTACIONES MATERNAS

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Objective: to get to know the maternal representations about the meaning of the paternal care of their premature child hospitalized in the Neonatal Intensive Care Unit. Method: qualitative study conducted with 15 mothers interviewed between May and December 2016. The Social Representations framework was used to undertake the analysis pursuant to the Collective Subject Discourse method. Results: five central ideas emerged: the father's care for the premature child generates satisfaction for the mother; valuing of the father's need to learn to care for the child; valuing the importance of the care the father gives to the hospitalized child; uncertainties about the father's ability to provide care, and fears and progress in the process of providing care. Conclusion: in general, the father's presence in the provision of care brought positive feelings to the mothers, reinforcing the need for the father to remain in the neonatal unit, providing emotional support to the mother and strengthening the family bond.

Descriptors: Neonatal Intensive Care Unit. Premature. Family. Nursing Care.

Objetivo: conhecer as representações maternas sobre o significado do cuidado paterno ao filho prematuro internado em Unidade de Terapia Intensiva Neonatal. Método: estudo qualitativo com 15 mães entrevistadas entre maio a dezembro de 2016. Para análise, utilizou-se o referencial das Representações Sociais, seguindo-se o método do Discurso do Sujeito Coletivo. Resultados: emergiram cinco ideias centrais: o cuidado do pai com o filho prematuro gera satisfação para a mãe; valorizando a necessidade de aprendizado do pai para o cuidado do filho; valorizando a importância do pai no cuidado ao filho hospitalizado; incertezas frente a capacidade do pai para realizar cuidados e medos e avanços no processo de cuidar. Conclusão: a presença paterna na promoção de cuidados, de modo geral, gerou sentimentos positivos nas mães reforçando a necessidade da permanência do pai na unidade neonatal, proporcionando apoio emocional para a mãe e fortalecimento do vínculo familiar.

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Descritores: Unidades de Terapia Intensiva Neonatal. Prematuro. Família. Cuidados de Enfermagem.

Objetivo: conocer las representaciones maternas sobre el significado del cuidado paterno al hijo prematuro internado en Unidad de Terapia Intensiva Neonatal. Método: estudio cualitativo con 15 madres entrevistadas entre mayo a diciembre de 2016. Para análisis, se utilizó el referencial de las Representaciones Sociales, siguiéndose el método del Discurso del Sujeto Colectivo. Resultados: surgieron cinco ideas centrales: el cuidado del padre con el hijo prematuro genera satisfacción para la madre; valorando la necesidad de aprendizaje del padre para el cuidado del hijo; valorando la importancia del padre en el cuidado al hijo hospitalizado; incertidumbres frente a la capacidad del padre para realizar cuidados y Miedos y avances en el proceso de cuidar. Conclusión: la presencia paterna en la promoción de cuidados, en general, generó sentimientos positivos en las madres reforzando la necesidad de la permanencia del padre en la unidad neonatal, proporcionando apoyo emocional para la madre y fortalecimiento del vínculo familiar.

Descriptores: Unidades de Terapia Intensiva Neonatal. Prematuro. Familia. Cuidados de Enfermería.

Introduction

The family is the most ancient social institution; however, it is noted that this concept is under continuous diversification, as are the activities performed by the individuals who make up the family unit[1]. The mother is usually in charge of childcare, while the father is responsible for supporting the family financially.

Because of cultural changes and of economic and social needs, the role parents play in caring for their children has changed, and, today, the father shares childcare with the mother, and is no longer accountable only for financial support. It is noticeable that fathers wish to have more participation in the provision of care to their children[2,3].

However, adverse events may occur, such as premature birth, and this may pose a threat to the man insofar as the safety and the concreteness of pregnancy within the paradigm of normality is concerned, leading him to experience feelings opposite to those desired, such as fear, worry, and yearnings.

Premature birth is a challenging experience that greatly alters family dynamics. Lack of preparation for fatherhood, the hospitalization itself, in addition to pain and isolation, contribute to a very difficult emotional situation for the family. There is joy for the birth of the long-awaited child, even if premature. On the other hand, there are also feelings, such as suffering, frustration, and a sense of incompetence due to the newborn child's frailty. Experiencing ambivalent feelings is almost a constant in a family that experiences premature child birth[4,5].

The fragility of the mother's health status immediately after birth renders it impossible for her to be the first one to accompany and provide care to her child in the Neonatal Intensive Care Unit (NICU). Thus, it is usually the father who has the first contact with the child in the unit and gets the first information and guidance from the health team[2,6].

It is a well-known fact that NICU care has undergone many changes in recent years, which can be attributed to the implementation of humanization care practices that have helped increase the survival rate of preterm newborns (PTNB) and of those with low birth weights[7]. Care is no longer centered solely on the newborn. It now also includes the family, a fact that leads to the need not only for the parents to be present, but also for them to be trained to provide care[3,8,9].

In Brazil, the promotion of family care is ensured under Ordinance n. 930, of May 10, 2012, which determines the participation of the mother and of the father, i.e., of the family, in providing care to the newborn[10], as a guideline.

To give the families of hospitalized PTNBs the opportunity to provide direct care and improve the quality of care provided in the NICU, by including the paternal figure in it, this study aimed to get to know the maternal representations

about the meaning of paternal care to the premature child admitted to an NICU.

Method

This study is part of a broad research project titled "The paternal figure in the care of premature and low birth weight neonates hospitalized in the Neonatal Intensive Care Unit," funded by the National Council for Scientific and Technological Development (CNPq). Based on a qualitative approach, the study used as its scenarios the NICU and the Intermediate Neonatal Care Unit (INCU) of a school hospital located in the northern region of Paraná, which is accredited by the Unified Health System (SUS). The NICU has seven beds in its neonatal area, while the INCU has eight beds.

Parents are not considered as visitors in the INCU and in the NICU, thus, they are encouraged to be with their children for as long as possible and can stay overnight at the unit. Other family members may visit at pre-established times. The care provided in the following unit allows parents to carry out activities to deal with the child and its special needs during hospitalization, and this participation is gradual and done according to existing possibilities. Preparations for discharge are initiated at the time of the child's hospitalization: The health team provides several moments of activities that help parents to take ownership of their caregiving role and, as a result, to become more confident in practicing PTNB care.

Study participants were 15 mothers whose low birth weight preterm infants were admitted to the NICU/INCU between March and December 2016, whose companions, the fathers of their children, performed the activities the protocol proposes for the fathers to provide care to the premature newborn. The Protocol features 14 activities: 1 - Touched/caressed the baby; 2 - Held the baby in his lap; 3 - Provided the kangaroo care, 4 - Did eye hygiene; 5 - Did oral hygiene; 6 - Changed diapers, 7- Bathed; 8 - Made the baby sleep or calm down; 9 - Helped the mother to breastfeed; 10 - Administered oral medications; 11 - Fed the prescribed bottle; 12 - Fed the prescribed milk in the cup; 13 - Was knowledgeable about choking maneuvers and danger signs; 14 - Was knowledgeable about milking.

After an infant with a very low birth weight and/or fewer than 34 weeks of gestational age (GA) is admitted to the NICU/INCU, the family was personally invited by the researchers, informed about the research objectives, about the data collection procedures, about information treatment confidentiality, about possible risks, and about the possibility of interrupting participation in the study at any time, without prejudice to their activities or to their child's hospitalization. With the agreement of the person in charge, it was requested that the informed consent be signed, and the researcher kept a copy of such consent. The inclusion criteria were mothers who had preterm children with gestational ages of fewer than 34 weeks and/or weighed less than 1,500 grams (n = 32). Exclusion criteria were mothers whose partners/fathers of their children did not provide the care proposed for the father in the care protocol (n = 15), and premature infants who died during hospitalization (n = 2).

This study was approved by the Research Ethics Committee of the State University of Londrina (UEL), pursuant to CAAE n. 30709814.0.0000.5231, as per Opinion n. 694,303.

Data were collected through a semi-structured interview, scheduled with the mother's agreement, and performed individually, in the parents' living room in the NICU, ensuring them privacy and minimum interruptions. The guiding questions used in the interview to motivate the mothers' to talk were: Could you tell me how you felt when you saw the father providing care to your child? What is your opinion about the father taking part in the care given to your child here at the hospital?

The researchers' meetings with the mothers lasted, on average, 30 to 40 minutes, including the initial interaction and the interview itself.

The interviews were recorded, and the researcher used a field notebook to summarize them. At the end of the interview, the mother was asked

to listen to the recording of the interview, and the summary was read to her. She was then asked if she thought it was necessary to change any information.

The researchers transcribed the interviews in full, which were then coded in the order they were held, as M1, M2, so on and so forth, for further discussion, preserving the participants' identity. The data were analyzed by reading the interviews transcribed to the computer using Microsoft Word Starter 2010; they were analyzed based on the theoretical framework of the Social Representations, which comprise a series of opinions, explanations, and claims produced based on the groups' daily life, and communication is a primordial element in this process. Social representation formalizes a particular mode of knowledge, the function of which is the preparation of behaviors and communication among individuals[11,12].

After collected, the data were analyzed pursuant to the Collective Subject Discourse (CSD) methodological framework. This is a methodology used to organize and tabulate qualitative verbal data obtained from testimonials. Basically, the purpose of this discourse is to analyze the verbal material collected, extracting four methodological figures (key expressions, central idea, CSD, and anchorage) from the discourses to organize, present, and analyze the data obtained through the testimonials. Thus, the results are presented as one or several discourse syntheses, written in the first person singular and aiming to express the thought of a collectivity, as if this collective were the emitter of a discourse[13,14].

Results

The mothers interviewed were aged between 16 and 41 years. Concerning their marital status, 11 state they were married, three in consensual unions, and one, single. Of these, six were experiencing maternity for the first time, and nine already had other children. The corrected gestational age on the day of the interview ranged from 31 to 39 weeks.

Based on the CSD technique, the collected data were analyzed, and the central ideas and their corresponding key expressions obtained, which were then grouped per similarity, composing the discourse synthesis in the first person singular – the CSDs –, representative of the reality that was proposed to be studied.

Therefore, five central ideas (CIs) emerged from the empirical material analyzed: The father providing care to the premature child generates satisfaction for the mother; valuing of the father's need for learning to care for the child; valuing of the importance of the father in the care given to the hospitalized child; uncertainties about the father's ability to provide care and fears and progress in the process of providing care.

The results showed that mothers experiencing the fathers holding their child in their laps, providing kangaroo care and/or other types of care, felt happiness and joy, and that was a moment of great emotion, as shown in IC1 to IC3.

CI1: The father providing care to the premature child generates satisfaction for the mother

> *CSD1: Oh, I felt happy, you know? You obviously are very happy, it is a great emotion, you know? I felt great joy, lots of happiness (M5 M6 M7 M13 M15).*

> *CSD2: I thought he did even better on the first day. Because I had not, I had not cleaned its eyes yet, and he cleaned them first. He did it exactly right, just as the nurse instructed him to do. Something I wasn't able to do. I made a mistake the first time, but he didn't, he got it right. He already gave it a bath. He did a kangaroo. He had already done it before; he has always helped, ever since the first child. He felt insecure, particularly because of her size, but it was very nice. I thought he was even better than I was (M7 M9).*

> *CSD3: To me it was normal, because he has always helped me; he has always helped, ever since the first child; he is a very present father, he helps me at home (M2 M9 M15).*

CI2: Valuing the need for the father to learn child care

> *CSD4: Oh, I think they do have to learn. It is not only the mother who has to provide care. The team has to teach them, so they can learn. They have to help the mothers, it is a relief for mothers. I think it is good, it is a good thing, for sure. It has to be the same for both. It is important for both to provide care (M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12 M13 M14 M15).*

> *CSD5: It is great, he will learn, and if he needs help at home, he will already know how to do it. Otherwise, he will go home and, I think, feel very confused. If he does not participate here, I think he would not want to participate anymore, because then he would be afraid to provide care at home. My hope is that he will help when he gets home, because there is another child, there is a house to take care of (M10 M11 M12).*

CI3: Valuing the importance of the father in providing care to the hospitalized child

> *CSD6: We know that it is more difficult for the father to come, because he has other commitments. He is doing all he can to stay longer, but he had to go back to work too; he comes every day after work, though. He does not stay longer because he can't; if it were up to him, he would stay here with me all the time. But he needs to work; he calls all the time, asking, wanting to find out if everything is okay. He is a great dad, and I have nothing to complain about (M6 M10 M14).*

On the other hand, because it was a new and different type of experience, they had feelings of tension and fear, because they felt that the father did not have the proper abilities to hold the child in their laps or to provide some types of care, since these are small, fragile babies, as seen in CI4 and CI5.

CI4: Insecurity with the father's ability to provide care

> *CSD7: The first time was tense. It looked like he was going to break the kid in half [laughs]. I will not lie, I was afraid, but he did well. Because he had never held a baby in his lap; he got used to it, though (M8 M10).*

CI5: Fears and progress in the caring process

> *CSD8: Oh, he always participates, he has the initiative, he worries, he controls everything. I can see that he can do more things, he evolved, he improved, because in the first days he was afraid even to put his hand in the incubator to touch the baby, then, in the end, he even gave it a bath. This was major progress, because he was really scared (M6 M8 M9 M10).*

Discussion

The results showed that the mothers considered the implementation of paternal care as a beneficial, positive experience. To some mothers participating in the study, the perception was that the father was not only able to provide care, but also that he did it better than she did, showing security and dexterity in the process. The study[4] in which the parents of preterm infants gained confidence after practicing the kangaroo method says that providing care to the hospitalized children reinforces paternal empowerment and increases their knowledge about the general state of the child.

For some mothers participating in the study, paternal care was not a totally exclusive and new activity, since some had experienced it before, when their companions took care of their first children.

This reinforces that care should come from both, and not be centered on the maternal figure. The mothers also focused on the continuation of this care in the home environment, since arrival at home is a critical period of adaptation of both the newborn and the parents to the new environment, because from that moment on they will be responsible for all the care given to the new member of the family[15]. They expect their companions to continue providing care to the newborn, keeping things organized at home, and caring for the other children.

Therefore, the health team should plan a culturally flexible care, valuing the presence of the family[16], and seek to insert, support, and encourage paternal care from birth, aiming at paternal empowerment and at facilitating the development of this care in the household scenario after discharge from the hospital.

Many mothers reported that their companions provided kangaroo care to their children, and this pleased them a lot. Skin-to-skin contact between the NB and its parents is highly beneficial, as it reduces the separation time between the family and the newborn by driving bonding and allowing for adequate thermal control to the newborn, helping reduce the risk of hospital infection, decreasing the newborn child's stress and pain, increasing breastfeeding rates, improving neurobehavioral quality and psychoactive development, providing a better relationship between the family and the health team, reducing the number of readmissions, and providing parents with greater competence and confidence in their child's care, even after

discharge from the hospital[15].To avoid maternal overload during the kangaroo care and to increase the time the PTNB is in kangaroo, it is recommended that the team seek to encourage families to rotate mother and father in providing the kangaroo position.

Another issue the mothers focused on was the importance of the companion's presence in the neonatal unit, which is referred to as a synonym of support, including for the baby. The mother's presence with the child in the neonatal units is highly valued, but it should be kept in mind that the woman needs a support network and, by valuing and encouraging the presence of the parents and promoting care for the baby, one can provide such help[9].

A study[6] on the paternal experience in a NICU considered that the father should no longer be regarded as a supporting actor in the preterm infant's hospitalization process; instead, he should go on to play a leading role, like that of the mother. For this to happen, managers should seek to change the paternal stay, which is only during visitation times, as it may be that these fathers can only go to the NICU at times other than their working hours. Becoming active in the care of their children from birth increases confidence in the development of their paternal role[4].

In another study carried out with parents who stayed at the hospital with their children and spouses to promote the kangaroo method during the newborn child's hospitalization, it was noted that the father's opportunity to remain close to his child facilitated the provision of care and helped in bonding with the baby to later take the child home[5].

The support provider role also belongs to the paternal figure. Men view this activity as an obligation they cannot fail in. Because they cannot be more present at the NICU with their children, as they would like to be, fathers experience intense stress[16,17]. In Sweden, paternity leave is 480 days. Health care is free, and both parents of a baby admitted to a NICU get temporary financial aid until their child is discharged from the hospital. During hospitalization, both father and mother have the legal right to be with their child instead of working[4].

However, in Brazil the situation is different. The current Brazilian law only allows the father to be away from work for five business days after the child's birth[18]. However, a very premature baby is usually hospitalized for an average of 45 to 60 days, rendering it difficult for the father to be present at the unit, since he needs to return to work to provide for the sustenance of his family and to tend to the other domestic chores while his companion needs to remain in the neonatal unit. The interviewed mothers report that this was a factor directly associated with the absence of the father during the hospitalization time and that there is the paternal wish for a longer stay, since they demonstrate this desire seeking information on the newborn child's health status as well as alternative times to be in touch with their child.

However, the mothers' fear of allowing their companions to provide care, as they believed that they were not prepared for such activity, also emerged in maternal discourses. This notion is linked to the macho culture that sustains the idea that men are unable to provide care to children. This maternal fear can be justified based on the fact that this is the father's first contact with such a small or very ill baby, with fragile, weakened looks, causing the mother to feel apprehensive while the father provides care.

However, the mothers also spoke about the evolution there was in skill development during the process of providing care to the newborn. They reported on the parents' concern with providing the care as instructed by the team and about the initiative of carrying out the proposed care. They said that the fear of touching because of the prematurity was diminishing with time, and that the feeling of security was increasing.

A limitation of this study is the low level of paternal participation in the provision of care to the hospitalized child due to work difficulties. This limited the maternal representations regarding paternal care, which may represent a study bias.

Conclusion

The results of this study show that the father's inclusion in the provision of care to the premature newborn generated ambivalent feelings in the mothers. While feelings of satisfaction emerged from seeing their companions provide care, they were also afraid when their partners had no ability or had more difficulty performing certain activities. The evolution in the father's ability to provide care to the newborn child led to improvements in care, and feelings such as security were noted among the mothers.

The fathers' permanence during the hospitalization process is important, not only as emotional support for mothers, but also to promote the paternal bond, knowledge, and security in the care that will be provided after hospital discharge. However, paternal absence in the process of providing care to the newborn is noted due to the father's return to work.

It is incumbent upon the health professional, especially the nursing team, to encourage and promote actions that allow the paternal figure to provide care to the PTNB, affording the families autonomy in the provision of care to their child.

Collaborations

1. design, project, analysis and interpretation of the data: Jéssyca de Oliveira Santana, Karen Isadora Borges, Daniele Amaral de Souza, Keli Regiane Tomeleri da Fonseca Pinto, Edilaine Giovanini Rossetto, Adriana Valongo Zani.

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3. final approval of the version to be published: Jéssyca de Oliveira Santana, Karen Isadora Borges, Daniele Amaral de Souza, Keli Regiane Tomeleri da Fonseca Pinto, Edilaine Giovanini Rossetto, Adriana Valongo Zani.

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