Being a Resource for Both Mother and Child: Fathers' Experiences Following a Complicated Birth

Kerstin Erlandsson, RN, RM, PhD

Helena Lindgren, RN, RM, PhD

ABSTRACT

The aim of this study was to describe fathers' experiences of being present on a postnatal ward and during the first days at home following a complicated birth. Fifteen fathers were interviewed, and content analysis was used for the analysis. The theme illustrated that fathers were a resource for both mother and child through practical and emotional engagement. The categories describe how the father empowers the mother and illustrates adapting to new family roles. Following complicated birth, fathers should be invited to stay around-the-clock on postnatal wards because it gives them the opportunity to place their resources at the disposal of mother and child. In antenatal courses, fathers should be prepared for their empowering role after a complicated birth.

The Journal of Perinatal Education, 20(2), 91–99, doi: 10.1891/1058-1243.20.2.91

Keywords: postpartum care, fathers, complicated birth, cesarean surgery, content analysis

The current focus in postnatal care for parents and hospital staff is often the care of the newborn (Elattar, Selamat, Robson, & Loughney, 2008). However, care of the newborn after a complicated birth may differ from the natural focus on care of newborn infants after natural childbirth (Erlandsson, 2007); in Sweden, care on maternity wards is mainly for women who have had a complicated pregnancy and/or childbirth (Ellberg, 2008). As the length of postnatal care has decreased (Ellberg, 2008; Odland, Haglund, Pakkanen, & Otterblad Olausson, 2003), parents' responsibility for care of the newborn has increased. The relationship between mothers and fathers has been perceived to become stronger

during postpartum care. Today's routines in postnatal care promote a sense of attachment for the couple. During the 48 hours after birth, 55% of the mother–infant dyads stay in postnatal care before discharge (Ellberg, 2008). Hence, a single room is often desirable because it enables the father to stay on the postnatal ward around-the-clock (Svensson, Matthiesen, & Widström, 2005).

Unfortunately, fathers have been shown to be significantly more dissatisfied with postpartum care compared with mothers, especially in regard to fathers' ability to influence care and to actively participate in decision making (Ellberg, Högberg, & Lindh, 2010). In answering open-ended questions,

parents have described the need to morally support each other, to share the birth experience, and to plan for the immediate future. They expressed their attachment to each other and sense of family (Ellberg et al., 2010; Fägerskiöld, 2008). In Sweden, being entitled to 10 days paternity leave as part of the Swedish Social Security System makes it possible for a father to participate and to be involved in the care of his newborn during the first 10 days after the birth of the child (Swedish Social Insurance Agency, 2009). Consequently, staff members who are working in postnatal and primary health care need to be aware of the fathers' perspective so that they can provide moral support that enables fathers to participate and influence care and decision making (Ellberg et al., 2010).

An increased knowledge of fathers' need for integrity to build an independent relationship with the child has also been emphasized (Ellberg, 2008; Premberg, Hellström, & Berg, 2008). In addition, research on the support needed by fathers in the childbearing period has been proposed (Bremberg, 2004, p. 49). In general, fathers wish to be included and involved in the care of the newborn baby, and they want to experience this period of parenthood together with the mother (Fägerskiöld, 2008). However, as far as we know, fathers' experiences specifically following complicated birth have not previously been described. The aim of this study, therefore, was to describe fathers' experiences of being present on a postnatal ward and during the first days at home following a complicated birth.

METHOD

Design

In this study, conventional content analysis was used with the aim of describing a phenomenon (Hsieh & Shannon, 2005)—in this case, fathers' experiences of being present on a postnatal ward and during the first days at home following a complicated birth. "Being present" is defined as the father being together with mother and child on the maternity ward and during the first days at home after the birth of the child. The concept "following a complicated birth" is defined here as when mother and baby have to stay longer on the maternity unit because their state of health does not allow them to be discharged. In addition, their partner perceives the mother's need for support to manage her pain, activities of daily living, and breastfeeding, more so than for women who are

mainly in good health and who experienced fewer birth-related complications.

Study Participants

The study participants' children were born between the 37th and 42nd weeks of pregnancy. Mother and child stayed on the maternity ward, being weakened because of various birth-related complications (Erlandsson, Christensson, & Fagerberg, 2008; Erlandsson & Häggström-Nordin, 2010). Seven elective and four acute cesarean surgeries had taken place under spinal or general anesthesia because of maternal and/or fetal indications. The cesarean surgeries involved hypotension, postpartum hemorrhage, blood transfusion, pain relief medication, and antibiotic treatment for the mother and, afterward, for both the mother and her child. In one case, oxygen saturation was observed in the child after birth. Four vaginal births were complicated because of perineal injury and anal sphincter rupture or retention of placenta with or without hemorrhage. Mothers and children were discharged from postpartum care after 3–5 days. Table 1 lists the fetal and maternal indications for acute or planned cesarean surgeries and complications in vaginal births, as provided by participating fathers during the study's interviews.

Seven first-time fathers and eight fathers with other children participated in this interview study. For four fathers, the current birth represented their second child; for three fathers, their third child; and for one father, his fifth child. Two of the fathers had other children, whereas for their partners, the current birth was their first child. All of the fathers had participated in antenatal parental education classes. The 15 participating fathers had received either upper secondary or higher education, and they were between 28 and 54 years of age. Because of the complicated birth, the fathers took care of their child immediately after birth. All participating fathers had been present on the postnatal ward during daytime, and nine of the fathers had been present around-the-clock. In immediate conjunction with the discharge of mother and child, the fathers took paternity leave (Swedish Social Insurance Agency, 2009).

Procedure

This study was conducted at two district maternity clinics in Sweden. The total number of births conducted at both clinics was 2,500 per year, and the cesarean surgery rate was close to 20%. Six midwives identified fathers and gave them both written

TABLE 1
Fetal and Maternal Indications for Acute or Planned Cesarean Surgeries and Complications in Vaginal Births (*N* = 15)

Acute Cesarean Surgeries (<i>n</i> = 4)	
Fetal Indications	Fetal distress (<i>n</i> = 2) Malpresentation (<i>n</i> = 2)
Planned Cesarean Surgeries (<i>n</i> = 7)	
Maternal Indications	Aneurysm (<i>n</i> = 1) Anxiety (<i>n</i> = 2) Cholecystectomy (<i>n</i> = 1) Fibromyalgia (<i>n</i> = 1) Placenta previa (<i>n</i> = 1) Spinal arthrodesis (<i>n</i> = 1)
Complications in Vaginal Births (<i>n</i> = 4)	
Maternal Indications	Perineal injury and anal sphincter rupture (<i>n</i> = 2) Retained placenta (<i>n</i> = 2)

and oral information about the present study and obtained the fathers' informed consent to participate. The information covered the study procedure, confidentiality, and assurance that the fathers could withdraw from the study at any time. Two pilot interviews were performed before the open interviews took place. A quiet place for interviewing was emphasized during the two pilot interviews performed at the university, which were not included in the analysis (Erlandsson et al., 2008; Erlandsson & Häggström-Nordin, 2010).

We contacted the fathers by telephone after receiving signed informed consent by postal letter. An appointment for the interview at the university or at the informant's home was set up dependent on the father's preference. During the interview that took place 8 days to 6 weeks after birth, the fathers were asked to tell their story. Open-ended probes were used according to the methods of Hsieh and Shannon (2005), such as the following questions: "What happened?" "What did you feel then?" or "What did you think then?" and "Can you tell me more about that?" The informants narrated freely, and each interview lasted 45–90 minutes. The regional ethics board approved the study (Erlandsson et al., 2008; Erlandsson & Häggström-Nordin, 2010).

Analysis

Fifteen audiotaped interviews were number coded and transcribed verbatim for analysis. The text was

analyzed using conventional content analysis (Hsieh & Shannon, 2005) and divided into codes, subcategories, and categories. First, each interview transcript was read repeatedly from beginning to end to achieve immersion and a sense of the whole. Thereafter, in a more careful reading, words and phrases that appeared to describe fathers' experiences in line with the aim of this study were copied into an initial coding scheme.

Next, the copied text in the coding scheme was reread, and the concept of the text was reformulated in line with the informants' description and labeled with a code using the participants' words. In this initial analysis, we made special notes on our first impression and understanding of the text. The code seemed to capture the key concept of the text. When working through the transcripts, new codes developed. Nineteen different codes were identified, all data inclusive.

After preliminary codes were labeled for the entire initial coding scheme, the text within a particular code was reexamined and notes were reread to ensure that reformulated text and codes matched the transcribed interviews. When data accuracy was ensured, the coded text was sorted into clusters of codes based on how they were linked together.

The descriptions of similarities and differences within clusters of codes were linked together and constituted six subcategories organized into two categories that defined the ways fathers experienced being present on a postnatal ward and during the first days at home following a complicated birth. Finally, a relationship between categories was presented in the overarching theme, "Being a resource for both mother and child." Examples for each code, subcategory, and category are presented in Table 2.

As presented later in this article, quotations from the participants' narratives reflect the content in the different subcategories. In the quotations that follow, the participating fathers have each been assigned a number, which is presented in parentheses: 1–15.

RESULTS

The overarching theme and its two categories, six subcategories, and 18 different codes describing fathers' experiences of being present during the first week after a complicated birth on a postnatal ward and during the first days at home are presented in Table 3.

Fathers’ experiences of being present during the first week following complicated birth on the postnatal ward and during the first days at home meant being a resource for both the mother and child through practical and emotional engagement.

Being a Resource for Both Mother and Child

Fathers’ experiences of being present during the first week following complicated birth on the postnatal ward and during the first days at home meant being a resource for both the mother and child through practical and emotional engagement. For the father, being present meant the opportunity to place his resources at the disposal of the mother and child. In this way, the father relieved the pressure on the mother to recover; at the same time, he established a deeper relationship with the baby and with the mother, and he possibly even helped to strengthen the bond between mother and baby. New family relationships were established in this first week after the complicated birth, possibly enhancing further involvement and shared responsibility for care of the baby.

Empower the Mother

The first category under the overarching theme, “Being a resource for both mother and child,” was labeled “Empower the mother,” which included three subcategories. The three subcategories were “enable

the mother to take the child to herself,” “receive the mother with empathy,” and “support the mother’s recovery and return to strengths.”

Enable the mother to take the child to herself.

Fathers being present during the first week after a complicated birth empowered the mother. The father enabled the mother to take the child to herself by introducing the mother to the process of caring for their child, while waiting for her to collect herself after the birth. This process is reflected in the following comment from one of the participants: “I believe I taught Jane and instructed her how to change diapers and other things. It took almost a week until she changed the first diaper” (6).

The fathers noted that a strained mother–infant relationship as a result of the complicated birth did not enhance the relationship between mother and child. For example, as one participant understood, the mother perceived the baby as tiresome at the beginning of her bonding process:

She was exhausted during the first days, and it took time for her to bond. It was not just during the first hours and days that I had a sense of belonging to the child, and she said she did not . . . she did not feel real motherly feelings. It took weeks . . . (4)

Receive the mother with empathy. Fathers empowered mothers by talking to them about what

TABLE 2
Examples of the Content Analysis Process Used to Examine Fathers’ Experiences of Being Present on the Postnatal Ward and During the First Days at Home Following a Complicated Birth

Transcript	Reformulation	Code	Cluster of Codes	Subcategory	Category	Theme
It was enough with just herself afterwards. It was tiredness and medicine against pain. I believe she gained peace by concentrating on recovering. When she saw what I did, she saw that it worked well. She was not in a hurry because I managed. She could let things take their time . . . (9)	The father thought that it was good for the mother to be able to take her time to recover without being in a hurry, because she saw that the father managed to take care of the child. At the same time, he could show that he could manage.	Take care of the child	Take care of the child Give practical support to the mother	Support the mother's recovery and return to strength	Empower the mother	Being a resource for both mother and child

TABLE 3
Theme, Categories, Subcategories, and Codes of the Result Description

Theme: Being a Resource for Both Mother and Child		
Categories	Subcategories	Codes
Empower the mother	<ul style="list-style-type: none"> • Enable the mother to take the child to herself • Receive the mother with empathy • Support the mother's recovery and return to strength 	<ul style="list-style-type: none"> • Introduce the mother to caring for the child • Support mother–child interaction • The father wants to support mother–child interaction • Ready to talk • Ready to interact with the distressed mother • Take care of the child • Give the mother practical support
Adapting to new family roles	<ul style="list-style-type: none"> • A sense of great responsibility • A sense of being a father • A need for empowerment 	<ul style="list-style-type: none"> • Responsible for the child • The father “took his place” • Needed by the mother • Commitment to practical care of the child • Father and child getting to know each other • Bonding • Mother, father, and child stay together • Being involved in the care of the child • Relieving the pressure on hospital staff • Staying over night • Renewing contact

happened during birth because the mothers did not always remember. The father was present, ready to comfort the mother when she was upset, cried, and felt sad after the complicated birth. Additionally, the parents had conversations about topics related to birth, fulfilling the need to be understood, to discuss, and to describe events. For example, one of the fathers said, “We asked and did not get an answer, but actually we believe that the staff knew what they were doing during birth and had a reason to say ‘no,’ . . . and we talked about that afterwards” (8).

Support the mothers’ recovery and return to strength. The fathers felt comfortable serving the mothers in all kinds of practical ways. They provided the mothers with moral support and physical care. They took care of the child as much as possible around-the-clock during the first week to allow the mother to gain strength and let her recover. After homecoming, the father kept the child by his side in bed and gave the baby to the mother only for breastfeeding. As fathers explained, they made the baby burp, changed diapers, consoled the baby, went for walks with the baby, and put the baby to sleep. Apart from taking care of the baby, the fathers also helped

the mother to sit up and lie down in bed. They served the mother food and something to drink; they picked up what fell on the floor, such as pillows; and they fetched items that the mother and the baby required. As one father described, his actions assured the mother that she could relax and focus on her recovery:

It was enough with just herself, afterwards. It was tiredness and medicine against pain. I believe she gained peace by concentrating on recovering. When she saw what I did, she saw that it worked well. She was not in a hurry because I managed. She could let things take their time . . . (9)

Adapting to New Family Roles

The second category under the overarching theme, “Being a resource for both mother and child,” was labeled “Adapting to new family roles,” which included three subcategories. The three subcategories were “a sense of great responsibility,” “a sense of being a father,” and “a need for empowerment.”

A sense of great responsibility. The fathers wanted to protect and take care of the child on the post-natal ward because of the mother’s state of health. According to the fathers, they, afterward, felt proud

of their great responsibility on the postnatal ward. For example, one of the fathers noted:

My God, looking back, everything turned out fine. We had some complications and a rough start, but now the baby sleeps and eats in a good rhythm and he has not suffered because his mother did not feel like breastfeeding in the beginning . . . (14)

Some fathers' impression was that they literally had to "take" their place on the postnatal ward by arguing for food, a bed, or extended time for visitors. This impression is reflected in the following comment from one of the participants:

In the end, it is the mother and the father together who will take care of the child, and after only a couple of days we are expected to leave the hospital, and if I don't know much about things at that point it will not be easy when we come home. (12)

Some fathers stayed as long as they possibly could on the postnatal ward in the evening and came back early in the morning, because otherwise they understood that the mother would sometimes feel heartbroken if the father was not there.

A sense of being a father. Taking care of the child night and day required a practical and emotional commitment from the fathers: talking to the baby, feeding the baby, and being close to console the baby. This practical commitment gave the father a sense of self-esteem, of being a father. For example, as one participant stated, "I took care of her [the baby] on her first night because Annie [the mother] was really ill. She was ill for 2 days actually, and I just knew what to do. . ." (10). Another father reported:

The mother had gone through something traumatic and she needed to be unburdened . . . I could do something, I could do a lot, and that was a great feeling. It gave me self-esteem . . . I had something to offer my child, and at the same time it was good for my feelings for the child. (9)

Some fathers experienced that it was easier to become close to the child at home in a familiar environment. As one father expressed, "To feel 100% a father, I needed to have her on my chest at home, lying on our sofa" (11).

During the first week after a complicated birth, the fathers participated in the care of the child to

the extent that it gave them, as a parent, a unique opportunity to jointly share responsibility for the baby. For example, one father described his personal experience in taking responsibility for the care of his child:

I feel that I am participating just like Mary [the mother]. It might not have been that way if the baby had been put on the mother's breast for breastfeeding. I would not have been as much a part of things. (14)

After homecoming, fathers perceived that they started to worry about sudden death and conditions they could do nothing about. They found that the child contributed to the forming of new relationship constellations within the family. As one participant noted:

We talked about it, the baby's mother and I . . . He plays a role in our relationship . . . He plays a role that is just as important as the roles his mother or I play in our relationship. We do not just take care of him. He has something to offer . . . (3)

A need for empowerment. The fathers who were present during the first week after a complicated birth experienced that they needed to be empowered by hospital staff. When the fathers took care of the child in the presence of the mother, the child had access to the mother's breast. This situation made the father feel more comfortable about taking care of the child than when he took care of the child without the mother's presence. One of the father's comments echoed similar reports from other participants:

When the mother came to us, I felt much safer because now when Jeff cried, she was there; and even if she could not do much, I could put Jeff on her breast. In that way, even if she was exhausted, I could take care of the child in a way I could not do when she was not there, and that made me feel comfortable . . . (11)

When fathers took care of the mother and the baby, they understood that they were not a burden to the health-care system; rather, they were partly helping to relieve the pressure of care. As illustrated in the following comment from one of the participants, the fathers perceived that they might be invited to stay around-the-clock on the postnatal ward, and that maybe after discharge, they

would be able to call the postnatal ward for advice, if necessary:

Fathers could stay on the postnatal ward and they could participate. The baby might have a mother who could not get out of bed. The baby might have a mother that is exhausted. These babies and mothers need the father's presence . . . to take care of the child . . . (3)

DISCUSSION

According to Hsieh and Shannon (2005), content analysis offers a flexible method for extending knowledge of human experiences. Although this study's sample size was small, the findings highlight fathers' experiences in an area that has received little attention. Hence, this study maps the potential for further investigation of the consequences of complicated birth for term babies and their mothers, fathers, siblings, and relatives in postnatal care and after homecoming. To ensure trustworthiness and credibility (Creswell, 1998; Polit & Beck, 2008), this article was written so that it is possible for the reader to follow the reasoning through data gathering, the analysis process and its outcome, and the veracity of the data (Creswell, 1998).

In this study, the careful description of the method used for analysis reinforces trustworthiness (Hsieh & Shannon, 2005). If the interviews took place while the precipitating incident was very new in the father's mind, the father's anxiety could have distorted the findings. Therefore, the interviews took place between 8 days and 6 weeks after the birth, according to the fathers' wishes. All of the mothers and babies were discharged from the hospital before the interviews took place. Our own understanding as midwives could not be totally disregarded, but in data gathering and in analysis and interpretation of data, our understanding was at least bridled. Hence, the findings were derived from the participants. In addition, other studies in the field confirm our study's results and, therefore, strengthen confirmability.

A limitation on dependability is that our study was performed in Sweden within a health-care system undergoing constant change. Today, a mother and child in good health might leave the postnatal ward after 6–24 hours. Through its focus on fathers' experiences, this study illustrates that involvement and support during the newborn period could also be provided by others, such as a partner or a relative

(Erlandsson, Linder, & Häggström-Nordin, 2010). The role of the partner and relatives in the care of mother and baby appears to warrant urgent investigation through further studies.

In our previous studies, fathers saw themselves as a resource for the infant's well-being during maternal–infant separation (Erlandsson, 2007; Erlandsson et al., 2006, 2008). The findings in the present study take previous studies further by describing how fathers conceive themselves as a resource for both mother and child in the postnatal ward and during the first days at home following a complicated birth. The fathers could even be perceived to enhance mother–infant bonding (DiMatteo et al., 1996; Klaus & Kennell, 1976). Possible stress after a complicated birth and postoperative pain in mothers after cesarean surgery has been biologically explained (Nissen et al., 1996; Uvnäs-Moberg, 1996, 1998) to lead to a possible delay in the bonding process (DiMatteo et al., 1996). This delay is possibly illustrated by the experiences of the fathers' perception of mothers' decreased ability to take responsibility of care because of the complicated birth, thus affecting the mother–infant relationship.

Traditionally, the early postpartum period for mothers has been considered a time for convalescence (Ellberg, 2008), especially if the birth of the child was complicated. In this study, the fathers' commitment to take care of both the mother and baby on the postnatal ward and after homecoming echoes this cultural and traditional insight. In addition, in this study, fathers supported the mother's recovery and return to strengths and possibly also the mother–infant bonding and breastfeeding. They provided the mothers with both moral support and physical care. They did this by making it possible for the mother to rest and have time to reflect together with the father about what had happened during birth. Hence, the father's opportunity to take 10 days of paternity leave after homecoming from postnatal care makes it possible for fathers to be involved (Swedish Social Insurance Agency, 2009). The fathers in this study described a deepened relationship with their partners. For parents after a complicated birth, staying together can be seen as a strengthening process in a vulnerable period of parenthood (Fägerskiöld, 2008). For parents in this situation, the opportunity to stay together might mean being supported in the childbearing period (Bremberg, 2004, p. 49).

Early postpartum care can involve collaboration and shared responsibility between professionals and

Because fathers become empowered by being involved in the well-being of the baby and mother, fathers should be invited to stay around-the-clock on postnatal wards.

parents after a complicated childbirth because, according to the World Health Organization (1998), the whole family should be involved. In this study, the fathers felt that with their presence, they partly relieved the pressure on the health-care system by taking care of their baby and the baby's mother. Hence, they wanted to be invited to stay around-the-clock on the postnatal ward and maybe, after discharge, to be able to call the postnatal ward for advice, if necessary.

In this study, fathers reported that after homecoming, they started to worry about sudden death and conditions they could do nothing about. Their worry and great responsibility for the baby's well-being can be understood as bonding. The ability to create a bond might be one of the most important aspects of human behavior (Bowlby, 1969). As one father in this study noted, the presence of a baby created new family roles and new family relationships to which the members of the family started to adapt in the first week following complicated birth, illustrating an ongoing bonding process within the family. This new set of relationships within a family can be related to previous research into fatherhood as a change in life (Fägerskiöld, 2008) and could also be seen as an expression of belonging for the new family (Erlandsson & Lindgren, 2009).

CONCLUSION AND CARING IMPLICATIONS

This study's findings highlight fathers as an important resource for both mother and child in providing moral support and physical care. The mothers were in need of support to manage their activities of daily living and pain, and the fathers provided support through physical care of the mother and child. The father could also give moral support, thus empowering the mother. Because fathers become empowered by being involved in the well-being of the baby and mother, fathers should be invited to stay around-the-clock on postnatal wards. If the mother

feels tired, she could sleep and recover knowing that the father will take care of the baby (e.g., changing diapers and consoling the baby). The father's moral and physical support might help the mother to rest and recover. Hospital staff on postnatal wards can enhance care by empowering fathers to support the mother and baby through practical and emotional engagement. In addition, educational antenatal courses can help prepare fathers for their empowering role after a complicated birth.

ACKNOWLEDGMENTS

We thank the fathers who participated in this study and Mälardalen University, School of Health Care and Social Welfare, for financial support.

REFERENCES

- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York, NY: Basic Books.
- Bremberg, S. G. (2004). *New tools for parents—proposals for new models of parental support*. (In Swedish). Stockholm, Sweden: National Institute of Public Health.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. London, UK: Sage.
- DiMatteo, M. R., Morton, S. C., Lepper, H. S., Damush, T. M., Carney, M. T., Pearson, M., & Kahn, K. L. (1996). Caesarean childbirth and psychosocial outcomes: A meta-analysis. *Journal of Health Psychology*, 15(4), 303–314.
- Elattar, A., Selamat, E. M., Robson, A. A., & Loughney, A. D. (2008). Factors influencing maternal length of stay after giving birth in a UK hospital and the impact of those factors on bed occupancy. *Journal of Obstetrics and Gynaecology*, 28(1), 73–76.
- Ellberg, L. (2008). *Postnatal care—outcomes of various care options in Sweden* (Published thesis, Umeå University, Department of Nursing, Umeå, Sweden). Retrieved from <http://umu.diva-portal.org/smash/record.jsf?searchId=1&pid=diva2:142099>
- Ellberg, L., Högberg, U., & Lindh, V. (2010). "We feel like one, they see us as two": New parents' discontent with postnatal care. *Midwifery*, 26(4), 463–468.
- Erlandsson, K. (2007). *Care of the newborn infant during maternal-infant separation* (Published thesis, Karolinska Institutet, Department of Woman and Child Health, Stockholm, Sweden). Retrieved from <http://diss.kib.ki.se/2007/978-91-7357-373-3/thesis.pdf>
- Erlandsson, K., Christensson, K., & Fagerberg, I. (2006). Fatherhood as taking the child to oneself: A phenomenological observation study after caesarean birth. *Indo-Pacific Journal of Phenomenology*, 6(2), 1–9.
- Erlandsson, K., Christensson, K., & Fagerberg, I. (2008). Fathers' lived experiences of getting to know their baby while acting as primary caregivers immediately following birth. *The Journal of Perinatal Education*, 17(2), 28–36.
- Erlandsson, K., & Häggström-Nordin, E. (2010). Prenatal parental education from the perspective of fathers who have been acting as primary caregivers immediately

Hospital staff on postnatal wards can enhance care by empowering fathers to support the mother and baby through practical and emotional engagement.

- following birth: A phenomenographic study. *The Journal of Perinatal Education*, 19(1), 19–28.
- Erlandsson, K., Linder, H., & Häggström-Nordin, E. (2010). Experiences of gay women during their partner's pregnancy and childbirth. *British Journal of Midwifery*, 18(2), 99–103.
- Erlandsson, K., & Lindgren, H. (2009). From belonging to belonging through a blessed moment of love for a child—the birth of a child from the fathers' perspective. *Journal of Men's Health*, 6(4), 338–344.
- Fägerskiöld, A. (2008). A change in life as experienced by first-time fathers. *Scandinavian Journal of Caring Sciences*, 22(1), 64–71.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288.
- Klaus, M. H., & Kennell, J. H. (1976). *Maternal–infant bonding*. St Louis, MO: Mosby.
- Nissen, E., Uvnäs-Moberg, K., Svensson, K., Stock, S., Widström, A. M., & Winberg, J. (1996). Different patterns of oxytocin, prolactin but not cortisol release during breastfeeding in women delivered by caesarean section or by the vaginal route. *Early Human Development*, 45(1–2), 103–118.
- Odlind, V., Haglund, B., Pakkanen, M., & Otterblad Olausson, P. (2003). Deliveries, mothers and newborn infants in Sweden, 1973–2000. Trends in obstetrics as reported to the Swedish Medical Birth Register. *Acta Obstetrica et Gynecologica Scandinavica*, 82(6), 516–528.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research principles and methods* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Premberg, Å., Hellström, A.-L., & Berg, M. (2008). Experiences of the first year as a father. *Scandinavian Journal of Caring Sciences*, 22(1), 56–63.
- Svensson, K., Matthiesen, A. S., & Widström, A. M. (2005). Night rooming-in: Who decides? An example of staff influence on mothers' attitude. *Birth*, 32(2), 99–106.
- The Swedish Social Insurance Agency. (2009). *About Swedish insurance*. Retrieved from http://www.forsakringskassan.se/irj/go/km/docs/fk_publishing/Dokument/Publikationer/Faktablad/Andra%20språk/Engelska/socialforsakringen_eng.pdf
- Uvnäs-Moberg, K. (1996). Neuroendocrinology of the mother–child interaction. *Trends in Endocrinology and Metabolism*, 7(4), 126–131.
- Uvnäs-Moberg, K. (1998). Oxytocin may mediate the benefits of positive social interaction and emotions. *Psychoneuroendocrinology*, 23(8), 819–835.
- World Health Organization. (1998). *Postpartum care of the mother and newborn: A practical guide* (Report WHO/RHT/MSM/98,3). Department of Reproductive Health and Research. Genève, Switzerland. Retrieved from http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/MSM_98_3_/en/index.html

KERSTIN ERLANDSSON is a senior lecturer in the School of Health Care and Social Welfare at Mälardalen University in Västerås, Sweden. Her main research focus is on fathers' care of their newborn. HELENA LINDGREN is a senior lecturer and research fellow at the Sahlgrenska Academy, University of Gothenburg in Göteborg, Sweden. The main focus of her research is on alternative birth settings.