A Grounded Theory of Becoming a First-time Father due to a High Risk Pregnancy

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Abstract: Nursing care during pregnancy usually focuses on the conditions of the mothers rather than fathers, especially during a high risk pregnancy, but first-time fathers confronting such a pregnancy face serious challenges and pressures that effect their lives and relationships. This study explored the process of Thai men becoming a first-time father with a high risk pregnancy to better understand what they faced and how they coped. Twenty-three volunteer informants were recruited from an antenatal clinic in northern Thailand. Interview data were collected and analyzed using grounded theory methodology.

The findings demonstrated that *Striving for a Healthy Baby* was the core category of the basic social process and consisted of three phases, each with its strategies. 1) *Stressing about high risk pregnancy,* with the strategies of dealing with emotions, seeking care, and modifying behaviors. 2) *Hoping baby and wife will be healthy*, with the strategies of dealing with emotions, seeking special care, modifying behaviors, and making a relationship with the baby, and 3) *Handling uncertain outcomes*, with the strategies of dealing with higher levels of worry, seeking the baby's safety, preparing for difficult outcomes, and making a relationship with the baby. Throughout the study Buddhist beliefs strongly influenced the actions of the fathers. This study adds new cultural knowledge about the concerns, needs, and strategies of expectant Thai fathers due to a high risk pregnancy that will enable nurses, midwives, and healthcare professionals to assist and care for them.

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Introduction

Becoming a first-time father is a great time of change in a man's life.[1,2] Men confront various challenges and pressures, especially when a high risk pregnancy (HRP) is involved.[3] Pregnancy is a demanding period for expectant fathers, and it is a part of their transition to fatherhood.[4] However, when complications and increased risks are added to the pregnancy, expectant

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fathers gain additional stressors that impact their emotional and physical energy to deal with their process of becoming a father.[3] They may lose a sense of control and become isolated as they face threats of risky physical conditions in their pregnant wives and unborn baby. Some special antenatal care and treatment may also affect expectant fathers who often act as a primary care giver.[5,6]

In the traditional Thai family, fatherhood has been influenced by religious beliefs, community structures, family relationships, and masculine and feminine roles.[7,8] The father's role was often traditionally that of a farmer working in the fields, while the maternal roles were of housewife, and care-taker of babies and elders.[9] Since the 1970s, Thailand has moved from an agricultural to an industrial society. Rapid socioeconomic development has had a great impact on the function and structure of Thai families.[10] The roles of women have changed, and working fathers are now expected to share in household work. The new generation of Thai fathers are required to be both breadwinners and involved in parenting.[9] They are now expected to be involved in their partner's pregnancy, birth, and childcare activities. These changes have been promoted and supported by national policies and projects encouraging men to participate in childbearing and childrearing[7,11] with the aim of improved physiological and psychological development of the children and of the well-being of the family. The role of Thai expectant fathers has a core centered around protecting the unborn baby.[12] Previous studies have explored fathers' experiences with normal pregnancies rather than HRP, the latter of which has been increasing in Thailand and globally.

From 2013-2015, HRP in northern Thailand was reported at 42.60, 38.90, and 39.20 percent of all pregnant women visiting university hospital antenatal clinics, respectively.[13] Causes of maternal mortality during pregnancy include severe bleeding, infections, and hypertensive disorders, associated with neonatal mortality.[14] High-risk pregnancy is classed into medical and obstetrical complications. Medical complications include heart disease, thalassemia, and systemic lupus erythematosus. Obstetrical complications include pregnancy-induced hypertension, gestational diabetes mellitus, and multiple gestations.[15] High-risk mothers are referred to high-risk clinics of tertiary or university hospitals for specialized care. These mothers require advanced diagnostic investigation and management. Most also need specialized care and support from their husband, which can be quite demanding. As a consequence, expectant fathers may lose a sense of control, and/or become isolated while they confront the threats facing their pregnant wives and unborn child.[16,17] These stressors impact expectant fathers' lives and roles, as well as their actions and interactions with themselves, their wives, and their social network.

Unfortunately, no studies were found investigating expectant fatherhood in the context of HRP. Most of the literature has addressed HRP more or less exclusively via the experiences of women. When HRP and fatherhood is discussed, it is often as an interesting footnote to the central issue of the expectant mother. The clinical and scientific knowledge that is available on men and HRP provides much raw material for reflection and investigation, yet is insufficient to provide conclusions about the processes of fathers struggling with this. Therefore, this study explored the gap of knowledge concerning the process among Thai expectant fathers with a HRP.

Study aim

The research question of this study was "What is going on in the process of becoming a first-time father among Thais whose wives have a high-risk pregnancy?"

Theoretical framework

Symbolic interaction (SI)[18] was used as the theoretical framework in this study by way of grounded theory methodology. SI is not only a philosophical orientation underlying the method, but is also a

dominant theoretical code to guide analysis.[19,20] It was the underlying assumption that Thai expectant fathers in this study shared a common social psychological problem, which they are normally unaware of at a conscious level.[21] This guided an assessment of expectant fathers and an understanding of how they interpreted the meaning of their experiences, situations, actions, and interactions; and discovered the processes of individual interactions and human behaviors during the HRP situation.

Method

Study Design

Grounded theory methodology is based on symbolic interaction to explore social processes with the goal of developing a theory[22] that can account for a pattern of behavior which is relevant and problematic for whose involved.[21] It is also useful in generating initial substantive knowledge that emerges from the grounded data through social interaction.[22]

Sample and Setting

Informants were recruited from an antenatal clinic (ANC) at a university hospital in northern Thailand. A purposive recruitment criteria was used: Thai men whose their wives had been diagnosed with a HRP, >20 years of age, living with their wife during the pregnancy, and never having experienced a live birth with this or another female partner. All of the HRP conditions could be managed and none progressed into a more severe class of HRP.

Ethical Considerations

This study was approved by the ethical committees of the Faculty of Nursing and Faculty of Medicine, Chiang-Mai University [study code=NONE-2557-02547]. All informants completed written consent forms, and their rights were protected throughout the study. Data collection, management and analysis processes met ethical standards of confidentially and security.

Data collection

Grounded theory guided data collection and analysis that was concurrent and spiral, rather than linear, and involved constant comparison.[22] Informants were recruited when women diagnosed with HRP visited the ANC of the university hospital. Informants were invited to participate in this study by an invitation letter. Interested fathers who volunteered to participate left their names and phone numbers in a response box at the ANC. The principal investigator (PI) connected with the informants by phone to make an appointment for interviewing. In-depth interviews were conducted using an interview guide which was developed on the research question using open-ended questions[20,22], for example: "Can you tell me about your experiences of being a father with your wife diagnosed as having a high risk pregnancy?" During the interview, the PI used probing questions to clarify and elaborate the details of each participant's experiences such as "... can you tell me more about that", "...I am not quite clear about that, can you explain more about that please?", and "...what do you mean?". Each informant was interviewed for 25-60 minutes, 1-3 times until the data was saturated.

Data analysis

After finishing each interview, a verbatim transcription was done. Line-by-line open coding was performed to identify concepts, and conceptualize underlying patterns.[22] As data analysis progressed categories were formed, and with properties and dimensions.[23] The PI wrote memos of her thoughts and striking ideas about what needed clarification, what additional questions should be asked, and guidelines for the next participants.[19,21] Theoretical sampling to select the next participants was based on the emerging categories and their properties, until saturation was reached.[23] Constant comparison and verification was done, comparing to codes within the same interview, across interviews with the same participant, and across participants. Similarities and

differences in codes were noted, and related codes were clustered into categories. Theoretical coding was done by giving names to codes that explained how the substantive codes were related to each other. Then, core categories became woven into the whole of the study by the linking of all categories around selective coding[20,22]. The main concerns of Thai men becoming fathers during a HRP situation emerged from the data.

Rigor of study

This study used fit, workability, relevance, modifiability[20,23] and credibility[22] as the rigor of grounded theory. Fit means that the categories must fit with the data. The PI checked this by constant comparison and conceptualization of the data.[23] For relevance the emergent concepts relating to the true issues of the informants in the substantive area were checked by using theoretical sensitivity and considering the notion of the basic social process. For workability, the core categories and sub-core categories that accounted for most of the variation of behavior in the substantive area were examined to explain what was happening; predict what will happen; and interpret what happened in the substantive inquiry. Therefore, the concepts and their theoretical coding were tightly related to what was going on.[23] Modifiability is very important, and the researcher ensured that all the concepts important to the theory were incorporated during the constant comparison process.[23] Credibility refers to internal validity in qualitative research, which was approached by peer debriefing and member-checking. The PI showed transcripts, relevant documents, memos, and field notes during the investigation to the research team. The peers discussed and reviewed through the process of data analysis, coding and interpretation. Finally, the PI returned the results of the study to some informants to share the emerging picture with them, and they confirmed that the findings did indeed reflect the processes of expectant fathers[22] with a wife with a HRP.

Findings

There were 23 informants in this study. Their ages ranged from 20 to 38 years old. All were Buddhist and their occupations were categorized as a businessmen (n=9), freelance workers (n=5), government officer (n=3), government employee (n=2),a private company employee (n=2), and an agriculturist (n=2). Informants' household income per month ranged from 10,000 to 80,000 baht per month (US$362-$2,500 per month). Most informants had a fair economic status in that income was in the range of 10,000 – 20,000 baht per month (US$362-$625 per month)(n=10). The gestational age of informants' pregnant wives was between 37-38^{+} weeks (n=22) and 40^{+} weeks (n=1). Characteristics of the HRP were categorized by a pregnancy diagnosis of: 1) Preexisting disease (n=10); diabetes mellitus (DM), immunization disorder, thyroid disorder, rheumatic heart disease; 2) High risk diagnosis during pregnancy (n=12); thalassemia trait, GDM, pregnancy-induced hypertension (PIH), ovarian tumor or cancer; or 3) Gaining high risk with preexisting disease during pregnancy such DM with PIH (n=1).

The core category of *Striving for a healthy baby* was the process by which the informants managed their main concerns and developed into fathers. This process consisted of three phases:1) stressing about HRP; 2) hoping baby and wife will be healthy: and 3) handling uncertain outcomes. (Figure 1)

For many informants striving for a healthy baby began when they learned of the diagnosis of HRP through screening and diagnostic results given by the obstetrician. At this time, their wife presented with obstetrical complications such as diabetes or PIH. However, some informants had wives with preexisting medical diseases such as heart disease, immunization disorder, chronic hypertension, trait-thalassemia, and diabetes mellitus. These informants faced the stress of complications earlier than the other fathers. Their

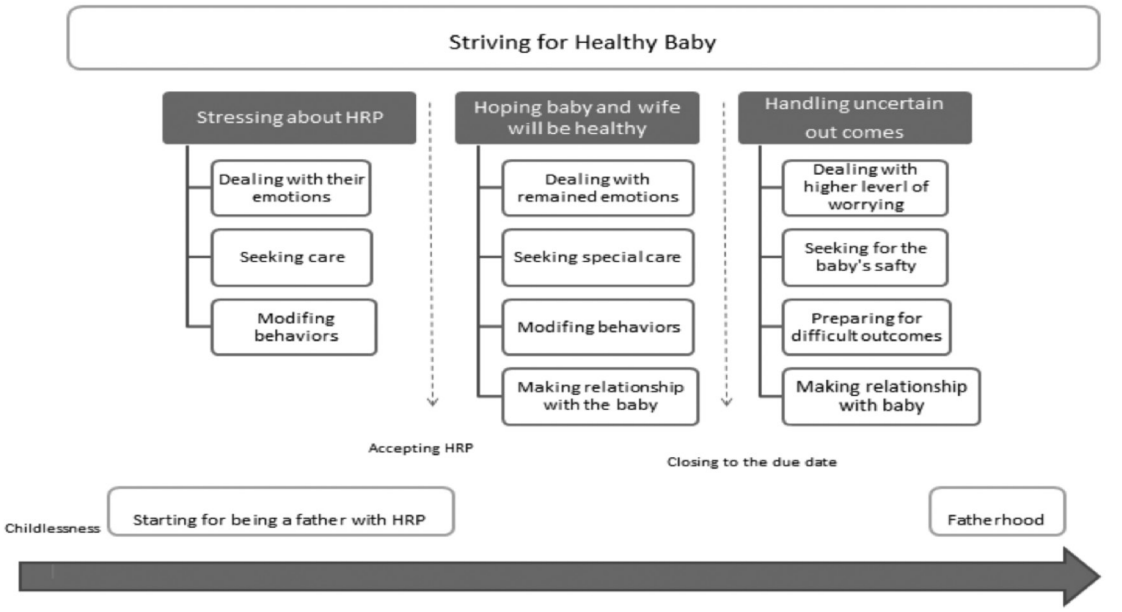

Figure1: Findings from study among Thai fathers whose wives had a high risk pregnancy.

stress began from the moment they knew that their wife was pregnant. Therefore, the starting time of knowing and facing the stress of high risk pregnancy among informants was different; however, the sequence of the three phases among *Striving for a healthy baby* was similar after the beginning point.

Stressing about HRP

Stressing about HRP was the beginning phase that informants experienced with the high risk pregnancy diagnosis. It made them feel worried and under pressure; they had many problems to cope with in this crisis situation. This phase lasted around 1-2 months after they received the HRP determination and they used three strategies to manage this stress: dealing with their emotions, seeking care, and modifying behaviors.

Dealing with their emotions: Informants had direct experiences with unfavorable emotions such as shock, sadness, disappointment, anxiety, fatigue, chaos, worry, and concerns about the pregnancy, their baby, and their wife. They felt unsure about the pregnancy screening, testing and diagnosis. They asked for re-confirmation of HRP screening tests to make certain that the situation was real, for example:

> *When my wife called me and told me that she has a risky pregnancy and it may affect our baby, I automatically asked her about the test, and was the result sure? In my mind, I was very confused and felt as disappointed...* (P11/1L182-186)

All informants were Buddhist with their own background and beliefs related to *karma* and *chao kam nai wen*. They felt the HRP happened to them and their family due to *karma* (the Buddhist law of cause and result) from this life and previous lives. *Chao kam nai wen* are spirits or ghosts of person who passed away, with whom one has previously interacted, and whom one has harmed in some way. The *chao kam nai wen* can appear in this life making trouble in a person's life, and requiring some kind of appeasement or retribution for the past wrongs done to them. These informants, facing karmic trouble, possibly from a *chao kam nai wen*, often went to temples and monks to make merit (doing good actions to create *good karma*), dedicated their merit to the *chao kam nai wen*, prayed to the Buddha, and made vows to the Buddha and/or supernatural entities until the baby was delivered safely. They

believed that making (and dedicating) good merit could improve their *karma* and appease *the chao kam nai wen*, both of which serve to help the HRP pass smoothly.

> *...I concerned all my activities, I went to making merit often more than the previous time. I did only good karma. I hoped that all my good merit or good Karma would send to chao kan mai wen of me and my wife. I hoped that it could help my baby would birth with healthy and less complications...* (P10/1L614-620)

Seeking care: Informants sought information about the HRP condition and how it might affect their unborn babies and wives. They looked for further treatments, and tried to find ways to help with some side effects that their wives may experience. They were worried that their baby may be lost through miscarriage.

Modifying behavior: Informants started to change their behavior because they thought that it might affect their baby, their wife, or the pregnancy condition. They managed their multiple roles by arranging their time to care for and accompany their wife to the clinic/hospital. They acted as a strong husband to support their wife, although in their mind, they felt weak, sad, and disappointed. But they could not express their feelings to their wives because they did not want them wives to feel even worse.

Hoping baby and wife will be healthy

This phase started after accepting the diagnosis of HRP, usually until 32 weeks of gestation. By this time the HRP wife had already been referred to a specialty clinic at the university hospital and received some specific treatment and care. Such treatments and medicine were used to manage the HRP, varying on the disease and severity. Informants did their best in their roles of father and husband. Their main concern was about whether their unborn baby would be healthy and safe, then they tried to deal their other motions, seeking special care, modifying their behavior, and making relationship with baby to manage their needs and concerns during this phase.

Dealing with remaining emotions: By this time informants had calmed down and felt better than in the previous phase, due in part to positive responses of their HRP wife to the medical treatment. However, they were still confused, worried and concerned about the effects of the disease and medicine on their wife and unborn baby. They dealt with their remaining emotions by seeking more information about the HRP condition from the internet, friends, obstetricians, nurses, or healthcare-providers:

> *...however the doctor said that my baby was growing well and has some resistance to the medicines that my wife had been taking. I still thought that my baby may have some effects from the disease or medicines. Although the doctor said that there was only a 1-2% chance of being disabled, I still felt that it may happen because it is not 100% safe...* (P11/1L412-417)

During this phase the men felt like they were quite often neglected, on the other side of the doors at the ANC examination and ultrasound rooms, while their wives were being examined. They were not allowed to accompany their wives into those rooms. They suggested that it might be good if they could stay with their wife because they wanted to know what was going on.

> *...when my wife goes to get examined by the doctors I never go with her. I don't know if could I go with her or not because no one told me about that. Every time the staff just called my wife's name and told her to see the doctor, just that. If I had some chance to go with her, it may be good because I wanted to see the examination. I wanted to see the ultrasound and I wanted to see my baby. I would feel better if I saw everything with my own eyes more than only hearing from my wife...* (P6/1L398-403)

Seeking special care: They started looking for special clinics or hospitals that were famous and popular for taking care of HRPs. They searched the internet, and talked with relatives, friends, colleagues, and healthcare professionals. They applied some of what they learned in their daily care for their wife, especially regarding nutritional concepts related to the disease or HRP conditions.

They also sought out local Northern-Thai traditional care, such as some physical activities, herbs, and foods that they believed that could control HRP, reduce the effect from the medicine/treatment, and promote the health of their pregnant wife and unborn baby. They prepared and gave boiled water of custard apple leaf, sweet gourd juice, and mangosteen juice to their wives. They believed that these herbs and fruits could help fight against dangerous cells, increase the body's immunity, control blood pressure levels, and improve general conditions. However, they confirmed with the obstetrician or nurses for before giving these foods to their wife.

> *...I searched form the internet about alternative care for my wife. I found that drinking mangosteen juice could kill abnormal cells in our body, so I thought that this would be good for my wife with her high risk condition. I hoped it could help her have good immunity and keep her well until the due date...* (P2/2L295-299)

Informants placed prohibitions on their wife according to local traditional beliefs that they had heard from their elder relatives and/or parents. They were concerned that certain behaviors may affect the HRP conditions. They prohibited their wives from eating salang food (e.g. rare meat/beef/food, strong smelling food, and salted food) because these were not good for the health. They prohibited their wife from going to funerals or inauspicious events because these could effect to their wife and baby's health. They did not allow their wives to sew any cloth during the night time because this activity may lead to problems or difficulties during the birth.

Modifying behavior: During this time all HRP mothers had regular visits to the HRP clinic of the university hospital. Informants performed the duty of protector and supporter. They used empathy to support of their wives emotions, took care and protected their HRP wife and baby. They also supported them with nutrition, dietary control, vitamins, medicine, housework; they adjusted their working time, managed the money, and importantly, accompanied their wife on ANC visits. They supported their wife emotionally because they felt empathy for her discomfort, the complications, and the suffering from the treatment. Significantly, during the HRP crisis situation, they felt that their relationship as a couple strengthened, for example:

> *...I spent more time with her than previously. I took her to the hospital, and other places. I accompanied her to as many places as I could. I felt empathy for her, but I could not do more. I just support her as well as I could by talking good and positive words or conversation to her. It would be good if we had more time together without her disease...* (P22/2L177/179)

Informants modified their own behavior, stopping some of their behaviors due to traditional beliefs about merit and sin. They thought that their activities may affect their unborn baby's health. They did not clip their nails or dig a hole in the ground because they believed that their baby may have a difficult birth or some disability. They did not kill animals, because it was a sinful activity that may cause some complication for their beloved baby, or could even make the baby disabled or die.

> *...I stopped my fishing and cock fighting. I believed that my baby could receive bad effects from these. I had seen with my own eyes - my niece, she was a clef-lift and clef-palate girl, because during her mother's pregnancy her father went fishing and got hooks into the fish's mouth. Then the sins were felt on my niece.* (P6/1L218-222)

Making relationship with baby: Informants were fully conscious that the pregnancy was a real when at around 6-7 months the abdomen was so much bigger than before. They only felt the pregnancy and the baby were totally real when they could touch and feel the baby's movement clearly. Perceiving the pregnancy as real was reported when they had seen ultrasound pictures of their baby. This was also when they felt that being a father was real. The relationship between informants and their babies in the womb was strengthened at this time. They made relationship with their baby by touching, talking, reading books, and playing music to their baby, because they wanted the baby to know them and recognize their voice. Importantly, they did these things that they learned from the internet, books, magazines and healthcare providers, in the hope that their baby would have good and normal development, such as:

> *...when she began five months, her belly was larger than four months. When her belly enlarged I just had awareness and it reminded me that the pregnancy was real. Even though I already know that she was pregnant I just became truly conscious now, that I will have a baby. It is a real. It was not a dream* (laughing)... (P4/1L79-80)

Handling uncertain outcomes

The last phase started around 32 weeks of gestation and continued until birth. The informants were dealing with high levels of worry about uncertain outcomes, striving for safety of their baby, preparing for difficult outcomes, and making a relationship with the baby in the form of unconditional love.

Dealing with higher levels of worrying: In this phase the informants had more worry and concerns about their wife and unborn baby's health even though they had known about the condition and possible complications for some time. They wanted their baby to be born safe and healthy. They often went to make merit, praying to Buddha and other supernatural spirits for their baby's health:

> *...I prayed every night for my baby and for my wife to be safe and healthy. I didn't pray for myself because I thought that it was enough for my life. But I just wanted my baby and my wife safe. I want my baby healthy without any complication when he is born. I want him to be like other normal children. I prayed and thought in my heart every night...* (P4/1L543-557)

Seeking for the baby's safety: Their higher levels of worrying was often about some emergency HRP condition that could happen, such as a "rigid abdomen". They searched for more information about labor and dangerous signs from the internet, health professionals, family, and friends. They looked for nearby private clinics and hospitals in case any complications happened. They planned and prepared their wife to ask for help from their relatives, colleagues, and neighbors, and prepared to use the emergency rescue service, which is by dialing 1669. Some were informed by the obstetrician that the birth method would be a cesarean section, so they asked friends, relatives, and colleagues to donate blood for their wife.

> *...I often told and reminded my wife that if she had labor pain when I wasn't with her she should call 1669. I told her to ask for help from our neighbors to bring her to the hospital..... and in the night time she should go in the main entrance of hospital and go directly to the emergency room...* (P13/1L284-289)

Preparing for difficult outcomes: Informants' feelings of insecurity and uncertainty about the baby's condition came back again. They prepared their mind and planned for difficult outcomes: if their baby was born unhealthy, or abnormal, or with disability. They comforted their mind by thinking that it was dependent on *karma* involving actions in many past lives. They had faith about destiny in that it could direct everything to happen with their family. They could accept if their baby was born with some problem or difficult outcomes

because they already loved their unborn baby. They also prepared their wife, comforting her mind that she should accept whatever outcome occurred.

> *I just loved my baby. And even though I didn't know if my baby would be affected from my wife's disease or not, I still loved and I accepted. This is my baby so I will take care the best that I can. I hope that all my good merit, good karma would affect my baby's health and the birth will be without complications...* (P10/1L66-620)

Planning for the baby's health care, deciding about baby items, and gathering the family's money for newborn care were reported. The expenditure for newborn care and treatment after birth could not be fully determined yet because it would depend on the baby's conditions and health. Thus, the informants thought about and prepared for the immediate baby care after birth.

Most did not prepare baby items because they had their traditional belief that their baby may be lost if they prepared such items before birth. This belief had been passed down from their parents, elder relatives, and from their experiences:

> *...my elder relatives, they told me that I shouldn't buy any things for my baby this time because it wasn't good for my baby and my wife. It could make a bad situation such birth difficulty or some other bad situation during the birth time.* (P5/1 568-575)

Making a relationship with the baby: Informants strengthened their relationship with the baby more during this phase. They wanted to see their baby's face soon, and in a healthy condition. They prepared a nickname for their baby, but they could not settle on a given name yet. By tradition, the given name depended on the date of birth because each day had some prohibited letters which could not be used in the name. They wanted to select the best given name for their baby, because, according to their belief the name had lifelong influence. So informants had to wait until the birth date for the proper given name, and before that they just used the baby's nickname.

> *...I called my baby in the womb 'Aey Aey'. It was just a word for calling my baby. We already had her nick name as "O-new" that my wife had chosen because it's related to her name. I didn't have her given name yet because I would wait until she was born.* (P2/1L138-65)

Activities of informants during this phase were concerned with their baby's safety and health more than their own. They could be brave their whole life for their baby. They often went to make merit and pray for their baby's health. They prayed to supernatural powers in the belief that it that could help their baby. Although the baby might be born with complications or disabilities, they would still love their baby and would take good care until the end. They interacted with their baby, strengthening the relationship with full love. Then all of their activities were as a brave father who loved his baby, striving for its survival and health:

> *...I could do anything and work hard for my baby. I may get tired in my work but I could do it for my wife and my baby. Today...please bring my life (crying)...could I give my life for my baby's life? I want to give anything that I can. I wanted to exchange my life and health for my baby's life and health. I only want my baby safe and alive...* (P2/2L391-396)

During the pregnancy, the informants faced and experienced many emotional changes, favorable, unfavorable, and mixed emotions related to each phase of the pregnancy, their concerns about the effects of HRP on the health of their unborn baby, and the process of becoming a first time father with a high risk pregnancy wife. All of this is part of the process of *Striving for healthy baby*.

Discussion

This study was directed by the perspective of symbolic interaction[19] to interpret the experiences, situations, actions, and interactions, and to discover the processes of individual interactions and human behaviors of expectant Thai fathers whose wife had a high risk pregnancy within the context of Thai society as a basic social process. *Striving for a healthy baby* emerged from the data as a core category, the process that the expectant fathers carried out through the period of pregnancy. They performed multiple duties and roles such family member, son, partner, worker, being a father, and member of society[7,9] all while their wife was having a HRP[1,5].They balanced all their roles and dealt their main concern of first dealing with their emotions as a strong family leader[2,5,7] and trying to be a good husband and father.[6,7,12] They also thought more about and made additional plans to deal with further uncertain situations concerning caring for mother and baby, finances, and their work.[5,24,25]

They were a major supportive and protective person for their wife. They provided good care involving nutrition, medicine, dietary control, and others things[12,16,17] in the hope that the HRP condition would not get worse, and that their unborn baby and wife would be safe and healthy. Importantly, this study found that the crisis situation of their HRP wife and unborn baby lead to a strong relationship between the father and their unborn baby. Men were inspired to be brave for their unborn baby. They proposed exchanging their life for their unborn baby. They were ready to die for their baby.

Buddhist perspectives influenced men's beliefs, their mind, their acceptance, and their behavior during the HRP period as a basic socializing process. They acted to solve their *karma* and *chao kam nai wen* issues. *Karma* was seen as an important contributing factor to the health and disease of their wife and baby. The present situation was the effect of good and bad karma in the past[7,12] *Chao kam nai wen*, spirits one has harmed in a past life, needed to be appeased to protect the mother and baby. In short, Thai expectant parents believe that their pregnancy condition and health were effect by their *karma* and bad situations with *chao kam nai wen* and so actions were taken to deal with both.

Northern Thai traditional cultural beliefs were represented as the background of men's behavior during the HRP period as part of a basic social process passed from the previous generation to the next.[12] Men acted themselves, doing some things and avoiding others to protect their wife and baby in accordance with these traditional beliefs. They were willing to follow the way of traditional beliefs for their baby's health and safety.

They needed and sought more information from the internet, other experienced people, and especially healthcare providers about taking good care of their HRP wife. They accepted themselves as a partner in the HRP and they wanted to engage as a part of the process rather than being left waiting outside the door.[1,26,27]

Strengths and Limitations

Member checking and peer debriefing was done as a thoroughly and as rigorously as possible, and this research was guided by grounded theory and theoretical sensitivity was employed. This is of concern during interviewing for data collection. Doing theoretical sensitivity during each interview helps the researcher reach and get more data by further probing interviewing questions in real time during the interview rather than later seeing something in the transcription and data analysis process and going back to the field again. One limitation is that this study was undertaken in northern Thailand and the findings may not be applicable to other parts of Thailand with some different cultural understandings about fatherhood.

Conclusion and Implications for Nursing Practice

This study adds new knowledge about the concerns, needs and strategies of expectant Thai fathers with HRP wives that will enable nurses, midwives,

and healthcare professionals to assist and care for them. The study presents the process of *striving for a healthy baby* as the center of a core category which was divided into three phases: *stressing about HRP; hoping baby and wife will be healthy; and handling uncertain outcomes*. They used the strategies to manage their needs and concerns: dealing with emotions, seeking care, modifying behavior, dealing with remaining emotions, seeking special care, modifying behavior, making relationship with baby, dealing with higher levels of worry, seeking for the baby's safety, and preparing for difficult outcomes. Some of the strategies were used across all the phases; some were used only for specific phases.

Northern Thai traditional cultural and Buddhist beliefs influenced first time fathers' experiences, shaping their attitudes and performance around being a new father, especially the role of partner and father of the unborn baby. The unique knowledge gained from this study was that although they had many strong, difficult, and unfavorable emotions, the men performed their activities with their highest intention to be a brave father, striving their baby's safety and health. A better understanding of these experiences will enable nurses and midwives to assist and care for them to aid in their success in becoming a father.

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References

1. Poh HL, Koh SS, He HG. An integrative review of fathers' experiences during pregnancy and childbirth. International Nursing Review. 2014 :543-554. doi:10.1002/casp. 2183
2. Poh HL, Koh SS, Seow HC, He HG. First-time fathers' experiences and needs during pregnancy and childbirth: A descriptive qualitative study. Midwifery. 2013 30(6): 779-87. doi: 10.1016/j.midw.2013.10.002.
3. American Psychological Association. The changing role of the modern day father. 2016. [cited 2018 April 28]. Available from http://www.apa.org/pi/families/resources/changing-father.aspx
4. Asenhed L, Kilstam J, Alehagen S, Baggens C. Becoming a father is an emotional roller coaster - an analysis of first-time fathers' blogs. Journal of Clinical Nursing. 2013 : 1309-1317. doi.org/10.1111/jocn.12355
5. Betts D, Dahlen H G, Smith C A. A search for hope and understanding: An analysis of threatened miscarriage internet forums. Midwifery. 2014 30: 650-656. doi: 10.1016/j.midw.2013.12.011.
6. Tanasirijiranont, R. Becoming a father: Childbearing perspective. Nursing Journal. 2016 43:139-147.
7. Sriyasak, A., Almqvist, AL, Sridawruang C., Neamsakul, W., & Haggstrom-Nordin, E. The new generation of Thai Fathers: Breadwinners involved in parenting. American Journal of Men's Health. 2016:1-11.doi:10.1177/1557988316651062
8. Sriyasak A, Almqvist AL, Sridawruang C, Haggstrom-Nordin E. Father role: A comparison between teenage and adult first-time fathers in Thailand. Nursing and Health Sciences. 2015 17:377-386. doi.org/10.1111/nhs.12200
9. Mclaughlin, K. & Muldoon, O. Father Identity, Involvement and Work-family balance: An In-depth interview study. Journal of Community & Applied Social Psychology. 2014 : 439-452. doi:10.1002/casp.2183
10. World Bank. Country and lending group, 2016. [cited 2018 April 28]. Available from http://data.worldbank.org/about/country-and-lending-group#Upper_middle_income
11. Ministry of Health. Action plan for 2018: Reproductive Health Office. Department of Health. 2018. [cited 2018 April 28]. Available from https://www.anamai.moph.go.th/main.php?filename=Department_2016 [in Thai].
12. Sansiriphan N, Kantaruksa K, Klunklin A, Baosuang C, Jordan P. Thai men becoming a first-time father, Nursing and Health Sciences. 2012 12:403-409.
13. Sirivatanapa P, Tongsong T, Wanapirak C, Piyamongkol W, Sirichotiyakul S, Tongprasert F, Srisupandit K, Luewan S, Traisrisilp K, Sekararithi R, Yampochai A, Taggapichitti A, Leopreecha U. Maternal-Fetal Medicine 2013: Annual report. Chiang Mai: Department of Obstretrics and Gynecology Faculty of Medicine Chiang Mai University; 2016.

14. WHO. Maternal and reproductive health. Global Health Observatory (GHO). 2016 [cited 2018 April 28]. Available from http://www.who.int/gho/maternal_health/en/index.html
15. Rocci SS. Nursing management of pregnancy at risk; pregnancy related complications. In SS Rocci (Ed). Essentials of maternity, newborn, and women's health nursing, 499-540; Philadelphia, PA: Lippincott Williams & Wilkins; 2016.
16. Ge L, Wikby K, Rask M. Lived experience of women with gestational diabetes mellitus living in China: a qualitative interview study. BMJ Open 2017;7:e017648. doi: 10.1136/bmjopen-2017-017648
17. Hantoosh Zadeh, S., Shariat, M., Farahani, Z., Dehghan, P., Mansory, R., Chegini, N., Amini, F. Assessment of the relationship between recurrent high-risk pregnancy and mothers' previous experience of having an infant admitted to a neonatal intensive care unit. Journal of Midwifery and Reproductive Health, 2015 3(1): 293-297. doi: 10.22038/jmrh.2015.3585
18. Blumer, H. Symbolic interactionism. Englewood Cliffs: Prentice-Hall; 1969.
19. Glaser, B. G. Basics of grounded theory analysis: Sociology Press; 1992.
20. Glaser, B. G. Doing grounded theory: Issues and discussions. Mill Valley, CA: Sociology Press; 1998.
21. Wuest, J. Grounded theory: The method. In P. Munhall (Ed). Nursing research: A qualitative perspective. Sudbury, MA: Malloy; 2012, pp.225-256.
22. Glaser, B. G. & Strauss, A. L. The discovery of grounded theory: Aldine; 1967.
23. Glaser, B. G. Theoretical sensitivity. Mill Valley, CA: Sociology Press;1978.
24. Alio AP, Mbah AK, Shah K, August EM, Dejoy S, Adegoke K, et al. Paternal Involvement and Fetal Morbidity Outcomes in HIV/AIDS: a population-based study. American Journal Men's Health. 2013 9 (1): 6-14.
25. Hildingsson I, Johansson M, Fenwick J, Haines H, Rubertsson C. Childbirth fear in expectant fathers: Findings from a regional Swedish cohort study. Midwifery. 2013 30 (2):242-7. doi: 10.1016/j.midw.2013.01.001
26. Nilsen AB, Waldenström U, Rasmussen S, Hjelmstedt A, Schytt E. Characteristics of first-time fathers of advanced age: a Norwegian population-based study. BMC Pregnancy Childbirth. 2013:13-29. doi: 10.1186/1471-2393-13-29
27. Schytt E, Bergström M. First-time fathers' expectations and experiences of childbirth in relation to age. Midwifery. 2014 30 (1):82-8.

การเข้าสู่การเป็นบิดาครั้งแรกขณะที่ภรรยามีภาวะเสี่ยงสูงขณะตั้งครรภ์: การศึกษาโดยใช้ทฤษฎีพื้นฐาน

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บทคัดย่อ: การพยาบาลส่วนใหญ่ในขณะตั้งครรภ์มุ่งเน้นไปยังสตรีตั้งครรภ์มากกว่าผู้ที่จะเป็นบิดา โดยเฉพาะอย่างยิ่งเมื่อสตรีตั้งครรภ์มีภาวะเสี่ยงสูง ผู้ที่จะเป็นบิดาครั้งแรกต้องเผชิญกับความท้าทาย ความกดดันต่างๆ ที่อาจกระทบต่อความสัมพันธ์และชีวิตส่วนตัวของผู้ที่จะเป็นบิดาเอง วัตถุประสงค์ของการศึกษาครั้งนี้เพื่อศึกษากระบวนการและความห่วงกังวลของผู้ที่จะเป็นบิดาครั้งแรกขณะที่ภรรยามีภาวะเสี่ยงสูงขณะตั้งครรภ์ ผู้เข้าร่วมวิจัยเป็นชายไทยจำนวน 23 คน ที่มารับบริการจากคลินิกฝากครรภ์ของโรงพยาบาลมหาวิทยาลัยแห่งหนึ่งทางภาคเหนือของประเทศไทย ข้อมูลถูกเก็บรวบรวมโดยการสัมภาษณ์เชิงลึกและวิเคราะห์ข้อมูลบนพื้นฐานของระเบียบวิธีวิจัยเชิงทฤษฎีพื้นฐาน

ผลการศึกษาแสดงว่า “การฝ่าฟันอุปสรรคเพื่อสุขภาพที่ดีของทารก” เป็นกระบวนการพื้นฐานทางสังคมที่ได้มาจากข้อมูลหมวดหมู่หลัก ซึ่งเป็นกระบวนการผู้ที่จะเป็นบิดาใช้ในการจัดการกับความห่วงกังวลและความต้องการ และเพื่อพัฒนาการเป็นบิดาเมื่อภรรยามีภาวะเสี่ยงสูงขณะตั้งครรภ์ ซึ่งแบ่งเป็น 3 ระยะ 1) ความอึดอัดใจจากการเผชิญการตั้งครรภ์เสี่ยงสูง กลวิธีเพื่อจัดการความห่วงกังวลและความต้องการของตนเองได้แก่ การจัดการกับอารมณ์ การแสวงหาการดูแล และการปรับเปลี่ยนพฤติกรรม 2) การปรารถนาให้ภรรยาและบุตรในครรภ์ปลอดภัยและแข็งแรง กลวิธีเพื่อจัดการความห่วงกังวลและความต้องการของตนเองได้แก่ การจัดการกับอารมณ์ที่ยังคงค้างอยู่ การแสวงหาการดูแลพิเศษ การปรับเปลี่ยนพฤติกรรม และการสร้างสัมพันธภาพกับบุตร 3) การจัดการกับผลลัพธ์ที่ไม่แน่นอน เริ่มประมาณเดือนที่ 8 ของการตั้งครรภ์จนถึงกำหนดคลอด กลวิธีเพื่อจัดการความห่วงกังวลและความต้องการของตนเองได้แก่ การจัดการกับความห่วงกังวล การแสวงหาวิธีการให้บุตรปลอดภัย การเตรียมตัวสำหรับเหตุการณ์ไม่คาดคิด และการสร้างสัมพันธภาพกับบุตร

ผลการศึกษาครั้งนี้เพิ่มเติมความรู้ใหม่เกี่ยวกับการจะเป็นบิดาในชายไทย ซึ่งรวมถึงข้อมูลเกี่ยวกับความห่วงกังวลและความต้องการขณะที่ภรรยาตั้งครรภ์เสี่ยงสูง และกลวิธีที่ใช้ในการจัดการความห่วงกังวลและความต้องการของตนเอง ความเข้าใจอย่างดียิ่งของประสบการณ์เหล่านี้จะสามารถทำให้พยาบาล/ผดุงครรภ์และผู้ดูแลทางสุขภาพอื่นๆ ให้การช่วยเหลือและดูแลผู้ที่จะเป็นบิดาครั้งแรกขณะที่ภรรยามีภาวะเสี่ยงสูงขณะตั้งครรภ์ได้อย่างเหมาะสม

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คำสำคัญ: ผู้ที่กำลังจะเป็นบิดา ผู้ที่กำลังจะเป็นบิดาครั้งแรก ทฤษฎีพื้นฐาน การตั้งครรภ์เสี่ยง ทฤษฎีปฏิสัมพันธ์เชิงสัญลักษณ์

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