
Support Needs of Expectant Mothers and Fathers: A Qualitative Study

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ABSTRACT

The aim of this study was to describe expectant mothers' and fathers' perceived needs of support during pregnancy. Twenty-two women and 10 men were interviewed in four focus groups and 13 individual interviews. Systematic text condensation was performed to analyze the data. Parents described not only a broad spectrum of social support needs but also needs of psychological and physical support. They also requested to share their experiences with others. The foci of care and parents' needs of support are more harmonized with medical support than with psychological and emotional support. Mothers' needs were predominately addressed in the health services, but fathers often felt "invisible." Antenatal services may need to offer more customized individual support and emphasize peer support in groups; the challenge is to involve both parents through communication and encouragement so they can support each other.

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There are many studies concerning support during pregnancy, but to our knowledge, few studies examine the demands of expectant parents themselves. Life stress and the lack of social and partner supports are associated with depression, which is one of the most common complications during pregnancy (Lancaster et al., 2010). Support for pregnant women may have short- and long-term beneficial mother–child effects (Lederman & Weis, 2009), yet studies have shown that some expectant parents feel

unprepared for parenthood (Börjesson, Paperin, & Lindell, 2004; Boyce, Condon, Barton, & Corkindale, 2007; Deave, Johnson, & Ingram, 2008). Therefore, the purpose of this study was to describe the support needs of both expectant mothers and expectant fathers during pregnancy.

In Sweden, all pregnant women receive antenatal care free of charge through primary health-care maternity units and a few publicly financed, private alternatives. In addition to providing high

quality medical care during pregnancy, another goal of Swedish antenatal care is to promote psychological and physical health through helping and supporting expectant parents in their transition to parenthood. Care is given through individual visits to midwives and through parenting classes led by midwives. A Swedish national quality register of maternal health reports that parental education in groups is offered by 100% of antenatal clinics for first-time mothers and by 50% of clinics for experienced (i.e., not first-time) mothers. The participation rate is 75.5% for first-time mothers and 7.8% for experienced mothers (Nationellt Kvalitetsregister för Mödrahälsovård [National Quality Register for Maternity Services], 2010). No data are available on men's participation, but the general picture is that fathers participate in these groups to a very high extent.

The general curriculum of group parental education programs in Sweden includes the social, emotional, psychological, and physical aspects of pregnancy. Emphasis is placed on improving women's confidence in their ability to give birth, preparing expectant parents for childbirth and parenthood, enhancing the coparental relationship, developing social support networks, promoting the parents' self-confidence, and contributing to the reduction of perinatal morbidity and mortality rates. However, these aspects, although important in many respects, do not necessarily capture the expressed needs of expectant parents attending antenatal classes (Gagnon & Sandall, 2009; Koehn, 2008). This shortcoming yields important differences in the administration and content of parenting classes both within and between maternity care units (Statens Offentliga Utredningar [Swedish Government Official Reports], 2008). In fact, Swedish researchers attempting to evaluate the effects of antenatal classes on the experiences and outcomes of childbirth found that, although the mothers' social networks increased, no effect was evident on the actual birthing experience or outcome (Fabian, Rådestad, & Waldenström, 2005).

Furthermore, studies on the experiences of expectant mothers and fathers have often been framed from the perspective of the mothers. This perspective has resulted in many important insights but, currently, there is a greater emphasis on the fathers' experiences. Researchers have reported that expectant fathers often feel displaced and set aside by routine antenatal care (Deave et al., 2008; Leite,

2007; Premberg & Lundgren, 2006). Men often express a desire to be prepared and participate in the pregnancy, yet they experience feelings of isolation by being excluded from antenatal appointments, classes, and the available literature (Deave et al., 2008; Hinckley, Ferreira, & Maree, 2007). It seems important to take into account the views of both expectant parents when considering their needs of support.

Further research is needed to understand how to make antenatal services more client-centered and responsive to the support needs of both expectant parents during their passage to parenthood. The aim of this study, therefore, was to describe both expectant mothers' and expectant fathers' perceived needs of support during pregnancy.

METHODS

Study Design and Population

A qualitative design was employed using a naturalistic inquiry, with focus groups and individual interviews as data sources. To enhance transferability, participants were recruited from diverse settings by an open lecture at the hospital describing facilities for obstetric and neonatal care, by a midwife at a community center serving newly arrived immigrants, and by midwives at maternity care units. Parents interested in participating in the study provided their telephone numbers to receive further information. Thirty-five expectant parents volunteered to participate. Of these, three individuals withdrew their participation before the interviews because of childbirth (one woman) and personal reasons (a couple). A total of 32 expectant parents participated in the interviews: 22 women and 10 men. Of these, 22 were first-time parents and 10 were experienced (i.e., not first-time) parents. The mean age of participants was 31 years old (range 21–56 years old). Ninety-seven percent were married or lived together with their partner, and 87% had, as a minimum, completed high school. Pregnancy lengths were between 13 and 39 (median 33.5) weeks.

Four focus group interviews and 13 individual interviews were conducted by the first author. An observer was present at the focus group interviews to assist the moderator. One focus group interview consisted of three women and two men; two focus group interviews consisted of only women (three and seven, respectively); and one focus group interview consisted of four men. All of the focus

group interviews included a mix of first-time and experienced parents. The focus group interviews were conducted at the Centre for Clinical Research in Västerås, Sweden, and lasted from 71 to 109 minutes. The individual interviews were conducted according to the participant's preferred location, either at home or a community center, and lasted for 31 to 65 minutes. Five of the 13 individual interviews were conducted in English or through an interpreter.

Procedure

Ethical approval was granted by the regional research ethics committee. Informed consent was obtained from all participants who also completed a questionnaire with demographic background variables. The parents' confidentiality was guaranteed. Expectant Swedish-speaking mothers and fathers who participated were given the opportunity to choose between an individual interview and a focus group interview. The individual interviews were offered in Swedish, English, or the participant's native language through an interpreter. An interview guide was used in both the focus group and the individual interviews. The interviews addressed the following three research questions: (a) What types of support needs do expectant parents describe? (b) Are the foci of care and parents' needs of support during pregnancy well harmonized? and (c) Do prenatal health services attend to the needs of mothers and fathers equally well? Each interview was recorded and transcribed verbatim. Seventeen interviews (four focus group interviews and 13 individual interviews) were included in the analysis.

Analysis

The transcribed interviews were analyzed using systematic text condensation according to Malterud's (1996) description. Each interview was listened to, and the verbatim transcripts were read several times to develop a sense of the content. After naive reading of the 17 transcribed interviews, seven common themes were identified from the text. The supervisor, who was also one of the coauthors, acted as a coreader to validate the analysis and check the designated themes against the original interview contents.

The next step was to break down each theme into categories (decontextualizing) by using meaningful units belonging to the theme as the unit of analysis rather than the whole interview. A final recontextualization was done by the first author and coreader during a 2-day consensus conference. All

TABLE 1
Themes and Categories

Themes	Categories
To be in the pregnancy	Expectations Unrest Restrictions Loneliness
Sharing with others	Attention Social network Media In the same situation
Expert resources	The midwife Parental groups Insurance—a jungle New opportunities—coordination
Desired support	Seen and confirmed Involving the prospective father Renewal of parenting groups More visits to the midwife Clarification of parental insurance Sorting through information Interaction central—a challenge
New focus—the unknown world	Transposition/adjustment Preparation New resources Giving birth
Norms in the community	Welfare society Working life Information flow Not adaptable to the template
Own resources	Family Friends Workmates and employers Internet

designated themes and categories were compared with the original interviews, and appropriate quotations were selected. Special care was taken to identify negative cases and in tracking uncoded text units for content. A comprehensive summary of all identified themes and categories is presented in Table 1.

RESULTS

We present the results in the subsequent paragraphs, focusing on the four themes most pertinent to the support desired by both women and men: (a) to be in the pregnancy; (b) sharing with others; (c) expert resources; and (d) desired support (the latter two themes are described under one heading). After each quotation from a participant, the abbreviation FGI (focus group interview) or II (individual interview) is presented in parentheses, along with the designation of first-time parent or experienced parent, to identify the participant's status.

To Be in the Pregnancy—Unexpected Physical Symptoms

Many of the expectant parents thought pregnancy would be a pleasant time when they would enjoy themselves, but those expectations were not met by the majority. The participants often described pregnancy as a time of worries and limitations, when the woman's body changed due to physical symptoms of nausea and fatigue. As one woman described, "Then came the tiredness, the great weariness, and then the nausea came back, so now I'm at a stage when I'm really tired and feel sick" (II, first-time expectant mother).

Most of the men said that they had not expected their partner to feel so ill or weak. They tried hard to offer assistance, adjust to the situation, and reorient themselves toward a different life as pleasurable as possible for their partners; however, even if the men tried to adapt to the new situation, they often felt that they were helpless. One man described his situation as follows: "She lost weight and she didn't retain any food and couldn't eat . . . so that felt pretty . . . felt a little helpless, you can't do anything" (FGI, first-time expectant father).

To Be in the Pregnancy—Missing the Midwife's Support

Several women said that as soon as it was confirmed that they were pregnant, they felt the urge to make an appointment with the midwife. Although the women expressed positive feelings about their present and future situations, their contact with maternity health care left them feeling frustrated because their expectations were not fulfilled. One woman explained,

You book an appointment with a midwife and build up such a lot of expectations . . . but we got such a late appointment . . . and then you just fill in a questionnaire . . . we thought that was really strange . . . I am pregnant, is there nothing more to do? (FGI, first-time expectant mother)

Several women described the stress they felt when not having the opportunity to meet the midwife, and they missed her support. One woman described how lonely and lost she felt in the early part of her pregnancy when visits to the midwife were rare:

I remember when I talked to my midwife, it was after those 3 months, and she asked me, "So, we haven't seen each other in a very long time, how have you been?" and then I said, "It's been a little tough" . . . so I felt that I maybe would have wished to share my

feelings with her then, but back then I was alone. (II, first-time expectant mother)

Most of the expectant parents found the medical support and information they received useful in helping them understand their pregnancy. A woman described her appreciation: "It's great to have a professional to turn to if you have questions . . . it's nice to be able to go there . . . ask some of the questions that have been on one's mind and so on" (FGI, first-time expectant mother).

Sharing With Others—The Private Sphere

The expectant parents expressed a need to share their experiences with someone. Most expectant parents mentioned their partner as their greatest source of support. One woman described her husband: "I think that my husband supports me most of all. I think that he is so sympathetic and amazing . . . he has really supported me" (FGI, first-time expectant mother).

Personal support and the feeling of being allied with families were important, particularly for expectant mothers. For example, one woman said,

Yesterday, my father and his new wife came over . . . and by the look in her eyes . . . she just understood . . . "Are you having a tough time?" . . . "Yes, it feels like I can't take it anymore" . . . and she just replied, "I know, I know what it feels like," in such a humble way, it felt great. (FGI, first-time expectant mother)

Living close to the family was also expressed by the women as being desirable. Expectant mothers who had recently moved or immigrated felt lonely in the absence of their families. One woman described how she missed her mother who lived in another country: "My relationship with my mother was really strong. We were friends and she meant and means a lot to me in my life. I really miss her" (II, first-time expectant mother).

Being able to meet with and have conversations with their families was a source of happiness. However, several women sometimes felt overwhelmed by the extraordinary attention they received because of their pregnancy.

Maybe I will miss it [the attention] when the child is born, but I guess I'll mostly like the feeling that . . . the focus . . . it's on the child instead then, and not on myself all the time. It's nice to experience this positive attention, but it can easily become too much. (FGI, first-time expectant mother)

Friends were highly valued by expectant parents, particularly friends who were or had been in the same situation and with whom the expectant parents could share their experiences of pregnancy. They also searched for advice and support from friends. As one of the men described,

Friends who have children you could say are a support in a way . . . they are so encouraging and it feels like they know what they are talking about or they have their own experiences of what it's like. (II, first-time expectant father)

Sharing With Others—The Role of Antenatal Services

In spite of the support offered by families and friends, women and men requested a forum where they could meet other expectant parents. In the words of one woman: “In the parental group . . . my expectation was that I was going to be able to share the feelings and thoughts of others about birth, pregnancy, and parenthood and all this” (FGI, experienced expectant mother). The parental group, especially the father group, was seen as a source of strength and support, as illustrated in the following comment: “There are other expectant fathers in the same situation that also worry over things; I think that it felt really good . . . there are others there who are exactly the same, in the same situation” (FGI, first-time expectant father).

The importance of being involved in parental groups that were stimulating and encouraged relationships with others was emphasized. Expectant parents wished to find friends who they could socialize with after childbirth. One woman described her experiences: “I believe many use the parental groups to get to know lots of other couples with whom they stay in contact afterward” (II, experienced expectant mother).

In addition to personal meetings, women used the Internet to connect with other expectant mothers. The Internet was also used as an information channel for women and men, even if several expectant parents, often the men, expressed concerns about the reliability of the information received. They felt a need for someone to help organize the flow of information, to discuss information they found, and to know if any Web sites were considered more appropriate than others by maternity health officials. As one of the men described, “So there is an enormous flow of information that you must sort through, that for me is more frustrating than useful” (II, experienced expectant father).

Expert Resources and Desired Support—A Need to Consider Both Parents

The expectant parents valued the ultrasound examination, which appeared to be part of adjusting to their future situation as parents. One woman described her husband's experiences at the ultrasound examination:

My husband could see that there was a baby in there . . . that it was a turning point for him to see [it in] reality. For even though I myself have gone through this, I couldn't really explain what was happening to me. (II, first-time expectant mother)

Although the expectant parents were content with the information and medical support they received from the health profession, they described their dissatisfaction with the antenatal clinic services. Parents had hoped for more psychosocial and emotional support. One man described his needs as follows: “You have different needs, and you are different as people and different people have different needs. I would have probably needed more support than I feel I've had” (FGI, first-time expectant father). Some expectant fathers were left feeling invisible and expressed a need to be more involved in the antenatal clinic services and, thus, to find the appointments more meaningful. As one of the men described, “I accompanied her [to the midwife] a number of times, but I never received any questions about whether I had anything to ask or so, I'm just company to the mother, besides that I'm just invisible there” (FGI, experienced expectant father).

Also, expectant mothers expressed a desire to involve the expectant father more in the pregnancy, from the first visit with the midwife until the birth at the hospital. Some women expressed a need for special customized father education. For example, one of the women said, “Maybe it should be a little more compulsory that you also have like a father group where they are by themselves in a way and are able to talk about their own thoughts and worries” (II, experienced expectant mother).

DISCUSSION

The aim of this study was to describe expectant parents' perceived needs of support during pregnancy. The main results indicate that mothers and fathers have different kinds of support needs. The participants in this study described not only a broad spectrum of social support needs, including emotional, informational, tangible, and anchorage support, but

also a necessity for psychological and physical support. The results also indicate that the foci of care and parents' needs of support are well harmonized with the medical care received, but not harmonized to the same extent with psychological and emotional support. It appeared that the mothers' needs were dominant at the prenatal health services and that the fathers often felt "invisible," which was frustrating for some of the expectant parents.

Methodological Considerations

Three criteria of rigor in qualitative research were considered in our findings: credibility, dependability, and transferability.

Credibility. An interview guide was used in both the focus group interviews and the individual interviews, and the same interviewer conducted all the interviews. The interview guide was pilot tested with one expectant mother and one expectant father, and adjustments were made to increase the face validity of the questions. Expectant parents could choose how they preferred to participate, in either a focus group interview or an individual interview.

The expectant parents in this study generously shared their lived experiences in the focus groups with one another, which was in accordance with participants in previous studies (Bradbury-Jones, Sambrook, & Irvine, 2009; McLafferty, 2004) and reinforced our finding that expectant parents want to share their experiences with others who are in the same situation as themselves. The strength of a focus group interview is the interaction between participants. This interaction was clearly proven by this study's participants when they turned to each other, listened carefully when somebody talked, and encouraged each other, as also described by Morgan (1996).

However, in the individual interviews, there was a risk for therapeutic or educational conversation, especially with a professional as the interviewer. The interviewer in all cases was the first author, who is a midwife. She was aware of the risk described and, in some of the individual interviews, guided the discussion to maintain the purpose of the interview.

The strength of offering participants the choice between a focus group interview and an individual interview was that we reached individuals who could not join a focus group interview. The results from both interview methods revealed similar content and did not contradict each other. However, although the use of an interpreter allowed for interviewing a broader range of parents, individuals who

participated through interpreters might have been limited in what they were able to share.

Dependability. Reliability of the findings was increased by several researchers accessing and discussing the data and respondent validation. After the interviews, the research midwife (first author), the observer (second author), or the participants wrote a short summary, and the participants had the opportunity to verify what was written (Krueger & Casey, 2000). After each focus group interview, the moderator (first author) and observer discussed the findings, and notes from the observer were used. Use of a coreader is seen as a measure of enhancing the dependability of findings (i.e., how well the final descriptive categories correspond to the original raw material).

Transferability. Several strengths enhanced the transferability of this study. Both first-time and experienced parents participated, and the expectant parents included both Swedish and non-Swedish individuals. There are, of course, also limitations. Most of the participants were recruited from an open lecture, were self-selected, and had higher educational levels than the average, but all levels of education were also represented. Only one single expectant mother was included, so the needs of single parents are not sufficiently represented in the present study.

Pregnancy—A Time of Support Needs

In this study, the expectant parents' greatest support came from their partners, which is in accordance with findings from previous research (Börjesson et al., 2004), followed by family and friends. The parents expressed social support needs similar to those reported in earlier studies (Finnbogadóttir, Crang Svalenius, & Persson, 2003; Hodnett & Fredericks, 2003). Thus, emotional, informational, tangible, and anchorage support needs were all represented in the testimonials of the expectant parents. Sharing experiences with other expectant parents is an important source of peer emotional support, and something clearly desired by the participants in this study. The need for anchorage support in this transitional period was also clear. The parents often sought support from the older generation. Parents who had recently moved into a new home or were newly arrived immigrants missed family and friends to share their experiences with. Antenatal education in low-income countries is often less structured; knowledge is passed from mother to daughter (Jaddoe, 2009), enhancing the feeling of anchorage in the family and the particular social circumstances. Although the immigrant women

in this study participated in structured antenatal care, they often described how they specifically missed their mothers. The extended family was called upon, where possible, to provide tangible support. Most expectant mothers, however, identified their partners as their most important source of practical help.

The literature clearly demonstrates the impact of support on the well-being of expectant parents (Feinberg & Kan, 2008; Hohmann-Marriott, 2009). Online information or videoconferencing may become useful in providing some of the support needs (Larsson, 2009; Lindberg, Christensson, & Öhring, 2009) that the parents in this study described. Internet-based methods could offer possibilities for parents to access and follow lessons anywhere and could be a fruitful intervention for prenatal education purposes in the future (Nyström & Öhring, 2004). Several of the parents in this study, however, wanted help to sort information and find dependable, authentic Internet sources. This finding was in accordance with results from two previous studies (Kunst, Groot, Latthe, Latthe, & Khan, 2002; Weiss & Moore, 2003) but in contrast with results from another study in which expectant mothers found online information trustworthy and reliable (Larsson, 2009). In the area of antenatal care, the Internet has both potential advantages and disadvantages, and it offers new possibilities for surpassing geographical and office-hour constraints (Weiss & Moore, 2003). The expectant parents in this study demanded up-to-date information, which could be improved by the Internet.

The Focus of Care

In the past few years, researchers have found that expectant parents often describe antenatal classes as being unhelpful and ineffective regarding perinatal outcomes and birthing experiences (Deave et al., 2008; Fabian et al., 2005). A possible explanation for this deficit might be the focus of care. Parental support is often based more on the health-care workers' beliefs of appropriate care rather than on the expectant parents' perceived needs (Carver, Ward, & Talbot, 2008; Jaddoe, 2009).

Participants in this study felt that the antenatal groups often followed a given program, which they could not influence. This perception has also been described by others (Nolan & Hicks, 1997). Our study's participants also felt that the education offered in antenatal classes was too basic, and they suggested that midwives should initiate the groups but not necessarily participate during all the sessions, a finding congruent with results reported by Premberg and Lundgren (2006). Our study's parents wanted parent education groups to be an opportunity to share experiences

with others in the same situation rather than serve as a forum to convey information. For example, some expectant fathers in this study attended special father groups. They were content with these groups because they had the opportunity to share their needs and experiences with other expectant fathers, a finding that is in accordance with previous research involving all-male models for discussing issues prenatally (Fletcher, Matthey, & Marley, 2006; Friedewald, Fletcher, & Fairbairn, 2005). In our study, participants also pointed out that midwives need to improve their skills in creating an interactive environment and leading group processes and to increase their active listening skills, which is in line with other studies regarding patient-centered care and the demands of expectant parents (Ahldén, Göransson, Josefsson, & Alehagen, 2008; Erlandsson & Häggström-Nordin, 2010; Gunn et al., 2006). Thus, models of care that focus on the needs of the participants rather than the professional's agenda could be useful in developing future services.

Some expectant mothers in this study asked for more visits to the midwife, especially at the beginning of the pregnancy, which is consistent with findings reported by Hildingsson, Rådestad, and Waldenström (2005). In line with researchers' reports from other studies (Carver et al., 2008; Hildingsson & Thomas, 2007), our findings emphasize the importance of individualized approaches for expectant parents.

"Invisible" Men

During pregnancy, women enter the domain of midwives and obstetricians in a world where fathers have little influence (Boyce et al., 2007). Similar to findings from earlier studies (Finnbogadottir et al., 2003; Lindberg, Christensson, & Öhring, 2005), some expectant fathers in this study felt ignored, excluded, and not welcome during visits to the midwife. In this study, the expectant father was identified as the most important supportive person for the expectant mother, which resonates with findings from an earlier study (Hildingsson, Tingvall, & Rubertsson, 2008). In another study, men with higher levels of anxiety perceived that they gave less support to their partner, and men whose partner was more anxious also perceived that they gave less support (Wilson, Rhoads, Simpson, & Tran, 2007). This perception underscores the need for health professionals to support both parents so that they, in turn, may better support each other (Cabrera, Fagan, & Farrie, 2008), rather than failing to do so because of their own feelings of anxiety or inadequacy (Lundqvist, Westas, & Hallström, 2007). Most health professionals in perinatal care view the

father as an important support to the mother but often not until after the child's arrival (Hallberg, Lindbladh, Petersson, Råstam, & Håkansson, 2005).

Our finding about the “invisible” father may describe gender differences in antenatal health care similar to previous research (Polit & Beck, 2008), which suggests that the needs of expectant mothers and fathers are not adequately met. With the knowledge of the importance of the father, it is particularly important to ensure his prenatal involvement and commitment to promote postnatal commitment in the child (Cabrera et al., 2008; Erlandsson & Häggström-Nordin, 2010).

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

It is possible that existing health-care services fail to meet the support needs of expectant mothers and fathers, which suggests a need to refocus antenatal services to become more client-centered, such as offering customized individual support and peer support in groups. It may also be important to initiate classes in several languages and attend to the needs of fathers to a greater extent. Midwives facing the important challenge of offering appropriate support to expectant parents may need additional professional development training that enables midwives to provide psychological and emotional support to both expectant mothers and expectant fathers during pregnancy, so they, in turn, may better support each other in parenthood.

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REFERENCES

- Ahldén, I., Göransson, A., Josefsson, A., & Alehagen, S. (2008). Parenthood education in Swedish antenatal care: Perceptions of midwives and obstetricians in charge. *The Journal of Perinatal Education, 17*(2), 21–27.
- Börjesson, B., Paperin, C., & Lindell, M. (2004). Maternal support during the first year of infancy. *Journal of Advanced Nursing, 45*(6), 588–594.
- Boyce, P., Condon, J., Barton, J., & Corkindale, C. (2007). First-Time Fathers' Study: Psychological distress in expectant fathers during pregnancy. *Australian and New Zealand Journal of Psychiatry, 41*(9), 718–725.
- Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2009). The phenomenological focus group: An oxymoron? *Journal of Advanced Nursing, 65*(3), 663–671.
- Cabrera, N. J., Fagan, J., & Farrie, D. (2008). Explaining the long reach of fathers' prenatal involvement on later paternal engagement. *Journal of Marriage and the Family, 70*(5), 1094.
- Carver, N. A., Ward, B. M., & Talbot, L. A. (2008). Using Bradshaw's taxonomy of needs: Listening to women in planning pregnancy care. *Contemporary Nurse: A Journal of the Australian Nursing Profession, 30*(1), 76–82.
- Deave, T., Johnson, D., & Ingram, J. (2008). Transition to parenthood: The needs of parents in pregnancy and early parenthood. *BMC Pregnancy and Childbirth, 8*, 30.
- Erlandsson, K., & Häggström-Nordin, E. (2010). Prenatal parental education from the perspective of fathers with experience as primary caregiver immediately following birth: A phenomenographic study. *The Journal of Perinatal Education, 19*(1), 19–28.
- Fabian, H. M., Rådestad, I. J., & Waldenström, U. (2005). Childbirth and parenthood education classes in Sweden. Women's opinion and possible outcomes. *Acta Obstetrica et Gynecologica Scandinavica, 84*(5), 436–443.
- Feinberg, M. E., & Kan, M. L. (2008). Establishing family foundations: Intervention effects on coparenting, parent/infant well-being, and parent-child relations. *Journal of Family Psychology, 22*(2), 253–263.
- Finnbogadóttir, H., Crang Svalenius, E., & Persson, E. K. (2003). Expectant first-time fathers' experiences of pregnancy. *Midwifery, 19*(2), 96–105.
- Fletcher, R. J., Matthey, S., & Marley, C. G. (2006). Addressing depression and anxiety among new fathers. *The Medical Journal of Australia, 185*(8), 461–463.
- Friedewald, M., Fletcher, R., & Fairbairn, H. (2005). All-male discussion forums for expectant fathers: Evaluation of a model. *The Journal of Perinatal Education, 14*(2), 8–18.
- Gagnon, A. J., & Sandall, J. (2009). Individual or group antenatal education for childbirth or parenthood, or both [Review]. *Cochrane Database of Systematic Reviews, (4)*, CD002869.
- Gunn, J., Hegarty, K., Nagle, C., Forster, D., Brown, S., & Lumley, J. (2006). Putting woman-centered care into practice: A new (ANEW) approach to psychosocial risk assessment during pregnancy. *Birth, 33*(1), 46–55.
- Hallberg, A. C., Lindbladh, E., Petersson, K., Råstam, L., & Håkansson, A. (2005). Swedish child health care in a changing society. *Scandinavian Journal of Caring Sciences, 19*(3), 196–203.
- Hildingsson, I., Rådestad, I., & Waldenström, U. (2005). Number of antenatal visits and women's opinion. *Acta Obstetrica et Gynecologica Scandinavica, 84*(3), 248–254.
- Hildingsson, I., & Thomas, J. E. (2007). Women's perspectives on maternity services in Sweden: Processes, problems, and solutions. *Journal of Midwifery & Women's Health, 52*(2), 126–133.
- Hildingsson, I., Tingvall, M., & Rubertsson, C. (2008). Partner support in the childbearing period—A follow up study. *Women and Birth, 21*(4), 141–148.

- Hinckley, C., Ferreira, R., & Maree, J. G. (2007). The case of expectant fathers: Negotiating the changing role of males in a 'female' world. *Early Child Development and Care*, 177(5), 461–478.
- Hodnett, E. D., & Fredericks, S. (2003). Support during pregnancy for women at increased risk of low birth-weight babies [Review]. *Cochrane Database of Systematic Reviews*, (3), CD000198.
- Hohmann-Marriott, B. (2009). The couple context of pregnancy and its effects on prenatal care and birth outcomes. *Maternal and Child Health Journal*, 13(6), 745–754.
- Jaddoe, V. W. (2009). Antenatal education programmes: Do they work? *Lancet*, 374(9693), 863–864.
- Koehn, M. (2008). Contemporary women's perceptions of childbirth education. *The Journal of Perinatal Education*, 17(1), 11–18.
- Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Kunst, H., Groot, D., Latthe, P. M., Latthe, M., & Khan, K. S. (2002). Accuracy of information on apparently credible websites: Survey of five common health topics. *BMJ: British Medical Journal*, 324(7337), 581–582.
- Lancaster, C. A., Gold, K. J., Flynn, H. A., Yoo, H., Marcus, S. M., & Davis, M. M. (2010). Risk factors for depressive symptoms during pregnancy: A systematic review. *American Journal of Obstetrics and Gynecology*, 202(1), 5–14.
- Larsson, M. (2009). A descriptive study of the use of the Internet by women seeking pregnancy-related information. *Midwifery*, 25(1), 14–20.
- Lederman, R., & Weis, K. (2009). *Psychosocial adaptation to pregnancy: Seven dimensions of maternal role development* (3rd ed.). New York, NY: Springer Science+Business Media, LLC.
- Leite, R. (2007). An exploration of aspects of boundary ambiguity among young, unmarried fathers during the prenatal period. *Family Relations*, 56(2), 162–174.
- Lindberg, I., Christensson, K., & Öhrling, K. (2005). Midwives' experience of organisational and professional change. *Midwifery*, 21(4), 355–364.
- Lindberg, I., Christensson, K., & Öhrling, K. (2009). Parents' experiences of using videoconferencing as a support in early discharge after childbirth. *Midwifery*, 25(4), 357–365.
- Lundqvist, P., Westas, L. H., & Hallström, I. (2007). From distance toward proximity: Fathers' lived experience of caring for their preterm infants. *Journal of Pediatric Nursing*, 22(6), 490–497.
- Malterud, K. (1996). The analysis of qualitative data. In *Kvalitativa metoder i medicinsk forskning [Qualitative methods in medical research]* (pp. 86–101). Lund, Sweden: Studentlitteratur.
- McLafferty, I. (2004). Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing*, 48(2), 187–194.
- Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, 22, 129–52.
- Nationellt Kvalitetsregister för Mödrahälsovård [National Quality Register for Maternity Services]. (2010). *Sammanställning av individdata för 2008 [Summary of individual data for 2008]*. Retrieved from http://www.ucr.uu.se/mhv/index.php/arsrapporter/doc_download/11-individdata-2008
- Nolan, M. L., & Hicks, C. (1997). Aims, processes, and problems of antenatal education as identified by three groups of childbirth teachers. *Midwifery*, 13(4), 179–188.
- Nyström, K., & Öhrling, K. (2004). Parenthood experiences during the child's first year: Literature review. *Journal of Advanced Nursing*, 46(3), 319–330.
- Polit, D. F., & Beck, C. T. (2008). Is there gender bias in nursing research? *Research in Nursing & Health*, 31(5), 417–427.
- Premberg, A., & Lundgren, I. (2006). Fathers' experiences of childbirth education. *The Journal of Perinatal Education*, 15(2), 21–28.
- Statens Offentliga Utredningar [Swedish Government Official Reports]. (2008). Föräldrastöd – en vinst för alla: Nationell strategi för samhällets stöd och hjälp till föräldrar i deras föräldraskap [Parental support – a win for all: A national strategy for community support and assistance to parents in their parenting (in Swedish)]. Retrieved from <http://www.regeringen.se/content/1/c6/11/89/80/5f5945ee.pdf>
- Weiss, E., & Moore, K. (2003). An assessment of the quality of information available on the Internet about the IUD and the potential impact on contraceptive choices. *Contraception*, 68(5), 359–364.
- Wilson, C. L., Rholes, W. S., Simpson, J. A., & Tran, S. (2007). Labor, delivery, and early parenthood: An attachment theory perspective. *Personality & Social Psychology Bulletin*, 33(4), 505–518.

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