THE EXPECTANT FATHER'S EXPERIENCE OF HIGH RISK PREGNANCY
AND ANTENATAL HOSPITALIZATION

By

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Abstract

Despite increasing interest in the role of the father in pregnancy, birth, and parenthood, little attention has been given to the expectant father's experience of coping with a high risk pregnancy and the hospitalization of his partner. This study was undertaken to further understanding regarding the experience of the expectant father from his own unique perspective. Using the grounded theory method, fathers' experience of the phenomenon of high risk pregnancy and antenatal hospitalization was explored, resulting in a descriptive analysis that conveyed a common conceptualization of the experience.

Participants were selected from the tertiary care facility serving the province of British Columbia. Nine fathers participated in the study; they contributed a total of 16 interviews. The fathers' ages ranged from 29 to 40 years. At the time of the first interview, pregnancy gestation ranged from 24 weeks to 35 weeks. Pregnancy complications varied in nature reflective of a high risk population.

Central to the fathers' descriptions were the roles they assumed in relation to their participation in the phenomenon. The two predominant roles were providing emotional care to their partner and sustaining the family's functional responsibilities. The primary theme that evolved through analysis was a process of finding a balance between these two roles. A number of factors served to influence the balance, including the support system available to the fathers, high risk condition factors, and geographical circumstance. Specific strategies were identified that contributed to the fathers' ability to cope with the experience. The findings indicated that the
experience had a significant personal impact on the fathers, affecting both their emotional and physical wellbeing.

Based on the findings of the study, implications for nursing practice, education, and research were identified that promote recognition of the important and unique needs of expectant fathers in high risk pregnancy and antenatal hospitalization.
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CHAPTER ONE
INTRODUCTION

Background to the Problem

The transition to parenthood is recognized as a critical developmental event in the lives of both men and women. While some argument exists regarding the degree of stress associated with this life experience - whether the process is determined to be one of crisis or transition - the significance of the event in the lives of developing families is acknowledged by parents and professionals alike (Cronenwett & Wilson, 1981; Duvall, 1977; Erikson, 1950; Griffith, 1976; Hobbs, 1965; LeMasters, 1957; Rubin, 1975).

Early attention to fatherhood was limited to anthropological and psychoanalytic perspectives (Malinowski, 1966; Ross, 1979; Wainwright, 1966). The natural childbirth movement in the 1950s triggered a small, but growing interest in the role of the father in pregnancy and childbirth (May & Perrin, 1985). Widespread and serious consideration of the importance of the role has only been evident since the 1970s. This corresponds with the immense social changes that have occurred in the western world during the same period, and which have led to a redefinition of sex roles and a closer examination of the man's role in the family (Hangsleben, 1980; May & Perrin, 1985).

The body of knowledge about the experience of fatherhood has been growing over the past decade. Specifically, more is known about the father's role transition during normal pregnancy, his participation in the birth

There are, however, some aspects of fatherhood less well understood. Little consideration has been given to the impact of a high risk pregnancy on the fatherhood experience. In the clinical setting of a high risk antepartum unit, the author has observed that, in high risk pregnancies, attention has been very much directed to the mother-fetus diad. Whether intentionally or unintentionally, health care professionals have treated the father as an important but subsidiary participant in the events. The result appears to be a father left to cope with a variety of complex emotions and additional responsibilities without substantial understanding or support from his partner, family, friends, or members of the health care team.

It has been suggested that a woman's experience of a high risk pregnancy may be altered significantly from the experience of a normal pregnancy (Kemp & Page, 1987; Penticuff, 1982). Hospitalization contributes additional dimensions to this phenomenon (Carty, Crawford & Ross, 1992; Curry, 1987; Loos & Julius, 1989; Merkatz, 1978; White & Ritchie, 1984). The question that remains unanswered is how do these circumstances change the experience for the expectant father? Once this is well understood, intervention strategies designed to meet these men's needs can be developed.
Theoretical Perspective of the Study

The grounded theory approach was the research method used for this study. When using grounded theory, a frame of reference has a purpose different from that in traditional quantitative research. In quantitative studies, a framework organizes the development of the study and provides a context for interpretation of findings (Burns & Grove, 1987). In qualitative research the emphasis is on theory building rather than on theory testing, therefore, a specific frame of reference was not explicated at the beginning of the study, but was developed through data collection and analysis. A broad framework did, however, guide the study. The framework guiding grounded theory is symbolic interactionism.

The symbolic interaction theory of human behaviour was first advanced in 1934 by George Mead, a social psychologist, and further developed by Herbert Blumer (1969). Symbolic interaction is concerned with the particular meaning of events to people in their natural environment. How people define events from their own perspective and how they act in relation to their beliefs is of primary concern. The concept of self is central to the theory. It is believed that the concept of self, a quality held only by humans, forms the basis of how humans create meaning and interpret experience in the world. Meaning is created from experience. It is through interaction between self and objects, people, or events that individuals are able to define and attach meaning to experience (Chenitz & Swanson, 1986). Grounded theory attempts to explicate that experience.
Review of the Literature

The purpose and timing of a literature review is also dependent on the choice of research methodology. Grounded theory strategy dictates a limited overview of the subject initially, only to identify previously conducted studies. There was no attempt to use the literature for the direction of data collection, either to identify theoretical or conceptual frameworks, or to identify variables and potential relationships for study (Strauss & Corbin, 1991). Study findings can be jeopardized when there is an overemphasis on the preliminary review of the literature. Strauss and Corbin (1991) explained that "We do not want to be so steeped in the literature as to be constrained and even stifled in terms of creative efforts by our knowledge of it!" (p. 50).

Later in the research process the literature was used for a different purpose. During advanced stages of data collection and analysis, the literature became an important resource for furthering the refinement of concepts and verifying relationships in the developing theory (Burns & Grove, 1987). It was also used to validate the accuracy of findings and to demonstrate how the findings differed from previous work (Strauss & Corbin, 1991).

This review includes an overview of the father's participation and role in normal pregnancy, followed by literature that is relevant to the fatherhood experience in a high risk pregnancy.

Fatherhood in Normal Pregnancy

As mentioned previously, expectant fatherhood has only become of
wide interest since the 1970s. Before that, most literature could be divided into two categories, anthropological and psychoanalytic.

The anthropological literature mostly involved studies exploring the phenomenon of ritual couvade (see Dawson, 1929). Ritual couvade has been defined as the culturally sanctioned learned behaviours enacted by expectant fathers that usually involved such restrictions as special dress, social confinement, limitations on physical labour, sexual restraint, avoidance of polluting substances, mock labour, and postpartum seclusion (Clinton, 1987). Ritual couvade is usually limited to preindustrial societies (Klein, 1991). Interestingly, Heggenhougen (1980) proposes a similarity between the contemporary western practice of fathers' participation in childbirth and the accompanying rituals such as prenatal classes, and the couvade practices associated with more primitive cultures.

The influence of Freudian psychoanalytic thought on the understanding of fatherhood was limited to interest in the deviant behaviours sometimes exhibited by expectant fathers. May and Perrin (1985) identified a number of disorders reported by psychoanalysts including depressive and psychotic reactions, impulsive behaviour, deviant sexual behaviour, suicidal behaviour, and fears of homosexuality. The authors noted that this particular approach to fatherhood contributed little to our understanding of the patterns of thought and behaviour in the normal father, except to support the concept that a man's transition to fatherhood represents a period of vulnerability.

More recent work on fatherhood has included studies on developmental tasks in pregnancy (Valentine, 1982), couvade syndrome
When examining the developmental tasks of expectant fathers and mothers, Valentine (1982) noted that the processes were remarkably similar. She went on to suggest that despite our culture's lack of recognition of fatherhood, fathering is "probably as involving and as varied an experience as mothering" (Valentine, 1982, p. 246).

Four developmental tasks were identified by Valentine (1982):
1. acceptance of the pregnancy and development of an attachment to the fetus
2. concern with practical issues such as finance, accommodation, and developing a sense of being a good provider
3. resolution of dependency issues
4. coming to terms with his relationship with his father

Congruent with developmental theory is an assumption that unless a father can successfully complete the required tasks of pregnancy he will have difficulty in his adjustment to his new role as father.

A surprising amount of attention has been given in the literature to a phenomenon labelled couvade syndrome. Couvade syndrome is a separate entity from ritual couvade discussed earlier. It is a constellation of physical and emotional symptoms that occurs among expectant fathers. The incidence of couvade symptoms is estimated to be anywhere between 22 and
79 percent (Klein, 1991).

Clinton (1987) examined the physical and emotional health of expectant fathers compared with that of non-expectant men. The findings revealed that in general, expectant fathers and non-expectant men experienced similar patterns of physical and emotional symptoms. However, expectant fathers had a higher incidence of colds, unintentional weight gain, insomnia, and restlessness. These findings were congruent with previous studies except that others found a higher incidence of depression in expectant fathers (Brown, 1983; Davis, 1978). In the early postpartum period, there was a more significant difference between the new fathers' health and men who were not fathers, with a higher incidence of nervousness, irritability, inability to concentrate, headaches, restlessness, fatigue and insomnia. Clinton (1987) concluded that the psychological transition to parenthood is as dramatic for the father as it is for the mother, and that the father deserves considerably more attention than health professionals have been providing.

Another area that has only begun to receive attention is paternal-fetal attachment behaviour. Weaver and Cranley (1983) conducted a study to explore this relationship. The findings supported the hypotheses that expectant fathers demonstrate attachment behaviours towards the fetus, and that there is an association between attachment behaviours and the strength of the marital relationship as perceived by the father. The presence of couvade symptoms were found to be weakly related. This study, and subsequent research, supports the notion that fathers, like mothers, begin
to develop a relationship with the baby prior to birth.

The last area of research to be described in this section is that which explores the experience of expectant fatherhood from the perspective of the man himself. May (1980), examined the different types of father participation in a pregnancy. Three separate styles were identified, with each style differing in the degree of attachment to the pregnancy. The observer style was the most prevalent, and described the father who was least likely to be involved with the pregnancy. This type of man was described as a "bystander" or "onlooker" and did not contribute to much of the decision making that occurred during the pregnancy. Men who fell into this category varied in their degree of desire for the pregnancy, from pleased to very unhappy.

The second type of father participation, and second most common, was the expressive style. This man was more involved in the pregnancy than those in the other two categories. He had intense emotional responses to the pregnancy and strove to be in touch with the experience. His relationship with his partner was likely to be one of equality. These fathers not only experienced the emotional highs of the pregnancy with greater feeling, but exhibited equally intense reactions to negative events such as threatened loss of the baby.

The instrumental style was the third and the least commonly occurring style identified. May (1980) noted that men in this category were likely to be of an ethnic minority, possibly reflecting different cultural values. These men were organizers and prided themselves on their efficiency in managing the practical aspects of the pregnancy. Their emotional participation was
less evident, however, placing their involvement into the middle range of the continuum. May (1980) noted that a primary factor that seemed to determine involvement style was the father's degree of readiness for the pregnancy. Other possible factors included the man's age, developmental status, and the distribution of power in the marital relationship.

Another study by May (1982a) explored the father's involvement in the pregnancy, but focused on the progressive aspect of involvement over time. May (1982a) identified three phases of involvement: the announcement phase, the moratorium, and the focusing phase. Each of the phases was characterized by certain activities and emotions. It was the moratorium phase that distinguished fathers' readiness for a pregnancy. Fathers who required more time to work through their ambivalence and to adjust to the reality of the pregnancy required more time in this phase.

Most recently, Jordan (1990) reported a grounded theory study that built on May's work. Jordan conducted more than 180 interviews on 56 expectant fathers at selected intervals in the pregnancy. The theme of the father's experience was "labouring for relevance" which described a father's attempts to integrate the new father role into his own and others' concept of himself. Three developmental subprocesses were explicated: grappling with reality, struggling for recognition as a parent, and the role-making of involved fatherhood. Important findings included the lack of recognition accorded the fatherhood role, the continued exclusion of fathers from the childbearing experience, and the lack of effective role models.
Father's Experience in High Risk Pregnancy

Estimates of the incidence of high risk pregnancy vary by definition and population, but range from 10 to 20 percent (Kemp & Page, 1986). High risk is defined as any pregnancy in which there is significant possibility of fetal demise, anomaly, life threatening illness to the newborn infant (Penticuff, 1982, p. 69), or threat to the health or life of the mother. A number of authors have suggested evidence of the psychosocial impact of a high risk pregnancy on the woman (Snyder, 1979), and the family (Kemp & Page, 1986; Mercer, May, Ferketich, & deJoseph, 1986; Penticuff, 1982).

In the past twenty years, a number of advances in perinatal care have resulted in improved outcomes for both mothers and babies. One of these advances has been the creation of high risk antepartum units in tertiary level hospitals that specialize in the care of the high risk mother and fetus. Hospitalization is recognized as a significantly stressful event for any individual and family (Williams, 1974). Hospitalization during a pregnancy contributes to the degree and range of complex experiences that must be negotiated by a family in transition.

A number of authors have begun exploring the experience of hospitalization from the woman's perspective. The findings indicate that women hospitalized for a high risk pregnancy undergo varying degrees of stress which can lead to feelings of boredom, loneliness, and powerlessness (Loos, 1989). This stress can impair maternal-fetal attachment (Curry, 1987), and impede successful accomplishment of the developmental tasks of pregnancy (Merkatz, 1978; White, 1984).
Little is known about the experience of high risk pregnancy and hospitalization from the perspective of the expectant father. Penticuff (1982) explored the potential impact of the stress of a high risk pregnancy on both expectant parents. It was suggested that the effect of the high risk pregnancy could alter a father's progression through the developmental process of fatherhood. In applying theories of stress/adaptation and learned helplessness, Penticuff concluded that ultimately what determined both a mother's and a father's ability to cope with the uncertainties and fears inherent in a high risk pregnancy was their ability to develop a realistic appraisal of the problem, and to adapt their behaviours and environment in such a way that either a solution was found or the stress was minimized.

Conner and Denson (1990) reviewed the literature on expectant fathers' response to pregnancy and the implications for research in high risk pregnancy. A number of areas for research were identified and suggested a need to better understand this experience from the perspective of the expectant father.

Problem Statement

Despite increasing interest in the role of the father in pregnancy, birth, and parenthood, little attention has been given to the expectant father's experience of coping with a high risk pregnancy and the hospitalization of their partner. The research that is available on fathers' experience of high risk pregnancy suggests that this is a stressful event that requires coping behaviours beyond what is normally required for a
pregnancy with an expected healthy outcome.

Purpose

The purpose of this study was to understand the experience of high risk pregnancy and hospitalization from the perspective of the expectant father. This purpose resulted in the formulation of the following question: "What is the experience of an expectant father when his partner is hospitalized with a high risk pregnancy?".

Definition of Terms

**High risk pregnancy**: A pregnancy in which there is significant possibility of fetal demise, anomaly, life threatening illness to the newborn infant, or threat to the life or health of the mother.

**Hospitalization**: Inpatient hospitalization on an antepartum unit.

**Expectant father**: The father of the baby.

Assumptions

This study was undertaken on the assumption that expectant fathers whose partners were diagnosed with a high risk pregnancy and hospitalized, were subject to a unique experience. As a result, their specific needs and concerns differed from the experience of the expectant father who anticipated a normal pregnancy and healthy outcome for both mother and baby. Furthermore, it was assumed that the most accurate and richest source of information was the expectant fathers' own description of their
experience, and that fathers would be willing to share their experiences with the investigator in an open and honest manner.

Limitations

Initial data collection took place while the man's partner was hospitalized on an antepartum unit. This created a concern regarding the potential influence of the hospital environment on the expectant fathers' responses. It is possible that they may have felt unable to verbalize certain feelings for fear of alienating their partners' caregivers. However, it was felt that the advantage of interviewing the fathers as the experience was being lived outweighed the disadvantage of the above concern. Furthermore, interviewing fathers after the birth of the baby could have introduced confounding variables that could have influenced their perception of the experience under study. For example, a father's perception of his experience might have been quite different if the outcome of the pregnancy had been a fetal or neonatal loss instead of a healthy baby.

Given the nature of the chosen method, specific limitations exist regarding the generalizability of the study findings. The participants in the study were selected from two antepartum units in one hospital and the numbers were small. The data that emerged from the experiences of these fathers are, however, relevant in so far as anyone's experience, if well described, represents a piece of life (Denzin, cited in Sandelowski, 1986, p.32).
Summary

This chapter has identified the background to the problem that led to the study. The purpose, definition of terms, assumptions, and limitations have also been explicated. Chapter two outlines the study methodology and reviews the selection criteria, selection procedure, the process of data collection and analysis, reliability and validity, and ethical considerations.
CHAPTER TWO
METHODOLOGY

Research Design

A qualitative research approach using the grounded theory method was chosen for this study. Qualitative research "seeks to gain insight through discovering the meaning attached to a given phenomenon" (Burns & Grove, 1987, p. 75). A number of different methods fall into the category of qualitative research; grounded theory is one approach.

Grounded theory is both an inductive and deductive research method originally developed by Glaser and Strauss (1967). It is a systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that contributes to the understanding of social and psychological phenomena (Chenitz & Swanson, 1986). Grounded theory is directed towards developing an understanding of how groups of people define their reality via social interactions (Stern, 1980). By systematic study of human behaviour in specific situations, the investigator develops abstract concepts and propositions about the relationships between them. This inductive/deductive approach to theory generation is in contrast to the deductive process most commonly applied to quantitative research whereby variables relevant to concepts in already established theories are tested. For this reason, grounded theory is most commonly applied when an area under examination has had limited research and for which a greater understanding of the phenomenon is
required (Hutchinson, 1986).

Selection Criteria

Nine participants were selected from those expectant fathers' whose partners were admitted to either of two antepartum units in Grace Hospital, Vancouver. The Grace Hospital was chosen because it is the only tertiary level obstetric center in British Columbia and therefore provides care to the majority of high risk women and their families in this province. Women who were admitted to an antepartum unit and who were diagnosed with a high risk pregnancy requiring inpatient assessment and treatment were used to gain access to the population of interest. The following criteria provided direction for initial selection of potential study participants. Rationale is provided to substantiate the criteria.

Selection Criteria:

1. Expectant fathers whose partners were hospitalized for a high risk pregnancy condition as defined under definition of terms.
   Rationale: This is the target population.

2. Singleton pregnancy.
   Rationale: A multiple pregnancy may present additional stressors that could confound the experience.

3. Married or living with their partners.
   Rationale: An uncommitted relationship may confound the experience.

4. No plans to relinquish the baby for adoption.
Rationale: Plans to give the baby up for adoption may confound the experience.

5. English speaking.
   Rationale: To facilitate communication.

6. Age 19 or older.
   Rationale: The concerns of teenage fatherhood may confound the experience.

Selection Procedure

Expectant fathers who met the criteria for participation in the study were determined by the investigator in conjunction with the Nurse Managers and primary nurses on the antepartum units. The nursing kardex that details the basic medical and nursing information for each patient was reviewed regularly to identify potentially suitable participants. These candidates were approached by the investigator and given an introductory letter (appendix A) outlining the study as well as a verbal explanation of the study's purpose and the requirements for participant involvement. Where possible, initial contact was made with the expectant father himself when he was visiting on the unit. If this was not feasible, the partners of potential participants were approached with the information and a request that the introductory letter be given to the expectant fathers for consideration. If they were interested in participating or desired more information, they were directed to complete the form attached to the introductory letter (Appendix A) and return it to a designated box at the nursing station. The
investigator regularly collected the completed forms from this box.

In qualitative research, representativeness of experience is the primary sampling consideration rather than representativeness of the population - a concept relevant to quantitative research. In qualitative work, depth rather than breadth of experience is desirable.

Integral to the grounded theory method is the principle of theoretical sampling. Theoretical sampling is "sampling on the basis of concepts that have proven theoretical relevance to the evolving theory" (Strauss & Corbin, 1991, p. 176). This sampling technique is dependent on the need to explore fully all identified categories and their relationships and to ensure that representativeness of each has been achieved. For example, when the category "providing childcare" was identified, an attempt was made to seek out fathers who were caring for children at home. These fathers were then asked questions designed to explore the implications of this component of their role in the context of the overall experience.

Sampling and data analysis are simultaneous processes, with data analysis providing direction for further data collection. Every category requires testing against new data to develop the category to its fullest. Decisions regarding sampling are based on the need to test, elaborate and refine categories, to develop relationships between categories, and to develop fully the core concept. Sampling continues until theoretical saturation is reached. Saturation has been achieved when categories and relationships between categories are fully developed and validated. This
process is viewed as one of the most important aspects of grounded theory (Strauss & Corbin, 1991).

Data Collection and Analysis

Data collection in grounded theory may consist of formal or informal interviews, participant observation, and technical and nontechnical literature, depending on the phenomenon of interest. When in-depth information that is best obtained from subjects in private settings and from predetermined sites is desired, then a formal interview is the tool of choice (Swanson, 1986). This was the principal source of data for this study.

Data gathered from formal interviews was supplemented with information obtained from technical and nontechnical literature. The literature became a secondary source of data. Published research reports that included quotations from expectant fathers or descriptions of the expectant fathers' perspective were analyzed along with interview data.

Informal interviews and participant observation are two methods that were not used for data collection. The investigator did, however, during the later stages of this study, return to her role as nurse manager of one of the antepartum units designated for the study. It was valuable (and even unavoidable) for the author to observe, with heightened sensitivity, the experiences of expectant fathers on the unit. This opportunity lent validity to observations drawn from formal interviews alone.

Initial data collection consisted of unstructured in depth audiotaped interviews of nine men. Five men were interviewed a second time in
person. Two men had returned to their home towns at the time of the second interview and, because of the distances involved, were interviewed by telephone. Of the two fathers not interviewed a second time, one declined a second interview, and the other was not contacted, despite several attempts.

The setting for the first interview was a private office on one of the antepartum units. Since all the women had been discharged from the hospital at the time of the second interview, this interview took place in the participants' homes. The length of the interviews varied, with most lasting approximately one hour.

Each initial interview began with the question, "What is it like for you to have your wife/partner hospitalized for a high risk pregnancy?" The interviewer then encouraged the subject to elaborate on the concepts that emerged from the data. In accordance with the methodological principles, loosely structured questions that guided initial interviews were modified in subsequent interviews as concepts and categories emerged and required clarification and/or elaboration. Data analysis of verbatim transcripts occurred simultaneously with data collection to meet the requirements of theoretical sampling.

The constant comparative method of analysis was fundamental to the data collection and analysis process. The focus of this method is "the generation of theoretical constructs that, along with substantiative codes and categories and their properties, form a theory that encompasses as much behavioural variation as possible" (Hutchinson, 1986, p. 122). Data from
verbatim transcripts were first broken down into discrete parts, closely examined, compared for similarities and differences, conceptualized, and categorized. The data was then reconstructed in new ways by making connections between categories. Finally, a core category was identified, the major categories were related to it and each other, relationships were validated, and categories requiring further development were refined.

Data collection continued until a point of saturation was reached where no new conceptual information was emerging. The outcome of such a process resulted in a substantive theory that was grounded in the experience of the phenomenon under study (Strauss & Corbin, 1991).

The above analysis was carried out using the three steps of coding described by Strauss and Corbin (1991).

1. **Open Coding**

   Open coding involves the "process of breaking down, examining, comparing, conceptualizing and categorizing data" (Strauss & Corbin, 1991, p. 61). The transcript was read and each discrete incident, idea, or event was given a conceptual label. Concepts that appeared to relate to the same phenomenon were then categorized, and the category was named. A category was then developed by identifying its characteristics, known as properties and dimensions.

2. **Axial Coding**

   Axial coding includes a series of steps whereby data are reassembled in new ways by making connections between categories (Strauss & Corbin, 1991, p. 96). A category was specified by its related conditions, context,
action/interaction strategies, and consequences. It was a complex process, involving several steps that required both inductive and deductive thinking.

3. Selective Coding

Selective coding encompasses the process of selecting the core category, relating it to other categories in a systematic fashion, validating those relationships, and refining categories that need further development (Strauss & Corbin, 1991, p. 116). This process of integrating categories led to the development of a grounded theory. Selective coding is similar to axial coding except it demands greater abstract analysis.

Thus, conceptual labels such as “being there”, “staying overnight”, and “visiting” were identified as being related to the same phenomenon, were categorized together, and named “maintaining a physical presence”. This category was then related to other apparently similar categories including “comfort and compassion”, “psychological coach”, “advocate”, and “protector”. These categories were identified as subcategories of the “emotional caregiver role”. This role became a major concept, along with the “family sustainer role”.

The core category evolved from analysis of the relationships between these two major concepts and related conditions which included “social support”, “high risk condition factors”, and “geographical circumstance”. The category of coping strategies with its subcategories of “positive attitude”, “one day at a time”, “faith”, and “knowledge”, were identified as action/interaction strategies. The subcategories under “personal impact” were the consequences of the fathers responses to the central phenomenon.
Finally, a process of "finding a balance between roles" emerged as the central phenomenon of the study, and became the core category around which the other categories were systematically related.

Throughout the process of data collection and analysis an essential skill called theoretical sensitivity was required. Strauss and Corbin (1991) described theoretical sensitivity as "the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't. All this is done in conceptual rather than concrete terms" (p. 42). Theoretical sensitivity required a balance between creativity and science and was cultivated from a number of sources including literature, professional and personal experience, and the analytic process itself.

Reliability and Validity

Rigor in qualitative research is equally as important as research employing quantitative methodology. In qualitative research, however, the traditional methods to determine reliability and validity are not applicable, therefore, alternative methods have been developed.

Sandelowski (1986) identified auditability as a key strategy in ensuring rigor in qualitative research. Auditability is achieved when the researcher leaves a clear decision trail that allows any reader to follow the study from beginning to end and understand the logic of what was done and why. Sandelowski (1986) identified four additional tests of rigor that can be applied to qualitative research. They are: 1) truth value, 2) applicability, 3)
consistency, and 4) neutrality. Throughout this study a concern for rigor in data collection, analysis, and reporting was applied to optimize the reliability and validity of the findings.

Ethical Considerations

Permission to conduct this study was received from the Research Coordinating Committee of Grace Hospital, Vancouver, British Columbia, and from the Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects of the University of British Columbia.

At the beginning of the first meeting, the investigator reviewed the consent form (Appendix B) with the participants. It was not anticipated that there would be any harmful consequences for the participants. In fact the opportunity to discuss their individual experience with an attentive and accepting listener could be seen as a benefit. However, it was recognized that as with any study requiring discussion of potentially emotional material, there was a risk of feelings arising that might be distressing to the participants. Qualitative research methodology allows for interaction between interviewer and subject, therefore emotional responses could have been addressed directly by the investigator during the course of the interview or, if appropriate and agreeable to the subject, referred to the hospital social worker, physician, clergy, or to an outside agency. As discussed in the findings, many men expressed feelings of helplessness, fear, worry, and emotional stress. None of these men requested any
intervention beyond the understanding and supportive acceptance by the interviewer.

Summary

This chapter has reviewed the grounded theory method used in the study. The selection criteria, selection procedure, process of data collection and analysis, reliability and validity, and ethical considerations, were also discussed. Chapter three presents a detailed description of the findings from data analysis with supportive quotes from interview transcripts that illustrate and substantiate the interpretations.
CHAPTER THREE
FINDINGS FROM DATA ANALYSIS

In this chapter the outcome of data analysis is described. The chapter begins with a description of the participants followed by a theoretical portrait of the experience under study that evolved through grounded theory methodology. Interspersed throughout this chapter are quotes from participants that serve to illustrate and substantiate the interpretations.

Description of the Participants

Nine expectant fathers volunteered to participate in the study. Their ages ranged from 29 to 40 years. Their partners' ages ranged from 23 to 40 years. All the couples were married except one; this couple had been living together for one year.

Six of the nine pregnancies had been planned. Three pregnancies had been unplanned, two by couples who were unmarried at the time, and one by a couple with a two year old child. None of the unplanned pregnancies was unwelcome, though each had necessitated psychological and practical adjustments for both partners. This was a first pregnancy for four of the couples (One father had a child by a previous marriage. This child had survived without handicap after being delivered at 26 weeks). Two of the couples had a small child at home. Three couples had experienced previous pregnancies resulting in loss. These included multiple spontaneous abortions, two stillbirths (at 28 weeks gestation and term), and a pregnancy
terminated due to a diagnosis of Down's syndrome.

The reason for admission to the hospital varied. Obstetrical problems included premature rupture of the membranes, preterm labour, abruptio placenta, pregnancy induced hypertension, premature dilatation of the cervix, and gestational diabetes. At the time of the first interview, the pregnancy gestation ranged from 24 weeks to 35 weeks, with five of the pregnancies below 32 weeks. The first interview was conducted from three days to three weeks after a partner's hospitalization. The second interviews took place within two weeks to three months of the birth. Some of the babies were delivered prematurely and required care in a special care nursery for a few days to a few weeks. However, all of the newborns were healthy and at home with the parents at the time of the second interview.

The occupations of the participants included a teacher, nurse, photojournalist, actor, union representative, automotive mechanic, plumbing contractor, owner of a waterproofing company, and a restaurant manager. Education ranged from high school to university. Six of the expectant fathers described their cultural origin as Canadian, with the remaining three of German/Italian, Caribbean, and Native/German extraction. All of the men identified English as their first language.

The Expectant Father's Experience: A Descriptive Analysis

Grounded theory analysis of expectant fathers' collective descriptions of their experience when their partners were hospitalized with a high risk pregnancy resulted in the following descriptive account.
The fathers' descriptions indicated that their participation in the pregnancy and hospitalization was substantive in nature. Substantive is defined as "having separate and independent existence, not merely subservient" (Concise Oxford Dictionary, 1982).

Central to the expectant fathers' descriptions of their experience were the roles they assumed in relation to their participation in the phenomenon of high risk pregnancy and hospitalization. The two predominant roles were providing emotional support for their partner and sustaining the family's functional responsibilities. The predominant theme that evolved through analysis was a process of finding a balance between these two roles. This conceptualization is illustrated by Figure 1.

The fathers' descriptions portrayed an experience that revolved around their enactment of these two roles. The first role, providing emotional support to their partner, will be referred to as the emotional caregiver role. This role was of primary importance for many of the fathers. It involved actions that were intended to provide support through physical presence, comfort and compassion, psychological coaching, advocacy, and protection. This role was mostly enacted within the environment of the hospital.

The other role, sustaining the family's functional responsibilities, will be referred to as the family sustainer role. This role involved maintaining the family's life in the world outside of the hospital, including work, childcare, and domestic responsibilities.

Each of the fathers was required to determine the amount of attention these two roles deserved. Since fathers possessed only a finite amount of
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Figure 1. Finding a Balance: A Substantive Experience
energy, a process of determining how much weight they would give each of the roles was necessary. The resulting balance was dependent not only on the emphasis placed on each of the two roles, but also on contributing variables that shall be called balancing factors. The nature of these factors determined the amount of time and physical and emotional energy that was allocated to either of the two roles. They included the support system available to the father, high risk condition factors, and geographical circumstance.

Based on the above factors, the fathers varied in their valuing and accomplishment of the two roles. Some fathers placed enormous emphasis on their emotional caregiving role, some on their family sustainer role, and others found an intermediate balance between the two roles. Every father found his own personal balance that was congruent with his individual circumstance and interpretation of the experience. Most of the fathers were relatively content with the balance they found for themselves. There were some, however, that expressed significant dissatisfaction with their position but were unable, under the present circumstances to influence a change in the balance.

A critical component to the description of their experience, which encompassed all of their discussions to some degree, was the personal impact of the phenomenon on their own emotional and physical wellbeing. Though the focus of their descriptions was on the enacted roles, both the phenomenon of high risk pregnancy and hospitalization, and the process of role balance had a significant impact on themselves as individuals. In turn,
the emotional and physical components of the fathers' experience influenced their ability to carry out the roles.

Each of the fathers identified a number of personal strategies that he believed contributed to his ability to cope with the experience. These coping strategies included maintaining a positive attitude, taking one day at a time, having faith in a higher being, and seeking knowledge. The strategies influenced both the fathers' ability to carry out the two roles and the nature of the personal impact.

Role Behaviors

The central theme in the fathers' descriptions was their assumption of two very different roles, that of emotional caregiver, and family sustainer. Most of the fathers enacted each of the roles to a certain extent but the emphasis placed on each varied depending on individual circumstances. The role of emotional caregiver was performed by and large within the hospital setting, while the family sustainer role was carried out in the world outside of the hospital. These two different settings contribute to the converse nature of the performance of the roles.

The Role of Emotional Caregiver

The fathers spent a considerable amount of time describing their role as an emotional caregiver. The fathers clearly articulated a belief that this was one of their fundamental roles. The men believed that as expectant fathers, they too were in need of emotional support. However, they believed their partners' needs were even greater.

Fathers offered three explanations to justify this belief. The first was
the physical reality of the pregnancy. Although they were involved in the pregnancy, and described themselves as undergoing an experience that was unique and legitimate in their own right, they acknowledged a very obvious fact of life; no matter how involved they were with their partner and the pregnancy, the reality was that they themselves were not physically pregnant, nor could they hope to fully appreciate the experience from the first hand perspective of their partner.

Cause she's the one that carried the child and the bond between them, a mother and a child, ...yeah there is the father also, but not such a degree at that stage.

...because she's carrying this child that, that, it's going to be, that it would be more devastating, the loss would be...have a greater impact on her, now that's not to say that it wouldn't be devastating for me...I don't have all the aches and pains and the body image distortions...

I didn't need any support myself. It wasn't me going through it, it was her...first of all she, as most women are, would be more emotional in the couple so she needs it more...even if the woman was less emotional than the man, she would still need more anyway because she's going through it.

The second reason given is also identified by the above father. This is the belief that women are inherently more emotional than men so will require the additional emotional attention. The next father elaborates by explaining his belief that it is also normal for pregnant women to worry.

...being pregnant and just having everything, you think of anything, a two headed baby on the ultrasound, or whatever so it's just sort of normal for a pregnant person to think things like that.

The third explanation given for the partner requiring additional support, was that she was confined to bed in the hospital with little to
occupy her time and distract her from worry. The fathers maintained their freedom to some degree and did not experience the physical restrictions and isolation from the outside world. Two fathers explained:

...it's a lot tougher on her because I've got stuff to do, and it's just like I can be distracted, she just lays here and thinks and, uh, and her thoughts go from sort of, uh, bad to worse.

...When she first got here she was just, well she was devastated, ...we were both devastated but she had more time to think about it...I was lucky to have [son] to look after...it kept my mind from wondering about the possibilities, you know, how things were going. [Partner] didn't have that, she was sleeping all the time thinking about that over and over...

The emotional support that fathers provided to their partners included maintaining a physical presence, providing comfort and compassion, acting as a psychological coach, being an advocate, and providing protection.

**Maintaining a physical presence.** All of the fathers held a strong belief that an important facet of being an emotional caregiver to their partners was the act of being physically present. Fathers demonstrated this by, almost without exception (and this was because of geographic separation), spending time with their partners virtually every day. The amount of time spent varied. Some fathers visited for periods of one to two hours after they had worked a full day. Other fathers spent time with their partners for extended periods during the day but returned home at night. One father stayed in the private room with his partner for her entire three week stay. Fathers gave several explanations for the importance of their presence including emotional and physical benefit for their partners, emotional benefit for themselves, companionship, and a sense of fairness and
obligation.

She needs me to be there, to be right there, and supporting her one hundred percent, and I feel like that's the contribution that I can make to having this be a successful pregnancy. Just by that, removing that aspect of anxiety like will I be there or won't I.

When questioned further, this father acknowledged that being present was so important to him because he felt he had very few other options available to "do something for her and to help this pregnancy".

Well, we're very used to seeing each other every day and so, how do I describe this, I feel like she doesn't get a day off, so as her partner I don't think it's fair that I get a day off. I mean, I get a change of scenery, she gets some striped curtains.

...it means a lot to her too. Like, like if I wasn't there, she'd be kind of probably twice as bad cause she'd be really scared and tense, you know.

For one father, the need to be present was particularly evident. This father lived in a distant community and had taken time off work and flown to the city in order to be close to his partner. When offered nearby hostel accommodation that was available for families he adamantly refused to be separated from his partner even during the night. In fact, when the hospital staff had perceived that he had 'overstayed his welcome' and told him so, he met with hospital administration to argue his point, and declared he was prepared to take the issue to the local paper. He explained his position this way:

...it makes her feel secure that I'm there beside her if she wakes up and needs something I can get it for her right away. I want to stay at her side now cause it makes her feel better and even that little bit, if that helps extend the pregnancy by a week, that's going to be helpful to the baby. And I honestly think that it's necessary at this point for me to stay with her...I'm making sure that I stay out of peoples way...I'm trying to be as helpful as I can...it's a single room so I'm not bothering anybody else...
This father's opinion regarding the reason for the resistance on the part of the hospital staff was the following:

...my personal opinion is that some of the older, perhaps nursing staff in the tradition of nursing where, you know, in the olden days husbands were supposed to wait outside in the waiting room. I think it goes back to that, and they feel uncomfortable with having the husbands around.

While this father was very outspoken and assertive regarding his need to be present 24 hours a day, several of the other fathers stated that they would have chosen, if given the option, to stay overnight at least on an intermittent basis. One father admitted:

..if you did it every once in a while you'd want to do it all the time, I know I would, I would want to stay all the time and I think [partner] would want me to...she gets up so many times in the night going to the washroom, she's waking up constantly so it would be probably be more comfortable to go back to sleep if I was there or if we were together.

Providing comfort and compassion. Most of the fathers identified a role of providing comfort and compassion to their partners as a component of their emotional caregiving. Comfort was demonstrated primarily through physical gestures and resulted in emotional benefit. Compassion describes the sympathetic care and understanding that was provided.

Fathers offered comfort to their partners in many ways. Some fathers, by virtue of their regular presence, were able to give much physical care to their partner. Activities such as back massages, assisting with bathing, tidying the bed, bringing in food and other treats and surprises from the outside contributed to their partners' sense of well being. Comforting was a measure that one father described as palliative care. This alluded to the fact
that these actions did not have direct impact on his partner's condition but served to make her life a little more tolerable.

...I feel like it's my role to, to do everything I can to make her more comfortable... bringing her little surprises every once in a while, some specialty food, music to listen to, comforts... palliative care...

Compassion was displayed by every father as a means of support. By virtue of his focus on how she was coping with the experience, and by withholding sharing his own emotions, attention was directed towards her thoughts and feelings. Each father described listening to his partner's worries and fears and responding to them by acting as a 'psychological coach'.

**Acting as a psychological coach.** Psychological coaching refers to the active role fathers played in influencing their partners' emotional status. The strategies used by fathers could variously be referred to as providing reassurance, reinforcing reality, encouraging a positive outlook, and taking one day at a time.

Reassurance was given in an effort to dispel their partners' realistic and unrealistic apprehensions. This father explained:

I tried to reassure her that, we just had to do basically what the doctor told us to do and, you know, that she was very, she's very healthy, she's a very active and healthy person...

Another strategy for psychological coaching was reinforcing reality by reminding their partners of the probability of a positive outcome given the facts of their situation. Partners often required ongoing reminders.
Well you know the baby's heart is fine, the baby is fine, you're fine and it's a matter of how long the baby is going to have to spend in the hospital.

I've tried to talk to her and she says that even just the fact that I keep reminding her that this is not necessarily going to happen to us helps...and I guess I have to keep reminding her continuously too...

One father clarified that his attempts to reassure his partner were not carried out with the intention of minimizing what she was experiencing. He acknowledged her fears and worries but tried not to elaborate on them. Rather, his desire was to encourage his partner to have a positive outlook. He admitted however, that his partner did not always perceive this distinction.

I would say, be trying to look on the bright side but she didn't want to right then because this is a worry, and she didn't want me minimizing it exactly, and it would cause some friction because I would be thinking, well, I'm just trying to maintain a positive attitude.

Taking one day at a time was another approach encouraged by these fathers. They attempted to focus their partner's attention on the here and now rather than waste valuable emotional energy on negative possibilities.

We've had a tour of the observation nursery, all the specialized equipment basically has been explained to us...my wife gets a little uncomfortable with all that stuff but at this point I'm trying to convince her not to really worry about that stuff yet cause we're not at that point yet. Worry about the stage now at the time. Just keep the blood pressure down as long as possible and we'll worry about that stuff when we get to it.

As will be seen later in the discussion, fathers themselves relied on their ability to maintain a positive attitude and to take one day at a time as coping strategies.
Being an advocate. Fathers acted as advocates for their partners when they perceived that the partners needed someone to act for them because they were either too shy or too vulnerable to act for themselves. At times their partners shared with them feelings or needs that the fathers felt required action on the part of others in order to ensure the partners', or the fetuses' well being. Advocacy was demonstrated by these fathers in several situations including the following:

I try to kind of insulate her from other problems...so, I'll pull the curtain, she doesn't want to pull the curtain because she feels like it's rude to her neighbour. Well I said it's not really, she's got to be, you know, you've got to look after yourself and that's the most important.

...when she called on the phone, I said, buzz, you know that's what the buzzer is there for and get somebody and she was upset because she didn't want to...so I just tried to get her to understand that everybody is there because there are women in there that need, that need attention and asking for attention is not wrong, I said you have to keep asking sometimes because everybody is human.

Providing protection. Fathers protected their partners from a number of real and potential psychological and physical threats. One of the protective actions the fathers all participated in was ensuring their partners were in the hospital receiving the best care that was possible. This will be explored further in the discussion regarding their feelings of security related to hospitalization. By ensuring their partners' and babies' security, they were able to partially fulfill their protector role.

A particularly significant strategy the fathers used to protect their partners from unnecessary worry was to withhold sharing all of their feelings. Most of the fathers felt that their partners were experiencing tremendous self-induced worry. They believed that as supporters, they
should not contribute to their partners' anxieties by verbalizing their own fears and concerns.

I've tried I guess to not, to not burden her at all with my worries because I feel like she's already worrying enough, probably for both of us, and that sharing my worries won't do anything more but, that, I guess, I guess I feel like I'd be asking her to help me deal with my worries, when I feel like probably, I, I'd be better helping with hers.

This father described the potential problem of legitimizing his partner's worries by sharing his own.

I wouldn't want to worry her. I might be worrying about something that... if she hasn't thought of it, why bother, why tell her...and if she is worrying about it herself maybe she needs someone to legitimize it then if I say something, then she'll think maybe it will happen.

During a second interview, a father's partner was present for part of the discussion. He acknowledged that he had intentionally not shared many of his fears and concerns with her with the belief that he would have then "validated her own fears". Of interest is that his partner confirmed that she had needed him to act as a supporter. She believed that if he had verbalized all of his fears it would have served to escalate her own anxieties.

The Role of Family Sustainer

The other role the fathers identified as significant was the role of family sustainer. The role behaviors include adjusting work demands, providing childcare, and taking on the sundry domestic activities of daily living. These activities were all directed towards the reality of sustaining the life of the father and his partner in the real world. Despite the fact that the couples were experiencing a significant crisis resulting in a major
disruption of their lives, most were unable to abandon all their practical responsibilities and focus exclusively on life inside the hospital. Someone was required to fulfill the role of maintaining this outside life, so that the couple had something to return to on resolution of the crisis. This role was, of necessity, assumed by the father.

Adjusting work. For all of the fathers, the impact of the high risk pregnancy and the hospitalization of their partners required adjustment in their usual work routine. It was necessary for the majority of fathers to continue working in order to maintain financial security for the couple. Most of these fathers, however, were able to manipulate their schedules and commitments so that they had greater time to attend to the other demands, both inside and outside the hospital. Two fathers stopped working during their partners' hospitalization.

Fathers were able to adjust their work commitments by a variety of strategies. Some were self employed and chose to either reduce their work commitments or to delegate work to employees. Others negotiated with understanding employers for greater flexibility in their schedules and reduced hours. None of the fathers described having to maintain inflexible work obligations in order to keep his job.

The two fathers who temporarily gave up work did so for different reasons. The first father left work because of the overwhelming nature of the circumstances. He had experienced past pregnancy losses and was unable to function at work due to the amount of stress he was experiencing. He had requested, and been granted stress leave for the past month.
The second father lived with his partner in a community 500 kilometers from the hospital. This father stated that he was able to take time off work to be with his partner in the hospital. He explained that if she had been hospitalized in their community hospital he would not have been required to abandon work altogether as it would have been possible to continue to work part time. The geographic separation however, forced him to leave his work in order to be with his partner. He explained that had his employer refused to grant him the leave, he would have taken the time off regardless because of the priority he gave to his emotional caregiver role.

...if it was required I would say hey, you know, I'm sorry but I have to go and that's that...cause there's no question about that, she needs me and that's, that's a priority, that's what you have to do.

Fathers reported that financial security was a significant worry for themselves and their partners, and that this was the principal reason for their continued commitment to work. Factors that contributed to their financial concerns over and above those of couples experiencing a normal pregnancy were the unexpected loss of the woman's income earlier in the pregnancy than was originally anticipated, the loss of income the fathers experienced due to adjustments in their work schedule, and the costs associated with hospitalization. A father, who took time off work to be with his wife, explained his situation:

...there's always the problem of funds as well. I mean, I consider myself fortunate that I'm in a position that I can take all this time off to stay with my wife but at the same time I paid for a commercial air fare for both of us for the return...I'm taking time off work, I still have to pay rent and hydro and telephone and all that stuff at home. The financial end of things, even
like staying at a place that is forty dollars a night, but, you know, to look at something like that for one or two nights is not unreasonable but you start talking three weeks, maybe a month, that's a lot of money. I mean I'm not made of money.

Providing childcare. Whether or not a father had a child at home to care for determined, to a great extent, the amount of emphasis placed on the sustainer role, and therefore the resulting balance of roles. Only two fathers were required to be responsible for another child at home. For both men, this new role represented a departure from their usual involvement with their children. Although the fathers described different degrees of involvement with their children prior to the hospitalization, both experienced a significant challenge associated with the additional responsibilities of assuming their new role as a 'single father'.

Each father described the stress of suddenly being left with sole responsibility for the physical and emotional welfare of his child.

...it's tough, you know, in more ways that one. In, in the physical sense it's tough cause you're running after him all the time and he looks for you all the time. Any time he thinks I'm gone, he's 'daddy, daddy'...in an emotional sense too of constantly trying to keep track of what's going on and knowing you're it. You know, you're responsible for everything.

You've got so much responsibility, if anything happens it's you that's got to deal with that. You're totally responsible for him...I think the big thing about having two parents around and being a single parent, there's someone else to share the responsibility and that's a really big part of it.

Despite the disadvantage of being, at least temporarily, a single parent, the fathers recognized the advantage the opportunity gave them to develop a closer relationship with their child. Both fathers continued to work full time, but on return from work they spent undivided time with their child.
that they might otherwise not have experienced. This was identified as a unique opportunity to explore their father-child relationship and to perhaps influence it positively in the future.

...we are spending a lot of time together and I'm starting to understand where he's coming from...I have a much better relationship with him, though I spent a lot of time with him before, I think now I'm spending more, just that much better time with him and understanding him that much better.

In order to continue to work, as these two fathers did, child care arrangements were necessary. Neither of these men's partners worked outside the home, so the full-time childcare support they required was found as a result of scrambling on short notice. One father had great family support from a mother who took on the care of his child during the day. The other father had no family support, but found a reliable babysitter whom he trusted and who was able to meet his needs. While both these fathers found workable solutions relatively easily, they considered themselves fortunate.

Taking on domestic responsibilities. Whether the fathers had children to care for or were on their own, they were left with the responsibility of ensuring the ongoing activities of family life were attended to. These included doing housework, shopping, preparing meals, budgeting and paying bills, and running errands. Two fathers were also in the process of selling and purchasing a home. Some of these activities they would have carried out even if their partners were at home, but they would not have had sole responsibility for them. Some chores were completely foreign to them.
Regardless of their familiarity, the fathers took on these responsibilities and described varying degrees of success. 'Hectic' was the term most often used to describe their daily schedule.

...we've got to get that and we've got to get that, and I've got to get this and I rush off to the store and I run to the bank and get some money and I look at the account and I got, [gasp] not much left, and I run off over here and then I go, well, geez, did I pay that bill, oh, got to go back to the bank and put the hydro bill in, you know, it really is hectic and, uh, you don't have an awful lot of time to yourself.

There's periods I hit like today I was, it was a real hectic day, lots of things...had to do laundry at home, [partner] wanted clothes down here for tonight. So I had to go home last night and do laundry, got to go to bed about maybe twelve thirty, quarter to one, okay, I'm up at six. And then you start, you go again.

And so I leave him with her and I go to work and I just work like crazy...so about quarter to four I say I start, oh, supper, geez, I have to do something, wow, the store is closed, I phone [babysitter] and tell her that I'm going to be late cause I've got to go to the store and get something and, oh, I've got to get some money so I can pay her too...

**Balancing Factors**

In order for the fathers to determine the amount of energy and attention either of the above competing roles deserved, as well as the amount of energy personally available, he was required to acknowledge, either consciously or unconsciously, a number of balancing factors that had influence upon the decision. They included the support system available to the father, high risk condition factors, and geographical circumstance.

**Support System**

Fathers described receiving emotional, practical, and informational support from a number of sources, including their partners, families,
friends, churches, and health care providers. Fathers varied in their assessments of their need for external support from these sources and the extent to which they received it. Some fathers explained that they had little need for outside support since they were coping adequately on their own. Others spoke of an acute awareness of their lack of support and the desire for better recognition of their needs from others. It was obvious that the reality of their involvement created a substantial need for support in their own right that was not being met.

The type and degree of support provided to the fathers contributed to their ability to carry out the two roles, and to the relative balance between the roles. Fathers who themselves received support were assisted in their role of providing emotional caregiving to their partners, and in fulfilling the responsibilities of sustaining the family. It was evident that fathers who received inadequate support from others were likely to encounter increased difficulty in fulfilling the roles. This situation invariably required some compromise in at least one of the two roles. For example, a father receiving little in the way of practical support was required, by necessity, to devote much of his time and attention towards this role, and relatively less on his role as emotional caregiver.

Partner. The fathers believed that they should protect their partners from their own emotional distress. They thereby effectively prevented themselves from seeking support from the very person who was closest to them. The physical separation served to compound the resulting emotional isolation. The fathers’ descriptions of their experiences in these two areas have been discussed previously but will be elaborated upon.
This father explains his reluctance to share his worries with his partner (and others).

...I didn't want to share it with other people and the only, but I didn't want to share it with [partner] either because I didn't want her to worry...at night especially going to sleep I would really worry and I didn't want to talk to [partner] about it particularly because I didn't want her to worry anymore than she was.

When asked what he needed from his partner, this father explained:

...if I do everything I can to help her deal with it, all she can do is do her best to deal with it, and that is looking after herself as best she can. I guess I feel like it's not a time where she's really got anything to give to me or to anybody else.

The above discussions might suggest that the fathers received little support from their partners. This is not the case. Regardless of the desire to protect their partners from the full impact of their own worry, in the end, the fathers inevitably received most of their emotional support from their partners. This would be logical since their partners were considered to be their major support in the rest of their lives. One father explained that he and his partner were mutually supportive, though he went on to acknowledge that he was the one to give additional support because she was more "vulnerable".

...the worry is there and it's just, it's such a state that, um, like there's not denying it. So we sort of take turns picking one another up, you know, like she'll, she'll just see the look on my face and, uh, don't give up. We keep on telling each other that it's going to be okay.
This father also described the situation of limiting expectations regarding fully mutual support:

I think I share concern, when she's concerned I'll share concern with her but, but only so that, because if I pretend there was no problem at all she'd be thinking well, don't you care?...I'm concerned but I am trying to hide worry, or not share worry, not so much hide it, I guess, but just not look for support from her, because I feel like I'm, we're sort of supporting each other, I guess, but I think she probably needs more support because she's the one doing it.

When emotional support was received from people other than their partner, which was rare, it by and large came from family and the church, rather than from friends.

Family. For some fathers, family members were also sources of emotional support.

Not in so much a counselling kind of way, just, my brother for one...he's been very what am I saying, untypical...I know he's being more supportive than he normally would be...Same with my Mum and Dad, they call...to talk to me about how things are going and, um, then I get a chance to tell them and I guess in that way I share my concern with them, I share my worries with them.

Most fathers, however, emphasized the practical support received from family. Assisting with childcare, providing home cooked meals, helping with household chores, and providing a place to stay were some of the supportive actions that were described.

...my mother and sister were great...I didn't need to cook much, they had me over to dinner most of the time or sent home, you know, uh, frozen care packages to eat...my mother, she doesn't live far from where, on my way to work, so I dropped [child] off with her...it worked out well but it was a bit of a hassle...
Not all fathers described receiving beneficial family support. Several fathers gave examples of inadequate or nonexistent support from family.

...my problem is because I've had both, my Mum dying and my Dad dying, and, my sister, I was always the one that looked, was the support person...that's the kind of position I have is, a position I probably made myself have...and, it's really good until I need the support and then I'm, when I stop that's were the, it gets real hard.

One of the hard things for me is coming to the, abandoning the illusion that we're a close family, that we're close in superficial ways...like if you need anything, just don't be afraid to call us which is the biggest cop out, I'm not going to be calling them all the time saying, you know, I need you, or whatever, can you cook me a meal...

Friends. Friends were mainly seen as sources of support for their partner. Several fathers commented on their relief when friends were able to provide emotional support and entertainment for their partner. When support was received directly by the father, and this was mentioned infrequently, it was most often of a practical nature.

We've been getting along pretty good I think, we've been making out. But, yeah, people are there if we need it, someone is always there to help us out...

The majority of fathers, however, described little support from friends - either of a practical, or emotional nature. This was mostly attributed to the fact that friends, particularly male friends, had no understanding of what the father was experiencing.

If I have one thing that is eating me up right now is that fact that I do feel rather alone like, you know, like I don't feel like, uh, that most of my, my friends don't understand what I'm going through, or they haven't put themselves on the line to help take the pressure off.
When one father was asked whether he received any support from his male friends he replied:

No, no, not really. They're, uh, they're just sort of "what's going on?", you know, uh, "oh yeah, so when's the baby due?" You know, the same sort of questions regularly...I guess I suppose they're not exactly sure how to react...I'm not going to cry on their shoulders or anything and it's sort of a weird thing because it's..a weird thing to describe to somebody else...

I don't think they really understand what it's about...I think they seem to comprehend either you go into labour and you have a baby or you might have a slight complication and go home, they don't understand, they don't ask too many questions...

**Church.** One father specifically described his church as a significant source of support for both himself and his partner. This father described religion as a major part of his life and was very involved in the activities of the church.

We take our council from the Lord and our family, and yeah, we've been well comforted like I say by many people in the church...

**Health care providers.** Of the three types of support described by the fathers, health care providers were mostly identified as a source of informational support. Informational support was received either directly from the health care providers or, most commonly, second hand via their partner. This form of support will be discussed further in relation to the fathers' coping strategy of seeking knowledge. It is of interest that only two fathers mentioned the fact that they received some of their information from a nurse.

...one nurse offered to since you missed the prenatal stuff do you sort of want to, uh...and giving sort of [on] the spot prenatal class here if you want, so that was pretty good.
Not all fathers expressed a need for support. This father stated:

Um, I would say for me it doesn't make as much of a difference. I'm, I tend to be a very self sufficient person I think.

One father described a feeling that he had no right to seek support from others; that it was somehow illegitimate.

See, but it's the kind of stress where you don't tell anybody because if you complain it's, what have you got to complain, you're not going through...that's the problem with the father, you always feel you have no right to complain because it's not physically happening to you. You don't have to carry the baby, you know, you should be happy, you should be this, and that's the problem.

This same father went on to suggest that an opportunity for fathers to share their feelings with others either individually or in a group would be valuable.

...I think the best thing would be, I think if every father or something could go through something like this [referring to the interview] I think that's a pretty good idea...I guess I, you almost wish there was a, in a situation like this, you wish there was a group, a men's, fathers' group that you could come once a week and talk to all the other fathers...

When another father was asked how fathers could be better supported than they are at present he suggested that an ideal system would be modelled after how he understood the Japanese supported those coping with a death of a family member. His description vividly portrays the difficulty some fathers encounter when attempting to balance both roles with inadequate support.

[In] Japan when, when a person dies...you have a lottery system or something so that some other family has to take care of all the funeral arrangements so it allows all the people the time to grieve, you don't have to go out and look after and arrange the funeral...you almost wish there was a
set up like that, you as a husband...you could drop everything and your time could then be devoted to, you know, being there...but you can't, because there is this whole life set up...

Yet another father explained why some fathers do not express the need for emotional support for themselves.

Guys don't tend to open up to people trying to help them...lots of times I don't want to talk about it...I can handle it...men don't want to allow the barrier they have put up around them down in case, they won't gamble...if the bubble breaks, they may be defenseless.

He suggested that the biggest support to the father was knowing that his partner was receiving the best physical and emotional care, and that he had "around the clock access" to his partner whenever he wished to be with her. Other fathers reiterated these thoughts, and added the request for more practical support. This father responded to the question of whether there was anything more that could be done for him with the reply...

Oh God, come and clean the house!

High Risk Condition Factors

Another category that influenced the balance of the roles was the collection of factors directly related to the high risk condition. These factors included anticipated versus unanticipated risk, perceived severity of risk, and prior high risk experience.

Anticipated versus unanticipated risk. Whether the high risk condition and hospitalization was anticipated or not appeared to influence, for some fathers, the emphasis placed on either the emotional caregiver role or the family sustainer role. Fathers who had the opportunity to anticipate
risk either because of past high risk experience or because the development of the current high risk condition was gradual were able to prepare themselves for the experience. For one father, this meant releasing himself of all other responsibilities so that he would be free to focus himself on the emotional caregiving role. This father had already anticipated risk to the pregnancy based on his past pregnancy experiences:

...its been like walking on eggshells this whole pregnancy and she's been on sick leave from the moment we found out she was pregnant...we expected that it would be difficult.

Others were completely unprepared for the change in events.

I was actually quite surprised when she phoned me at work...I knew she had gone to the doctor's and she didn't tell me what was wrong at first, she just said come down and get me right away and all kinds of things were going through my mind...

Fathers who were unprepared for the experience were left to scramble to organize their resources, resulting in less opportunity for choice regarding their role emphasis. When risk to the pregnancy was already acknowledged, fathers were prepared for the uncertainty accompanying a high risk diagnosis. Fathers who had no prior knowledge of pregnancy risk were surprised by an unexpected diagnosis that instantly changed the anticipated normal course of pregnancy to a pathway of uncertainty.

When the diagnosis of a high risk pregnancy was made, the resulting medical interventions were either progressive in nature, allowing for some degree of acclimatization, or abrupt, requiring immediate and sometimes drastic adaptation by both partners. Medical interventions that were
initially relatively minor provided fathers with the time needed to accept the developing reality of the potential risk. Interventions such as bedrest at home, oral medication, and increased monitoring of the pregnancy, frequently preceded the more drastic intervention of hospitalization.

In some cases, however, there was very little time between initial diagnosis of a problem and hospitalization. Another father lived with his partner in a community 600 kilometers from the tertiary hospital. When high risk problems were diagnosed she required immediate medivac, leaving a shocked and unprepared father with a two-year-old son behind.

Yeah, we didn't have time to react really, basically it was just like, okay, if you have to be in the hospital in Vancouver then you have to be in the hospital in Vancouver, let's just get you there now.

Perceived severity of risk. Another important weighting factor is the degree of threat to the pregnancy that the father believes to be present. This awareness may be influenced by a subjective as well as objective assessment of the situation. In other words, the father's perceived severity of risk may be quite different than the actual risk associated with the high risk condition. When a higher degree of risk was perceived, fathers appeared to place a greater emphasis on the emotional caregiving role. This was demonstrated by the father who gave up work to remain with his partner 24 hours a day. This woman's pregnancy was complicated by hypertension, which was relatively minor given her advanced gestational age, however, the father perceived a significant risk and acted accordingly.

Another father described minimal perceived risk to a partner's
pregnancy that was complicated by chronic abruptio placenta and severe oligohydramnios in a 29 week fetus. This condition does, in fact, place the fetus at a relatively high risk and warranted greater concern than was demonstrated by the father. This father's assessment of risk appeared to influence the role balance resulting in relatively less emphasis on the emotional caregiving role. He described his assessment of the risk by explaining:

Even though she was on the high risk ward she was the lower of the high risks, that's the way I perceived it.

Prior high risk experience. Prior high risk experience appeared to influence role balance in a similar fashion. Four of the participants had previous experience with a high risk pregnancy or a pregnancy loss. Three of the fathers had experienced losses ranging from spontaneous miscarriage, elective termination due to Down's syndrome, a stillbirth at 28 weeks, and a stillbirth at term. One father had experienced a positive outcome when his 26 week baby survived and had no neurologic sequela.

Those fathers who had negative past experiences tended to express a greater sense of distress at the diagnosis of the current high risk problem and appeared to place a greater emphasis on their emotional caregiving role. One father expressed a tremendous amount of anxiety related to the belief that this was their last chance to achieve a healthy baby. They had experienced a number of previous losses and the negative impact on each of their lives and on their relationship had taken its toll. He explained:

We more or less said that this was our last attempt. So it feels that there's, there's a hell of a lot riding on it, both her and I....we're getting too
old to have a baby...It's just, I guess it's, uh, if it goes wrong, what do we do, like there's, we can't really do this again.

Another father explained that he would not rest easy until the baby was delivered.

Well, I think because of our past problems that we just were always worried...there's always that, even now your worried, even if she's at 36 weeks there will always be, just because of our past, once you've been in a house fire you're always worried...I think until the baby's out, when the baby's out and healthy, I think alot of that will just [go]...

Another father who had experienced a previous pregnancy (with another partner) that resulted in the delivery of a 26 week infant who was healthy applied that knowledge to his current situation and explained:

I wasn't too worried, mainly because of [name of 26 week child]...from a life threatening point of view...I felt pretty competent that everything would be O.K.

As a result, this father seemed comfortable with the high risk process as it was unfolding and attempted to convey this expectation to his partner. It is significant to note, however, that because his partner had not had experience with a previous high risk pregnancy herself, more energy was directed to the emotional caregiving role that what might have been expected had she also experienced a previous positive outcome.

**Geographical Circumstance**

When the couple's residence was remote from the hospital, as frequently occurred in a tertiary level hospital that provided service for an entire province, the impact of the geographic distance had a profound influence on the father's role balance.
Fathers who live a great distance from the hospital are faced with a variety of obstacles and decisions not experienced by the father whose partner is closer to home. The primary problem is an inability to find an easy compromise between the two roles. The fathers were forced to make a difficult choice. Either remain in their home community, meet the obligations of sustaining the family, and neglect their partner hundreds of miles away at a time of crisis...

I'm finding that's possibly the toughest, toughest part right now, it's, like we're separated by, 1000 kilometers, and, you can't just turn to your partner and say, you know, I'm having a problem, or I've got an idea this isn't going to be so bad, but you need to handle it this way and get it all worked out, and the economics of the situation how is that I just can't phone her anytime I feel like it...

Or alternatively, abandon their responsibilities at home and devote themselves to the unfolding events in the hospital, and to their support role for their partner. This father, who had left taken time from work and joined his partner in the hospital commented on how the situation would have been different had she been hospitalized in their home community.

...[had partner been hospitalized in home town], I would have probably have continued working and then just in between shifts and lunchtime and everything, go in and see her.

Fathers who choose to join their partners are faced with the need to negotiate time off from work, organize their transportation to the city, find appropriate accommodation, and discover their way around a foreign city. Fortunately the hospital where the study was conducted has hostel accommodation available nearby for families.
Personal Impact of the Experience

The personal impact of the experience included two components: emotional and physical impact. Fathers' descriptions of their emotional and physical responses convey the impression that theirs is a highly individual experience with significant meaning. Though the content and intensity of the emotions varied to some degree from father to father, it was uniformly evident that every father was substantially affected by the high risk pregnancy and hospitalization. What follows is a description of the emotional and physical responses that were most commonly discussed by the fathers.

Emotions Surrounding the High Risk Pregnancy

The realization that the pregnancy was at risk resulted in a range of emotions that began at the time of discovery, and continued with varying degrees of intensity for the remainder of the pregnancy. The predominant feeling described by the fathers was fear. Other emotions included uncertainty, helplessness, and loss of control.

Fear.

I was really worried that something would happen to the baby because we were so excited and this was only, this was at twenty weeks that we found this out, so we weren't very far anyway... I started to think, oh God, what happens if we don't have this baby and then that, that got worse because then I started to think well, if the baby is in danger, what about [partner], like is she in danger too? ...It worried me enough to think we'd lose the baby, but then to start thinking, you know, something might happen to [partner], that was even scarier for me...

Fathers' fears, anxieties, or concerns (the terms will be used interchangeably), were divided into three basic categories: concern for the
baby and for their partner, concern regarding the potential impact on their relationship, and concern regarding their performance as a supportive partner. Financial concern, which was also expressed, was addressed earlier in the discussion as it related to the family sustainer role.

All of the fathers described at least some degree of concern for the baby, though some of the fathers' fears were more profound than others.

Yeah, one of the fears is that the baby will be born today... the baby at this point could suffer serious brain damage... serious brain damage or physical damage... those are the fears instantly, that the baby won't survive at all or won't survive properly.

One father was more confident that the baby's life was not threatened.

I was worried because we know it is a boy and, uh, boys tend to not fare as well as girls so it's just, I was, I was concerned that it was a boy and it might be premature delivery. But I also felt that because it was about 32 weeks at the time that he had a pretty good chance...just from a life threatening point of view I felt pretty competent that everything would be okay.

One father, when asked if he feared the baby surviving with a handicap more than the possibility of it dying, replied:

Yeah, I have a huge fear of that, it's my greatest fear. Absolutely, I'm terrified that I, I feel like I could cope if we were childless...we would just re-evaluate what, you know, our goals and the direction our life is going to go. But I don't know what it would be like to have a special needs kid...It scares me.

Other fathers shared his feeling that fear of a mentally or physically handicapped child was greater than the fear of death. They described the potential for lasting impact on them and on other family members' lives, and wondered about the quality of life for a severely handicapped child. One
father elaborated by describing the uncertainty that he and his partner
would be able to deal with such a challenge.

You know the fear that if the baby is handicapped will you be ready to
meet the challenge, because, I know, I've seen people deal with handicaps,
it's tough, really tough, it has to be done for the rest of your whole life having
a handicapped child...if the baby didn't survive, I'd think well, okay, we can
start again.

Most couples had, at one time or another discussed this possibility.
Some had decided together that they would request 'no heroics' if the
newborn's chances of intact survival was remote.

Not all fathers feared potential handicap more than death. One father,
who had worked with handicapped children as a teacher, explained that this
knowledge helped him understand the challenges and rewards of life with
these children. While this allowed him to be even more cognizant of the
great difficulties encountered by the children themselves and their families,
it reassured him to know that families could survive this kind of tragedy.
This father believed he was more worried about losing the baby altogether.

Many of the fathers said they feared that their partners' lives were in
danger. They acknowledged the fact that this possibility, in reality, was very
unlikely. Nevertheless, they described a deep unsettling fear that they
might lose their partner as a result of the problems they were experiencing.
There was an underlying awareness that women throughout the ages and
around the world have died in childbirth, and that their partners, despite
modern advances in heath care, may not be immune to this phenomenon.

I had a dream the other night that the baby had survived and (partner)
hadn't and, uh, that's just life, because suddenly sure you have another baby,
you have your daughter or son, but you don't have the mother, you don't have
your wife...it really made me think that, its childbirth right, having babies, but childbirth is dangerous too.

One father explained the unpredictability of such tragedies:

Oh yeah, because of life, even the most minute things, I have a friend who had a gall bladder operation, she went in, its a normal thing but she died, its just a strange thing, you know, there's always the chance that unbeknown, something will go wrong.

Some fathers feared the impact of a potentially negative outcome on their relationship. They were aware that the stress of coping with the resulting emotional upheaval would create difficult challenges in the relationship. This awareness did not necessarily reflect current difficulties in their relationship, but more an understanding of the process required of couples following a loss. One father's misgiving about the potential impact on their relationship was based on past experience with a perinatal loss.

I mean, that's central to my emotions right now because I saw, it took a good couple of years for her to pick up the pieces of that...I mean, human beings being what they are I suppose we will survive...I just hate to imagine what this one would be like if she lost it and how long, cause it was really hard on our, on our relationship because of the, the different stages we went through the grieving process.

Some fathers verbalized anxiety related to their role as a support to their partner. They perceived that their actions were being judged by the health care providers, their partner, and others. Were they being as helpful and understanding towards their partner as they should be? Or as much as the husband of the woman in the next bed?

Am I seeing her enough, or do they think that I'm a, do the nurses that are around think that I'm not...that husband does so much, you know, she's
talking with somebody else, "Oh, I love your husband, he's so lovely...what he does for her"...am I doing enough, is that what she's saying?

One father elaborated on this feeling and related it to his general perception of fatherhood. He felt that society was encouraging fathers to enact the "new father" role but was doing very little to support him in the process. This led to anxiety regarding his ability to carry out this desired role, particularly as it related to his involvement with the pregnancy, and his support for his partner.

Society is saying we want the father up there, we want the father up there, but at the same time they're pushing him back to the side so it's, that's the quandary.

While fear, or anxiety and concern, were the predominant emotions for most of the fathers, other feelings were also expressed. These included uncertainty and helplessness.

**Uncertainty.** Feelings of uncertainty were expressed by most of the fathers at some point in their experience. Uncertainty existed in multiple areas, but primarily concerned the health of the baby and their partner, and the ability of the medical profession to intervene.

I think the thing that was sort of the biggest worry, was that nobody could exactly say do this or take this medication and everything will be fine...that element of not really sure exactly what's going to happen, nobody can really say, don't worry, this will happen or at least expect this to happen but there's not any boundaries.

I feel like obstetrics is 'smoke and mirrors' because nobody really has a clue of what's, you know, why it works or when it works.
Helplessness/loss of control. While helplessness would be a logical feeling for these fathers, it was voluntarily expressed in surprisingly few men. One father alluded to helplessness when he described the things that he was doing for his partner and explained:

But, I still feel like I wonder if there's something more that I could do for her to put her more at ease.

Two fathers explained the feeling of helplessness when their partners were abruptly transferred to Vancouver from their remote community.

I was in [name of community] going, you know, "what can I do", I stay home and look after [my son].

You know, it was pretty frustrating to be at the other end of the phone a thousand miles away trying to calm her down and not being able to do anything about it.

Other fathers, admitted to some degree of helplessness only in the second interview when questioned directly about this feeling. One father acknowledged some helplessness but explained:

I probably didn't think about it much...when she first came in I just sat there and the doctors were talking to her and examining her and I didn't feel like I could do anything.

Another father, during the second interview only acknowledged a sense of helplessness because he was unable to convince his partner that everything was going to be O.K, "a piece of cake". His partner continued to worry despite his attempts to reassure her which left him feeling helpless.

Helplessness is an emotion that is associated with a loss of control. When questioned about a sense of loss of control, fathers denied this feeling.
They believed that pregnancy was not an event that was within their control at the best of times, and particularly not since high risk problems had developed. They saw themselves as supporters to the process and not controllers. Fathers offered the following explanations:

I didn't feel like it was something I guess, it wasn't anything I expected to control...I don't think I ever felt like I was going to be in control that I was sort of, watching in amazement, so I didn't feel like I lost anything by not being in control.

I couldn't even imagine what she was going through, so I had no right to take control...not forcing my way on someone else in a situation I couldn't even comprehend...pregnancy is an experience I could never experience or comprehend so it wouldn't be right for me to take control.

It is perhaps revealing that while fathers denied feeling a loss of control when questioned directly about this feeling, they gave numerous examples in the rest of their discussions suggesting feelings related to loss of control. Loss of control particularly related to their role behaviors, discussed previously, and coping strategies which will be discussed later in this chapter.

Emotions Surrounding the Hospitalization

Feelings surrounding the hospitalization of their partner were conflicting. They included loneliness and loss of intimacy, security, feeling like an outsider, and belonging.

Loneliness / loss of intimacy. Hospitalization inevitably led to some degree of separation from their partners. Being apart under such stressful circumstances created feelings of loneliness and loss of intimacy. Loss of their best friend on a day-to-day basis was significant for most of the fathers.
Several of the couples shared remarkably close relationships, so for these fathers the separation was particularly disturbing. The loss of intimacy was also a significant issue for most fathers.

It's definitely been harder on both of us having her in here...it's a big strain being apart...that's a big deal, for her and in fact for myself, I think, to be apart...it is a big difference not sleeping together because we really look forward to that, and it's nice, you miss that kind of intimate time when your not sleeping together and waking up together in the morning. You talk about things when you're going to sleep or when you wake up that are important because you've got time to lay and think about them, you know, kind of relaxing.

One father, who was separated from his partner by 600 kilometers and was kept busy caring for his small son explained:

I'm so busy trying to keep things going anyhow, that, it's only late at night when you're kind of sitting back and going okay, you know, like I guess I should go to bed, oh, right, bed, yeah, empty bed, you know, its just like, that's the only real time when you start to think you know, there's no one around...and I find I don't go near the bedroom too much, cause its just a, there's no one there.

This father found ways to make up for this loss of intimacy with his partner by spending more time cuddling with his son.

It's nice (my son) is a cuddler too, so...instead of spending my time , you know, thinking about wow, I wish [my partner] was here, I spend my time doing things with [my son].

Security. Despite describing feelings of loneliness and loss of intimacy, a predominant emotion related to hospitalization was a feeling of security. The hospital and its caregivers offered a haven of safety for their partners and babies that they could not provide. Fathers described the conflicting emotions of loneliness and wishing their partners were at home, versus the
security offered by their hospitalization.

Because we can't say how quickly something can go wrong and, of course we both want her home. She wants to be home and I want her to be home, but you know we'd really hate ourselves if we did that and then something happened to the baby, you know, that could have been prevented or helped had she been in here... cause its not a big period of time to really give up.

When fathers had the opportunity to cope with managing the high risk pregnancy at home, they discovered that the stresses inherent in this home support role were often overwhelming. One father, who had cared for his partner while she was on bedrest for four months prior to her hospitalization, described a sense of relief from the responsibilities of home care.

We have a lot of things on our plate right now and I am, thank the Lord that she's in here, because she will get the proper care that I can't give her at home...it eliminates my schedule and gives me a bit of peace cause I don't have to attend to [her] needs...I catered to her, like I cooked the meals, cleaned the house, vacuumed the carpets plus, you know, everything else...

The security felt by the fathers was related to the availability of the best health care possible. Fathers explained that in ensuring their partners were in the "best place in B.C. and perhaps the world", they had done all that they could to influence the outcome. Fathers acknowledged that this need to have their partners in "the best place" was important because of their feelings of helplessness in being unable to influence the outcome of the pregnancy in any other way. Fathers explained the feeling this way:

This is probably the best place for her right now if anything would go wrong. It makes you feel secure that you've got, you know, all the specialists and all the care, all the equipment that's needed, everything is right here at your fingertips so, I don't think there's a better place in B.C. for sure.
That's what you do right, trying to make the baby's chances the best... so even, with, um, it would be nicer to have her up there, the advantages here, is security...that's a big weight off my shoulders...its in the best place it can be. What else can you do...

One father related his role in ensuring his partner received the best care possible to smart consumer behaviour.

Because of the, you know- you buy a VCR you're going to check consumer reports...you're going to try to get the best possible...I've talked to some other people, you know, everybody says that [this hospital] is good...[if she had not been admitted here] I would have tried my best to get her down here.

When it appeared that their partners were not to be hospitalized in what they perceived to be the "best place", fathers experienced a certain amount of anxiety. One father described the stress that he felt because his partner was initially refused admission and was to be sent to another hospital. In the end she was admitted to the tertiary level hospital and his anxieties were relieved.

Even when the pregnancy risk factors had resolved, and it was feasible to return one woman to her community hospital for care so that she could be closer to home, the father was not comfortable.

She'd be here with people who knew her, knew the case, knew everything that's going on, why suddenly get up and leave the best place possible for a baby...Sure it's a drag, I would much rather she was [in community hospital] and I could visit her every day but, you know, looking at the practical end of things, it's the best thing for the baby is to be here.

Feeling like an outsider. Many of the fathers described feeling like an outsider in the hospital. They explained that the care in the hospital was so
focused on the mother and the baby, that they were really rather peripheral to the experience.

...to actually feel comfortable, I think that's the hardest thing, for a father coming in in that situation is, so much of the care is given towards the patient, so much is given towards that, that the father, you know, a father always does for me, sort of this thing from the outside...its very hard for him to be comfortable...you feel like you're in a bit of a, well you are in a foreign environment.

One father, when interviewed after eight weeks of his partner's hospitalization, admitted to a growing sense of feeling 'in the way'.

Maybe I'm in the way, which I really didn't think I should be thinking that because I thought well no, we're here because [my partner is] here and this is not just her problem, it's our problem.

Another father described a past experience that indicated to him a failure to acknowledge his role.

I've experienced some things in other hospitals, yeah, where there was no consideration for the father whatsoever, and I think that was out of lack of wisdom. What they were looking at is well, here is the mother pregnant, that's what they're concentrating on, in other words, well this is what we're getting paid for, but not looking at the husband's point of view also.

One father, when asked to describe how he felt he was treated by the health care providers explained:

I guess I'm on the periphery and an interested bystander, and who occasionally, uh, he gets his two cents worth and asks the odd question if it's pertinent.

Even the most simple things contributed to this feeling of being an outsider and emphasized the feeling of helplessness. A father described
feeling helpless because he even had to ask the nurses to get his partner a jug of ice water because of the location of the ice machine, even though he was perfectly capable of doing this for her. He went on to describe a feeling of apprehension because he felt he may be blamed by staff for something he may not do correctly in the hospital.

You're almost like this person...You're always the person, you're waiting for somebody to blame you for doing something wrong, or "why haven't you done this?" rather than, "oh, come on over here".

When this father was asked to suggest how this "outsider" feeling might be alleviated, he made a proposal that eloquently illustrated his feelings of discomfort with the current system.

The ideal thing of course is, if possible, if a father could come, this would be the real home for them. You could even sleep in the bed, you know, it would be an ideal thing...you'd move into a hotel or something like that, under constant supervision...there would be a nurse on staff...it would be as normal, it would be as close to being at home as possible, except it's not like you're interfering, I'm interfering. It's like, you're allowing the other people to come into your environment rather than you're in their environment...we'd be working together, and at this point we're not really working together.

**Belonging.** While the idea of feeling like an outsider was expressed strongly by several fathers, and acknowledged by others, most of the fathers also had positive feelings toward the hospital suggesting an element of belonging that was not entirely absent. Positive comments were related to the environment and satisfactory interactions with health care givers.

Fathers who felt accepted described the hospital as being unlike others they had been exposed to. They described the ward as "feeling as if someone lives here", instead of sterile and unwelcoming. One aspect of the
environment that contributed to this sense of belonging was that patients' rooms were decorated with personal belongings and items such as pictures of their children and family.

As important as the physical environment was to creating a welcoming atmosphere, it was not as important as fathers' perceptions of health care providers' attitudes towards their presence. Men who felt that the health care providers respected and valued their role as expectant fathers described a feeling of acceptance and inclusion in the hospitalization.

...the one thing I appreciate is the nurse coming to do stuff and they don't sort of, kick me out.

...[the doctor] certainly spoke to both of us...if [partner] felt like she couldn't mention one of [their questions], I knew some of them she didn't want to talk about, so I would ask [the doctor] and to start with I felt sort of funny about it, but the doctor's response was just as if [partner] had asked the question, she would answer to both of us, and if [partner] asked the question she would answer to both of us.

One father caught himself when he called the hospital "home". He chuckled at the mistake and acknowledged that he did feel, in a way, that this was his temporary home. This father had managed to spend a considerable amount of time with his partner in the hospital and this undoubtably influenced his sense of belonging.

An important factor for some fathers that relates to the above, and contributes to determining fathers' level of comfort within the hospital milieu, was their past exposure to illness and hospitals. One father described great difficulty when his partner was initially hospitalized. He related his discomfort to the death of three close family members, including
his father, during the past year.

...suddenly all those feelings start coming back, you know, and so it was very hard for me the first couple of weeks coming in here...because I'd sort of, a month and a half in the hospital and feeding him and stuff like that, you know, and here it was coming back again...I think probably stuff that I had pushed aside...

Physical Impact

The experience had wide ranging impact on the fathers' physical wellbeing. This information was rarely volunteered. Fathers usually mentioned the effects only when they were asked to comment on how the experience was specifically affecting their lives in these areas. Why this was so is open to speculation. Fathers in second interviews were only able to suggest that the reason may have been the lack of focus on their own lives at the time. Almost all of the fathers identified negative effects on several health related areas including diet, sleep, exercise, and leisure activities. Only one father described specific physical symptoms of illness. He reported that he had been unsuccessfully fighting a cold for the past three weeks.

Diet. Most of the fathers reported a poor diet since their partner was hospitalized. They frequently ate on the run in fastfood restaurants or the hospital cafeteria. They explained that inadequate time, the lack of their normal daily routine, and the absence of their partner who usually assumed the role of cook, all contributed to their culinary decline.

I don't like cooking by myself so I just grab something. Eat at a restaurant or eat down here...
I find that I don't really have time to get out and do, do shopping and stuff like that.

This father explained that food had become a necessity rather than an enjoyment for him.

Well, you know, not all that great, I mean I look after myself and I get enough food, I eat to live at the moment...I'll cook something and, put it in the fridge and then just go through it so, I liken it to a wolf going back to the kill every now and again, I gorge myself, then go flying off in another direction...

Another father clearly related the change in his eating habits to his increased level of stress.

I'm probably more tense than I was before and basically I think I'm, I'm usually fairly laid back and I never have had stress problems or, I think I've basically just enjoyed things and so I'm very relaxed but I find myself in the morning, if I'm ever worried about something I have trouble eating breakfast, and I haven't eaten breakfast properly for ten days.

**Sleep.** Most fathers reported a reduced amount of sleep. On average, they were sleeping one to two hours less than usual. Most fathers did not believe this was having a deleterious effect, though their descriptions suggested the contrary. For example, this father was getting two hours less sleep a night. When asked if this was beginning to wear him down he replied:

Not really, I feel like I'm back in college you know. In college I used to go on four hours a night and that's what it feels like...always, constantly studying for an exam and trying to keep ahead of the assignments.

Some fathers however, did describe feeling tired and worn down.
I don't get a lot of sleep anymore cause I'm here all the time and I go home and I worry and she phones all the time and so I don't sleep too much lately.

Fathers reported difficulties getting adequate sleep because of their worries, their hectic life, and because they were not used to sleeping without their partners. Fathers explained that they were often able to make up for their lack of sleep by sleeping for extended periods on the weekend.

**Exercise/leisure activities.** Time for exercise and other leisure activities was a luxury that few of the fathers reported being able to pursue since their partners were hospitalized. Routines such as going to the gym, running, or hobbies were abandoned as a result of their hectic schedules. For some, this meant that an important component of their normal routine for physical and mental health was no longer available.

**Coping Strategies**

The fathers articulated four specific coping strategies which influenced both the ability to carry out the two roles and the nature of the personal impact. They included maintaining a positive attitude, taking one day at a time, having faith in a higher being, and seeking knowledge.

**Positive Attitude**

The ability to maintain a positive attitude was crucial to these fathers, and they used a variety of approaches to accomplish this. Some fathers relied on 'focusing on the positive'. These fathers explained their philosophy this way:

I try to put fears or worries basically out of my mind at this point and try to focus on the positive that we're going to have a long boring time here
and we're going to have a healthy baby that can go home with us...I hope that other things don't happen, that he doesn't have to get the...respirator...you know, that stuff like that isn't required. And I guess I have basically acknowledged all these things that are possible to happen. I, you know, any one of those could be considered a fear I guess but I try not to focus on those because you know I have no way of knowing that those things are going to happen so it's not beneficial to sit there and keep thinking about those things.

It seemed, it seemed like it was sort of under control, like, I suppose I never really thought of it a lot, never, she always like if something, like I'm the type of person, like if something bad is happening I'll just, or could happen, I'll just think well, it happens to other people. I try to keep that attitude, I always like to keep a more positive attitude so...

Another father related his approach to his optimistic personality.

I'm an optimist, I keep thinking that she'll be here till the very end.

Within the above descriptions of these fathers' attempts to maintain a positive attitude there is evidence of a certain amount of denial. Other fathers were clearer in their description of denial:

I wanted to trivialize it a little bit I think and say, well, that's not a big deal, it's happened to other people...I wanted to think that it was just a little thing that was going to happen for a while and then go away.

I had my share of worries...I didn't like it if [partner] said "What if...", I didn't want to talk about it...stuff like that, I might have had it but I just suppressed them...I tend to not want to think about it and suppress it and it's difficult when [partner] says "I had this dream..." I say don't worry it's not going to happen, everything's going to be fine.

Rather than denial, this father described a process of 'holding back' to protect himself from a potential loss.

I'm still well, you know, this little part of me because of the, a lot of it's because of just the rotten luck we've had, you know. I know it's looking pretty good and everything...I want to make sure that everything is okay, I don't want to treat this as another person again and to have something bad
happen again, and go through all that again, so, it's a measured sort of time. I'm coming around and now it's pretty obvious that there will be a little baby coming...

One father described hope as being what sustained him through the experience. He explained how on good days, when he and his partner were optimistic, they would allow themselves to focus on their hope and spend time anticipating their future child.

Just the hope that at least this time it will be different...we usually find ourselves talking about, what we'll do, planning for the future, this kid's named and dressed and the nursery is built and everything else, and bad days you just try to get through them.

**One Day at a Time**

Integral to the ability to maintain a positive attitude seemed to be the ability to approach the experience one day at a time.

I just cope with it the best I can I guess. I take it day by day. You know, that's all I can really do.

I'm trying to deal with it as best as I can... It's a bit like the alcoholics anonymous, one day at a time.

You could worry about that stuff for two or three weeks and then it doesn't happen and you worried for nothing, right. So you have to be aware of the possibilities of, that things could happen...you have to deal with it as it comes. You know if the baby is born premature we'll have to deal with that then, but at this point the baby is still inside her so why worry about prematurity or not. I'm basically trying to think of the positive.

Some fathers acknowledged that by taking such an approach, they were able to cope with a process over which they had no control.

It took me a long time to develop that attitude...I just finally one day came upon the realization that why worry about it, like you cross that bridge when you get to it...it's a very helpful philosophy in life to do that, you know,
you try not to let things bother you that you have no control over. And at this point we don't. I mean if that baby decides he's going to come out or if the blood pressure goes up, then it's going to happen and there's nothing we can do about it. We can just deal with it when the time comes...that's helped me out of a lot of frustrating things, you know, to remind myself that, that some things happen and they're out of your control so why get uptight over it...it's frustrating if something goes wrong and I think if a person can remind themselves, hey, well, you know, I couldn't have prevented this anyway, so why waste the energy on getting upset over it, you know, just deal with it as best as you can, at the time, when something has happened or whatever, and carry on from there.

Another father described how his experience as a photojournalist had allowed him the opportunity to see a great many tragic experiences that other people had learned to cope with. From this he had developed an understanding of how to approach the types of challenges over which he had little control.

...it's given me some information, and also it's given me, you know, a background preparation of how other people have dealt with such things. You know, knowing that you just have to get on, get on with it and not stand and dwell on it too much, cause if you do you won't get, it won't be handled, you won't change anything and so if you could just make sure everything is set up the best you can and go for it, that's all I can do.

Faith

Faith in a higher being gave several of the fathers strength to cope with the experience. By believing that God, or another vaguely defined 'spiritual being' had control over the events in our lives, fathers were able to acknowledge and accept the potential poor outcome.

...It is a possibility this child might not be born. We understand that, accept that, and know if it's not to be, that's God's will, and we're to try and understand and acknowledge if that be his will, that be his will.
So, you know, you sort of say thank you to the big guy and hope that, uh, that everything is going to turn out all right...

One father explained that if he didn't maintain his belief in a higher power he would be forced to accept the fact that he himself was in control of everything, or that there was no control at all. He found both of these alternatives frightening because the result would be an overwhelming feeling of helplessness. Instead, because of his belief in a spiritual being who did have control over our lives, he was able to relinquish responsibility for the outcome.

I have difficulty living too far in the future, and I just know I have no control over what happens so I just turn it over to God and what happens, happens; but I usually expect something good...I couldn't do anything about it so thinking about it would just get me upset, so I just think 'it's out of my hands'.

Knowledge

All the fathers discovered that increasing their knowledge of the physiology of the high risk pregnancy and understanding the rationale for the subsequent interventions by health professionals served to enhance their ability to cope with the experience.

I didn't know too much about it, you know, I don't, you know she's been here five weeks and I'm starting to learn a lot more. When we first came in here, like I didn't, you know, very little if anything...so I was pretty scared and asked a lot of questions...it helps to understand what's going on too. So we're, we're ready I think for, you know, anything they tell us now.

All fathers felt comfortable asking questions in order to increase their knowledge and generally felt that their questions were answered thoroughly and honestly. Nevertheless, they commented on several areas that resulted
in less than ideal communication between health care givers (by and large physicians) and themselves.

One father felt physicians answered all of his questions but he would have liked to have seen them volunteering more information.

I'm not afraid to ask questions and if I don't get the answer I want I'll keep pressing until I get the answer that I need to hear...I find that sometimes that the doctors aren't the most readily flowing sources of information in that they won't necessarily explain things if you don't ask them. They're quite good about answering if you do ask and especially if you show some savvy I guess of perhaps general ideas of medical care...But I feel that perhaps sometimes a doctor could volunteer information a little more freely rather than have to be asked about it.

This next father identified a problem in the level of communication of information by physicians. He called this "doctor talk", and felt it was not always directed to the level of understanding of the patient and family.

They answer everything you ask them...Like they'll start talking, like we'll start doctor talk. Don't forget we're not doctors and we don't understand half so we try to tell them the simple parts so we understand.

Some fathers commented on the difficulty in obtaining information first hand from physicians. This occurred because most of them were unable to be present during the doctors' rounds. For a few of the fathers this meant they were unable to obtain all the essential information. This father explained:

I like to know what's going on too right. I don't like to hear, like I've missed a few things where the doctor has come in and told her, and so you know I hear it from [partner] and she forgets a lot because she gets upset. So I like to be here when the doctor sort of comes by to talk to her...first hand.
When asked what he did when he did not hear the information first hand he responded:

...then I wait, you know, like I run to [doctor] or [doctor] or something like that, then I'll ask them about what [partner] has told me and I'll ask them some more questions too. They're pretty good, like I said, they'll tell you anything you want to know.

Another father commented that:

I probably get about eighty percent of the information and twenty percent of course [partner] would naturally forget.

The information he received was "filtered" through his partner. This did not represent a problem to him at the time, because he felt that he was able to seek out the information when he had questions. He recognized, however, that if his partner's condition was less stable, he would have a greater need to receive the information first hand.

For some fathers, obtaining information second hand was not a problem.

...whenever the doctor speaks to her I'm never here, I haven't been here anyway cause he has a schedule and he comes when he can, you know, and then she just tells me what he says...that's how I find out because I'm just not here all the time.

When asked if he would rather be hearing the information first hand he responded:

No, it doesn't matter to me. She's very thorough.

It is important to note that when fathers obtained information second hand this occurred not because the physicians did not acknowledge their
equal need to understand what was happening, but because of their frequent absence from the bedside. This is in contrast to past experiences fathers had with health professionals. One father compared his experience with a prior pregnancy to his current experience.

...nobody really talked to me that much, they'd tell my wife what they were doing and she'd have to tell me what was happening in, instead of sort of explaining to all of us.

Compared with,

...[doctor] has come in while I was there and talked to us...like I've never been sort of excluded.

There was some concern about the number of different sources of information and their lack of consistency. One father explained:

...I find that we find too many doctors tell us too many different things...we requested to talk to [doctor] on the phone the other day there at work, I was at work,,, and I, you know, I was confused and you don't know what's going on anymore cause there's just so many people telling us so many different things...one doctor says one thing and the other doctor says another thing, and another doctor comes in and he'll tell you something totally different too, so that's hard too.

Despite being an exception, it is revealing to know just how far one father was willing to go to obtain information. In this case it was not regarding his partner's specific condition, but was about the qualifications of the attending physician. This father took what one might consider drastic measures to ensure he had all the information he required to make decisions.
I believe and also took council from the College of Physicians and Surgeons. I checked out (doctor) and, you know, everyone. Also we had a security company that I did some background checks also, cause this time, hey, we're going to know data. How can you assess a situation unless you have the data?

Finding a Balance

It was necessary for each father to find a balance between his roles as emotional caregiver and family sustainer. The relative emphasis placed on each role varied from father to father, and with the same father, from time to time. These variations were dependent on the influence of the balancing factors as well as the inherent importance placed on the roles themselves. For the most part, the balance that each father achieved was a compromise between the two roles. Most of the fathers were relatively content with the position they found for themselves. Some, however, expressed significant dissatisfaction with their position but were unable in the present circumstances to influence a change. The following four examples portray the complexity of the interacting factors that determine the father's ultimate position.

One father lived in a remote community, had financial responsibilities that prevented him from taking a leave from work, and had a son to care for. This father, by circumstance, not choice, remained in his home to carry on with the responsibilities associated with the role of family sustainer. If he had been able to choose, he would have been with his partner providing emotional support. He was able to compromise to some extent by speaking to her frequently on the phone, traveling to the city every few weeks to be with her for extended weekends, and making plans to come immediately to
the hospital if her condition should change. This last action demonstrates how the high risk condition balancing factor of perceived risk can fluctuate, and thus influence a change in the determined balance. This father was required by circumstance to maintain his role as family sustainer and place relatively less emphasis on the emotional caregiver role.

A second father found a different balance between the two roles. He too lived in a remote community. While work was important to him, he chose to take the time off work to accompany his partner throughout her hospitalization. This father viewed his emotional caregiving role as being of primary importance, and virtually abandoned his family sustainer role in order to remain in the hospital with his partner 24 hours a day. He demonstrated his own comfort with the hospital environment, but was unavoidably aware of the system's discomfort with his presence. His decision to remain with his partner was not supported by a high degree of objective risk to the pregnancy. In fact, his partner's condition was of relatively low risk since the fetus was an advanced gestational age. This father placed greater emphasis on his role as an emotional caregiver, and significantly less emphasis on the family sustainer role.

A third father found a different balance but expressed significant dissatisfaction with his position. Though he viewed his role of emotional caregiver as being very important, he did not feel entirely comfortable assuming this role for a number of reasons. These included his perception of the health care system's inability to truly accept and accommodate the needs of the father, his lack of support in fulfilling his role, and his discomfort with the hospital environment. This father clearly described the
feeling of being an outsider to the whole process, including the
hospitalization. His family maintenance role was partially compromised as a
result of being unable to accept work opportunities that would take him
away from the city and his partner. He arrived at a balance that he
described as follows:

I'm now the connection to her, to the outside so all the stuff she has to
get done, I'm [doing that]. The staff nurses deal with the stuff on the inside,
I'm the guy on the outside, I have to bring the videos, bring the so and
so...we put our house on the market so there's all that stuff, and "have you
seen any house yet?, clean the house", blah, blah, blah, all those things at
home plus coming here.

Another father found a different balance again. He lived relatively close
to the hospital and visited often, more because of the recognized desire of
the partner for support than for his own expressed need to provide support.
He continued to work almost full time as well as care for his young child,
with the support of family. He did not perceive that there was any risk to
the pregnancy, so expressed a minimal amount of fear, or any other
emotion. His approach was matter of fact and rather distant to the potential
drama of the high risk pregnancy. Nor did he consider the hospitalization
particularly distressing in any way, though it was inconvenient. This father
found his balance by expending more energy and attention on the family
sustainer role, and less emphasis on the emotional caregiver role.

These examples serve to illustrate the complexity of the factors that
contribute toward each father finding a balance between the two roles, and
together with our understanding of the impact of the experience on the
father's own emotional and physical self, support the conclusion that the experience was substantive in nature. The experience clearly holds substantial personal significance for the father and is not simply a subsidiary experience to that of his partner. There is evidence, however, that many fathers perceived, to a greater or lesser degree, that others considered their participation to be of a subsidiary nature. This was not a concern for some fathers because they did not perceive that they were being neglected in any way as a result of this attitude. These fathers believed that while they were experiencing the phenomenon from their own unique perspective, the emphasis for themselves and others was appropriately on their partner and the baby. They did not perceive a need for any more attention or support from others than was already being provided.

You're sort of going along with the game plan, yeah, it's really, no it's not happening to you at all, you're just helping your wife, helping her to feel good, doing whatever you can to help her feel good...I didn't need any support myself, it wasn't me going through it, it was her.

Others were decidedly dissatisfied with being treated as a subsidiary participant in the process. These fathers also acknowledged that the focus for themselves and others was on their partners and their physical and emotional experience. This focus away from themselves, however, resulted in a perception that they were supplemental to the primary experience of their partner. The failure of others to acknowledge the fathers' own experience as significant resulted in discomfort and unmet needs for recognition and support.

...you're this thing on the outside, trying to get in, you know, trying to get like this little sperm, that's what you are...it's like you have the baby, and
the woman and, you have all these people around the woman, you're over here, trying to get in, and then you're called in to do stuff and then you're sent away to do that stuff. Then the other people come in, you know, the relatives, the mothers, the nurse, and, you know, and your like the person on guard waiting to be called to do something. And, a lot of that, I think it's half of me and half the way it's, it's set up.

Summary

This chapter has described the analysis of the data that portrays the father's experience of high risk pregnancy and antenatal hospitalization. The findings indicate that the father's experience was substantive in nature and involved finding a balance between two predominant roles - emotional caregiver and family sustainer. A number of factors served to influence the balance, including the support system available to the father, high risk condition factors, and geographical circumstance. Specific strategies contributed to the fathers' ability to cope with the experience including maintaining a positive attitude, taking one day at a time, having faith in a higher being, and seeking knowledge. The consequences of the phenomenon had a significant personal impact on the fathers' emotional and physical wellbeing.

The relative emphasis placed on each role varied from father to father, and with the same father, from time to time. These variations were dependent on the influence of the balancing factors as well as the inherent importance placed on the roles themselves. Most of the fathers were relatively content with the position they found for themselves. Some, however, expressed significant dissatisfaction with their position but were
unable in the existing circumstances to influence a change.

The fathers' descriptions portrayed an experience that was unique and significant in their own right. A separate and individual version of the phenomenon of high risk pregnancy and hospitalization that was intimately related and interdependent to their partner's parallel experience, yet substantively different was revealed.
CHAPTER FOUR
DISCUSSION OF FINDINGS

Introduction

Chapter Three presented the outcome of grounded theory analysis of expectant fathers' collective descriptions of their experience when their partners are hospitalized with a high risk pregnancy. In this chapter, the description of the father's experience is discussed in relation to the literature.

Researchers have by and large concentrated their attention on the maternal experience of pregnancy and childbearing. Despite this focus, over the years there has been increasing interest in the experience of expectant fatherhood in normal pregnancy (Colman & Colman, 1971; Cronenwett & Kunst-Wilson, 1981; Glazer, 1989; Hangsleben, 1980; Hines, 1971; Jordan, 1990; May, 1980, 1982 a & b; Roehner, 1976; Wapner, 1976; Weaver & Cranley, 1983). Very little attention, however, has yet to be directed towards the experience of the father when the pregnancy is determined to be high risk, let alone when there is the additional variable of antenatal hospitalization.

A few theoretical papers have explored the impact of high risk pregnancy on the family, including, to varying degrees, discussion regarding the father (Gyves, 1985; Kemp & Page, 1986, Mercer, May, Ferketich, & deJoseph, 1986; Penticuff, 1982). Although it has been recognized that research is needed to further our understanding of the expectant father's
experience related to high risk pregnancy (Conner & Denson, 1990) and antenatal hospitalization (May & Perrin, 1985), no research has been published in the literature to date.

Given the above, the following discussion will necessarily rely on work that has examined the father's experience either within the context of normal pregnancy, from the perspective of the woman, or from a related subject area.

Finding a Balance

The central theme that emerged from data analysis was a balancing of roles. The fathers were in the position to carry out two primary roles - that of emotional caregiving and sustaining the family. In order to meet the requirements of either of these roles, each father found it necessary to find a balance that fit with his individual circumstance.

A substantial body of knowledge has developed surrounding role theory. Role theory emerged through the collective contributions of a wide variety of behavioural scientists since the 1930's and earlier (Biddle & Thomas, 1966). Roles are defined as “the more or less homogeneous sets of behaviours which are normatively defined and expected of an occupant of a given social position” (Nye, 1976, p. 7). Role behaviours are what a person does in response to role expectations which are determined by society and refined by the individual (Friedman, 1981). Individuals may carry out a number of roles related to their particular position or social status (Friedman, 1981). A father's related roles may include, among others,
provider, companion, leader, child caretaker, and sexual partner.

Role conflict occurs when a person perceives that there are incompatibilities regarding role expectations (Hardy & Conway, 1988). Interrole conflict may occur within an individual when he or she is required to enact many roles simultaneously, and at least two of the roles are perceived to be contradictory (Hardy & Conway, 1988). Role overload occurs when there are excessive demands made upon an individual relative to the amount of time available (Hardy & Conway, 1988). Both role conflict and role overload may result in role strain which is the individual's subjective state of emotional arousal (Hardy & Conway, 1988).

Role theory has been applied to the structure and function of the family (Friedman, 1981). Eight basic family roles (including marital and parental roles) were identified by Nye (1976) including: the provider role, the housekeeper role, the child-care role, the child-socialization role, the recreational role, the kinship role, the therapeutic role, and the sexual role. It is through the interactive, interdependent performance of these roles that individuals are able to maintain a dynamic equilibrium and satisfactorily function as a family unit (Turner, 1970).

It has been demonstrated that the illness of a family member may disrupt this equilibrium, and that illness in the mother may be the most disorganizing to the family because of her pivotal role in family functioning (Friedman, 1981; Turk & Kerns, 1985). It has been noted that when healthy family functioning exists, remaining family members will adapt by either assuming the necessary roles left vacant by the ill member or by
seeking outside support to assist in performing essential roles. Dysfunctional families are often unable to respond effectively to the new demands brought about by family illness (Leavitt, 1982). However, even when a family is functioning adequately, role strain may result (Friedman, 1981).

The fathers in this study demonstrated some evidence of role strain as a result of both role conflict and role overload. Role strain may be exhibited by an increased level of awareness, overall emotional arousal, or feelings of distress, anxiety, or frustration (Hardy & Conway, 1988). In the role of family sustainer, the fathers were required not only to carry on with previously adopted roles such as financial provider, but to assume roles that may normally have been carried out by their partners, such as housekeeper and child caretaker. Even in families where the division of family roles may have been blurred, the fathers were now required to assume sole responsibility for the family sustainer role.

In taking on the emotional caregiver role, the men assumed a role traditionally assigned to women (Benson, 1968). In the past, men in our society have usually assumed instrumental roles while women have been responsible for expressive roles (Benson, 1968). Though these role expectations and behaviours are currently undergoing change in today's complex society, in most partnerships the woman continues to assume most of the responsibility for emotional support. Because of this, and the relative importance the fathers placed on their ability to carry out this role, the fathers were placed in a situation where they were vulnerable to role strain.
Furthermore, the necessity to balance the roles of family sustainer and emotional caregiver created potential for role conflict and overload. For some fathers, it was physically impossible to carry out both roles to their satisfaction, which inevitably lead to role conflict. This was true in the case of the father who was geographically separated from his partner. Other fathers were able to find a more moderate balance between the roles. These fathers were faced with role overload until they were able to adjust to their new roles. While evidence of role strain is evident in their descriptions, it appears that all the fathers interviewed were able to adapt and assume the roles necessary to maintain family functioning.

The analysis of data gave evidence to suggest that the central theme of role balance was recognized by the fathers as an experience that was substantive in nature. The fathers' descriptions portrayed a separate and individual version of the phenomenon of high risk pregnancy and antenatal hospitalization to that of their partners'. Their experience indicates that fathers are deserving of attention from others, particularly health care professionals, not just as appendages to their partners, but as individuals worthy of care in their own right.

It is well documented in the literature that the expectant father's experience of normal pregnancy is different from his partner's experience (Antle, 1975; Heinowitz, 1982; Wapner, 1976). May (1978) noted that "while pregnancy is for most men an emotional, if not physical, experience shared with their partners, many of the concerns and emotions of the expectant father are sex-specific" (p. 10). Despite this recognition, an
examination of the literature reveals that the father continues to be cast almost exclusively in the role of supporter to his partner, regardless of the relevance of the events to his own emotional and physical wellbeing.

In another grounded theory study, Jordan (1990) described the experience of expectant and new fatherhood. One process the fathers underwent was "struggling for recognition as a parent". This father's description of his experience supports the notion that fathers may need recognition of their own:

It's always in reference to how [my wife] is doing, and I feel like I have resigned myself more to just responding to what they are asking and that is to say how [she] is doing as opposed to me and how I am doing....I really tried to initially go out...and open myself up and really share...but, so much of the response is, "You've just got to stick it out. This is her time." There is no validation of the feelings. There is no recognition. I don't feel like I should deny my feelings and deny what's going on for me. The message is clear..."You need to focus on her." I just haven't found anybody that [sic] is real understanding, like "What is the experience like for you?" (p. 14).

Jordan (1990) also identified the impact that health care providers have on the father when this attitude is conveyed. The findings support the notion that interactions with health care providers may convey the impression that fathers are subsidiary. In Jordan's study, the participants believed that health care providers did not consider fathers to be their client. They reported that when they attended prenatal or pediatric visits to the physician they were infrequently recognized as a parent in their own right, and were treated simply as supports to their partner.

Wapner (1976) reported that in normal pregnancy, fathers feel that they are at the centre of action, not merely supporters of their partners.
The findings of this study do not agree with this assertion, since the fathers very clearly indicated that they did not place themselves at the centre of attention. This difference might well be explained by the critical differences between a normal pregnancy and a high risk pregnancy requiring hospitalization. It would seem logical that, if fathers experiencing normal pregnancy feel at times that they are not recognized as legitimate participants in the process, fathers experiencing high risk pregnancy and antenatal hospitalization of their partners would have even more of a reason to feel isolated from the experience.

It is worth comparing the findings in this study with Valentines' (1982) work that identified four developmental tasks of the expectant father (As described in chapter one, p. 6 of this paper). The first task related to fetal attachment was not necessarily a behavior identified in this study, though indications of fetal attachment were found in the fathers' descriptions of fear regarding loss of the baby. The second task, concern with practical issues such as finance, accommodation, and developing a sense of being a good provider relate to the role of family sustainer. The third and fourth tasks, resolution of dependency issues, and coming to terms with his relationship with his father were not identified in the data obtained from the fathers in this study.

There may be two possible explanations for this difference. The first is that there may be a difference in the necessary developmental tasks of fathers experiencing normal pregnancy and fathers participating in a high risk pregnancy. Fathers in high risk pregnancy may have other primary
issues to resolve at the time and may or may not address these two
developmental tasks at a later date. A second possible explanation is this
study did not seek to intentionally obtain these types of data, therefore
discussion regarding thoughts and behaviors related to these developmental
tasks may simply not have been mentioned by the fathers.

The Role of Emotional Caregiver

The role of emotional caregiver was well articulated by the fathers in
this study. This role has received a considerable amount of attention in the
literature. Roehner (1976) found that, in normal pregnancy, fathers ranked
helping the mother deal with her physical and emotional problems as their
most important function. Marquart (1976) found that it is normal for
expectant fathers to become more protective and nurturing of their partners
during pregnancy. This complements the woman's increased introversion,
dependency, and increased demand for nurturance that Caplan (1960)
identified in women experiencing normal pregnancy. Thus, when the
pregnancy develops complications, and the woman requires hospitalization,
it would be expected that evidence of even greater nurturing and protection
on the part of the father would be found. This study supports this theory.

Gyves (1985) postulated that a father may well be able to offer the
required support in normal pregnancy, however, in high risk pregnancy he
may be distracted by his own emotional responses including excessive
concern for the baby, resentment, guilt, and inadequacy. Gyves suggested
that the father's own emotional reaction might prevent him from fulfilling
his supportive role to his partner. However, in this study fathers gave
evidence to the contrary, suggesting that - at least from their perspective -
they were very able and willing to provide support to their partner. In fact,
they viewed this as one of their primary roles. Perhaps the fathers' own
emotional responses promoted rather than prevented the enactment of
their support role. Of note is that fathers in this study did not describe
feelings of resentment, guilt, or inadequacy per se as postulated by Gyves,
which may account for the contrary findings.

In a study on fatherhood in normal pregnancy, Roehner (1976)
concluded that society and health care providers place so much emphasis on
the woman's experience, that fathers feel that they must also concentrate on
her needs and virtually ignore their own needs related to parenthood.
Roehner cited the Coleman's (1971) description of the forgotten father who
is left out of the entire pregnancy experience, yet is expected to carry the
demands of emotional as well as material support. The fathers in this study
demonstrated that the focus for them and others was on support of the
woman.

The fathers were able to articulate three reasons why this was so,
including the physical reality of the pregnancy, their partners' greater
emotional needs as a function of being female, and the isolation and
boredom associated with their partners' hospitalization. The last reason in
particular is specific to antenatal hospitalization and has not been previously
reported in the literature.

The fathers gave detailed accounts of the ways in which support was
provided to their partner. These included maintaining a physical presence,
providing comfort and compassion, acting as a psychological coach, being an advocate, and providing protection. While the literature supports the general concept of the father as supporter, there is very little available discussion regarding the specific ways the support is provided.

Maintaining a physical presence was very important to the fathers in this study. The literature addresses the importance of the fathers' presence in antenatal hospitalization from the woman's perspective (Carty et al., 1992; Loos & Julius, 1989; Merkatz, 1978; Waldron & Asayama, 1985; White & Ritchie, 1984). These references provide evidence that a significant stressor for the woman who is hospitalized with a high risk pregnancy is the separation from her partner. Separation during such a well recognized period of vulnerability for both partners creates potential for impaired ability to successfully negotiate the required developmental tasks (Rubin, 1975; Valentine, 1982). The previous discussion regarding feelings of being an outsider supports the importance of providing the partners with unrestricted access to each other.

In research related to labour and birth, MacLaughlin and Taubenheim (1983) interpreted the fathers' need to be present and act as the primary supporter to their partners in labour as a need to establish territorial rights. A similar interpretation could be made for the fathers in this study.

Providing comfort and compassion are well recognized methods of providing emotional support in any stressful situation, and high risk pregnancy certainly qualifies as a stressful event. The specific role of psychological coaching by the techniques identified in this study -
reassurance, reinforcing reality, encouraging a positive outlook, and taking one day at a time - have not been previously mentioned in the literature.

The fathers' protective action of withholding the sharing of their own emotions has been addressed in previous work on fathers in normal pregnancy. In a study on marital support during pregnancy, Brown (1986), identified that in normal pregnancy men were less satisfied than their partners with items related to sharing of private thoughts and dealing with fears of an abnormal baby. In another study, May (1975) found that fathers may encounter problems dealing with their own anxiety about labour and delivery since they may feel that by telling their partners about their own anxieties they only add to her burden and thereby violate their role as protector. The significance of the fathers' reluctance to share their emotions with their partner will be evidenced in the discussion of the support system for the father.

The Role of Family Sustainer

The other focus for the father was the role of family sustainer. This role was multidimensional and included responsibilities related to work, childcare, and domestic activities. These three areas of responsibility actually correspond to three of the basic family roles identified by Nye (1976): the provider role, the child-care role, and the housekeeper role.

A number of authors have identified the role of financial provider as the primary focus for fathers in normal pregnancy. Glazer (1989) cited financial concern as the most frequently identified stressor of expectant
fathers (Antle, 1975; Colman & Colman, 1971; Heinowitz, 1982). Obzrut (1976) concluded that the provider role is of primary importance to the expectant father. The activities of preparing the living arrangements for the baby, and making financial purchases for the baby were the most frequently reported activities by expectant fathers in that study. However, May (1978) reexamined Obzrut's (1976) findings and suggested instead, that the data indicated the opposite conclusion - that the provider role is not of primary importance to most men. May supported this interpretation by noting that while 80% of the men in the study expressed concern about their infant care skills, and 68% about their adequacy as a father, only 35% expressed concern about financial security.

In another study, Roehner (1976) also found that functional support was felt to be a function of lesser importance than emotional support. Only 19% of fathers indicated that "providing money for the care of mother and baby" was their most important function, whereas 50% felt that "making sure the baby's mother remains healthy" was more important, and 84% felt that to "help the baby's mother deal with her physical and emotional problems" was more important (p. 18).

Beyond discussing the maintenance of financial security for the family, the literature does not deal with the other components of the family sustaining role in the specific circumstances that are the focus of this study. The literature related to hospitalization in general does provide empirical evidence that role changes occur within the family during illness and hospitalization. The hospitalization of a family member may lead to "role
gaps" when the patient is no longer able to fill certain responsibilities. The remaining family members must learn to reorganize and adopt these roles or confusion may result (Stember, 1977). The role components of childcare and domestic responsibilities remain, in most families, a primary function of the mother. The fathers in this study provided evidence that the assumption of primary responsibility for these tasks was a challenging if not stressful endeavour, particularly in light of the existing anxiety surrounding the hospitalization.

Balancing Factors

Support System

It is well documented in the literature that social support is a mediator for the ability to cope effectively with life stress (Cobb, 1979; House, 1981). Researchers have examined the particular implications of social support in relation to the transition to parenthood (Cronenwett, 1985; Wandersman, Wandersman, & Kahn, 1980), and more specifically, in relation to the transition to fatherhood (Cronenwett & Kunst-Wilson, 1981). Social support has been defined by House (1981) as "a flow of emotional concern, instrumental aid, information, and/or appraisal (information relevant to self-evaluation) between people" (p. 26).

Each of the fathers in this study identified a support system of some form or other that influenced his ability to carry out the two roles. A support system is an "enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical
integrity of the individual over time" (Caplan, cited in Garland & Bush, 1982, p. 118). The fathers' support systems included their partner, family, friends, the church, and health care givers. Fathers did not necessarily use all of the above sources of support. In fact, what was evident was that most fathers used only a few of these sources, and some relied, by choice or circumstance, on virtually no external supports.

The father's primary source of emotional support was his partner, yet he recognized that because of the need to protect his partner from her own worries, he was unable to take full advantage of her support. In a study on marital support in the normal pregnancy, Brown (1986) found that both men and women relied on their partners for an overwhelming amount of support. A further finding was that men expressed less satisfaction with their partners' support in the areas of being allowed to talk about personal and private things, and being helped to deal with fears of an abnormal baby. Given that the fathers in Brown's study were experiencing a normal pregnancy, it may be reasonable to hypothesize that fathers experiencing a high risk pregnancy and separation from their partner would express even less satisfaction in this area. This hypothesis is supported by the findings in this study. However, there is also evidence from some fathers that although they did give more support to their partner than they received, their partners were able to reciprocate with some support for themselves.

Very little emotional support was received from sources other than their partners. This finding is supported by Brown's (1986) work, and by
Lein (1979), and Kempter (cited in Cronenwett & Kunst-Wilson, 1981). Some fathers reported receiving emotional support from their families but this was described as minimal, and one father whose religious faith was strong received substantial emotional/spiritual support from his church. By and large, little support was sought or received from friends, male or female.

Practical support was mostly received from family, particularly mothers and sisters. Lein (1979) confirms this finding. In a study of fathers experiencing a normal pregnancy, Jordan (1989) reported that material (practical) support was most often identified by fathers as both helpful and desired. Lein also found female neighbours a source of support. Only one father in this study described practical assistance offered by neighbours.

Lein (1979) found that men's social networks mostly included co-workers who typically offered little practical support. Fein (1976) found that when support was received from people from work, it was usually not in the form of practical support such as flexible hours or paternity leave. Contrary to those findings, the fathers in this study were well supported by employers who accommodated their need for flexibility and leave from work. Fein's study was examining fathers of normal pregnancies however, and this may explain the difference in employers' willingness to accommodate the fathers' needs.

Informational support was received either from health care givers, or second hand from their partners. The finding that few of the men described receiving information from nurses is of concern, and has not
previously been noted in the literature. Given the importance of information (as noted previously in the discussion regarding information seeking behaviour as a coping strategy), and the infrequency of physician - father contact, the opportunity for nurses to act as significant informational supporters is obvious.

House (1981) identified a fourth type of support - appraisal support. Appraisal support is the "transmission of information relevant to self-evaluation" (House, 1981, p. 24). This type of support is received from others who are in the same situation. Self-evaluation is accomplished by comparing one's actions and responses with that of others. None of the fathers described receiving this form of support from other fathers sharing a similar experience. At least one father did, however, suggest that a fathers' support group would be valuable, and it is in a group such as this that appraisal support would be received. Taubenheim and Silbernagel (1988) described the successful implementation of an expectant fathers support group with a low risk pregnancy focus. The additional needs of fathers experiencing high risk pregnancy suggest that this type of group might be even more important for these men. A salient point, however, was made by one father when he stated that many men do not want to share their feelings. Obviously, the need for appraisal support of this kind varies depending on the particular individual.

It is perhaps appropriate to complete this discussion of support with a quote almost twenty years old:

"It is in the area of providing support for the husband during pregnancy and during fatherhood that the health professions have been most
little is said about the needs of the expectant father and new father....he is expected to take on all the former functions of the extended family himself in relation to his expectant wife and new mother, but who is going to provide the support for the father?" (Hines, 1971, p. 195).

The findings in this study reveal that the problem of insufficient support, at least for some fathers experiencing high risk pregnancy and antenatal hospitalization, remains to be adequately addressed.

**High Risk Condition Factors**

The high risk condition factors of anticipated versus unanticipated risk, perceived severity of risk, and prior high risk experience were identified as having influence on the balance of the roles. Some evidence can be found in previous work to support the findings.

Snyder (1984) discussed the impact of anticipated versus unanticipated risk and the resulting abruptness of intervention. It was suggested that a high level of anxiety is usually associated with unanticipated problems requiring acute intervention such as preterm labour whereas anticipated admissions due to known problems are less likely to be perceived as stressful. There was no documentation offered by Snyder to validate this theory.

There is empirical support for the finding that the perceived severity of illness influenced the fathers' emotional response. In research surrounding the familial response to illness and hospitalization in patients with medical and surgical problems, Stember (1977) found that the more severe the illness, the greater the degree of stress experienced by the family upon admission of the patient to hospital. Of significance is the finding that
the families perceived the illness to be more severe than either the patient or physician. This suggests not only that it is their perception that is the relevant factor rather than actual severity of illness, but also that inaccurate perception results from inadequate understanding - a consequence of lack of communication with the family.

Fathers' past experience with high risk pregnancy or a pregnancy loss also mediated their response. This is intuitively logical and is supported by theory related to stress and coping. Lazarus (1984) proposes that an individual's response to stress and the way he copes is related to how he appraises his relationship to environmental events, and that appraisal is dependent on past experience and memory. Lazarus' theory supports this study's findings that fathers who had experienced past success with a high risk pregnancy felt a certain amount of confidence about the outcome of the current pregnancy, whereas fathers who had experienced poor outcomes in previous pregnancies were more apprehensive about the result. This also supports the finding that fathers who perceived there to be more at stake displayed greater distress than the other fathers.

Geographical Circumstance

Snyder (1984) identified antenatal hospitalization in a distant perinatal centre as an additional stress factor for women. There is little mention in the literature, however, of the impact of geographical separation on the father. It was clear from the two fathers in this study who lived far from the hospital that geography had a significant impact on their ability to carry out their defined roles. Compared with fathers who resided near the hospital,
fathers separated by a substantial distance were less able to find a compromise between the two roles. For various reasons, both of these fathers were only able to focus on one role, and direct less attention to the other. This author has, however, observed fathers who found a middle ground even when geography was a factor. One father spent one week at home working and keeping the home together, and the next week in the hospital with his partner. He was able to sustain this activity for almost a month. Though he acknowledged feeling exhausted, he felt that he would not have done it any other way.

Personal Impact of the Experience

Emotions Surrounding the High Risk Pregnancy

Research in normal pregnancy has determined that the safety of the woman and fetus is a major concern for the father (Antle, 1975, Colman & Colman, 1971; Gerzi & Berman, 1981). Glazer (1989) found that the stressors most frequently identified by men were "if your baby will be healthy and normal" (95%), "your partner's pain in childbirth" (95%), "your baby's condition at birth (94 %), and "any unexpected things that might happen during childbirth" (90%). May and Perrin (1985), in their review of the father in pregnancy and birth, listed the common concerns of fathers: financial pressures, fears about labour and birth, fears about their own role in birth, fear for the safety of their partner and baby, anxiety about their ability to succeed in the father role, and worry about the effect of the child on their marital relationship.

The above research supports this study's findings that fathers
experienced a tremendous amount of fear for the wellbeing of the fetus. It could be expected that fathers facing the additional problems and risks of a high risk pregnancy would focus even greater emotional energy on this particular fear than fathers in normal pregnancy.

The fathers in this study described a fear that their child would survive, but with a handicap. For most of the fathers this was the greatest fear. Gerzi (1981) found that normal pregnancy induced in some fathers the fear of a "defective child". Penticuff (1982) acknowledged this fear as a possible inhibiting factor for normal psychological adaptation to the high risk pregnancy for both men and women but does not reference any specific research to support this statement.

Fathers in this study also described a fear for their partners' health, and even life; this supports previous research (May & Perrin, 1985). The implications of illness derived from the high risk pregnancy status, and the need for their partners' hospitalization could only contribute to their fear. Almost all of the fathers would have spent some time in the high risk labour and delivery unit. The environment of high risk, high technology, pregnancy care involving intravenous lines, medications, tests, beeping monitors, ever present vigilant nurses and multiple physicians conducting murmured consultations in the corner of the room no doubt contributed to the frightened father's confusion regarding whose life is actually at risk - the mother's or the fetus's.

The research in normal pregnancy suggests that fathers have concerns about the effect of the pregnancy and child on their marital relationship
(May & Perrin, 1985). Penticuff (1982) and Gyves (1985) both noted that the emotional upheaval that a couple faces when the pregnancy is high risk may place considerable strain on their relationship. In this study, the focus was more on the impact of the potential loss of the baby or of the birth of a handicapped baby on the couple's relationship. The fathers were aware that either scenario had the potential to bring the couple closer together, but that there was also risk to the stability of the relationship associated with the stress of a negative outcome.

Fathers also expressed concern about their ability to meet their partners' and others' expectations regarding their support role. This performance anxiety suggested an underlying discomfort related to the "ideal father" role promoted by current societal beliefs and values. There is much evidence in the literature to suggest that fathers display different involvement styles ranging from fathers who are comfortable with simply observing, to those that prefer to manage, and those who have intense emotional involvement (May 1980). May (1982b) concluded that current expectations regarding the ideal level of father involvement may lead to the lesser involved father feeling a certain amount of guilt and anxiety because he is not living up to his role. Similarly, the highly involved father may encounter disappointment when his experience falls short of his expectations.

In addition, fathers who are wishing to become more involved may encounter the "quandary" described by the father in the study who believed that while society claims it wants the father to be involved, we have not yet
constructed our practice to facilitate full participation. The literature is rich with evidence to support this father's finding (Jordan, 1990; Hangsleben, 1980; May & Perrin, 1985).

Concerns that are described in the literature as common for fathers in normal pregnancy, but were mentioned less frequently by the fathers in this study, are worry regarding their partners' pain in childbirth and concern regarding their own role in labour and delivery (Glazer, 1989; May & Perrin, 1985). The decreased prominence of these particular worries might be explained by an adjustment in the emphasis of concern so that the process of labour and delivery took on relatively less meaning to fathers who were not even certain of the health of their baby. It would seem reasonable that a process of priorization may take place allowing a father to focus on only so many anxieties at one time.

The emotional distress due to feelings of uncertainty expressed by the fathers in this study are supported by other authors. In research on women's feelings in response to high risk pregnancy, uncertainty is identified as a potential source of anxiety (Clauson, 1992; Kirk, 1989; Riddell, 1992; Snyder, 1984; Waldron & Asayama, 1985). Penticuff (1982) hypothesized that the impact of ongoing uncertainty in high risk pregnancy is also highly stressful for the father, though there is no other empirical data to support this.

Studies related to women's experience identify helplessness as a significant emotion (Carty et al., 1992; Loos & Julius, 1989; Waldron & Asayama, 1985). In Penticuff's narrative paper (1982) learned helplessness
theory was applied to couples experiencing high risk pregnancy. It was hypothesized that the diagnosis of high risk pregnancy creates an unpredictable and uncontrollable situation that prompts behaviours intended to reduce the risks. However, when the behaviours fail to alter the risk status, a sense of helplessness may develop. It is notable that though there was evidence of feelings of helplessness in their discussions, this emotion was not openly acknowledged by most of the fathers in this study.

It is possible that fathers were reluctant to reveal feelings of helplessness since it is an emotion associated with loss of control. Evidence of loss of control was mostly identified in discussion related to other facets of their experience rather than when discussing their emotional response. In fact, fathers were able to articulate reasons why they did not even feel as if they should be in control in the first place. Research on fathers' participation in labour and birth suggest that the need for control is relevant to most men but to different degrees (Chapman, 1991). Leonard (1977) noted that fathers felt helpless during their partners' labour. It was hypothesized that the fathers' passive roles of supporter and protector in labour are contrary to the predominant masculine image of the male dominating and taking control of the situation.

The father's role antenatally in high risk pregnancy is mostly, but not exclusively, a passive one. It is possible that the fathers' reluctance to admit they felt a loss of control - despite this emotion being apparent in their descriptions - is a result of societal conditioning which implies that it is not an acceptable masculine emotion.
Emotions Surrounding the Hospitalization

The fathers in this study described feelings of loneliness, loss of intimacy, feelings of security, feeling like an outsider, and feelings of belongingness related to their partner's hospitalization. With one exception (Gyves, 1985), a thorough review of the literature failed to find any discussion regarding the father's feelings related to antenatal hospitalization from his perspective. The literature available for review was limited to research on women's experience of antenatal hospitalization, the father's experience in normal pregnancy, and the medical-surgical literature. The findings in this study may therefore be considered of particular interest to the development of our understanding of the father's experience.

Loneliness is a feeling well documented in the literature on high risk women who are hospitalized (Carty et al., 1992; Loos & Julius, 1989; Taylor, 1985). However, feelings of loneliness for fathers has not been previously described in the literature, except as it related to loss of intimacy. There has been some work in the area of men's sexuality during pregnancy (May, 1987), suggesting that most men experience some period of disruption of their sexual relationship with their partner, and that most are able to adapt without much difficulty. The fathers in this study have, however, experienced virtually a complete loss of all forms of intimacy with their partner. Fathers readily volunteered feelings related to loss of intimacy, but did not discuss feelings specific to their sexual relationship with their partner.

A feeling of security was a predominant emotion related to
hospitalization. There is some evidence in the literature to support this finding in relation to the woman's experience. Women identified the security the hospital provided as the most positive aspect of their hospitalization (Carty et al., 1992). Merkatz (cited in Gyves, 1985), found that a woman who has experienced a previous pregnancy loss may be relieved to be in the hospital. The attentiveness of hospital staff and the available technology can be very reassuring to the woman and her partner experiencing a high risk pregnancy. What has not been reported previously in the literature is the particular security felt by the fathers knowing that their partners were not only in the hospital, but in "the best place" - referring to the tertiary level care provided by the hospital where their partners were admitted.

Feeling like an outsider is a concept that has previously been addressed in the narrative literature by Gyves (1985). Gyves suggested that "whereas the husband was at one time an integral part of the pregnancy experience, he abruptly finds himself to be an outsider, physically separated from his wife for all but a few hours of visiting each day" (p. 77). This feeling has also been described in the literature addressing the father's role in labour and birth. Hangsleben (1980) stated that fathers may feel like visitors in a foreign environment when they accompany their partners to the hospital. This feeling is related to the fact that all of the attention in the hospital is focused on the mother and baby.

Hangsleben (1980) and others (May & Perrin, 1985) suggested that hospitals should make every effort to include the father as an essential
member of the family, not simply as a visitor. One father suggested that the ideal situation would be a hotel-like setting with health care supervision. This father was not only describing his feelings related to being an outsider in the system, but also the resulting feelings of helplessness and loss of control. His suggestion has been considered by others. Rosen (1975) and Merkatz (1978), both advocated the creation of policies and facilities in the hospital to accommodate the partner and/or other family members on the antenatal unit. This practice is well supported in other "family centered" care facilities such as pediatric care by parent units (Stember, 1977).

Bothamley (1990), noted that fathers may feel inhibited in the foreign environment of the hospital to the degree that they do not even feel comfortable moving a chair without permission. This feeling was well described by the fathers in the study. For instance, because of the physical layout of the ward, performing a simple task such as obtaining ice water for their partners required asking a nurse to help them.

Nevertheless, many of the fathers were able to identify several positive feelings related to comfort and belonging. The most important determinant of feeling either like an outsider, or of feeling as if they belonged, was the fathers' perceptions of health care providers' attitudes towards their presence. When fathers perceived they were treated with respect, and were made to feel welcome by staff, they felt as if they belonged - at least to a certain extent. Stember (1977) provided evidence to support the importance of including families in hospital care in order to increase their sense of belonging.
Physical Impact

The physical consequences of pregnancy for the father have been explored in the literature as they relate to symptoms of couvade syndrome. Fathers experiencing normal pregnancy have been found to have a higher incidence of a variety of somatic symptoms including indigestion, gastritis, food cravings, nausea and vomiting, increased or decreased appetite, weight gain, diarrhea, constipation, colds, insomnia, headache, toothache, nosebleed, puritus, muscle tremors, rashes, styes, or non-specific aches and pains (Clinton, 1987; Klein, 1991). The fathers in this study described a change in diet resulting from a disturbance in normal routine and leading to a general decline in the quality of their nutritional intake. They did not indicate whether they experienced a weight change as a result of their alteration in diet. Consistent with previous work is their report of reduced sleep. Only one father reported specific symptoms of illness which was lingering cold symptoms.

Clinton (1986) examined the risk factors associated with couvade symptoms and found that, among others, general stress was a risk factor for couvade symptoms. Others have also found an association between stress and anxiety and couvade syndrome (Strickland, 1986; Trethowan, 1968). More specifically, anxiety created by concern over his wife's pregnancy has been identified as a risk factor (Trethowan, 1972). This would appear to be a logical relationship and invites the hypothesis that men whose partners are experiencing a high risk pregnancy would be at greater risk of couvade symptoms. Surprisingly, however, Lipkin and Lamb (1982) failed to find an association between couvade syndrome and pregnancy complications
experienced by the mother. While the numbers in this study are too few to
draw any specific conclusions about this relationship, it is evident that many
of the fathers experienced a recognized alteration in their physical
wellbeing as a result of their experience. Further exploration of the
relationship between high risk pregnancy and couvade symptoms appears to
be indicated.

Coping Strategies

Given the dearth of research in general on fathers' experience of high
risk pregnancy, it is not surprising that there is limited reference in the
literature to specific coping strategies used by fathers. Again, discussion
will rely on the literature available in related subjects.

The fathers' reliance on maintaining a positive attitude, taking one day
at a time, having faith, and seeking knowledge correspond with discussions
in the literature about learned helplessness (Penticuff, 1982). Penticuff
(1982) suggested that the high risk couple must implement suitable coping
strategies in order to avoid the detrimental effects of learned helplessness
including an overwhelming sense of vulnerability, passivity, fatalism, and
depression.

The strategy of denial was alluded to by some fathers when they
described their attempts to maintain a positive attitude. Denial, while often
defined as maladaptive, may allow a person to maintain hope in the light of
overwhelming odds (Wong, 1986). In high risk pregnancy, denial may be an
effective coping strategy to relieve stress on the family (Jones, 1986).
"Holding back" was a form of denial described by one father. He used this strategy to protect himself from another potential loss. By not allowing himself to become fully involved, he hoped to limit the emotional trauma if the outcome was poor.

Seeking knowledge has been generally accepted as an important coping strategy for anyone experiencing the unknown. The need for high risk mothers to be fully informed has been well documented (Carty et al., 1992; Loos & Julius, 1988; Merkatz, 1978; Snyder, 1984), and the informational needs of expectant fathers in normal pregnancy have been reviewed (Hangsleben, 1980; May & Perrin, 1985; Taubenheim & Silbernakel, 1988). Empirical evidence is limited regarding the information seeking behaviours of fathers in high risk pregnancy. Penticuff (1982) postulated that actively dealing with the possibilities of high risk pregnancy requires the couple to obtain information related to the well being of the fetus, to the result of tests, and to medical management. This knowledge is critical to a father's ability to understand and participate in any decisions and thereby maintain some sense of control and prevent helplessness. Waldron and Asayama (1985) concluded that information provided to the mother and family may enhance their sense of mastery.

Summary

In this chapter, the findings of the study are compared with the available literature. For the most part, little research has been previously conducted in the specific area of fathers' experience with high risk
pregnancy and hospitalization. For this reason, much of the discussion referred to related subject areas. Certain components of the study’s conceptualization were validated; others were found to be contrary to previous findings or hypotheses. Overall, however, there was evidence in the literature to support the findings in this study.
CHAPTER FIVE
SUMMARY, CONCLUSIONS, AND NURSING IMPLICATIONS

Summary

Despite increasing interest in the role of the father in pregnancy, birth, and parenthood, little attention has been given to the particular experience of expectant fathers coping with a high risk pregnancy and the hospitalization of their partner. This study was undertaken to further understanding regarding the experience of the expectant father from his own unique perspective. Using the grounded theory method, fathers' experience of the phenomenon of high risk pregnancy and antenatal hospitalization was explored, resulting in a descriptive analysis that conveyed a common conceptualization of the experience.

Participants were selected from the tertiary care facility serving the province of British Columbia. Nine fathers participated in the study contributing a total of 16 interviews. The fathers' ages ranged from 29 to 40 years. At the time of the first interview, pregnancy gestation ranged from 24 weeks to 35 weeks. Pregnancy complications varied in nature reflective of a high risk population.

Transcripts were analyzed using the coding procedure described by Strauss and Corbin (1991). The outcome of the analysis was an explanatory theory that describes the experience of high risk pregnancy and hospitalization from the perspective of the expectant father. Central to the fathers' descriptions were the roles they assumed in relation to their
participation in this phenomenon. The two predominant roles were providing emotional caregiving to their partner and sustaining the family's functional responsibilities. The primary theme that evolved through analysis was a process of finding a balance between these two roles.

The relative emphasis placed on each role varied from father to father, and with the same father, from time to time. These variations were dependent on the influence of specific balancing factors as well as the inherent importance placed on the roles themselves. Specific strategies contributed to the fathers' ability to cope with the experience. The consequences of the phenomenon had a significant personal impact on the fathers' emotional and physical wellbeing.

For the most part, the balance that each father achieved was a compromise between the two roles. Most of the fathers were relatively content with the position they found for themselves. Some, however, expressed significant dissatisfaction with their position but were unable in the present circumstances to influence a change.

The findings indicate that the father's experience was substantive in nature. The substantive nature of the experience is emphasized by the range and intensity of the emotional and physical impact described by the fathers. These fathers were not simply experiencing the phenomenon as "interested bystanders". They were intimately involved in the process and considered themselves to be legitimate participants, despite their perception that others did not necessarily support this belief.
Conclusions

This study characterizes fathers' participation in the phenomenon of high risk pregnancy and hospitalization as a substantive experience. Central to the expectant father's experience were two roles: emotional caregiver and family sustainer. The predominant theme that evolved through analysis was a process of finding a balance between these two roles. Several balancing factors contributed to the relative emphasis placed on each of the roles. A number of conclusions can be made based on this conceptualization.

1. The experience for fathers is substantive in nature. This describes a personal participation in the phenomenon that has particular meaning and significance separate from the experience of his partner. This conceptualization lends support to the belief that fathers deserve care and attention from health care providers and others not just as appendages to their partner, but as individuals with equal validity.

2. Fathers are profoundly affected emotionally by the experience. The predominant feelings are related to either emotions surrounding the high risk pregnancy, or those emotions related to the actual hospitalization of their partner.

   Emotions related to the high risk pregnancy include fear/anxiety regarding the wellbeing of the baby and their partner, the potential impact of the experience on their couple relationship, and their performance as a supportive partner. Emotions related to hospitalization include feelings of loneliness and loss of intimacy, security, feeling like an outsider, and a sense
of belonging.

3. Fathers are affected physically by the experience. There exists a potential for negative impact on their health, including diet, sleep, and exercise/leisure activities.

4. The role of emotional caregiver is one of the fathers' fundamental roles. The role of emotional caregiver comprises the following behaviors: maintaining a physical presence, providing comfort and compassion, acting as a psychological coach, being an advocate, and providing protection. Fathers believe that while they are deserving of emotional support, their partners' needs are greater than their own.

5. The second fundamental role is the role of family sustainer. Role behaviours include maintaining work, providing childcare, and taking on domestic responsibilities. These activities are directed towards the reality of sustaining the life of the couple in the real world.

6. Coping strategies influence fathers ability to carry out the roles. They also exert an influence on the emotional and physical components of the experience. Four specific coping strategies are identified. They include maintaining a positive attitude, taking one day at a time, having faith in a higher being, and seeking knowledge. Through the effective enactment of these coping strategies fathers are able to successfully negotiate their own participation in the experience.

7. The support system available to the father serves as a balancing factor. Fathers vary in their assessment both of their need for support and the extent to which they receive it. The primary support for fathers is their
partner - a person with whom they are frequently unable to openly share their fears and emotions due to feelings of protectiveness. Family is a primary source of practical support, and friends are only infrequently identified as sources of support. Health care professionals are the providers of informational support. While some fathers do not perceive a greater need for support, others acknowledge an acute awareness of lack of support and a desire for better recognition of their needs from others.

8. Certain high risk condition factors may also influence the balance of the roles. These include whether the risk associated with the high risk pregnancy and hospitalization were anticipated or unanticipated, the father's perceived severity of risk, and any prior experience related to high risk pregnancy.

9. The distance a father lives from the hospital where his partner is hospitalized may have a profound influence on the father's balance of roles. These fathers are often forced to make a choice between the two roles, and this may result in neglect of one of the roles.

10. Fathers go through a process of balancing the two predominant roles. The resulting role balance is not static, and may be influenced by changing conditions in either of the two roles or the balancing factors.

11. The father's experience deserves considerably more attention than it has thus far received from health care providers. In fact, the findings of this study support the contention that the father's experience is as deserving of attention as his partner's. A father who is supported through his own experience may be better able to enact both the role of emotional
supporter and family sustainer. The more able he is to carry out these two roles effectively, the healthier the overall family functioning will be, resulting in an improved experience for both the high risk mother and father.

**Nursing Implications**

Little is known about the experience of high risk pregnancy and hospitalization from the perspective of the expectant father. This study provides evidence that the father's experience is highly personal and significant in his own right, and is not simply an adjunct to the experience of his partner. As a result, there are a number of implications for nursing practice, education, and research that will promote greater understanding of these men's unique needs.

**Implications for Nursing Practice**

Health care providers in general, and nurses in particular, must finally cease giving lip service to "family centered care" and develop patterns of practice that support the intent of this concept. While this can be said of obstetrical care in general, the importance of adopting a truly "family centered" approach for families experiencing high risk pregnancy and hospitalization is evidenced by this study.

Our understanding of the needs and concerns of high risk women, and ways to provide sensitive, effective hospital care is developing. The time has come to direct our attention towards the needs and concerns of the expectant father. Fathers have remained the "outsider" far too long. It is
recognized that every father will respond to the pregnancy and subsequent high risk events in his own way, reflecting individual patterns of communication, coping, and involvement. However, nurses must be prepared to provide an environment of caring that recognizes the father's experience as having significant individual meaning that is interdependent yet separate from that of his partner's.

Specific attention should be directed towards encouraging fathers to verbalize their own emotional responses. By providing recognition that his fears, anxieties and concerns are not only legitimate, but deserving of attention, the nurse can validate the significance of his emotional experience. This can be done at the bedside with the couple, however, consideration should be given for providing the opportunity for a private discussion with the father separate from his partner. This may be worthwhile given the desire most fathers had to limit sharing of their own fears in order to protect their partner. The nurse can then facilitate discussion between the couple, encouraging when appropriate, the mutual sharing of emotions.

Discussion should include feelings that fathers might potentially be experiencing. Presenting common feelings to the father gives permission for these emotions to be expressed and normalizes their nature. Such introductory statements as "It's not uncommon for fathers to fear that their partner's life is in danger because of the high risk pregnancy. Have you had any similar worries?" opens the discussion to an emotion that the father might otherwise have felt uncomfortable verbalizing. Similarly,
acknowledging the potential feelings of fear for the life of the baby, fear of a handicapped child, uncertainty, helplessness, loss of control, and loneliness, offers the opportunity for discussion of these and other emotions.

Based on the study finding that the experience had wide ranging impact on the fathers' physical well-being - yet this information was rarely mentioned by fathers voluntarily - the nurse should explore the ways in which the experience is impacting the father physically. Fathers should be informed that their own health may be affected by the pregnancy, that this is a common occurrence not reflecting any inherent weakness on their part, and that as caregivers we are genuinely concerned about their symptoms. Specific questions should be asked about their own health history both on admission, and on an ongoing basis. Questions about diet, rest, exercise, and specific physical complaints, particularly those symptoms identified with couvade syndrome, will identify areas requiring support and intervention. By providing an opportunity to discuss the father's symptoms, information may be obtained that reveals the possible underlying meaning of the symptoms as they relate to his overall pregnancy experience. These issues may then be explored in greater depth.

Few of the fathers in this study had been able to reserve any private leisure time to pursue exercise or hobbies. Encouraging the father to allow himself even a small amount of time each day to himself may promote his own physical and mental health and increase his ability to cope effectively with the experience.

It is important to recognize that fathers often feel like "outsiders" in the hospital environment, and there are measures nurses can take to
alleviate this feeling. In the study, one father suggested that a heightened awareness regarding this feeling was necessary. He explained that no one intentionally tried to make him feel uncomfortable, but that there were some simple things that the nurses could have done to promote his sense of belonging. "By not taking any action they make the person feel uncomfortable, so they actually have to be proactive to make them feel comfortable".

Simple routines that are easy to implement may go a long way towards alleviating the "outsider" feeling. Taking the time to specifically welcome the father to the unit, and giving him a tour of the surrounding environment will help him feel more comfortable. Showing him where the linen cart is located, how to obtain ice water, what to find in the unit kitchen, and how to access wheelchairs will increase his sense of usefulness. A unit specific pamphlet with information regarding hospital routines and resources can be directed towards both the woman and her partner's needs.

It is critical that the concept of the father as a "visitor" be eliminated entirely from antepartum family centered care. Recognizing the father as an essential team member, not just a visitor who makes unnecessary demands on the system, requires nurses to truly embrace family-centered care philosophy. Several authors have suggested the development of antepartum family care facilities that resemble housekeeping units or hostel facilities (Merkatz, 1978; Rosen, 1975). Such adaptations to the environment can shift the source of power away from the health care providers to the family. In the study one father suggested that this would eliminate his sense of
"interfering" because the family would then be allowing the health care providers into their environment - "We'd be working together, and at this point we're not really working together".

Fathers' access to their partners should not be restricted in any way. Visiting hours should not apply to fathers as they are not visitors. Fathers who wish to remain with their partner for extended periods should be encouraged, as should overnight stays. The importance of promoting access for the father is emphasized by the relatively high value fathers in the study placed on their ability to maintain a physical presence. Obvious limitations exist, however, when a woman is confined to a multi-bed room. Attempts should be made to accommodate fathers who wish to stay overnight with their partner. If private rooms are not available for this purpose, then one option is to set aside a room on the unit as a family overnight room that couples can rotate into as the need arises.

Assistance can be given to fathers in their role as emotional caregiver. Besides unrestricted physical access to their partner, couples should have access to a telephone 24 hours a day, preferably at the bedside. Fathers attempts to provide comfort and compassion can be facilitated by nurses. Understanding their need to act as an advocate, protector, and psychological coach will allow nurses to recognize such behaviors and facilitate them.

An assessment should be made of the father's role as family sustainer. Exploring with both the father and his partner the work, childcare, and domestic responsibilities that he must maintain, and encouraging discussion regarding these obligations will allow the father an opportunity to verbalize
his feelings regarding these activities. Discussion will also promote problem solving in areas that are of concern.

The nurse can assist the father to identify the strategies he is using to cope with his experience. Allowing discussion to focus on how he is coping, rather than on how his partner is coping, validates his experience and provides opportunity for exploring the effectiveness of his coping skills.

A coping strategy that is particularly amenable to nursing intervention is the seeking of knowledge. It was noteworthy that most of the fathers obtained information regarding the condition of their partner and the pregnancy second hand via their partner. Nurses can facilitate first hand information in several ways. It was revealing that few of the fathers described nurses as sources of information. This is unfortunate since there is an obvious role for nurses to provide information to fathers. This is particularly true since nurses are always available at the bedside, even in the evening hours when a working father may be present. Nurses can also promote physician - father interaction by facilitating opportunities for discussion. For example, the nurse can arrange specific consultation times when the father will be available, or encourage the father to phone the physician for first hand information and discussion.

Other sources of information include prenatal classes, and written and audio-visual teaching materials. Programs may be developed for the hospitalized woman without specific consideration given to the partner’s needs. Is the father given an opportunity for prenatal classes? Does he have access to the written and audio-visual material available on the unit? Is
there material available that specifically addresses his needs? What may also be required is a change in the way the availability of the resources are presented to him. Fathers should be specifically informed about the education opportunities so that he receives the message that health care providers consider the information to be relevant to him and his needs.

Determining with the father who comprises his support system and ways in which to access the different forms of support is indicated. Remembering that the hospitalized woman is likely to be the father's primary source of emotional support emphasizes the importance of facilitating unrestricted contact between the couple. Furthermore, consideration needs to be given to allowing for some privacy for the couple in order to encourage intimate conversation. Couples may need assistance in successfully addressing the emotional support needs of the father since the fathers in this study demonstrated protectiveness by withholding the sharing of their fears with their partners.

Nurses need to validate that it is legitimate for the father to request both emotional and practical support from family and friends. Fathers may require encouragement to seek or accept support from others. Nurses can assist by helping fathers identify tasks that could be reasonably delegated to others.

Opportunities for appraisal support could be facilitated by nurses. A high risk father's support group could provide fathers with support from other men sharing a similar experience. Since this type of support has proven successful in other areas (Taubenheim, 1988), this strategy might be
effective. Other ways to increase opportunities for appraisal support include having a family lounge available on the unit that promotes informal interaction not only between patients, but fathers as well, and the development of a video directed towards fathers that explores, in a support group format, the experiences of other men.

Nurses need to be aware that high risk condition factors such as anticipated versus unanticipated risk, perceived severity of risk, and prior high risk experience will influence a father's experience. These factors should be taken into account when assessing the father's response and planning care to meet his needs.

Similarly, the geographic location of the couples residence relative to the antenatal unit is a factor relevant to understanding the specific demands placed on the father. These fathers require particular attention since they are inevitably required to compromise either the emotional support role or the family sustainer role. Assessment of the father's unique circumstances and a review of the possible options available to the couple will provide support with complex decisions. Certainly the availability of accommodation for fathers either on the unit with their partner or in nearby facilities is essential. Consideration must be given to providing the father with as much information as possible on an ongoing basis regarding the condition of his partner. When possible, advance notice of plans for delivery should be given to the couple so that the father can be with his partner at this critical time.

Current administrative leadership requires revision in order to support the above changes in practice. Without explicit support from
administration, the current clinical "inertia" hindering full implementation of a family-centered care practice will remain unobtainable. The obstetric department must have a written philosophy that is explicit in describing beliefs and values which recognize the role of the father during the childbearing period, his rights to participation in the process, and obligations the hospital and its' caregivers have to provide optimal care to the father as well as the mother and fetus/newborn.

Written policies must be developed where indicated to implement the above philosophy. For example, policies need to reflect support of the father's access to his partner 24 hours a day, particularly in relation to overnight stays. Policies regarding his presence at other times, such as during procedures must also be made explicit. Admission policy and procedure routines should be developed that reflect the inclusion of the father in the process. By including in the admission policy the expectation that fathers are given a full orientation to the unit, staff will be directed to include this practice in their everyday care. Communication regarding administrative policy supporting the role of the father must be carried out during orientation of new staff, staff inservices, and reinforced on a daily basis in the clinical setting.

Care planning and documentation tools should reflect the recognized role of the father. Admission assessment forms, teaching records, standard and individualized care plans, and nursing kardexes could all appropriately include father focused assessment, planning, and care.

In order to obtain evaluative information, hospital quality improvement
programs should reflect the philosophy as well. Chart audits could include reviews on father related assessment and interventions, and patient satisfaction questionnaires could include a section for the father to complete to provide an opportunity for feedback related to his experience.

Finally, the implications for changes in practice derived from the findings of this study should not be limited to the high risk population. The demonstrated need for greater awareness and sensitivity in our provision of care to the father of a high risk pregnancy must also be applied to the majority of fathers who are participating in a low risk pregnancy and birth.

Implications for Nursing Education

The findings of this study provide initial information that increases the understanding of the father's experience. It offers direction to nursing students in providing care to families that incorporates the father's experience as an essential and relevant aspect of care.

In most programs, maternal-child nursing curricula already promote the philosophy of family centered care for the childbearing family. General concepts appropriate for the family experiencing a normal pregnancy may be applied to high risk families. However, the specific considerations of fathers experiencing high risk pregnancy and hospitalization deserve increased attention. Other than providing introductory content, this topic may be beyond the basic level relevant for nursing students in general programs. It is, however, appropriate and essential that it be covered in advanced maternal-child nursing programs. It is desirable that equal time is given in education programs to the experiences of fathers in their own
right, and not just as "interested bystanders" or supports to their partners.

Educators must also examine why the health care system has responded so slowly to the required changes necessary to implement care for the childbearing family that recognizes the role of the father. Fathers participating in a normal pregnancy and childbirth experience have yet to be fully embraced by a system that is responsive to his needs. Until this occurs, fathers experiencing high risk pregnancy and antenatal hospitalization are unlikely to advance in the quality of care they receive. Both nursing program curricula and inservice education programs need to address the sociological and political factors that hinder implementation of changes in practice so that graduating and practicing nurses are better prepared to act as change agents with in the system.

Implications for Nursing Research

The study question: "What is the experience of an expectant father when his partner is hospitalized with a high risk pregnancy" was approached using grounded theory methodology. The resulting conceptual framework provides a basis for further research. A number of areas of investigation arise from this study that are worthy of exploration:

1. Further qualitative and quantitative research is required to determine whether the sample population in this study is representative of the population of expectant fathers experiencing high risk pregnancy and antenatal hospitalization.

2. The fathers in this study were primarily of Canadian cultural origin. Assumptions about the influence of culture on fathers' experience can not be made on the basis of this study. Further exploration of the experience as
described by fathers of other cultures is very important.

3. Research has now been conducted exploring individually, the expectant woman's and the expectant man's experience of high risk pregnancy and hospitalization. Since there is some evidence that couple interviews may provide richer data than individual interviews (Chapman, 1992), it would be valuable to obtain the combined perspective of the couple through joint interviews.

4. This study demonstrated that nurses have potential to be important contributors to the type of experience the father undergoes. Research into nurses' perceptions of the role of the father in high risk pregnancy and hospitalization would provide valuable insight into the caregivers' values and beliefs and how these influence nursing care.

5. Further research is needed on the influence of the various balancing factors on the father's experience.

6. Greater exploration of the differences in experience between fathers with and without young children at home is necessary.

7. All of the fathers in this study appeared to have been able to adapt to the role strain they experienced. A larger study that was able to include fathers who were having problems adapting or whose family response was considered dysfunctional in some way would provide greater understanding of ineffective or maladaptive behaviors.

8. The development of a family centered antepartum unit with administrative, clinical, and practical support for care that recognized the role of the father is recommended. This would give opportunity for a pre
and post implementation study that could examine the impact of this model of care.

9. All of the fathers in this study experienced a pregnancy that concluded in a healthy outcome. A study that included fathers who experienced a negative outcome such as significant neonatal morbidity or mortality would identify the ways in which the experience is different for this group.

10. With larger numbers, a qualitative study could explore how the three different types of father participation (as identified by May, 1980), might influence fathers' experience of high risk pregnancy - with and without hospitalization as an additional factor.

11. A study exploring the implications of high risk pregnancy on the developmental tasks of expectant fathers would provide comparative data with fathers experiencing a normal pregnancy.

12. Further research is needed to explore the relationship between high risk pregnancy and the incidence of couvade syndrome.

In summary, this thesis has described the experience of expectant fathers when their partner is hospitalized with a high risk pregnancy. The findings indicate that the father's experience is substantive in nature and involves finding a balance between two predominant roles - emotional caregiver and family sustainer. A number of factors serve to influence the balance, including the support system available to the father, high risk condition factors, and geographical circumstance. Specific strategies contribute to the father's ability to cope with the experience including
maintaining a positive attitude, taking one day at a time, having faith in a higher being, and seeking knowledge. The consequences of the phenomenon have a significant impact on the father's emotional and physical wellbeing. The fathers' descriptions portrayed an experience that was unique and significant in their own right. Nursing care of the high risk childbearing family that incorporates consideration for the father's experience will result in true family centered care.
References


Appendix A
THE EXPECTANT FATHER'S EXPERIENCE OF HIGH RISK PREGNANCY AND ANTENATAL HOSPITALIZATION

June 1992

My name is Meggie Ross. I am a registered nurse with over ten years experience in caring for women and families during pregnancy, labor and birth, and after delivery. I am completing my Master of Science in Nursing at the University of British Columbia. I am interested in learning more about the experience of men whose wife/partner has been hospitalized because of a high risk pregnancy. This study is being done because we have little information about how a woman's high risk pregnancy and hospitalization affect the expectant father. It is hoped that the information that is gained from this study will help us find ways to be of more assistance to expectant fathers such as yourself.

You are invited to participate in this study. Should you agree, your participation will involve one or two interviews. The first interview will take place, with your permission, at Grace Hospital. The second interview will be arranged at your convenience, either at Grace Hospital or in your home. Interviews will be thirty minutes to one hour in length. In order for me to concentrate on our discussion, I would like to tape record the interview. If at any time you wish a part of the interview erased; it will be erased immediately. Confidentiality will be maintained throughout the study by the use of subject code numbers and the tape recordings will be erased at the
end of the study. At no time during the study or in any report will personally identifying information be revealed. Results of this study will be available to interested participants on completion of the report.

Participating in this study will not involve any risks to you or your partner. Your participation in this study is voluntary and you are free to withdraw at any time without jeopardy to the conduct of you or your partner's care by health professionals. The interviews should provide you with an opportunity to express your thoughts and experiences to an interested and concerned nurse.

If you are interested in learning more about this study please complete the attached form and leave it at the Dogwood nursing station, Grace Hospital, or call Dogwood Square 875-2424 local 6296 and leave a message. I will call you and answer any questions you may have about the study and if you wish to participate, I will arrange an interview at your convenience.

Sincerely,

Meggie Ross, R.N., B.S.N.

Thesis supervisor: Elaine Carty, U.B.C. School of Nursing, 822-7444
The Expectant Father's Experience of High Risk Pregnancy
and Antenatal Hospitalization

I am interested in learning more about this research study and may be willing to participate.

My name is: ________________________________

My partner's name is: ________________________________

I can be reached at the following phone number/s:

_____________ (home)

_____________ (work)

Date: ________________________________
Appendix B
Consent Form

THE EXPECTANT FATHER'S EXPERIENCE OF HIGH RISK PREGNANCY
AND ANTENATAL HOSPITALIZATION

Investigator: Meggie Ross, R.N., B.S.N.,
U.B.C. Master's of Science in Nursing student

Thesis Supervisor: Elaine Carty, U.B.C. School of Nursing, 822-7444

The purpose of this study is to explore the experience of men whose
wife/partner has been hospitalized because of a high risk pregnancy. It is
hoped that the information that is gained from this study will help nursing
and other health professionals find ways to be of more assistance to
expectant fathers.

I understand that the study will involve 1 or 2 audiotape recorded
interviews, each lasting 30 minutes to 1 hour. I am aware that my
participation in the study is strictly voluntary and I have the right to
withdraw at any time without influencing the care my family receives.

I agree to participate in this study, and I have received a copy of this
consent form. I am aware that confidentiality will be maintained throughout
the study by the use of subject code numbers and the tape recordings will be
erased at the end of the study. I have been assured that at no time during
the study or in any report will personally identifying information be revealed.

If I have questions about the study or about my participation I can contact Meggie Ross by leaving a message at the Dogwood nursing station, Grace Hospital (875-2424 local 6296).

DATE

SUBJECT'S SIGNATURE

INVESTIGATOR'S SIGNATURE