HUSBAND-FATHER'S PERCEPTIONS OF LABOUR AND DELIVERY

by

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**Husband-Father's Perceptions of Labour and Delivery**

This study was concerned with the husband-father's perceptions of labour and delivery, how he perceived his role during this period, and his perceptions of the nursing care provided to his wife and himself.

Sample selection was by random sampling and included twenty husbands. All were Caucasian, Canadian or British born, between the ages of twenty-two and forty years of age, and all had attended prenatal classes. Eighteen fathers attended the delivery. Seventeen were fathers for the first time and three were fathers for the second time.

Data were obtained via one hour-long interview with the husband during the first three days postpartum. An interview schedule was used and contained rating scales, fixed-alternative and open-end questions. The data were subsequently analyzed by single variance analysis, nonparametric (Chi-square) tests, and by content analysis of the open-end questions.

Major findings were that labour and delivery were seen as positive experiences, delivery being the most positive; that husband focus during labour was on his wife until late second stage when it shifted to the baby and to his own feelings. Labour was stressful for many, their wives' pain being a major contributor
to their uneasiness. The major function of the husband in labour was cited as providing moral support, encouragement, and the provision of bodily care to his wife. Most felt that they were effective in their role but needed to confirm this with their wives.

Prenatal classes were viewed as having a positive influence on husband attitudes toward labour and delivery.

The attitudes and responses of the nurses during labour and delivery were noted as having a significant effect on the husband's confidence and relaxation. The major weakness of the nursing care was the inadequate assessment, explanation, and nurse contact time during the active phase and second stage of labour.

The study results have implications for the prenatal preparation of couples, for care of the parents during labour, delivery, and the early postpartum period. Recommendations for future study centered on the need for more information about husband-father response during labour and delivery, early responses to the newborn, and information about the effects of husband-father participation in childbirth on the husband-wife-child relationship.
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Linda Gaye Leonard
CHAPTER I

INTRODUCTION

Background of the Study

There is a growing trend to view the childbearing experience within the framework of the family. Nursing of families and family-centered care are concepts familiar to virtually all nurses, especially those who work with expectant or new parents.

Within the past decade, involvement of husbands in the childbearing experience has steadily increased. Prior to this time, the major focus had been on the expectant mother and the resulting mother-child relationship. Little attention had been paid by behavioral scientists and health team members to the needs of the husband-father. Several reasons for his lack of involvement in and exclusion by others during the childbearing experience have been offered. English states that fatherhood, unlike motherhood, is not a clearly defined role, with the exception of the provider role. Colman and Colman note that society does not validate the experiences of fathers-to-be as important. They further cite a lack of acceptance of male interest in the essential feminine secret, childbirth. Josselyn emphasizes
that men tend to avoid those experiences which require a display of tenderness. She states that tenderness and related emotions have been labelled as feminine and, therefore, when displayed by males as atypical of "men". These attitudes and values are changing and these changes have meant that pregnancy and childbirth are evolving into more of a shared family experience.

It is believed by many that these changes will enhance family unity through improved relationships: more specifically, those of the husband-wife, father-mother-child. Interest in the family and the relationships within the unit has been renewed, partly because of the social upheavals in the last two decades. The one stable institution in our society has been the family. Keane states that:

the family in whatever form it takes, continues to be the major influence for good or ill in the lives of all human beings.

Duvall shares this view and sees the family as the nurturing center for human development, the primary agent for physical and mental health. These functions have particular relevance for Canadians as there are approximately 3.2 million families in Canada with children living at home.

Hymovich and Barnard believe that the trend to focus on the family unit is a realistic and reasonable one for nursing. It emphasizes the dignity and the personality of the family as well as the dignity and
personality of the individual. Keane comes out strongly in favour of nursing's commitment to the family and states:

it deserves at this time, perhaps more than ever before, the fullest possible understanding and support in carrying out its mission.

In order to improve the nursing care to families during the childbearing stage, more complete answers are needed to some very fundamental questions. Nurses need a base of knowledge in order to plan nursing interventions that are theory based, rather than ritual based. For without this base, it becomes impossible to predict with any degree of accuracy, the kind of support family members require and in particular, that needed by the husband-father.

Unanswered questions pertaining to the husband-father are numerous. Some examples which have relevance for nursing are: What is the father's perception of labour and delivery? What factors influence the father's ability to take on the fathering role. Are these the same as those of his wife? What is the psychological sequence in taking on the role of father? Is the taking on of the maternal role dependent on the stage of paternal role development and vice versa? Before nursing can provide quality care to the family members and the family unit, more complete answers to the above questions are needed.

Whether or not the husband-father chooses to be present for the labour and delivery, he is still affected by the childbirth experience. As prospective parents,
it is likely that they have tried to imagine the forthcoming labour and delivery, revealed some of their anxieties and worries to one another, and tried to predict what kind of an impact a new family member will have on the family unit as well as on their own roles.

In Canada, approximately 99.5 percent of babies are born in hospitals. Each year, nurses in Canada have contact with approximately 370 thousand expectant and new parents. It is unknown how many husbands accompany their wives through labour but it would seem that the majority are present for all or at least a portion of it. An ever increasing number of husbands seem to attend the delivery of their infants. Estimates of husband-attendance at delivery run from ten to ninety percent, depending on the hospital facility and the sample of parents.

Prenatal classes have attempted to lessen the anxieties of parents by educating them about the psychophysiological changes occurring during pregnancy and the succeeding stages. The classes have attracted increasing numbers of expectant fathers in recent years. In one study, it was reported that sixty-two percent of the husbands accompanied their wives. Of the total population of expectant parents, the percentage of husbands attending the classes is unknown.

In part, the classes are designed to assist the husband in playing an active role in the upcoming labour
by teaching him how to coach and supervise his wife. One group claims that an important modification has been made in the area of goal setting for parents.\textsuperscript{21} Previously, success or failure of the labour and delivery was based on the need for medication or obstetrical intervention. Now, it is believed that the couple who set their own realistic goals for the experience are more likely to perceive the outcome as successful, i.e., a happy and fulfilling experience.

An outcome of husband-coached labour has been that nursing must re-examine its goals and role with the labouring couple. The amount of direct care that the nurse once gave to the mother may be reduced, depending on the couple and the labour. However, the amount of support that the nurse must give has not been altered, only the form that it takes.\textsuperscript{22-24} Some authors note that the concept of supporting a patient through a family member has been a difficult adjustment for nursing. For now, the husband is not at the periphery of the experience. He is the one that his wife depends on and the one to whom she often says: "I couldn't have made it without your."

Relating the proceeding in a more personal vein, the writer's interest in the husband-father during labour and delivery stems from two inter-related commitments. One is the belief that nursing can and
must help support the family unit by preventing untoward
difficulties in the assumption of new roles. The second
stems from the observation that nurses are being asked
to support a human being, the father, during the
emotionally-charged situation of labour and delivery.

Weidenbach's definition of an individual's need
seems appropriate for those caring for the expectant
and new parents: "anything the individual requires to
maintain or sustain himself in his situation."25
She suggests that help is any measure or action that
enables the individual to overcome whatever interferes
with his ability to function capably in relation to
his situation.26 Both of these definitions are
applicable to the woman in labour and to her partner,
her husband. Support to the family members achieves
two interdependent objectives. Not only is the father's
self-concept strengthened but also his ability to
support another human being, his wife, is heightened.

Having observed and worked with numerous
husbands during the childbirth experience, the writer
has noted that some fathers become actively involved
in most all aspects of their wives' care while others
lend what might be described as a more passive type of
support. Yet, whether or not they have been formally
prepared for labour and delivery, in the course of it
a father may demonstrate any combination of anxiety,
suffering, awe, joy, bewilderment, tenderness, anger, fatigue, and exhilaration. This became apparent during a recent exploratory study of parents' reactions to a family-centered maternity program. The writer observed the spontaneity with which husband-fathers discussed their perceptions of labour and delivery, and their role during this period. Some husbands were initially reluctant to admit specific feelings, especially those which are not tied into the socially prescribed masculine role. However, once their trust was gained, they seemed very eager to share their "uncomfortable" moments of labour and delivery.

The writer noted similarities between the maternal phenomenon of "taking in" described by Rubin and the paternal responses during this period. Just as newly-delivered women need to review and understand what has happened, so it appeared did the husbands.

The author believes that it behooves nursing to discover the wealth of information that husband-fathers hold, and once discovered, to use it in a systematic way to improve the support offered to this family member and the family.
Statement of the Problem

The questions asked in this study about the husband-father's involvement in childbirth were:

What were the husband-father's perception of labour and delivery?
- What were his thoughts and feelings about labour and delivery?

What were the husband-father's perceptions of his role during labour and delivery?
- What were some aspects of the decision-making process related to his participation during labour and delivery?
- What were his thoughts and feelings about his role during labour and delivery?

What were the husband-father's perceptions of the care received by his wife and himself during labour and delivery?
- What was seen as helpful?
- What was seen as non-helpful?

Statement of the Purpose

The purpose of this study was to learn about the husband-father's perceptions of labour and delivery, his perceived role during this period, and his perceptions of the care received by his wife and himself.
Definitions

For purposes of this study, the following definitions were employed:

**Husband, husband-father, father.** The labouring woman's legal husband.

**Wife, wife-mother, mother.** The wife of the husband.

**Perception.** A process whereby man selects, organizes, and interprets sensory data available to him.

**Labour.** The series of medically defined phases and stages characterized by cervical dilatation and descent of the presenting part.

**Delivery.** The period of labour which usually occurs within the delivery suite, as opposed to the labour suite, and ends with the delivery of the baby and products of conception.

**Role.** An organized set of behaviors that belongs to an identifiable position.\(^{29}\)

**Perceived role.** How a person thinks he behaved.\(^{30}\)

**Support, care, help.** Any measure or action on the part of those caring for the labouring woman and her husband and which enables the individuals to overcome whatever interferes with their ability to function capably in relation to their situation.\(^{31}\)
Beliefs

The following beliefs represent a particular stance in relation to this study:

- The family is a unity of interacting individuals; changes occurring within and outside the unit affect the functioning of the whole or its parts.
- During pregnancy, profound emotional, physiological and social changes occur; changes which have relevance for the roles of husband, wife, father, and mother.
- Labour is a psychophysiological crisis experience for the expectant woman, her husband, and the baby.
- Every husband and wife enter labour with a set of role expectations.
- For the husband, the role assumed and emotions evoked during labour and delivery may or may not be congruent with his perception of the role expectations for man, husband, and father.
- The perceptions of experiences during and the outcomes of the labour and delivery experience may have a positive or negative influence on the husband-wife, father-mother-child relationship.
- Family-centered care enhances the solidarity of the family unit as well as the role satisfaction of individual family members.
FOOTNOTES


3. Ibid., p. 135.


14 Ibid., p. 250.


17 Carl Goetsch, "Fathers in the Delivery Room -- 'helpful and supportive!,'" *Hospital Topics* 44 (No. 1, January 1966): 105.


20 Lara Khairat and Guy Costanzo, Preparation for Parenthood, A Project to Evaluate the Effectiveness of an Educational Program for Expectant Parents, Metropolitan Health Service of Greater Vancouver, May 1974: p. 1. (Mimeographed)


26 Ibid., p. 20.

27 Helen Elfert and Linda Leonard, "An Evaluation of St. Paul's Hospital Family-Centered Maternity Program: An Exploratory Study," University of B.C., School of Nursing, September 1974. (Mimeographed)


CHAPTER II
REVIEW OF THE LITERATURE

In order to demonstrate the inter-relationship between the husband's perception of labour and delivery, his role during the period, and his perception of the care provided to his wife and himself, a framework was selected. Sarbin and Allen's theory of role enactment and expectation was chosen. With these boundaries established, three major areas of the literature related to husband-father were reviewed.

The literature pertaining to masculinity and fatherhood was briefly examined and that relating to the historical changes in husband-father involvement in labour and delivery was reviewed. Finally, the few studies concerned with the husband-father during pregnancy, labour and delivery were examined.

Role Theory as the Framework

Sarbin and Allen's concept of role enactment and role expectation was chosen because of the emphasis on the complementary nature of the husband-wife-health team member relationship during labour and delivery. Role is defined as "an organized set of behaviors that belong to an identifiable position." These behaviors are activated when the position is activated.
Role enactment does not occur in isolation; it takes place in relation to other persons. The individual must know the expectations of all the complementary roles -- the role set, as defined by Merton -- before one can say that he has learned the role. Role expectations include the rights, privileges, duties, and obligations of any occupant of a social position in relation to persons occupying the complementary positions in the social structure. Not only is there a quantitative component to role expectation, there is also a qualitative component. It is expected that when one enacts a role, the appropriate amount of commitment and involvement is demonstrated.

Persons enacting a role may be viewed as facing a task; the task is to fulfill to the best of their ability, the expectations of that role. Role enactment calls for the possession of cognitive and motoric skills, the development of which is enhanced by the coaching and prompting of others. The role of the coach is to provide social reinforcement in the form of praise or criticism to the learner and, at the same time, provide feedback which can be used to improve role performance. The behavior of others, i.e., the audience, is the basis for one's own further behavior. Skill in taking on the role of the other in the form of empathizing with the other, facilitates social interaction. While the role enactor observes and evaluates his own behavior, he becomes more vulnerable when this enactment occurs in a highly visible place. It is likely that too much visibility
of enactment could place the performer under heavy stress.\textsuperscript{8}

Self-congruence, or how well one's traits, values, or beliefs concur with those of the role to be enacted, influences performance.\textsuperscript{9} If one's concept of self is congruent with the requirements of the role, it may result in attachment, involvement, or pleasure in enacting that role.\textsuperscript{10}

**Masculinity and Fatherhood**

Changes in the social and economic structure of North American society have been responsible for the redefinition of masculinity and fatherhood.

Today, there is a narrowing of the differences in culturally approved behavior of males and females.\textsuperscript{11} In spite of this narrowing, one is still able to identify significant aspects of male socialization and the resulting behaviors. The male's basic orientation is instrumental, as opposed to expressive for the female.\textsuperscript{12} The disciplined pursuit of goals encourages resistance to any emotional involvement as an end in itself. In effect, affective restraint along with a desire for achievement are fostered in the instrumental orientation.\textsuperscript{13} Males are expected to combine expressive and instrumental qualities in the varying roles.\textsuperscript{14} The role of the husband calls for a greater emphasis on the expressive qualities and the role of the father demands an equal emphasis on the two types of qualities.\textsuperscript{15}

Fulcomer believes that males are conditioned not to express their feelings, especially feelings about
personal matters, as for example, pregnancy. He states:

The need (cultural) for the husband to pretend he knows it all and can cope with it all keeps him from letting others, including his wife, know that he, too, needs reassurance and some helpful information.

Josselyn writes:

Tenderness, gentleness, a capacity to empathize with others, a capacity to respond emotionally ... is not the prerogative of women alone; it is a human characteristic.

These qualities are a natural part of the role of husband and father but are often considered to be repressed femininity. The male is often fearful of being feminine and the corollary, of not being fully masculine. To be a man, he must deny his dependency on others and particularly upon women.

Changes in the position of the father within the family are noted by English. Where once the father was in the central position, he is now at the periphery. The significance of his role has been minimized and has prompted the contemporary question of "are fathers really necessary?" Now, the role is seen as manifesting itself in a more co-operative, affectionate and socially integrated pattern within the family unit.

Further theoretical discussions of fatherhood and fatherliness have been undertaken by Benedek, Engel, Josselyn, and Jessner et al. Fatherhood and motherhood are seen as complimentary processes which evolve within the culturally established family structure in order to safeguard the physical and emotional
development of the child. 28 Fatherhood is not only the means for further evolution of the parent's personality but it is also a biologic fulfillment. 29 Preparation for fatherhood is seen as taking place throughout the man's life and by some, as evolving during pregnancy, delivery and the postpartum period. 30, 31 Becoming a father is a stereotyped role and is assigned to the father by others: namely his wife, his parents, in-laws and peers. 32 The results of caricatures characterizing his non-role has resulted in the acceptance by many fathers that there is little about pregnancy to interest and involve them, except perhaps, the economic burdens. 33, 34

The existence of fatherliness, as compared to motherliness, has not been enthusiastically supported by theorists. Fatherliness is seen as a binding together and amalgamation of the meanings of the child to the father into an emotional unit. 35 Tender love is identified as the cohesive force in fatherliness. 36 It is a desirable goal in this culture for a man to be an endocrinological father while successfully repressing or hiding his fatherliness. 37 Fatherliness is believed to stem from two sources: the relationship with the mother and that with the father. 38

Clinical knowledge about expectant fatherhood is scarce. Much of what has been learned about the husband and his status prior to labour and delivery has been gained from interviews with pregnant women or from husbands undergoing psychiatric support. Fatherhood is seen as
a significant precipitant of mental illness by Wainwright. Liebenberg studied sixty expectant primiparae and, during the project, interviewed the husbands. She found personality disturbances, exaggerated dependency and acting out in these normal fathers. She encourages understanding the husband's involvement in pregnancy and childbirth as it points toward preventive intervention with fathers. Caplan also stresses that support for the husband-father during pregnancy is important, not only for his own benefit, but also for the future father-child relationship.

**Historical Changes in the Role of the Husband-Father During Labour and Delivery**

The husband-father of the nineteenth century commanded respect from all members of the family; authority was lodged in the male head. Pregnancy fell under the influence of Victorian codes of behavior, it was hidden and not openly discussed. Pregnancy was not deemed a suitable interest for the male and was, therefore, not a shared emotional experience as one knows of it today. Delivery of the infant took place in the family home, and for this reason, the experience was family-centered.

Prior to the 1930's, hospital delivery was reserved for the poor or for those women who experienced obstetrical complications. As care in hospitals began to improve, it was realized that home delivery carried a high mortality rate for both mother and infant.
The development of medical techniques and the application of scientific principles meant that hospitals were to become the scene of labour and delivery. With the shift in the delivery site came surgical delivery techniques, loneliness of the expectant woman and isolation from her family and friends. Fathers were left with no role in childbirth.

Women gradually moved away from drugs as a means of relieving the pain of labour and delivery to a new concept of preparing themselves to cope with labour. Natural childbirth and psychoprophylaxis meant active participation of the woman with support needed from a companion when her ability to cope was threatened. Husbands first appeared in the labour and delivery areas because women objected to being left alone and unsupported during this experience.

As a result of shared labour, both husband and wife realized that this experience had implications for their own husband-wife relationship as well as for their relationship with their child.

Concern was soon being expressed by interested medical practitioners regarding the role of the husband during labour. Publications directed at the expectant father were written in an effort to help him understand the psychophysiology of pregnancy, labour, and delivery. Suggestions were made on how the father might be supportive to his wife during these periods.

By 1964, a heated controversy was brewing over
whether or not husbands should be present in the delivery room. A significant number of couples were asking for his admission. A preponderance of medical and some nursing opinions were revealed with the opponents focusing on the following beliefs. Permitting husbands into the delivery room would increase the infection rate, lawsuits against the physician would increase, and the father would likely divert attention away from the mother and infant by fainting, asking too many questions, or contaminating the equipment. 55-57

Concern about the husband-wife relationship was expressed, such as one partner letting the other down, or women finding it distasteful to have the husband present. 58-60 Some felt that his presence might increase the effect of the problems that he was already experiencing as an expectant father, and some believed that an inexperienced husband witnessing the birth would contribute little to his wife's emotional support or to family solidarity. 61-63

Obvious discomfort on the part of the physician and nurse was apparent when some admitted to feeling uncomfortable with a father "looking over one's shoulder," or when trying to teach students in the presence of the husband. 64-66 Attitudes concerning childbirth and sexuality were viewed with the belief that childbirth is women's work and that the delivery room is no place for sightseeing, sentimentality, and sex gratification. 67-69
Those supporting the husband's presence saw the benefit as family-centered care, with the delivery seen as a peak experience that unites father-mother-infant psychologically.\textsuperscript{70-72} Some stressed that it is a supportive and valuable interpersonal experience for both husband and wife and that the husband is the only person with whom a wife can fittingly share this.\textsuperscript{73-80}

Other benefits included the belief that the trust of the apprehensive woman in labour is more likely to be gained if the husband is there to support her, with the result being a woman requiring less analgesia, and the fostering of dependency of the wife on the husband rather than on the physician or nurse.\textsuperscript{81-86}

The status of the husband was seen by some to be elevated to a participating team member as he serves as coach, companion, and provider of physical care to his wife.\textsuperscript{87-90} He could also learn that interest and involvement in delivery is dignified, not demeaning.\textsuperscript{91}

He was seen by this group as an ally of the nurse, as less of a legal risk, and as someone who does not affect the infection rate.\textsuperscript{92-95} In the event of the birth of an abnormal infant, it was the belief that parents do better to share grief immediately and meaningfully, just as they had anticipated sharing joy.\textsuperscript{96,97}

Out of this discussion of viewpoints came the establishment of criteria for the husband's admission into the delivery room.\textsuperscript{98}
There was concern expressed regarding the husband's motives for watching the delivery. Many saw the acceptable role as that of supporter to his wife. One author believed that it was necessary to assess the husband's attitude and to ensure that it was a real desire to share and provide support in his wife's experience. The motive of "curiosity" seemed to be an unacceptable one.

There was the belief expressed that control over who enters the delivery room is still necessary and that the husband's presence is a privilege, not a right to be demanded. A nurse asked if the health team had the right to deny the father the privilege of watching the birth of his child.

The Husband-Father during Labour and Delivery

To support Wonnell's theory of why husbands returned to the childbirth scene, i.e., at the request of their wives, a short review of the studies illustrating a woman's need for support is presented.

Lesser and Keane interviewed newly-delivered women in hospital. They learned that two of the five needs of the women in labour were to be sustained by another human being and to have attendants accept their personal attitude toward and behavior during labour. The need for the sustaining human was the most important and the fulfillment of other needs was dependent on how well the need for another human was met.
The stresses of the childbearing year were studied by Larsen when she interviewed 130 mothers using an open-end questionnaire. She discovered that the dominant stress of labour and delivery was the unmet need for support, interest, and the presence of husband, nurse, and doctor.

Allen demonstrated the decreased need of women in labour for analgesics as well as the changes in the type of contraction when a supportive person was present with the labouring woman.

A study of 208 couples, which focused on the husband and his wife, was made by Jordan. The study was directed at comparing the reactions to two types of maternity care and was extended from the ninth month of pregnancy to eight weeks postpartum. She contrasted attitudes, feelings and experiences of parents exposed to family-centered care with those who experienced a more traditional type of maternity care. More fathers of the former group wanted to see the birth of their baby, felt that it was a thrill to see the birth and had feelings that the baby was theirs at the time of delivery. More of the family-centered care group believed that a deeper husband-wife relationship had occurred during the experience of labour and the husbands believed that they had known how to help their wives during labour. None of the fathers in the traditional care group had attended prenatal classes. Anxiety was experienced by many husbands of both groups when asked to leave their
wives during the labour and delivery for examinations, injections, and the arrival of the physician. Many husbands believed that their presence during labour had helped relieve their spouses' anxiety. One of the strongest findings from both the traditional and family-centered care group was the husband's desire to be alone with his wife immediately after the delivery.

Jordan's anecdotal comments revealed a mixture of husbands from both "care" groups who found the nursing staff to be considerate, tolerant, and supportive, to those who found them to be cold, non-communicative, and unhelpful.

Cronenwett and Newmark studied the effects of formal childbirth education and father attendance at the birth on the father's response to the childbirth experience. They administered a self-contained Likert-type questionnaire to 152 fathers following the delivery. Before the father left the hospital, he was asked to turn in the completed form. The researchers concluded that there was a positive relationship between attendance (at prenatal classes and childbirth) and the positive response to childbirth. There was no measureable difference in the paternal-child relationship and the attendance or non-attendance at delivery. Those who attended prenatal classes and the birth demonstrated a more positive husband-wife relationship than those without one or both of these experiences. The husbands who attended prenatal classes and the birth tended to
view themselves more positively than those husbands who did
not attend either the birth or classes. Of interest was
the researchers’ discovery that regardless of preparation,
the fathers who attended delivery perceived childbirth as
a more positive experience than the non-attenders at the
birth.

Both Jordan’s and Cronenwett’s results may have to
be viewed and interpreted carefully as neither study
accounted for the differences in the father’s motives
for or for not attending prenatal preparation and child­
birth. Are there significant personality or marital
differences between those persons who choose to attend
prenatal classes or the birth of their children and
those who do not attend? If this is found to be so,
then one must be guarded, especially at this point,
in concluding that prenatal classes or attendance at
the birth accounts for the differences in post-delivery
attitudes.

Kopp and Schindler, in an unpublished study,
interviewed seventeen fathers on the second day post­
partum regarding the fathers’ feelings and experiences
during labour and delivery. The researchers
developed an interview schedule utilizing open-end
questions and rating scales. The sample was chosen
randomly, cultural variables were not controlled. None
of the fathers attended the delivery. They asked the
fathers to rate their feelings according to adjectives
provided for each of three categories: happiness, fear, and depression. The fathers claimed to feel happier during the time of delivery than during the labour, denied that they experienced strong feelings of fear such as panic, but commonly admitted feelings of uneasiness and worry. There were no significant findings on the depression scales. The father thought that trust in his wife's doctor and confidence in the nurses was a positive influence but seeing his wife uncomfortable was noted as a negative influence on how he viewed the childbirth experience.

Kopp and Schindler found that the father believed that it was an important part of his function to be with his wife during labour. He saw his function as providing non-physical support such as hand holding, reassuring his wife etc. Those giving physical support to their wives were mostly fathers-to-be for the first time. Aspects of care deemed most helpful by the fathers were being with their wives, attention paid to both wife and husband, and progress reports from the nurse or doctor. After delivery, seeing, and secondly, holding the baby were rated as very important.

Hott investigated the relationship between psychoprophylaxis in childbirth and changes in self-concept of the participant husband and his concept of his wife.\(^{1,15}\) She studied first time fathers, specifically forty-four men who attended psychoprophylactic training (PPM) and thirty-five men whose wives chose the
traditional method of childbearing without husbands present (non-PPM). She hypothesized that men who participate in PPM would show greater concordance among prenatal measures of self and wife, and would show a greater increase in concordance postnatally among these concepts than men who did not participate. The Osgood Semantic Differential was used as a pretest in the prenatal period and was again administered on the third postnatal day. Results indicated a rejection of the hypothesis. Implications for nursing were, among others, acceptance and understanding of anxieties and tensions associated with the father's new role, parents' freedom to decide for themselves whether or not they want to share the birth, and the nurse's role as a "significant other" in helping the father cope with the responsibility of parenthood.

Aldridge, in a study of why expectant wives wanted their husbands in the delivery room, asked each of the marital partners whose idea it was. Of the 122 fathers, 31 percent saw it as their wives' idea, 25 percent as their own, 40 percent as both of their ideas, and 3 percent as the doctors. Answers to the same question given to the wives, resulted in very different perceptions.

The counterculture was studied by Bancroft when she participated in a project to increase the level of antepartum care to the members. She found that
the counterculture members sought their own solution to
the lack of family-centered care for childbearing by
having their babies outside of the hospital. The need
to incorporate the father, along with significant others,
into the entire childbirth experience outweighed the
dangers of home delivery for both mother and child.
For those who chose to have their babies in hospital,
a health facility that permitted father-attendance during
labour and delivery was essential. These findings are
supported by the experiences of Colman and Colman in their
exposure to members of the counterculture.11.8

A review of pertinent theoretical and research
findings were presented in an effort to provide a
framework for the study that was undertaken by the writer.
Role theory, theory related to the masculine, husband,
and father roles were included. The historical
development of husband participation in labour and
delivery and the recent studies concerning his thoughts,
feelings and behavioral changes were outlined.
FOOTNOTES


2 Ibid., p. 545.

3 Ibid., p. 549.

4 Ibid., p. 497.

5 Ibid., p. 548.

6 Ibid., p. 516.

7 Ibid., p. 497.

8 Ibid., p. 533.

9 Ibid., p. 524.

10 Ibid., p. 526.


13 Ibid., p. 21.

14 Ibid., p. 28.

15 Ibid., p. 28.


18 Ibid., p. 271.
29 Ibid., p. 171.
32 Ibid., p. 230.
36 Ibid., p. 267.
37 Ibid., p. 270.
38 Engel, Psychological Development, p. 191.
42 English, "Role of Father," p. 513.
43 Benedek, "Fatherhood," p. 177.
44 Ibid., p. 177.
46 Ibid., p. 777.
51 Ibid., p. 592.
52 Ibid., p. 592.


60 Colman and Colman, *Pregnancy*, p. 135.


64 Allan, "Husband-Attended Deliveries," p. 147.

65 Aldridge, "Initial Experiences," p. 489.


69 Morton, "Fathers in the Delivery Room," p. 103.


71 Ibid., p. 97.
34


75 Carl Goetsch, "Fathers in the Delivery Room -- helpful and supportive," Hospital Topics 44 (No. 1, January 1966): 104.

76 Schaeffer, "The Expectant Father," p. 661.


78 Miller, "Return the Joy," p. 105.


80 Colman and Colman, Pregnancy, p. 134.


82 Ibid., p. 93.


85 Colman and Colman, Pregnancy, p. 82.


89 Shu, "Husband-Father in Delivery Room?" p. 93.


92 Ibid., p. 109.

93 Ibid., p. 107.


Hayden, "Maternity Care," p. 104.


Shu, "Husband-Father in Delivery Room?" p. 94.


Ibid., p. 27.


Ibid., p. 17.

Ibid., p. 15-27.

114 Lois M. Kopp and Sharon L. Schindler, "An Exploratory Study of the Experiences of Fathers during the Intrapartal Period," (Yale University, School of Nursing; May 16, 1966) (Mimeographed)


116 Aldridge, "Initial Experiences," p. 490


118 Colman and Colman, Pregnancy, pp. 89-92.
CHAPTER III

RESEARCH DESIGN

Introduction

The central purpose of this study was to learn of the husband-father's perceptions of labour and delivery, his perceptions of his role during this period, and how he perceived the care provided to his wife and himself. Because of the nature of the data desired, a retrospective study was designed. Contact with the father was initiated as soon after delivery as was feasible. Data were obtained through semi-structured interviews with fathers and from the perusal of the newly-delivered mothers' hospital records. These data were recorded by the researcher and the variables were subsequently analyzed by the use of content analysis and non-parametric statistical tests. The research design will be elaborated upon in the following sections of this chapter.

The Setting

The setting chosen for this study was an urban maternity unit in a general hospital that records approximately 1,100 deliveries per year. Besides offering teaching and research opportunities to a
variety of students in the health professions, the maternity
unit supports the philosophy of family-centered maternity
care. Husbands are permitted to stay with their wives
during labour and, under most circumstances, are allowed
to enter the delivery room, if desired by the couple.
The labour and delivery facilities include four single
labour rooms, three delivery rooms and a two-bed recovery
room for the parturients. A waiting room for the
husbands adjoins the labour rooms.

All patients have access to nursing, anaesthesia,
interne/resident, and personal physician services.
Once the infant is born, his condition is assessed. All
newborns experiencing an actual or potential health
problem are taken to the intensive care nursery which
is located near the delivery area. Those infants whose
condition is judged to be stable are transferred to the
postpartum unit nursery, one floor above. When the
mother's condition stabilizes after delivery, she is
likewise transferred to the postpartum unit.

In the postpartum area, both parents are permitted
to see and care for their infant when and as much as
they desire. Visiting hours are non-restrictive for
the fathers.

The Sample of Subjects
Criteria for Selection

Twenty subjects were to be selected from the
population of fathers. Their selection was based on the
following criteria:

- married to the mother of the baby
- twenty to forty years of age
- present for all or a portion of the labour
- delivery must be vaginal
- a healthy newborn of at least thirty-seven weeks gestation must be born
- father must be Caucasian
- father must be born in Canada, United States, or British Commonwealth countries
- father must be fluent in English

The decision to control the cultural-racial variable in this study was based on Newton and Newton's research of cultural groups. They discovered a wide variety of male attitudes and practices surrounding the birth process in 122 cultures.

For this study, husbands with one or more labour and delivery experiences were included. Two additional criteria were applied: the wife must be well enough to approve of her husband's participation and she must consent to his being interviewed without her being present.

The hospital and delivery records provided information as to whether a father would meet the criteria pertaining to marital status, race, type of delivery, health of the newborn, gestation of the newborn. The remainder of the criteria were established on talking with both of the parents.
Demographic Characteristics

The sample consisted of twenty husband-fathers. Sixteen of the subjects were born in Canada, four were British born. Data relevant to the fathers' age, marital status and years of education is summarized in Table 1.

TABLE 1
FATHERS' DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Years Married</th>
<th>Number of Years of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>22-40</td>
<td>0.5-7.5</td>
</tr>
<tr>
<td>Mean</td>
<td>28.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Median</td>
<td>27.5</td>
<td>3.5</td>
</tr>
</tbody>
</table>

n= 20 subjects

The fathers ranged in age from twenty-two to forty years; the mean was 28.5 years. The length of time that all fathers had been married ranged from six months to seven and one half years; the mean was 3.5 years. The total number of years of education ranged from eight years to twenty-three; the mean was 14.75 years.

Seventeen subjects were fathers for the first time; none of these fathers revealed a previous marriage with a labour and delivery experience. Three were fathers for the second time; the length of time between
this delivery and the previous delivery ranged from eighteen months to three years.

A deliberate selection of this particular hospital was made by eight of the couples. Reasons given for the choice were related in seven cases to the family-centered philosophy of care, both during the labour and delivery, and the postpartum period. One father stated that he chose the hospital because he was born there, not because of the philosophy of care. The remaining twelve of the sample stated that they came to this hospital because their wives' physician was affiliated with the hospital.

Obstetrical Characteristics of the Wives

Sixteen of the pregnancies were cited by the fathers as being problem free. Within the group of women who experienced problems, one mother developed a third trimester bladder infection and another experienced first trimester bleeding with the passage of clots. Once therapy and rest, respectively, were instituted, these health problems were resolved. Two of the pregnant women experienced a prolonged health problem; one developed gestational diabetes and the other experienced frequent asthmatic attacks in the first and second trimesters of pregnancy. The former was controlled by a dietary regimen, the other with hospitalization and medication. No emotional problems
were mentioned for any of the mothers.

**Previous Pregnancies**

The husbands were asked about their wives' previous pregnancies, labours and deliveries, and postpartum periods. In the first pregnancy, one wife had vomited intermittently for nine months, the second delivered five and a half weeks prematurely, and the third experienced a painful eighteen hour labour. The mother who delivered the premature infant also experienced an exacerbation of arthritis in the early postpartum period. All children from these pregnancies were alive and well.

Three of the women in the sample underwent therapeutic abortions at varying times in the past. Of those revealed by the husband, one woman had a problem-free post-abortion period and another hemorrhaged.

The data related by fathers regarding the previous pregnancies and the present pregnancies coincided with those which were recorded on the mothers' hospital record.

**Present Labour and Delivery**

The length of labour of the sample was recorded and the results are summarized in Table 2. A graphic method for studying the labours of primigravid and multiparous women was developed by Friedman. The mean duration of labour in Friedman's sample for the
primigravida was fourteen hours; the mean duration for the multipara was eight hours.

### TABLE 2

DURATION OF LABOUR FOR SAMPLE WIVES

<table>
<thead>
<tr>
<th></th>
<th>Duration of Labour for Total Sample (Hours)</th>
<th>Duration of Labour for Primigravida (Hours)</th>
<th>Duration of Labour for Multipara (Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>4.10-23.5</td>
<td>4.75-23.5</td>
<td>4.10-8.0</td>
</tr>
<tr>
<td>Mean</td>
<td>10.79</td>
<td>11.36</td>
<td>6.14</td>
</tr>
<tr>
<td>Median</td>
<td>10.33</td>
<td>10.33</td>
<td>6.75</td>
</tr>
</tbody>
</table>

n= 20 wives

The length of labour for the study sample ranged from 4 hours and 7 minutes to 23 hours and 30 minutes. The mean length was 10.79 hours; the median was 10.33 hours. The range for the primiparous woman was 4 hours and 45 minutes to 23 hours and 30 minutes; the mean was 11.36 hours; the median was 10.33 hours. The range for the multiparous woman was 4 hours and 7 minutes to 8 hours; the mean was 6.14 hours; the median was 6.75 hours. The means of the study sample and that of Friedman's differ significantly. The data needed to calculate the active phase of labour was not available. Therefore, it is not known if these women's labours were representative.
Analgesia and Anaesthesia

Table 3 indicates the analgesia and anesthesia administered during the childbirth experience.

**TABLE 3**

**ANALGESIA AND ANAESTHESIA GIVEN DURING LABOUR AND DELIVERY**

<table>
<thead>
<tr>
<th>Analgesia Given during Labour (No. Wives)</th>
<th>Anaesthesia Given during Delivery (No. Wives)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Infiltration</td>
<td>13</td>
</tr>
<tr>
<td>Demerol</td>
<td>9</td>
</tr>
<tr>
<td>Nisentil</td>
<td>5</td>
</tr>
<tr>
<td>No Analgesia</td>
<td>6</td>
</tr>
<tr>
<td>Pudendal Block</td>
<td>2</td>
</tr>
<tr>
<td>Epidural</td>
<td>3</td>
</tr>
<tr>
<td>Spinal</td>
<td>1</td>
</tr>
<tr>
<td>General</td>
<td>1</td>
</tr>
</tbody>
</table>

n= 20 wives

During the labour, nine women received varying amounts of Meperidine hydrochloride (Demerol), five were administered Alphaprodine (Nisentil) and six received no analgesia or sedative medication. During the delivery, thirteen women were given a local infiltration of the perineum, two a pudendal block, three a lumbar epidural, and one a spinal anaesthetic. One mother received a general anaesthetic when fetal distress was diagnosed. In addition, one mother was administered a general anaesthetic during Stage III for retention of the placenta.
Type of Delivery

Fifteen of the women delivered spontaneously and five of the deliveries required the use of low forceps for fetal distress or prolonged second stage with failure to progress. All of the fetal presentations were vertex.

Newborn Data

One of the criteria for selection of fathers was the delivery of a healthy infant. However, two of the infants were given Apgar scores of less than 7 during the first minute after birth. One newborn received a rating of 2 and the other, 6. Both achieved 7 or better within five minutes. One additional infant of 37½ weeks gestation received an Apgar of 7 at one minute. He and the infant with the initial Apgar of 2 were placed in the intensive care nursery for twenty-four hours. Both sets of parents visited and handled their babies during this period. Neither infant displayed any further overt signs of distress during the observation period.

The data pertaining to the newborn at birth is presented in Table 4. Apgar scores at one minute ranged from 2 to 9 with the mean being 7.8. At five minutes they ranged from 7 to 10 with the mean being 9.2. The infants' birth weight ranged from 2880 to 5000 Grams; the mean was 3451 Grams.
### Table 4: Newborn Data at Birth

<table>
<thead>
<tr>
<th></th>
<th>Apgar at One Minute</th>
<th>Apgar at Five Minutes</th>
<th>Birth Weight (Grams)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
<td>2-9</td>
<td>7-10</td>
<td>2880-5000</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>7.8</td>
<td>9.2</td>
<td>3451</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>8</td>
<td>9</td>
<td>3490</td>
</tr>
</tbody>
</table>

\[ n= 20 \text{ newborns} \]

**Previous Hospital and Pain Experiences of Husbands**

Additional information was gained from the husbands by asking them how comfortable they were in a hospital and what previous experiences they had had with someone in a lot of pain. They were asked these questions to determine possible additional stressors that they might be bringing to the labour and delivery experience.

All of the husbands had been in a hospital before, either as a patient or a visitor. They were asked, on a nine-point scale, with +4 indicating very comfortable and -4 indicating very uncomfortable, to reveal their degree of comfort when inside of a hospital. The results are presented in Table 5. The mean was +1.05, the median +2, the range -4 to +4, and the standard deviation was 2.73.
TABLE 5

**HUSBANDS' EMOTIONAL COMFORT WHEN INSIDE A HOSPITAL**

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>+ 1.05</td>
</tr>
<tr>
<td>Median</td>
<td>+ 2</td>
</tr>
<tr>
<td>Range</td>
<td>-4 to +4</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>2.73</td>
</tr>
</tbody>
</table>

n= 20 subjects

*Response to rating scale, +4 (Very Comfortable) to -4 (Very Uncomfortable)*

The results indicate that a slight majority of the sample felt comfortable in hospitals but that the remainder experienced low or negative levels of comfort. As some fathers indicated, and the researcher would agree, that childbirth is the one time that positive feelings toward hospitals may be heightened. This is particularly true if the outcome of the labour and delivery was positive. The large number of men in the sample who admitted to discomfort or very low levels of comfort, seems to indicate that many men are faced with an additional stress to overcome, besides the actual labour experience.

The husbands were also asked if they had ever, before they came to hospital with their wives, had
experiences with someone who they would consider had a lot of pain. Nine husband-fathers had such experiences. They were then asked how well they coped or managed, knowing that this person was in pain. Of the four choices offered, five responded "very well", four "fairly well", and no one selected the other alternatives of "not very well" or "uncertain".

Responses to the question about the pain experience seemed to indicate an openness on the part of some fathers to admit to difficulty with the person in pain. For those indicating positive experiences in coping when someone was in a lot of pain, it may mean that they are better able to cope with future episodes of pain encounters. It may also mean that the answers given are not reliable, but socially acceptable. The instrumental orientation of the male may influence him to respond that he was successful with pain experiences.
The Interview Method

Kerlinger defines the interview as:

... a face-to-face interpersonal role situation in which one person, the interviewer, asks a person being interviewed, the respondent, questions designed to obtain answers to pertinent research problems.\(^4\)

He describes the standardized or structured interview as one in which the questions, their sequence and their wording are fixed. The interviewer may be allowed some liberty in asking questions, but relatively little. There are differing views regarding the stricture, the newest being the relaxation of it.\(^5\)

The standardized interview employs an interview schedule or questionnaire which includes three types of information: fixed-alternative questions, open-end questions, and rating scales. The fixed-alternative questions have the advantage of providing greater uniformity of measurement and thus greater reliability, but they also have several disadvantages. They are superficial and do not get below the surface response unless probes are used. They can also force responses, many of which are not reliable. Kerlinger notes that fixed-alternatives can be used to advantage if judiciously written, used with probes, and mixed with open items.

The second type of question, i.e., the open or open-end items, are those which supply a frame of reference for the respondents' answers but put a minimum of restraint on the answers and their expression.
These questions have possibilities of depth; they allow one to make better estimates of the respondents' true intentions, beliefs and attitudes; they allow for the detection of ambiguity; and encourage cooperation and rapport.

The third type of item used is the scale: "a set of verbal items to each of which an individual responds by expressing degrees of agreement or disagreement or some other mode of response." Scale scores can be checked against open-end question data for reliability.

It was this method of a standardized interview, using the three types of items, that was employed for this study. Pretesting was carried out by interviewing three husband-fathers. Their suggestions for improving the interview schedule and interviewing techniques were sought. It became apparent, both from the interviewees' responses and the observations of the researcher, that several modifications should be made in the pretest schedule (see Appendix C). In addition, the original intention of interviewing husbands within the first forty-eight hours after delivery was not feasible. Many had outside commitments which limited their available time, not only for visiting with their wives, but also for talking with the interviewer.
Procedure for Collection of Data

The nurse-researcher first encountered the subjects in the early postpartum period, after having screened the hospital and delivery records. (The criteria of marital status, race, type of delivery, health and gestational age of the newborn were available in the hospital records.) The researcher explained the nature of the study and the remainder of the criteria necessary for participation in the study. These criteria were the birthplace of the father, his age, his presence during all or a portion of labour and his fluency in English. If the husband met these criteria, he was invited to participate in the study. On occasion, four or five potential subjects existed after the screening of the delivery and hospital records. When this happened, the researcher chose every second father, approached him, and if he met the remainder of the criteria, invited him to participate in the study. In most instances, all potential candidates were eventually approached because the criteria of age, birthplace, etc. were selective.

A convenient interview time for the father was established. As was noted earlier in the study, no husbands refused to participate. However, four "multiparous" fathers were unable to keep their interview appointments. Reasons cited by the wives were failure of the father to secure a baby-sitter, sickness of the
children or the father. Three of the husbands left word with their wives to make alternate arrangements and the other husband became too involved with outside activities to pursue an alternate time. None of these fathers were included in the sample.

The number of hours after delivery that the interview took place was recorded. These data are summarized in Table 6.

**TABLE 6**

INTERVIEW LENGTH AND TIME AFTER DELIVERY

<table>
<thead>
<tr>
<th>Length of Interview (Minutes)</th>
<th>No. Hours after Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>30-90</td>
</tr>
<tr>
<td>Mean</td>
<td>61</td>
</tr>
</tbody>
</table>

n= 20 subjects

Table 6 illustrates that the interview length ranged from 30 minutes to 90 minutes; the mean was 61.0 minutes. The number of hours after delivery that the interview took place ranged from 13 to 107 hours; the mean was 51.8 hours.

The interviews took place in an office-lounge on the postpartum unit. Wives were not present. To facilitate relaxation of the husbands, smoking was permitted and hot beverages were available. The researcher
was dressed in street clothing. It was explained that the researcher would not be discussing their comments with their wives or with the nursing staff. They were also reminded that they were not obliged to answer any question which they found to be too personal. They were given a consent form to sign, a requirement of the hospital (see Appendix A).

To insure consistency, an interview schedule was used (see Appendix B). The subjects were informed that the researcher would be jotting down abbreviated versions of their comments and that she would complete the recording after the interview had terminated. Several fathers expressed relief that no tape recording was being done. The sequence of the schedule was followed for the majority of interviews. However, several fathers seemed eager to describe certain aspects of the labour and delivery experience before their appearance in the schedule. The fathers' spontaneity was encouraged. For those questions requiring the selection of one answer from several alternatives, a printed card with the question or statement and the alternatives was presented to the subject. Those statements involving rating scales were handled by giving the father a pencil and a copy of the statement with the rating scale. Explanations of how to use the scale were given to the husband.

Demographic and obstetrical data were obtained from the mothers' hospital records before the interview
took place. However, knowledge of this data was not introduced by the researcher unless done by the fathers. The interviewer did not reveal this data because of the possibility of influencing the fathers' perceptions.

In the hour following the completion of the interview, the researcher completed the recording of the observational data.

**Data Analysis**

Two methods of data analysis were employed. Content analysis of the husbands' responses to the open-end questions was carried out and nonparametric statistical tests were used for assessing significance between some extraneous independent variables and the dependent variables.

Holsti defines content analysis as "any technique for making inferences by systematically and objectively identifying specified characteristics of messages."?

The first step in the procedure was the establishment of the categories; a framework for categorization was adapted from the literature where possible. Data were segmented into analytic units and these were subsequently sorted into the categories. The analytic units were the word and themes, drawn from open-end questions posed to the husbands. A quantitative analysis was carried out with each item assigned an equal weight.

Nonparametric statistical tests were chosen for three major reasons. There was a question as to whether this sample was drawn from a normally distributed population.
Secondly, the sample size was small, and finally, many of the measures were nominal and ordinal in nature. The Chi-square was used to detect whether significant differences existed between the observed population and the theoretical population.

Single variable analysis was included, more specifically, the mean, median, range and standard deviation were calculated.

The Independent and Dependent Variables

The independent variable was the labour and delivery experience of the couple. Specific demographic and obstetrical characteristics were considered as extraneous independent variables. The extraneous variables relating to the mother were her previous obstetrical problems; those relating to the father were his attendance or non-attendance at prenatal classes, his attendance or non-attendance at a previous labour and delivery, his past experiences with someone in pain, his attitudes about hospitals.

The dependent variables were three inter-related areas of perception: the husband-father's thoughts and feelings about labour and delivery, his perception of his role during this time, and his perception of the care received by his wife and himself during labour and delivery.

The father's perceptions of labour and delivery, i.e., the first aspect of perception, were divided into
five subsets. These were:

- his expectations of labour and delivery
- his rating of the experience of labour and delivery
- his focus on his wife, baby, and self during labour and delivery
- his assessment of the amount of pain experienced by his wife during labour
- his periods of ease and uneasiness during labour and delivery.

The second aspect of perception was how he perceived his role during labour and delivery. This was divided into five subsets which were:

- some aspects of the decision-making process related to his attendance at labour and delivery
- his role preparation for labour and delivery
- his reasons for attending the labour and delivery
- his role assumed during labour and delivery
- his assessment of how helpful he was to his wife during labour and delivery.

The third and final aspect of perception was his evaluation of the care provided to his wife and himself during labour and delivery. There were two subcategories:

- what he saw as helpful
- what he saw as non-helpful.
Limitations of the Study

In reading this study, the reader is cautioned that there are some limitations. The study is retrospective in nature and, therefore, much of the reliability of the data is based on the subjects' ability to recall their thoughts and feelings. Fathers were interviewed over a time period ranging from 13 to 107 hours after delivery. It is possible that had all fathers been interviewed within a smaller time range, the data would have been slightly different.

The sample size was small, the racial-cultural variable was controlled, and all twenty subjects had attended prenatal classes. In addition, ninety percent of the sample were present at the delivery of the baby. The setting was a family-centered maternity unit, the deliberate choice of eight couples.

The tool's validity for measuring the husbands' thoughts and feelings was not well-established. In the stage of data analysis, the lack of existing categories and rules for sorting the data into these categories did not exist in the literature.
FOOTNOTES


6 Kerlinger, Behavioral Research, p. 485.

7 Ole R. Holsti, Content Analysis for the Social Sciences and Humanities, (Reading, Mass.: Addison-Wesley, 1969), p. 2
CHAPTER IV

FINDINGS AND DISCUSSION

Introduction

In this chapter, three aspects of the husband's perception will be presented. These are the husband's thoughts and feelings about labour and delivery, his perception of his role during this period, and his perception of the care provided to his wife and himself during labour and delivery.

In the first section, the husband's thoughts and feelings will be discussed. More specifically the subsets are:

- his expectations of labour and delivery
- his rating of the experience of labour and delivery
- his focus during labour
- his focus during delivery
- his emotional relaxation and uneasiness during labour and delivery

In the second section, the husband's perception of his role will be examined. The subsets for this aspect are:

- some aspects of the decision-making process related to his attendance at labour and delivery
- the husband's preparation for his role during labour
and delivery.

- the husband's role enactment during labour and delivery
- his assessment of his role during labour and delivery

In the final section of this chapter, the husband's evaluation of the care provided by others will be presented. The areas to be discussed are:

- his rating of the overall care
- his perception of helpful and non-helpful nursing care

The results for each of the specific subsets will be presented and then followed by a discussion and interpretation of the results. The discussion and interpretation will be guided by Sarbin and Allen's concept of role theory.

**Perceptions of Labour and Delivery**

**Expectations of Labour and Delivery**

In order to learn if the labour was congruent with the husband-fathers' expectations, the following question was posed: "In terms of what you had expected, how well did this labour go for you?" Table 7 illustrates the husbands' responses to the four categories which were provided for him. Some husbands gave more than one answer to the question, i.e., one aspect might have been better and another worse than he had expected.
TABLE 7
HUSBAND RESPONSE TO HOW WELL LABOUR WENT

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better than expected</td>
<td>12</td>
</tr>
<tr>
<td>Same as expected</td>
<td>5</td>
</tr>
<tr>
<td>Worse than expected</td>
<td>3</td>
</tr>
<tr>
<td>Uncertain what to expect</td>
<td>4</td>
</tr>
</tbody>
</table>

n= 20 subjects
*Some husbands gave more than one response

According to twelve fathers, the labour went better than expected for the following reasons: the length was shorter, there were no complications, their wives coped better than they had anticipated, or the pain was less than they had expected. For three husbands, the labour went worse than they had anticipated because of the amount of pain. Five husbands stated that the labour went as they had expected, the common response being, "it went just like the textbook." Four husbands admitted that they were uncertain of what to expect.

The husbands were also asked how well the delivery went. Again, some husbands provided more than one response to the fixed categories. Table 8 summarizes their responses to the question. Thirteen husbands believed that aspects of the delivery went better than
they had expected. Their reasons were that the pain experienced by their wife was less than they thought it would be, that their (husbands) own reaction was far more personal than they had anticipated, or the attitudes of the health team members were better than they had expected. Reasons given for the "worse than expected" category were the baby who failed to breathe at birth, the need for the manual removal of the placenta under general anesthesia, and the behavior of the health team members. The latter example will be discussed in the third section of this chapter.

TABLE 8
HUSBAND RESPONSE TO HOW WELL DELIVERY WENT

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better than expected</td>
<td>13</td>
</tr>
<tr>
<td>Same as expected</td>
<td>4</td>
</tr>
<tr>
<td>Worse than expected</td>
<td>2</td>
</tr>
<tr>
<td>Uncertain what to expect</td>
<td>3</td>
</tr>
</tbody>
</table>

n= 20 subjects
* Some husbands gave more than one response

The results indicate that the majority of husbands brought a set of expectations to labour and delivery. These expectations, whether they were positive or negative, provided him with a frame of reference. He had a set
of criteria against which he could assess the real experience of labour and delivery. These expectations centered on the length of time of labour, the amount of pain, their wives' ability to cope with the contractions, and the eventual outcome of the experience. Included were the husbands' own reaction and the behavior of others, namely the health team members.

For the majority, the labour and delivery surpassed their expectations in a positive sense; for the minority their expectations were surpassed in a negative sense. For some, in spite of prenatal preparation, they were uncertain of what to expect. Congruence of expectation was indicated by a small number. In interpreting these findings, one must be careful not to equate the expectation with good or bad. For example, the response of "better than expected" could have been the result of a good or a poor experience. One can only state that this finding indicates that the degree of congruence between expectation and perceived reality was low. Because of this, the fathers had to expend additional energy during the labour and delivery to adjust or adapt to these differences.

Rating of Labour and Delivery

The husbands were asked to rate what kind of an experience the labour was for them. A nine-point rating scale, ranging from +4 (excellent experience) to -4 (very bad experience), was used. The results for both
labour and delivery are provided in Table 9.

**TABLE 9**

**HUSBANDS' RATING OF LABOUR AND DELIVERY**

<table>
<thead>
<tr>
<th>Test</th>
<th>Result for Labour</th>
<th>Result for Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>+1.60</td>
<td>+2.26</td>
</tr>
<tr>
<td>Median</td>
<td>+2</td>
<td>+3</td>
</tr>
<tr>
<td>Range</td>
<td>-3 +4</td>
<td>-3 +4</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>2.062</td>
<td>1.78</td>
</tr>
</tbody>
</table>

n= 20 subjects

*Response to rating scale +4 (excellent) to -4 (very bad)

The results for labour indicate a mean of +1.60, a median of +2, and a range of -3 to +4. The standard deviation was 2.062. Many of the husbands who rated the experience on the positive end of the scale qualified their selection. The ambivalence in their minds is illustrated by the comment of one husband: "How can you say it was an excellent experience when your wife is in so much pain. It was a very meaningful and valuable experience but that does not mean that it was pleasant."

The husbands were asked to rate what kind of an experience the delivery was for them. The results for delivery are contained within Table 9. Eighteen fathers were present at the birth of the baby. Those not present were invited to complete the rating scale; one did and the other was unable to state what kind of an experience the
delivery was. The results obtained for delivery indicate a mean of +2.26, a median of +3, a range of -3 to +4, and a standard deviation of 1.78.

The results seem to indicate that the husbands felt more positive about the delivery than they did about the labour. These findings compare favourably with those of Kopp and Schindler, even though the husbands in their study did not attend the delivery.

The results also show that the degree of positivity towards labour was slightly more variable than that towards delivery. Possible reasons for the differences in the rating and the variance are multiple. Labour was a waiting period, a time in which progress was suggested by the incongruous: increased pain, feelings of helplessness and hopelessness, and "antisocial" behavior. During the labour, the father was forced to accept that his wife must submit to the contractions and that he must encourage her to do so. From the husband's point of view, the interaction with these elements was usually new and/or potentially threatening to him in his role as a man and a husband. The male's orientation, which is more instrumental than expressive, stresses the ability to solve problems. His success in dealing with the behaviors elicited during labour was a reflection of his role expectation and degree of skill in role enactment. One could safely predict that among the fathers there was considerable variation in these two areas. Successful
intervention by himself and/or by others was more likely to produce a feeling that was more positive than instances where interventions failed.

An additional factor would seem to play a part in the differences in rating. The experience of pain in labour is one that is not accepted in North American and British cultures. When pain is perceived, the usual remedy is to seek relief through the use of medication. When this relief is withheld or given judiciously, as was the case in labour, the experience may have been seen as more threatening than if the pain had been eliminated.

The positive features of delivery seemed to be that an "end was in sight", and that it was a period when the wife was more able to actively engage in the labour by pushing. Progress was made obvious to the couple by the sight of the ever-descending fetal head and medication was used that controlled some, if not all, of the pain. The onus to perform as he had been doing was reduced for the father because of the presence and activities of the professional team members. In North American deliveries, the husband-father assumes a less active role in comparison to that which he enacts before coming to the delivery room. The fathers confidence in the health team members' expertise likely contributed to the positive end of the rating. If, however, he saw them as lacking expertise, his evaluation of the delivery was lower. The period of birth is culturally defined as a period of happiness. It was the beginning
of fatherhood and motherhood, whether it was for the first or second time. There was always the possibility that things could go wrong during the delivery but when they did not, the sense of relief added to the positive. When complications did occur for either the mother or the baby, the delivery was seen less positively. Finally, one can not underestimate the fascination and awe that accompanied the sight of birth; the transformation of an imagined baby into a real individual.

The slightly greater variance seen in labour than in the delivery may be accounted for in terms of the possibilities that existed for negative attitudes to develop in labour. Many of the forementioned statements made about delivery were common to the majority of fathers. However, during labour, the degree of variability in such areas as the amount of pain or the fathers' feelings of helplessness were perhaps much greater.

Rating of Labour and Delivery and the Independent Extraneous Variables

Certain questions were asked related to certain independent extraneous variables and the husband-fathers rating of labour and delivery. The specific questions asked were:

Was there a significant relationship between the fathers' past experiences with labour and delivery and his rating of this labour and delivery? The results of the Chi-square indicated no
significant relationship. (The level of acceptable significance was .05 for this and the remaining questions. This and the remaining questions were handled by using a 2x2 contingency table. The positive rating scores and the negative (plus the neutral) scores were compared with the two sides of the extraneous variable, e.g. experience versus no experience.)

The lack of significance may be interpreted to mean that factors other than experience influence the rating of labour and delivery.

Was there a significant relationship between the presence of obstetrical problems in the mother or baby and the father's rating of labour and delivery? The results of the Chi-square indicated that no significant relationship existed. The lack of significance may be attributed to the fact that even though there were problems, the eventual outcome was a positive one for both mother and baby. Thus, the relief that all eventually turned out well may contribute to a slightly more positive rating of labour and delivery.

Was there a significant relationship between the deliberate selection of this maternity unit and the husband's rating of labour and delivery? Results of the Chi-square indicated that no significant relationship existed.
This may be interpreted to mean that parents who deliberately selected this setting did not rate the labour and delivery significantly higher or lower than parents who made no deliberate choice to come to this setting.

Was there a significant relationship between the husband's past experiences with someone in a lot of pain and his rating of labour and delivery? The Chi-square result for labour was $4.55$ with $p < .05$. This indicates that there was a significant relationship between the father's past experiences with someone in a lot of pain and his rating of labour. These fathers tended to rate the labour lower than the rest of the sample. Results of the Chi-square indicated no significant relationship existed between the father's rating of delivery and his past experiences with someone in a lot of pain. These results may be attributed to the negative regard that the Anglo-Saxon cultures have for pain. Seeing someone in a lot of pain again may serve to re-emphasize the point of view that pain is essentially a negative experience. Labour may be equated with the negative for this reason. Delivery may be viewed as less negative because of better pain control and because of the positive orientation that this culture has toward birth.
Was there a significant relationship between how the father rated labour and delivery and his presence or absence at delivery? The results were suspect because of the fact that only two fathers in the sample did not attend the delivery. (A significant relationship existed between attendance at delivery and the rating of labour. These fathers tended to rate the labour higher. The Chi-square obtained was 5.63, p < .025.)

The results for attendance or non-attendance at delivery and the rating of delivery were not calculated as only one of the non-attenders at delivery rated the delivery.

Was there a significant relationship between how the fathers rated labour and delivery and how they rated their degree of comfort when inside of a hospital? The results of the Chi-square indicate that there was no significant relationship between the two variables. One may interpret this to mean that the fathers' feelings about being inside of a hospital do not significantly affect how he will rate the labour and delivery.
Husband Focus during Labour

The focus of the husband on the baby, himself, and on his wife was ascertained in two ways. He was first asked via a rating scale: "How much did you think about (the baby, yourself, your wife) during labour?" A nine-point rating scale with +4 representing "all the time" and -4 representing "never" was used. He was first asked about the baby, then himself, and finally about his wife.

The second way of estimating his focus was by asking him an open-end question: "Would you describe what happened during the labour?" The resulting data were content analyzed in order to reveal who he talked about as well as what aspects of that person's behavior or thoughts caught his attention. The results of the rating scale will be presented for each person, followed by the results of the content analysis for that person. This in turn will be followed by a discussion and interpretation. The results of the rating scale for the husband's focus on his wife, himself and the baby are presented in Table 10.

Focus on Self

The husband's focus on himself received a very low rating. The mean was -2.80, the median -3, the range -4 to 0, and the standard deviation was 1.005. References to self when asked to substantiate his rating were
expressed as the need for food, fluids, sleep and the need to go to the washroom. Content analysis of the open-end question revealed a somewhat different finding. References to self were made frequently but in relation to the husbands' role enactment with their wives. Admissions of feeling calm, confident, useless, and out of control were accompanied by the events that produced these feelings.

The discrepancies noted in the amount of perceived energy devoted to himself, as indicated by the rating scale, and that indicated by the content analysis are understandable. The husband's interpretation of the question which asked him to indicate how much time he spent thinking about himself may have differed from that of the researcher. A second reason is that cultural conditioning may have played a part in influencing a set response. According to Josselyn, the expectation is that one loves another more than one does oneself. The third reason relates to the amount of identification and empathy displayed by the father when his wife is in labour. Seven levels of organismic involvement are mentioned by Sarbin and Allen. At the lowest end, the role and self are easily differentiated but at the higher levels, self and role are not differentiated. In terms of the father's focus on self versus others, it was likely that his focus on his wife (and later on the baby) and
his awareness of self became fused into one. The ability to differentiate self from the other probably became very difficult for him, if not impossible.

TABLE 10
HUSBAND FOCUS ON PERSONS DURING LABOUR*

<table>
<thead>
<tr>
<th>Test</th>
<th>Person Focus</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
<td>Baby</td>
<td>Wife</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>-3</td>
<td>-1</td>
<td>+3</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>-2.80</td>
<td>-1.90</td>
<td>+3.25</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>-4</td>
<td>+4</td>
<td>+4</td>
<td></td>
</tr>
<tr>
<td>Standard deviation</td>
<td>1.005</td>
<td>1.820</td>
<td>.639</td>
<td></td>
</tr>
</tbody>
</table>

n= 20 subjects
*Response to rating scale +4 (all the time) to -4 (never)

Focus on Baby

The husband's focus on the baby received a low rating during labour. Infant scores from the rating scale are presented in Table 10. These were a mean of -2.80, a median of -1, a range of -4 to +4, and a standard deviation of 1.820. For many husbands, this question left them at a loss for words and what might be interpreted as apologetic. Some were surprised that they had not thought very much about the baby during labour. Expressions were "he wasn't an individual to me then" or "I hate to admit it but I didn't think about it"
very much." This realization seemed to prompt the "amazed" fathers into trying to recall some instances related to the baby. For those who did think about the baby, they stated that the possibility of fetal distress, the lack of normalcy, and the sex of the baby occupied their thoughts. Content analysis of the open-end question asking fathers to describe what happened during the labour revealed rare references to the baby. These references were related to listening to the heartbeat of the baby and knowing that the baby was okay because of the nurses' assessments.

The results may be interpreted by the fact that the baby was not yet a reality, even though the father had felt the movements, heard the heartbeat and tried to imagine what fatherhood would be like. This should not be construed to mean that the father did not care about the baby; to the contrary. A common thought was the well-being of the baby. When the health of the infant was in jeopardy, as was the case in two instances, the fathers admitted to experiencing panic and sinking feelings. In labour, the father had to imagine what the baby was doing and what he looked like. He was powerless to do anything for him which was not the case with his wife.

Focus on Wife

The major focus of the husband during labour was on his wife. The results of the rating scale (Table 10) indicate a mean of +3.25, a median of +3, a range of
+2 to +4 and a standard deviation of .639.

Content analysis of the open-end question about what happened during the labour revealed five items related to his wife. These results are summarized in Table 11.

**TABLE 11**

**HUSBANDS' REFERENCES ABOUT WIFE DURING LABOUR**

<table>
<thead>
<tr>
<th>Reference about Wife</th>
<th>Number of Husbands Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Body sensation and bodily response to labour</td>
<td>18</td>
</tr>
<tr>
<td>2. Contractions</td>
<td>14</td>
</tr>
<tr>
<td>3. Verbal and body response to husband</td>
<td>14</td>
</tr>
<tr>
<td>4. Progress and outcome</td>
<td>9</td>
</tr>
<tr>
<td>5. Breathing pattern</td>
<td>8</td>
</tr>
</tbody>
</table>

n= 20 subjects

*Some husbands gave more than one response

The first and most commonly noted reference about their wives was that of body sensation and bodily response to the process of labour. Early in the labour, most of the husbands noted that their wives were comfortable or relaxed during the contractions. The later phases of labour received the majority of the husbands' comments.
Comments such as "she had a lot of pain ... she told me that she couldn't stand it anymore" and "I could see by her eyes that a few of the contractions freaked her out" were contributed by husbands. The element of surprise was evident for some husbands as indicated by two observations: "I've never seen J. like that before -- her body was like a board, her hands and feet were all twisted" and "the pushing contractions were so powerful -- her face was purple-- it wasn't like a bowel movement -- no bowel movement is that powerful."

One aspect of body sensation was also measured by a category rating scale; this was the amount of pain that husbands thought their wives experienced during the labour. A category rating scale was offered to the husband and the results are presented as follows. Nine husbands thought that their wives experienced an extreme amount of pain, two felt that it was between a lot to extreme in amount, and five husbands stated that she had a lot of pain. Three husbands stated that their wives had a little to a lot of pain and one husband stated that his wife had a little pain.

The second area of reference to his wife in the open-end question centered on the details of the contractions; their frequency, duration, and intensity (effect on his wife). Awareness of the changes in the nature of the contractions as labour progressed was revealed: "the contractions never seemed to leave -- she never got any rest," "she would no sooner finish one and another would
come," and "after she had the Demerol, they [contractions] changed -- they didn't come as often."

The third reference area made by the husband was his wife's verbal responses and bodily responses to others. These included the types and/or lack of verbal exchanges made by the woman in labour and were commented on by fourteen husbands. Sample comments were: "She told me 'don't touch me',' "I told her to go ahead and cry -- we cried together,'" and "she clammed right up." Some husbands explained that their wives pushed them away during the contractions and then looked for them once the contraction was over.

Recall of events related to progress in labour and the outcome is the fourth category noted by nine fathers. Some thoughts were: "She was already having a lot of distress. I wondered how she'd make it," and "in awhile I'm going to be a father."

The breathing patterns of their wives was the fifth category resulting from the husbands' description of what happened during the labour. The husbands recalled incidents when the breathing was not helpful, when they forced their wives to breathe along with them, and the independence of their wives in establishing their own patterns.

These data indicate that the husband's primary focus during labour was on his wife. His socialization and enculturation had already defined that the direction
in which his concerns and energy should go was toward his wife. The person who placed the most demands on him in the roles of husband and father-to-be was the woman in labour. She provided him with concrete behaviors throughout the labour and he was expected and likely expected, because of prenatal teaching, to react in varying ways to them. The husband brought some skills to help his wife, and he learned of others during the experience. His energy was directed toward helping her achieve a successful outcome.

In interpreting the findings of the open-end question asking the husband to describe what happened during the labour, the researcher cautions the reader against placing too much emphasis on the total number of responses in each category (see Table 11). Because some fathers were more articulate than others, the total responses may have been a reflection of their communicative ability.

An individual is expected to behave in certain ways, in the sense that the behavior is predictable. When the husband interacts with his wife in the non-pregnant state, there is a degree of predictability to her response. This response is perceived as an organized pattern or whole. During labour, the usual no longer existed. Certain responses became the focal point, i.e., the wife's responses of pain, contractions, the breathing patterns, and her changing verbal response. Progress and the outcome
became important to the husband because they signified the end of unpredictability and the resumption of the opposite, predictability.

The influence of prenatal preparation was probably significant in directing the husband's thoughts towards certain of his wife's behaviors. Sarbin explains that the individual can acquire the role expectations long before he actually occupies the role.\(^\text{10}\) Thus, if the husband was taught what to expect from his wife in labour, or if he drew on previous related experience, he was able to anticipate and look for certain responses. However, because he was an learner in the role, even though he may have had previous experience, the element of unpredictability of outcome was still a large one. Therefore, the progress that his wife made was important.

The results also indicate that husbands believe that their wives experienced a great deal of pain, bordering on extreme in amount for the mean of the sample. Pain and labour may almost be synonymous.
Husband Focus during Delivery

The focus of the husband during delivery was ascertained through analysis of an open-end question asking the father to relate what happened during the delivery. Discussion of the data will be placed at the end.

Before the birth of the baby the husband centered his attention on his wife, the activities of the health team members and on the baby.

Focus on Wife

The husband's attention in the latter part of the second stage of labour was focused on his wife's response to pushing and the progress that she was making. Several fathers were struck by the apparent comfort of their wives in comparison with what had preceded their coming into the delivery room. Five husbands remarked on the pain that was experienced by their wives during this period. Evidence of the progress being made was evident in the ever-descending fetal head. It was at this time that some husbands realized that the baby was a reality.

Focus on Others

The husbands seemed to be fascinated by the activities of other persons in the delivery room. The draping procedure, the administration of the local and epidural anaesthetics, and the performing of the episiotomy caught their attention. Eight fathers commented on the
type and/or size of the episiotomy; three fathers expressed concern about the amount of "cutting" that was done. Although forceps were used in three of the deliveries that fathers attended, only one mentioned their use.

**Focus on Baby**

The delivery of the baby was described in varying amounts of detail by fifteen fathers. Three fathers who accompanied their wives into the delivery room, chose not to watch the actual delivery because of "squeamishness". There was fascination by some, in the birth process, but there was also an over-riding anxiety related to the eventual health of the baby. Once the baby was born and pronounced healthy, the husband's focus seemed to shift towards himself. However, if the baby presented some problems according to the father's perception, his shift to himself seemed to be delayed.

**Focus on Self**

Once the baby was born and pronounced healthy the father's attention went towards himself. Ten fathers tried to express their feelings associated with the birth of their baby and most had difficulties finding adequate words: It was indescribable," "I can't tell you how happy I was," and " It was far more personal than I could ever have imagined. I can't tell you how I felt." Two fathers were unsure of how they felt, relating the birth in a flat, matter of fact matter. One husband's response was " Some fathers get off on seeing their child born. I don't."
Two fathers described their feelings as a "relief that it is over," and another as "Now we can get back to living."

Thoughts on first seeing the baby

The husbands were asked to describe their thoughts on first seeing the baby. Table 12 provides a summary of this data.

**TABLE 12**

FATHERS' THOUGHTS ON FIRST SEEING THEIR BABIES

<table>
<thead>
<tr>
<th>Aspect of Baby</th>
<th>Number of Fathers Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completeness</td>
<td>8</td>
</tr>
<tr>
<td>Health</td>
<td>10</td>
</tr>
<tr>
<td>General appearance and activity</td>
<td>6</td>
</tr>
<tr>
<td>Reality of the baby</td>
<td>3</td>
</tr>
<tr>
<td>Sex</td>
<td>4</td>
</tr>
</tbody>
</table>

n = 20 subjects

* Some fathers responded more than once

The majority of thoughts on first seeing the baby centered on the infant's health and completeness. Health of the infant was noted by 10 fathers and included comments about the breathing, colour and cry of the baby. These seemed to be the aspects that indicated health to the father: "He turned pink and that was what I was looking
for, "the baby was blue and its cry was a whimper," and
"I heard him breathe -- I thought, holy doodle, he's going
to be okay."

Completeness was indicated by comments from eight
fathers such as: "He was so complete," "I wanted a full
shot of him to see that he was all there -- he was."

Remarks relating to the general appearance of the
baby included the amount and colour of the hair, yawning,
general musculo-skeletal activity, and the size of the
baby.

That the reality of the baby did not occur to
them until after the actual birth was mentioned by
three husbands: "I was crying...then I realized that
it was real" or "all of a sudden it hit me. He was
real."

Remarks about the gender of the infant were made
by both first and second time fathers. Two fathers
expressed a definite preference for the sex of the infant
but the remainder stated that the sex did not matter.

Focus on Wife

References to their wives during the few moments
after birth were rare. None of the fathers commented
on their wives' reaction to the baby. One father said
that he was so enraptured and happy with the baby that
all that existed for him, at that moment, was the baby.
The results seem to indicate that late in the second stage of labour a shift in the husband's focus occurred. It would seem that because his wife was usually experiencing less pain than previously, that he was able to direct his energy elsewhere. His attention became directed toward those events which had a curiosity value: the surgical techniques of draping, anesthesia and the episiotomy. These aspects held a challenge for him. The legend of men fainting in the delivery room at the sight of blood or needles, the annoyance of the nurses and physician, and his embarrassment caused by the fainting are well cited in the literature and in daily living. He evaluated his own reactions to these events. Sometimes he was surprised that "it wasn't like that at all" and sometimes his "squeamishness" was confirmed.

As Stage II reached its completion, he tended to respond to the baby as less of a possibility and more of a reality. Engrossment in the newborn, his completeness and his health status seemed to occupy his thoughts. For a brief time at delivery, it seemed that the role of father superseded that of husband. This would seem to have been true for fathers with babies who presented no health problems at birth as well as for those who did.

The need to know that the baby was healthy and complete seemed to be paramount in the father's mind. He brought a set of criteria to delivery that assisted him in his assessment and he seemed to apply these very
rapidly. He seemed to be very aware of the baby's colour, the quality of the cry, and he looked for evidence of breathing. If the baby did not measure up to the criteria, he studied the reactions of others and based on their behaviors, made the judgement that all was or was not well. Most fathers revealed that they did not verbalize their concerns, indicating again, the reluctance of the husbands to express their anxieties to either their wives or the health team members.

For the majority of fathers, the specific gender of the baby did not seem to be an ultimate concern. However, there were definite preferences noted by some.

Relating the father's response to the newborn to Josselyn's theory of fatherliness, it appeared that fatherliness was only minimally active in labour but that it became more active when the possibility or actuality of threat to the baby's health was recognized. Expressions of fatherliness seemed to be heightened when the second stage progressed to reveal the presenting part. The birth and viewing of the baby further increased the reality.

Greenberg and Morris describe a similar phenomena which they call engrossment. They noted that some fathers were not engrossed or, in other words, the individual infant had not assumed large proportions for them. It is likely that the flat, casual and dismissing tones used by a few of the fathers during the description of the birth and their feelings was evidence of a lack or low level of engrossment or fatherliness. However,
the researcher is reluctant to interpret these behaviors as such, especially in view of how little is known about early fathering behaviors. A second reason for this reluctance was that some fathers may have been hesitant to admit such feelings to an interviewer. This was an observation made by Greenberg and Morris in their sample of fathers.
Relaxation and Uneasiness during Labour and Delivery

Labour

The fathers were asked about their feelings of ease and uneasiness during labour. The specific question related to the former was: "When did you feel relaxed or calm during this labour?" Six fathers stated that they felt calm or at ease during the early stages of labour, thirteen answered that they felt calm during almost all or all of the labour and one father stated that he never felt calm during the entire experience.

The fathers were then asked if there were times that they felt uneasy or worried during the labour. The results are presented in Table 13.

**TABLE 13**

UNEASINESS EXPERIENCED BY FATHERS DURING Labour

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number of Fathers Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to wife</td>
<td></td>
</tr>
<tr>
<td>her behavior</td>
<td>15</td>
</tr>
<tr>
<td>progress and outcome</td>
<td></td>
</tr>
<tr>
<td>Related to baby</td>
<td>6</td>
</tr>
<tr>
<td>actual fetal distress</td>
<td></td>
</tr>
<tr>
<td>concerns about health and normalcy</td>
<td></td>
</tr>
<tr>
<td>Related to self</td>
<td>6</td>
</tr>
<tr>
<td>own performance</td>
<td></td>
</tr>
</tbody>
</table>

n = 16 subjects

*Some fathers responded more than once
Sixteen fathers cited examples of uneasiness during labour. These were categorized according to the criteria established for the sorting of data seen in Table 10.

Fifteen fathers gave examples of their wives' behavior or concerns about the progress and outcome. Uneasiness was caused by the mother's verbal and physical responses to pain as well as her loss of control. Concerns about the progress and outcome of the labour were illustrated by comments such as "It seemed that she didn't make any progress for two hours," "It was always in the back of my mind; I hope everything goes okay," and "when she dilated so suddenly, no one was around." One father was confused about how much progress his wife was making: "For four or five hours I thought she'd have the baby in the next half hour. I was confused about how far dilated she was."

Six fathers gave examples of uneasiness related to the fetus. In two instances, fetal distress was detected just prior to delivery and in the case of four other fathers, the possibility of something going wrong with the baby was a worry to them.

The last cause of uneasiness relates to the husband's role expectation and his actual enactment of that role. Doubts about how well they would be able to help their wives and if they would remember all that they were taught were expressed by a few fathers. During the later phases of labour, four fathers expressed feelings of helplessness.
uselessness as their repertoire of skills to help their wives had been exhausted.

The results seem to indicate that the majority of fathers felt relaxed and calm in the earlier phases of labour. However, as the labour became more active, the experience became more stressful for the fathers. The results also seem to indicate that many of the items that were included in the fathers' focus during labour were also the cause of his uneasiness.

Uneasiness during labour seemed to stem from two sources: real and imagined. The real sources were those actual behaviors of his wife or baby which triggered his anxiety. Expressions of pain, evidence that he was no longer helpful, and pronouncements of fetal distress were common examples. The possibility that something might go wrong, i.e., the imagined, included the thoughts that the baby might be in difficulty, or not normal; that his wife might not be all right; or that he would not be able to help her. It would seem that labour was stressful for the husband, and that his ability to cope with those stressors was influenced by his role skills and those of others.

**Delivery**

The fathers were asked if there were times that they felt uneasy during the delivery. Nine fathers from the total sample stated that there were times of uneasiness or worry. The results are presented in Table 14.
TABLE 1.4
UNEASINESS EXPERIENCED BY FATHERS DURING DELIVERY

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number of Fathers Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to wife</td>
<td>3</td>
</tr>
<tr>
<td>Related to procedures</td>
<td>4</td>
</tr>
<tr>
<td>Related to baby</td>
<td>4</td>
</tr>
</tbody>
</table>

n= 9 subjects
*Some fathers responded more than once

Three husbands felt uneasy because of the amount of pain that their wives were experiencing during delivery. Four husbands expressed uneasiness on seeing the needles used for the administration of the anaesthetic agents and on seeing the episiotomy and the suturing of same.

Much of the worry about the baby was related to its oxygenation. Comments from the fathers illustrate this: "The baby was purple and he faded to grey," "It seemed that the head was out forever. I wondered if the baby was still getting oxygen from the cord," and "she was purple -- more than I expected -- I wasn't worried really -- actually I was freaking out."

The results for delivery uneasiness would seem to indicate a similarity between the husband's focus during delivery and the causes of his uneasiness. His wife's discomfort continued to affect him, and the procedures
performed on her contributed to his pain and anxiety. Schilder believes that one experiences sensation when one sees the body of others. Assaults to that body are perceived as assaults to one's own body. Therefore, the loss of body integrity through deliberate penetration of the skin or deliberate cutting as in the case of the episiotomy, has the potential for anxiety and pain production in man.

Incongruence between how he perceived that the baby should look and the overt behavior of the baby, namely colour, cry, and respiration, accounted for varying levels of uneasiness. The almost equal emphasis on the integrity of the infant as demonstrated by the father's need to see that the baby was all there, suggest another possible source of anxiety.

In instances when the baby was not breathing as well as he should be, the father's awareness of others' expectations of him kept him fastened to his seat. He watched the activities of others and was very aware of his powerlessness.

Summary of Findings

A summary of the husband-father's perceptions of labour and delivery reveals that:

- the majority of husbands believed that the labour and delivery went better than they had anticipated.
- labour and delivery were seen as positive
experiences by the majority, with delivery viewed more positively than labour.

- the major focus of the husband during labour was on his wife with low focus on the baby and himself.
- uneasiness during labour was common and was attributed to the pain experienced by his wife, his worries about her progress, and his worries about the outcome for his wife and the baby.
- the major focus of the husband during late Stage II was on the baby and his own emotions surrounding the birth.
- observation of the newly-delivered infant focused on his/her health status and completeness; gender of the infant received minimal discussion.
- uneasiness during delivery was attributed to the birth procedures (episiotomy, needles) and the health of the baby, independent of the Apgar rating.
- there was a significant relationship between how the father rated labour and delivery and his past experiences with someone in a lot of pain.
Husband's Perception of Role

In this section, the husband's perception of his role will be discussed. The subsets of this aspect of perception are:

- some aspects of the decision-making process related to his attendance at labour and delivery
- the husband's preparation for his role during labour and delivery
- the husband's role enactment during labour and delivery
- his assessment of his role during labour and delivery.

Decision-Making Process

Decision to Attend or Not Attend

The decision of whether or not husbands would be with their wives during labour and delivery was made at various times. Two husbands stated that they and their wives had taken it for granted that they would be there for the labour and delivery. Four couples had decided prior to pregnancy, five on learning that their wives were pregnant, and eight during the second and third trimesters of pregnancy. One father entered labour undecided regarding whether or not he would stay for either the labour or the delivery.

All fathers, with the exception of one, adhered to the original decision of attendance or non-attendance during delivery. (One husband planned to attend the delivery but was unable to do so because of exhaustion.)
Source of the Idea to Attend

The husbands were asked whose idea it was that they attend labour, and attend or not attend the delivery. The results are summarized in Table 15.

TABLE 15
HUSBAND RESPONSE REGARDING WHO SUGGESTED THAT HE ATTEND LABOUR AND DELIVERY

<table>
<thead>
<tr>
<th>Source of Idea</th>
<th>Attendance during Labour</th>
<th>Attendance during Delivery</th>
<th>Non-Attendance during Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>3</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Wife</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>8</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Uncertain</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

n= 20 subjects

Attendance at labour was primarily the idea of the wife (seven) or the couple (eight) whereas attendance at delivery was primarily the idea of the husband (six) or the wife (eight). One husband explained that his wife wanted him to be there during the birth but had left the decision up to him; "My wife wanted me to be there if I wanted to be there, not because it is in vogue now." The decision of not to attend the delivery was made by one father in the sample. He explained that his wife hoped that he would change his mind during the labour but
he did not. He stated, "The doctor can have the first few seconds with the kid; I've got years with him."

One husband attributed his attendance during labour to a source outside of the family and one husband was uncertain about whose idea it was that he be there during labour and delivery.

At the time of decision-making, thirteen husbands were content with the idea that they would be present during labour and present or absent during the delivery. Seven fathers were uneasy about their attendance at labour and/or delivery. Their uneasiness was decreased considerably after they attended prenatal classes.

The decision to attend labour and attend or be absent during the delivery seemed to be a reflection of the husband's perception of his role. His decision to attend was likely based on two interdependent factors: the commitment he has to the norms established by social forces and his estimation of the reward and punishment by his role partner. If a husband believed that the protection and support of his wife during labour took priority over other norms defined by society for him, he was more likely to attend. A crisis has high priority on a person's time and effort. Some authors have used the term "crisis" to describe the childbirth experience. If the husband saw the benefit of his attendance for himself and/or his wife or was cognizant of the punishment from self and significant others for not meeting
their expectation, it is more likely that he would attend.

The idea that husbands attend labour and delivery was acceptable to many wives and husbands. However, for some husbands, the idea of attendance was not congruent with their perception of their role. With incongruence came uneasiness. This meant that the husbands who felt uneasy had to try and resolve this anxiety. For many, this was accomplished as a result of attendance at prenatal classes.

Sarbin and Allen note that conformity to expectation can occur without a strong commitment on one's part.\(^1^7\) It is likely that some of the husbands in the sample conformed to their wives' wishes without feeling very committed to the idea of attendance at labour. However, as their attitudes changed and their concept of self became congruent with what was expected, involvement and commitment were likely heightened.\(^1^8\)

The results related to the source of the idea that husbands attend labour and delivery differ somewhat from those results obtained by Aldridge.\(^1^9\) In the study sample twenty percent (four) of the couples were responsible for the idea of attendance at delivery whereas in Aldridge's sample forty percent of the couples came up with the idea according to the husbands.

Uneasiness about attendance seemed to be greater in husbands whose wives wanted them to be there during the labour and delivery. When the husband was the source of
the idea, the uneasiness seemed to be less.

Preparation for Role Enactment

All of the sample attended prenatal classes during this or the previous pregnancy. The fathers were asked what they thought of the prenatal classes; their responses are recorded in Table 16.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Number of Husbands Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good to Excellent</td>
<td>16</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
</tr>
<tr>
<td>Fair to Poor</td>
<td>3</td>
</tr>
</tbody>
</table>

n= 20 subjects

Sixteen fathers thought that the classes were good to excellent, one father was neutral, and three rated the classes as fair to poor. Of significance was the fact that seven fathers were uneasy about labour and delivery before they came to the classes. They attributed the classes with decreasing their anxiety and with instilling positive attitudes about the child-birth experience.

The fathers who rated the classes as "fair to poor" and some who rated the classes as "good" had some suggestions for their improvement. Based on their
experiences during labour, four fathers asked that more emphasis be placed on the coping of pain during labour, both from the wife's and husband's point of view. Some found the presentation of classes to be boring and three fathers cited the teaching of incorrect information. A small group of fathers mentioned that some of the material was not relevant to their roles as fathers, as for example, breast feeding and infant clothing.

**Additional Preparation for Labour and Delivery**

Four fathers had additional preparation for the upcoming labour and delivery. Three were present during the labour and delivery of their first child and one had assisted women during labour as part of his occupation. These fathers stated that they entered labour feeling confident about their role with their wives.

It is believed that formal childbirth education prepares a father for an effective performance and therefore "makes his role in childbirth congruent with the strength and competency characteristics of the husband role." To achieve this objective, the fathers learned what acts they were to perform and developed skill by practicing them. Inherent in this education was the awareness of what others expected of them. When these expectations were not congruent with their view of themselves, as in the case of the fathers who did not see aspects of infant care within their role, the expectations of others were probably rejected. Prenatal education would seem to have been effective in producing positive attitudes...
toward childbirth.

Many of the parents in the sample had completed university education and were delving into the literature on pregnancy, childbirth and infant care. This meant that they were able to evaluate the quality of information offered by the instructor.

Role Enactment

Reasons for Attending Labour and Delivery

The reasons given for attending the labour and delivery centered around three areas. These were the need expressed by their wives, secondly, the desire to share the experience as a couple, and thirdly, the desire to experience the labour and delivery of their child. The results are summarized in Table 17. It should be noted that some husbands offered more than one reason for being present.

<table>
<thead>
<tr>
<th>Reason for Attending</th>
<th>Number of Husbands Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife needed or wanted him</td>
<td>15</td>
</tr>
<tr>
<td>To share the experience</td>
<td>6</td>
</tr>
<tr>
<td>To see the labour and the birth</td>
<td>5</td>
</tr>
</tbody>
</table>

*n = 20 subjects
* Some fathers gave more than one response
Fifteen husbands stated that they came because their wives needed them. Comments such as "my wife wanted me there" or I wasn't going to let her go through that alone" were common. Six husbands emphasized the team aspect of their marriage and stressed ideas such as "sharing the responsibility for the birth" and "strengthening the bond between us." Five husbands wished to experience the labour and to see the birth of the baby.

The results would seem to indicate that the reasons for attending the labour and delivery were a reflection of the man's role as husband and father-to-be. The majority saw their role as supporting and protecting their wives while others saw it as a joint or cooperative effort. The observation of the rites of passage, i.e., the transition from father-to-be to father entered for those who expressed the desire to watch the birth and experience the labour.

Role during Labour

Once their wives were in labour, the husbands stated that they performed a multiplicity of functions. These data are in response to the question: "What did you do during the labour?" and are summarized in Table 18. The categories were a result of the content analysis performed on their responses to the question. The categories were moral support and encouragement, bodily care to their wives, assistance with breathing and pushing, and assessment of the contractions.
TABLE 18
HUSBANDS' PERCEIVED ROLE DURING LABOUR

<table>
<thead>
<tr>
<th>Role Function</th>
<th>Number of Husbands Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral support and encouragement</td>
<td>18</td>
</tr>
<tr>
<td>Bodily care</td>
<td>18</td>
</tr>
<tr>
<td>Assistance with breathing and pushing</td>
<td>13</td>
</tr>
<tr>
<td>Assessment of contractions</td>
<td>5</td>
</tr>
</tbody>
</table>

n= 20 subjects
*Some husbands responded more than once

Moral support and encouragement included items such as the presence of the father, holding the wife's hand, and giving verbal reassurance. These were functions cited by eighteen fathers. Many fathers stated that they would not leave their wives, even to get something to eat. Some who did take a break, explained that they felt guilty about leaving their wives when they were in pain. The only reason that they did leave was because the nurses stayed with their wives.

The second category, bodily care, included massaging, effleurage, application of cool cloths and the offering of fluids. Eighteen fathers stated that they performed these functions.

Assistance to their wives by helping them with the breathing levels and pushing techniques taught at
prenatal classes was given by thirteen husbands.

Recording the frequency, duration and effect of the contractions was done by five husbands. Two of the husbands kept a diary of the major events of the labour; they planned to share this with their wives in the days following delivery.

Role during Delivery

Many of the husbands continued to help their wives with the pushing when they were in the delivery room. Others stated that they encouraged their wives and helped them to stay in control when they experienced pain. For the most part, the husbands' role was a less active one as they sat beside their wives and watched the activities performed for the babies' arrival.

The results indicate that the husbands' functions in labour and delivery were directed toward supporting and encouraging their wives. This then indicated congruence between why the husband wanted to come and what he was able to do. This finding concurs with that of Jordan and Cronenwett in two independent studies of couples who attended prenatal classes, labour, and delivery together.²¹,²²

Other functions not usually performed by husbands in their role of husband and man were undertaken. Bodily care, assistance with breathing, and the timing of contractions were functions defined for him in the prenatal classes. Kopp and Schindler observed that husbands who
had attended prenatal classes tended to play a more active role in their wives' care. The results of the study sample would seem to support their observations. The functions performed by first time fathers and those who were fathers for the second time did not seem to differ. The only difference may have been in the latter groups confidence and skill, areas that were not measured in this study.

The role performed by the father in the delivery period was a much less active one. It would seem to be one which allowed him to sit back and let others care for his wife.

The Right to Attend Delivery

Because of the controversy expressed in the literature and in many obstetrical settings about the husbands' right versus privilege to be present at the birth, an attempt was made to learn of the husbands' opinions. The husbands were asked to react to the statement "I believe that it is my right to see my baby born." On a nine-point rating scale, ranging from +4 (strongly agree) to -4 (strongly disagree), the fathers were asked to indicate their choice. The results are presented in Table 19. The results were a mean of +2.4, a median of +4, a range of -3 to +4, and a standard deviation of 2.161.
TABLE 19
FATHERS' RESPONSE TO HIS RIGHT TO ATTEND DELIVERY

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>+2.4</td>
</tr>
<tr>
<td>Median</td>
<td>+4</td>
</tr>
<tr>
<td>Range</td>
<td>-3 44</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>2.161</td>
</tr>
</tbody>
</table>

n= 20 subjects

Some of the fathers who felt moderately strongly and many of those who expressed some disagreement that it was their right to attend the birth explained their choices. The large majority stated that they wanted to be there during the birth but only if their presence did not endanger the health of their wives or the babies. They would abide by the wishes of their wives, the physicians or the nursing staff. Those who indicated strong disagreement stated that it was the right of the physician to allow them into the delivery room and that the father did not have the right to demand entry into the case room.

The results to this question would seem to indicate that there are rights associated with the father role and that the majority saw one of those rights as seeing the birth of their child. The sample majority
seemed to feel that it was their right but would give up the right if their presence in any way affected the comfort of their wives or the medical care provided to their wives and babies. He seemed to know that his presence may not be desired by others and that it might be a detriment.

Birth of a Potentially Unhealthy Newborn and Father Attendance

Many health team members who care for parents in the delivery area have expressed concern about husband attendance during the birth of a sick or malformed baby. The researcher presented the fathers with a hypothetical situation. They were asked what they would choose to do if there was a question about the health of their baby which was detected before delivery. There were three options given to the husband: to stay with his wife during the delivery, not to stay with his wife during delivery, and uncertainty about what he would choose to do.

Nineteen fathers wanted to be with their wives during such a delivery and one father did not. That latter father is the father who did not choose to be with his wife during this past delivery. The fathers' reasons for wanting to attend are summarized in Table 20. Fifteen fathers wanted to be there for their wives' sakes, three fathers for both of their sakes, and two fathers expressed the need to see the baby themselves. All noted that it would be a difficult time for them both
but most thought that it would be more difficult for their wives. Some of the husbands stated that they wanted to see the baby for themselves and if need be to contribute to the decision about whether or not it should be allowed to live. Some fathers stated that they and their wives had already discussed the possibility of infant abnormality and had done so at the prompting of the prenatal class instructors.

TABLE 20
FATHERS' REASONS FOR WANTING TO BE PRESENT DURING THE BIRTH OF AN UNHEALTHY INFANT

<table>
<thead>
<tr>
<th>Reason for Attendance</th>
<th>Number of Fathers Responding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>To comfort wife</td>
<td>15</td>
</tr>
<tr>
<td>For both wife's and husband's sakes</td>
<td>3</td>
</tr>
<tr>
<td>For father's sake</td>
<td>2</td>
</tr>
</tbody>
</table>

n= 19 subjects
*One father gave two reasons

The results tend to indicate that the majority of husbands wanted to be present during the delivery of an infant with a potential health problem. The majority saw it as their duty to be present in order that their wives could be comforted. It would also seem that the concern for infant normalcy and health is shared by both expectant parents and that some are discussing the
possibility of abnormality prior to labour. This could well be a factor that might assist parents if a malformed child is born.

**Husband Assessment of Role during Labour and Delivery**

The husbands were asked to evaluate how helpful they thought they were in assisting their wives during labour and delivery. Table 21 summarizes their responses to the fixed-alternative question providing them with the choices of "a lot", "a little", "no help at all", and "uncertain". Two of the husbands felt that their choice would lie somewhere in between the given alternatives.

**TABLE 21**

**AMOUNT HUSBANDS HELPED WIVES DURING LABOUR AND DELIVERY**

<table>
<thead>
<tr>
<th>Amount of Help to Wife</th>
<th>Number of Husbands Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>15</td>
</tr>
<tr>
<td>A little to a lot</td>
<td>2</td>
</tr>
<tr>
<td>A little</td>
<td>2</td>
</tr>
<tr>
<td>Uncertain</td>
<td>1</td>
</tr>
</tbody>
</table>

n= 20 subjects

Fifteen husbands stated that they helped their wives a lot, two believed that they helped a little to a lot and two stated that they helped their wives a little.
One husband was uncertain regarding how much help he was to his wife. Of interest was the fact that husbands with previous labour and delivery experience (four) replied that they had helped their wives a lot. However, this was not statistically significant.

Help to Their Wives

Most of the husbands were able to identify ways that they were able to help their wives. Comments such as "when each contraction was over, she would keep looking for me" or "I would make her breathe with me and she'd get right back on track" are two examples. The functions performed during labour (Table 18) were deemed, in most cases, to be helpful to their wives. Several husbands expressed confidence in performing them.

It became apparent, because of the way that the husbands answered the question asking them how much help they had been, that many husbands believed that they were of very little assistance during labour. It was only on discussing their role with their wives in the early postpartum period that they learned that they had been more helpful than they had originally thought. It is likely that had the researcher talked to these husbands shortly after delivery that their responses to the question might have been quite different.

Not Helpful to Their Wives

Even though the majority of husbands believed that
they helped their wives a lot during the labour, there were areas and times during the labour that many (fifteen) husbands believed that they were not able to help their wives. These areas related to the intense pain experienced by their wives and to their wives' lack of control in the transition phase of labour. Some husbands stated that they were unsure if they were helpful, especially when they were pushed away by their wives or when their wives reached a non-communicative stage of labour.

Three husbands stated that they were unable to help when they lost control themselves. This loss of control in the husbands was precipitated by the diagnosis of fetal distress and by panic feelings in their wives.

Many fathers were quite open about their own feelings during the "difficult" times of labour. Some expressed feelings of helplessness, uselessness, and intense frustration. One father noted "I'm used to doing things to overcome a problem -- this time there was nothing I felt I could do."

The results would seem to indicate that the aspects of their wives' behavior which were beyond their capabilities were pain experienced by their wives and maintenance of their wives' control during labour. Incongruence resulted when the father came to the labour believing that he could help his wife and then found that his efforts were not always successful. Feelings of frustration and helplessness resulted when he realized that he had exhausted his repertoire but still wanted to
be effective in his role.

It would seem that the early postpartum period is an important time for the husband to review his performance with his wife and vice versa. It seemed that many discovered that they had been effective in their role which should in turn lead to increased feelings of self-esteem.

**Husband Role in the Event of Another Pregnancy**

The husbands were asked if they wished to be with their wives during labour and delivery in the event of another pregnancy. Nineteen would choose to be with them during the next labour and eighteen would want to be present during delivery. One husband was uncertain about whether or not he would be with his wife during the next labour and delivery, but would come if she asked him. The husband who had not planned on attending the delivery this last time, would not choose to be present during the delivery in a future pregnancy.

It would seem that this labour and delivery experience had not altered the husbands’ desire to be with their wives during future labours and be or not be present with them during the next delivery.
Summary of Findings

A summary of the husband-father's perception of his role during labour and delivery reveals that:

- the decision to attend labour and delivery was made by fifty percent of the sample prior to pregnancy or during the first trimester. The remainder had decided by the eighth month of pregnancy.
- attendance at labour was primarily the idea of the wife or the couple whereas attendance at delivery was primarily the idea of the husband or the wife.
- prenatal classes were attributed with creating positive attitudes about labour and delivery and reduced much of the uneasiness of several fathers.
- major reason for attendance at labour and delivery was the support of his wife with less emphasis placed on the team aspect.
- major functions performed in labour were moral support and encouragement, provision of bodily care and assistance with breathing and pushing.
- overall majority would want to be with their wives during the birth of a potentially unhealthy infant.
- majority believed that it was their right to
attend the delivery but would waive the right if
their presence was a deterrent to the safety of
their wives or babies

• overall majority believed that they had done
everything possible for their wives during labour
and delivery

• many husbands had to confirm with their wives
about how much help they had actually been
during the labour and did this in the early
postpartum period

• overall majority wanted to be present for future
labours and deliveries

• majority recommended attendance at prenatal
classes for fathers-to-be

• some husbands recommended that more emphasis be
placed on coping with pain during labour in the
prenatal classes.
Husband's Evaluation of the Care

In the final section of this chapter, the husband's evaluation of the care provided to his wife and himself will be presented. The areas to be discussed are:

- his rating of the overall care during labour and delivery
- his perception of helpful and non-helpful nursing care

Evaluation of Overall Care

Each husband was asked to rate the overall care received by his wife during labour. Table 22, a summary of the fathers' rating of care during labour and delivery, indicates that twelve fathers rated the care during labour as "excellent" and two fathers believed that the care was "good to excellent", the latter category being devised by the fathers. Five fathers rated the care as good and one was uncertain how he would rate the care during labour.

The husbands' perception of care provided during delivery reveals similar results (see Table 22). Twelve fathers rated the care as "excellent", five as "good" and one father stated that the care was poor. Two husbands were not present during the delivery.
TABLE 22
FATHERS' RATING OF CARE DURING LABOUR AND DELIVERY

<table>
<thead>
<tr>
<th>Rating</th>
<th>Number of Fathers* Responding</th>
<th>Rating</th>
<th>Number of Fathers* Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>12</td>
<td>Excellent</td>
<td>12</td>
</tr>
<tr>
<td>Good-excellent*</td>
<td>2</td>
<td>Good</td>
<td>5</td>
</tr>
<tr>
<td>Good</td>
<td>5</td>
<td>Poor</td>
<td>1</td>
</tr>
<tr>
<td>Uncertain</td>
<td>1</td>
<td>Not present</td>
<td>2</td>
</tr>
</tbody>
</table>

n= 20 subjects
*Category devised by the fathers

The need of husbands to be informed of their wives progress during labour and delivery was indicated by two studies.\textsuperscript{24,25} For this reason, husbands were asked: "How well were you kept aware of your wife's progress during labour and delivery?" Table 23 reveals that twelve believed that they were well informed, three indicated that they were informed just enough and three responded that they were not informed enough. Two husbands were uncertain about how well informed they were about their wives' progress. The husbands' specific comments will be incorporated into the next area of this chapter.
TABLE 23
EVALUATION OF HOW WELL HUSBAND WAS KEPT AWARE OF WIFE'S PROGRESS

<table>
<thead>
<tr>
<th>Kept Aware</th>
<th>Number of Husbands Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>12</td>
</tr>
<tr>
<td>Just enough</td>
<td>3</td>
</tr>
<tr>
<td>Not enough</td>
<td>3</td>
</tr>
<tr>
<td>Uncertain</td>
<td>2</td>
</tr>
</tbody>
</table>

n= 20 subjects

Evaluation of the overall care to the husbands' wives by means of a category rating scale revealed that the overwhelming majority of husband-fathers believed the care to be good or excellent. The majority of fathers also indicated that they were adequately or well informed of their wife's progress during labour and delivery.

The researcher has some question about the validity of the ratings provided by some, but not all, fathers. When asked to rate the care or the amount of information given to them, the husbands seemed to be protective of the nursing and medical staff. The husbands made excuses for the nurses stating that they were busy and therefore unable to assist their wives and themselves.

Kerlinger notes a difficulty in category rating scales: namely the errors of leniency. He describes these as the tendency to rate all individuals too high.
The researcher suspects that this may have happened with some of the fathers. In addition, it seemed that asking the fathers to rate the care was interpreted by many as meaning only the physical or technical aspects.

Helpful and Non-Helpful Nursing Care

The data in this section resulted from the answers to three questions posed to the husband-fathers. These were:

- What did the nurses do that was helpful for your wife and for yourself during labour and delivery?
- What did the nurses do that was not helpful to your wife and yourself?
- What ways could the nurses have helped your wife and yourself more?

A content analysis was performed and the data were sorted into two major categories. These were “affective” and “presence of the nurse”. The first category included the responses and attitudes displayed by the nurses and secondly, the nurses’ inclusion of the husband into the labour and delivery experience.

The “presence of the nurse” category included four sub-categories: assessment of the mother and baby during labour with an explanation given to the couple, contact with the nurse for reasons other than assessment, provision of bodily care to the wife by the nurse, and finally, the bringing of needed items to the couple by the nurse.
It should be noted that in reality, the "affective" and "presence of the nurse" category are not mutually exclusive of each other, however, for purposes of sorting the data, they were treated as such. A summary of the findings is presented in Table 24. The results for each of the sub-categories will be presented and then followed by a discussion of that sub-category.

### TABLE 24

**FATHERS' EVALUATION OF HELPFUL AND NON-HELPFUL ASPECTS OF NURSING CARE**

<table>
<thead>
<tr>
<th>Category of Nursing Care</th>
<th>Number of Fathers Responding</th>
<th>Total Number of Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Fathers Responding</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes and responses of nurse</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Inclusion of husband</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Presence of Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and explanation</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Contact with nurse</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Bodily care</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Provision of care items</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

n= 20 subjects

*Some husbands gave more than one response
Affective Category
Attitudes and Responses of the Nurse

Attitudes and responses of the nurse that were perceived as helpful by fifteen husbands were "thoughtful", "kind", "interested", "pleasant", "smiling", and "cheerful". Many husbands stated that these responses and attitudes established a relaxed atmosphere for themselves and their wives at a time that was anxiety producing. Husbands observed that the nurses cared about their wives and one husband stated that he trusted the nurse because of the way that she related to his wife and himself. The one husband who entered labour undecided as to whether or not he would stay, attributed his decision to stay to the manner of the nursing staff: "they made me feel confident that I could handle this."

Four husbands related incidents that they labelled as "dehumanized", "impersonal" or "uninterested". One father noted: "When we came through the door, the nurses looked up and said 'oh no, not another one. Well I guess we don't get to coffee this morning'." Another remarked on the laughing and dancing of the nurses in the corridor outside the labour room where his wife was in active labour: "I can appreciate that you have to laugh in a place like this but when they didn't stop I kept looking at my wife in pain and thought to myself 'my God, what can they find so funny?'". A comment which has relevance was a father's observation: "When the nurses aren't as excited about the
birth of your baby as you are, it has a dampening effect on you. It's not a criticism of them, just an observation."

Sarbin notes that one aspect of role skill is the affective response made by individuals toward another. "Social sensitivity", "empathy", "identification" and "role taking" are terms indicating the ability to put oneself in the place of the other, to understand and be able to sympathize with the other. To convey this empathy, one uses the motoric skills, i.e., the movement of body parts, facial expression, and tone of voice. The expressive actions of the person reveal the involvement of the person while he is performing certain roles and in many roles, the expression of a particular emotion is the most important characteristic of that role. The attributes of empathy seemed to be highly valued by the husband-father during labour and delivery. The number who labelled the nurse's attitude as helpful and important supports this.

Young states that "human beings are so designed that they need to feel that people care about them." It would appear that, just as the woman in labour is sensitive to the responses of others toward her, so was the husband just as sensitive. His cognizance of the nurse's response was made through observation of the interaction between the nurse and his wife and/or between the nurse and himself. Because the childbirth
experience was a very personal event for many of the couples and because the husbands were highly involved with their wives, it seemed that they were very vulnerable to the reactions of others.

Inclusion of the Husband

Inclusion of the father by the nurses seemed to be greatly appreciated. This sub-category was commented upon by sixteen fathers. One father noted that the nurse made him feel that he was important and needed, and another stated: "she would ask me if I would help her do something with my wife -- she made me feel useful." Most of the husbands did not expect the nurses to go out of their way to include them. When the nurses did, however, it brought complimentary responses from the fathers. One husband stated: "the nurse showed me the baby's head when my wife was pushing and I listened to the baby's heartbeat on the amplifier. They were two extra bonuses that I hadn't expected."

Inclusion was also conveyed to the father by certain behaviors of the nurse, as for example, when she brought him coffee or when she "spelled" him off while he had a rest.

Inclusion of the father seemed to acknowledge his worth and importance, not only as the husband of the woman in labour but also, as a person. The nurses' response of providing the husbands with a time to rest and something to drink was akin to a gift. A gift
has been described as "a vehicle of expression which is one element in a communication process, i.e., a message is conveyed to the receiver from the giver through a material object."\(^{31}\) Rubin notes that the giving of food can indicate a relationship in which the receiver is honored, accepted...\(^{32}\) It is likely that the single cup of coffee, as mentioned by almost half of the sample, was interpreted as more than mere "nourishment".

That husbands did not expect such attentions, i.e., specific acts of inclusion, is indicative of their perception of the nurse's role. They expected that the nurse's energy would be directed toward their wives, not toward the two of them as a unit.

Another aspect of inclusion involved the issue of allowing the husbands to stay during pelvic examinations of their wives. Four husbands mentioned that they were allowed to stay and appreciated not having to leave. Of those who were asked to leave, four did not wish to go and one welcomed the opportunity to have a break.

It seemed that difficulties occurred for some of the husbands when they were asked to leave and therefore, separate from their wives. Being asked to leave was perhaps interpreted by those who objected as a negation of their importance or of their acceptance. Another facet enters when one remembers that the couple in labour are two complementary partners or a unit. Most fathers were very aware of the importance of
their presence to their wives and they most likely relied on the visual experience to reassure themselves that their wives were all right. It seemed that there was a period of time that the husband could manage being apart from his wife, but after that period had elapsed his anxiety level increased. Jordan observed similar reactions in the husbands whom she interviewed.33

It is possible that an outside force such as the nurse provided the husband who stated that he did not mind leaving when his wife was being examined with an acceptable reason for taking a rest. As reported earlier in this study, many husbands expressed guilt about spending time away from their wives.

Presence of the Nurse Category

The second category of nursing care included those activities which required varying amounts of interaction between the nurse and the couple. Table 24 indicates the subdivisions of assessment and explanation, contact with the nurse, bodily care and provision of care items.

Assessment and explanation

The assessment and explanation category included the assessment of the mother and baby through use of one or more of the assessment techniques available to the nurse plus explanation to the couple about the results of that assessment. The subcategory was not divided into two separate ones because of the manner in which the husbands
described their evaluation of the care.

Examples of the comments indicating positive feelings about the care were: "the nurse didn't hesitate to tell me anything" or her explanations of what was happening were brief but to the point."

The need for more frequent and/or accurate assessment by the nurses was cited by eleven fathers. One father-to-be commented that he wished the nurses had been watching his wife more carefully: "there was panic at the end -- no one was keeping track of her progress." Another father provided an example of inaccurate assessment: "she was told to push ... then the nurse left ... she had a lot of pain ... it turned out she had a rim left." Several fathers explained similar incidents to this one: "I had to go out and get the nurses a few times... they could have anticipated how quickly she was progressing."

One father whose baby developed fetal distress commented that "they were oblivious to my presence. I kept trying to figure out what they were saying and I'd get bits about what they were talking about." Some fathers stated that the nurses told them that their wives were doing "just fine". The husbands explained that they would have liked a little more information.

The results would seem to indicate that many husbands needed more feedback regarding their wives performance. Sarbin believes that an important function
of the coach, or the nurse in this instance, is to provide feedback. For the father, this feedback was the need to know how well his wife was performing in the labour. The need for information about progress seemed to serve as a milepost or means of orientation for the husband. In prenatal classes he had learned what behaviors to expect with what phases of labour. When the behaviors demonstrated by his wife and the amount of dilatation were congruent he was orientated. However, when he observed a set of behaviors but was lacking the nurses assessment, he was often confused and left without direction.

The response that everything is "fine" told the father how the nurse assessed the situation but did not provide him with enough information about why his wife was reacting as she was. That all was judged to be all right was not always reflected in the father's feelings about the situation. Seeing his wife in pain or being unable to help was not congruent with "fine".

The fathers' acquisition of knowledge at prenatal classes or from previous experiences meant that some fathers were able to evaluate the assessments of the nurse. If the nurse's findings were not congruent with what he was observing in his wife, the nurse's assessment was mentally questioned. Being cognizant of his role, few fathers shared their doubts with the nurse.
Contact with the Nurse

Contact with the nurse, other than for assessment purposes, is the second sub-category. Six husbands stated that they saw the nurse enough, whereas four wished to see her more often. Remarks such as "we saw the nurse just enough" or "they let us do our own thing" were included on the helpful side of nursing care. One father observed:

One nurse was just exceptional. She'd say that she would bring such and such in fifteen or twenty minutes and then she would. You knew that you only had to go for fifteen minutes, not forever, before she'd come back.

As noted, four husbands wished to see the nurse more often and one father stated that he wanted a nurse who was interested in them:

One nurse came in and then she'd leave after one contraction. You could tell that she wasn't very interested. Nurses have a responsibility to be there and to be interested.

There seemed to be a fine balance between seeing the nurse enough which was the case of a small majority and not enough as in the case of the remainder of the fathers. Some couples wanted to "do their own thing" and others desired much less isolationism. For the latter group, it seemed as if the presence of the nurse was comforting and contributed to the father's relaxation. Young writes that care "encompasses the provision of comfort.... This also includes the physical presence and support of one person for another." Some husbands
felt that the onus of total support and care of their wives had been placed on their shoulders. The need to search for the nursing staff in order to obtain pain relief for their wives or to find someone who would come when their wives felt like pushing left some fathers anxious, confused and angry. Their perception of the nurse's role seemed to be that she should be there to help their wives when they felt that they could not longer cope or when they had questions or doubts about her status.

The concept of the father's perception of time is relevant to the need for contact with the nurse. Knowing when and trusting that the nurse would return was significant for the fathers. The nurse who set the short term goals of fifteen to twenty minutes had placed a small but seemingly achievable goal in front of the father. For those fathers who knew when the nurse was going to return, it seemed that their uneasiness during labour was lower in amount. For those fathers who were not provided with an indication of when the nurse would return it was like as one father stated: "waiting until some unknown point in infinity."

Many husbands stated that they knew the nurse was outside and that all they had to do was ask her to come. However, they seemed to feel reluctant to do so because of looking foolish or "knowing that the nurse probably could not do anything anyways." Josselyn adds a dimension to the observation that husbands are
reluctant to seek the assistance of the nurse by explaining that men experience difficulties when they are dependent on someone, especially if that someone is a woman. 36

The researcher perceived that some husbands knew that progress was taking place but that their anxiety focused on another possibility. The possibility that their wives would deliver the baby when they were alone with her was noted by two fathers.

For those husbands who stated that they did not want to see the nurse more often, there may be several reasons for this. Some may have desired less visibility because of their need to maintain an emotional closeness during the labour. That is, an outsider may have been viewed as an intruder. A second reason may be the need to proceed through labour with the minimum amount of outside assistance. For some couples, feelings of accomplishment may be greater if they are able to rely on each other rather than on a professional person.

Sarbin provides a third explanation, i.e., that if enactment or role performance is visible to an outsider for a long time, the role performer may be placed under heavy strain. 37 The husband-father was a learner in labour, especially if this was his first time through the experience, and as a learner his skills and self-confidence may not have been as well developed as he would have liked. Some fathers may, therefore,
have felt self-conscious when performing in front of the expert, i.e., the nurse.

Bodily Care

The third sub-category, bodily care to the woman in labour, included those nursing interventions which modified the patients' behavior. These were suggestions to change a breathing pattern, rubbing the mother's back, or the administration of pain medication.

One husband was particularly impressed by the astuteness of the nurse: "I had been tapping my wife's shoulder to help her with the rhythm in breathing. When I left, the nurse picked up on it without my saying anything." Others pointed out that the nurse had just the right trick to get their wives back in control. One husband questioned the number of times that the nurse was asking his wife to push with each contraction and two others noted problems in getting pain relief for their wives.

Provision of Care Items

The provision of care items accounted for a large number of responses from husbands. Fourteen husbands noted that they were given ice water, ice chips, back rub lotion etc. and that they appreciated this. One father seemed to echo the thoughts of others: "We didn't lack for anything. They brought us whatever we needed."

According to Lysault, the lay public sees comfort
and the relief of pain as one of the major functions of the nurse. The number of husbands who observed "comfort" functions of the nurse seems to support Lysault's findings. The nursing interventions directed at their wives' comfort were well accepted by the husbands. The bringing of items to the couple seemed to convey to the couple that the nurses cared. It was only when their wives' comfort was not achieved that the husbands stated that the care was lacking, as in the instances of husbands trying to get pain relief for their wives. When pain relief is not achieved, frustration and disillusionment occur.

Additional Comments

The number of people caring for the couple during labour has been noted by Jordan as a difficulty in patient care. One husband stated that there were too many people involved in his wife's care and that he found it difficult to settle into his role as coach when new people would arrive. Two fathers noted that it was difficult to "give up" the good nurse at the end of a shift and then have to get used to another personality.

It would seem that the need to adjust to another individual in the nursing role required extra energy for these husbands, energy which they had intended to devote to their wives.
Summary of Findings

A summary of the husband-father's evaluation of the nursing care reveals that:

- the overall care was rated as good or better.
- the majority of fathers were kept well informed of their wife's progress during labour and delivery.
- attitudes and responses of the nurse to the couple were cited as very important.
- the majority of husbands felt that the nurse had included them in the childbirth experience.
- many husbands would prefer to stay with their wives when pelvic examinations are done in labour.
- a major strength of the nursing care was the comfort care provided by the nurse to the wife.
- major weaknesses of care centered on the inadequate presence of the nurse for:
  - assessment and explanation of progress during labour
  - support to the husband and wife during the active phase of labour and early Stage II.
FOOTNOTES


7 Sarbin and Allen, "Role Theory," p. 492-495.

8 Ibid., p. 502.

9 Ibid., p. 545.

10 Ibid., p. 547.


13 Sarbin and Allen, "Role Theory," p. 539

14 Ibid., p. 539


18 Ibid., p. 526.


21 Ibid., 214.


24 Ibid., p. 29.


28 Ibid., p. 515.

29 Ibid., p. 515.


31 Ibid., p. 165.


34 Sarbin and Allen, "Role Theory," p. 548.
37 Sarbin, "Role Theory," p. 533.
39 Ibid., p. 445.
Summary and Major Findings

This study was concerned with the husband-father's perceptions of labour and delivery, how he perceived his role during this period, and his perceptions of the nursing care provided to his wife and himself.

The sample selection was by random sampling and included twenty husbands. All were Caucasian, British or Canadian born, between the ages of twenty-two and forty years of age, and all had attended prenatal classes. Eighteen fathers attended the delivery. Seventeen fathers were fathers for the first time; three were fathers for the second time.

Data were obtained via one interview with the husband during the first three days postpartum. An interview schedule was used and consisted of rating scales, fixed-alternative and open-end questions. The data were subsequently analyzed by single variance analysis, nonparametric (Chi-square) tests, and by content analysis of the open-end questions.
The major findings will be discussed in this chapter. Specific findings are summarized at the end of each of the preceding sections of Chapter IV. Findings related to the husband-father's perception of labour and delivery were:

- the majority believed that labour and delivery went better than expected
- labour and delivery were seen as positive experiences with delivery viewed more positively than labour
- the major focus of the husband during labour was on his wife, with low focus on the baby
- uneasiness during labour was common for husbands; major causes were the pain experience of his wife, worries about her progress and the outcome for herself and the baby
- the major focus of the husband during late Stage II was on the baby and his own emotions
- observation of the newly-delivered infant centered on the health and completeness of the newborn and was independent of the Apgar rating.

Findings related to the husband-father's perception of his role during labour and delivery were:

- the idea for attendance at labour was initiated by the wife or the couple whereas the idea for attendance at delivery was initiated by the wife or husband
major reason for husband-attendance at labour and delivery was support of his wife

major functions performed by husbands during labour were moral support and encouragement, provision of bodily care to wives

overall majority believed that they had helped their wives a lot

majority believed that it was their right to attend the birth but would waive the right if their presence was a detriment

overwhelming majority wished to be present during the delivery of a potentially unhealthy infant

overwhelming majority of husbands wanted to be with their wives during future labours and deliveries

many husbands recommended that more emphasis be placed on coping with labour pain/discomfort in prenatal classes

prenatal classes had a positive effect on the husbands' attitudes toward labour and delivery

Findings arising from the husband-father's evaluation of nursing care during labour and delivery were:

overall care was rated good to excellent

majority of fathers felt well informed of their wives' progress

major strengths of nursing care were the nurses' attitudes and responses, their provision of
bodily care to the wives

majority of husbands felt included in the experience

major weakness of the nursing care centered on
the inadequate presence of the nurse for:

- assessment of the wife's progress
- explanation of progress and related events
- support to husband and wife during the active stage of labour and early Stage II.

Implications and Recommendations for Nursing Practice

The implications for nursing arising from these findings are multiple. They have implications for the role preparation of the father-to-be, the role performance of the husband-father during labour and delivery, and in the postpartum period. Nurses are involved in all of these phases and it is likely that an increased emphasis will be placed on nursing the family as a unit. A preliminary step in the approach to nursing care is cognizance of the feedback offered by husband-fathers.

The recommendations arising from this study for the prenatal education of parents are:

- that instructors be cognizant of the fact that many husbands may feel uneasy or be undecided about their participation in the labour and/or delivery;

- that an assessment of husbands' and wives' expectations for labour and delivery be done
for congruence with reality

- that an increased emphasis be placed on teaching the husband how to evaluate his effectiveness during labour and delivery

- that an increased emphasis be placed on helping the parents cope with the pain/discomfort of labour

- that parents be encouraged to review the labour and delivery together in the postpartum period and that this review include an assessment of the husband’s effectiveness during labour and delivery

The recommendations arising out of this study regarding the husband-father’s role performance during labour and delivery are:

- that nurses, when possible, assess at the beginning of labour how much contact the couple desires with the nursing staff during the labour and that reassessment take place when the nature of the labour changes

- that nurses be cognizant of the fact that their attitudes and responses play a significant role in assisting the husband

- that nurses be aware of the increased need for their presence during the active phases of labour and second stage

- that nurses assist the husband in evaluating his effectiveness in supporting his wife during the labour
that nurses establish short term goals for the husband during labour
that nurses keep the husband informed of his wife's progress
that nurses, whenever possible, provide breaks for the husband during the labour
that nurses allow the couple to decide if the husband should leave during pelvic examinations
that nurses interpret the health status of the newly-delivered baby, independent of the Apgar rating, to the couple
that nurses observe the husband-infant-wife interaction at delivery and that this be communicated to those caring for the couple in the postpartum period.

The recommendations arising from this study for the role enactment of parents in the postpartum period are:
that couples be encouraged to review the labour and delivery together or with a small group of parents and that some emphasis be placed on the assessment of the husband's effectiveness during labour and delivery
that nurses observe the father-mother-child interaction in order to identify fathering and possible non-fathering behaviors
that husbands, along with their wives, be
encouraged to verbalize their concerns or questions about the childbirth experience.

**Recommendations for Further Study**

Because so little is known about the husband-father during the time of labour and delivery and the early postpartum period, the following recommendation for further study are made:

- that replication of this study be done on a larger scale, that it be cross-cultural, and that it include a comparison between husband-fathers in a family-centered maternity setting and one which is more traditional
- that a double-barrelled study of this nature be done on husbands and wives for the assessment of similarities and differences in perceptions of labour and delivery and the nursing care
- that a prospective study be done during labour and delivery on fathers' needs, reactions to nursing interventions, and engrossment in the newborn
- that a study be done to learn of the effects of husband performance during labour and delivery on fathering and on the marital relationship
- that a study be done to learn what effect a review of the labour and delivery has on future fathering.
SELECTED BIBLIOGRAPHY

Books


Periodicals


Unpublished Material

APPENDIX A

CONSENT FORM
CONSENT FORM

I agree to participate in a study of husbands' thoughts of and experiences during labour and delivery. I understand that:

- what I say will be confidential
- there are no risks involved
- only one interview of approximately one hour is necessary
- the discussions with husbands will form the basis of the interviewer's thesis
- the aim of the study is to improve the experience of husbands during the time of labour and delivery.

__________________________
Signature of Participant

__________________________
Signature of Interviewer

__________________________
Date
APPENDIX B

FINAL INTERVIEW SCHEDULE
PART I  GENERAL INFORMATION

Delivery Date and Time

Interview Date and Time

# Hours Post-Delivery

Birthplace

# Years in Canada

Age

# Years Married

Education (Total # Years of Schooling)

PART II  PREVIOUS RELATED EXPERIENCES

Have you ever been in a hospital as a patient or a visitor before coming this time? Yes___ No___

How do you feel about being in a hospital, generally? Please place a cross in the appropriate box.

<table>
<thead>
<tr>
<th>Very Comfortable</th>
<th>Very Uncomfortable</th>
</tr>
</thead>
</table>

Have you ever had previous experiences with someone who was in a lot of pain? Yes___ No___

How well did you cope (or manage) considering that he/she was in pain?

1. Very well
2. Fairly well
3. Not well
4. Uncertain

Your reason for saying that?
### Part III Previous and/or Present Pregnancy, Labour, Delivery and Postpartum

<table>
<thead>
<tr>
<th>Gravida</th>
<th>Abortions</th>
<th>Premature</th>
<th>Parity</th>
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<table>
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<th>Pregnancy #</th>
<th>Date of Delivery and Hospital</th>
<th>Problems during Pregnancy</th>
<th>Problems during Labour and Delivery</th>
<th>Outcome for Mother, Baby</th>
</tr>
</thead>
</table>

#### Details of Present Labour and Delivery

- **Official Length**

- Significant events during labour, delivery occurring to mother, infant?

- **Forceps** Yes__ No__

- Medications, anaesthetics administered during labour and delivery?

- **Infant weight** _____ **Sex** _____ **Apgar 1** _____ **5** _____

(From Records)
Did you attend prenatal classes for this or previous labours? Yes____ No____

if yes,

What did you think of the classes?

Did you stay with your wife during a previous labour? Yes____ No____

...delivery? Yes____ No____

Had you planned on staying with your wife during this labour? Yes____ No____

...delivery? Yes____ No____

When did you decide to be with your wife during this labour?

When did you decide to be (not be) with your wife during this delivery?

Whose idea was it that you be present for the labour?

<table>
<thead>
<tr>
<th></th>
<th>Labour</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Who?)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Were you happy with these decisions at the time? Yes____ No____

Why did you want (or agree) to come to the labour? delivery?
PART IV  PRESENT LABOUR AND DELIVERY

Did you or your wife make a deliberate choice to come to St. Paul's Hospital?  Yes__ No__

How many hours were you present during labour?

What did you do when your wife was in labour?

How well did this labour go for you?
1. better than you expected
2. same as you expected
3. worse than you expected
4. uncertain what to expect

if 1-3 What was better/same/worse?

Please rate what kind of an experience this labour was for your. Please place a cross in the appropriate box.

Excellent Experience [ ] [ ] [ ] [ ] Very Bad Experience

Would you describe what happened during the labour?

When did you feel relaxed or calm during this labour?

When did you feel uneasy or worried during this labour?
How much pain do you think your wife experienced during the labour?

1. an extreme amount
2. a lot
3. a little
4. none
5. uncertain

During labour, how much did you think about the baby?

All the Time

Never

about yourself?

All the Time

Never

about your wife?

All the Time

Never

For those at the + end for baby and self, what were your thoughts?

How would you rate the care that your wife received during labour?

1. excellent
2. good
3. fair
4. poor

What was (his choice) about it?

Were you present for the baby's birth? Yes__No__

How well did this delivery go for you?

1. better than you expected
2. same as you expected
3. worse than you expected
4. uncertain what to expect

What was better/same/worse?
Please rate what kind of an experience this delivery was for you.

Excellent Experience

Very Bad Experience

Would you describe what happened during the delivery?

What were your thoughts when you saw the baby?

How much were you able to help your wife during this labour and delivery?

1. helped her a lot
2. helped her a little
3. was no help to her
4. uncertain

What ways do you think that you were helpful?

Were there any ways that you were not able to help her?

Yes No

if yes, What were they?

How would you rate the care that your wife received during delivery?

1. excellent
2. good
3. fair
4. poor

What was (his choice) about it?
How well were you kept aware of your wife's progress during labour and delivery?

1. very well  
2. just enough  
3. not enough  
4. uncertain  

if not enough, what was lacking?

You mentioned that the nurses were helpful, (name ways that he noted) What other ways did the nurse help your wife during labour and delivery?

What ways could they have helped her more?

What ways did the nurses help you during labour and delivery?

What ways could they have helped you more?

If your wife were to become pregnant again, would you want to go through labour with her? Yes__ No__ delivery?

Yes__ No__

What are your feelings about the following statement?

"I believe that it is my right to see my baby born."

Strongly Agree  __________ Strongly Disagree

Comments?

If there were a question about the health of your baby which was detected before delivery, would you choose:

1. to be with your wife during delivery  
2. not to be with your wife during delivery  
3. uncertain what you would choose

Comments on choice?
APPENDIX C

PRETEST INTERVIEW SCHEDULE
PART I  GENERAL INFORMATION

Delivery Date and Time
Interview Date and Time
# Hours Post-Delivery

Birthplace
# Years in Canada
Age
# Years Married
Education
  Highest grade attained in school
  or
  # years post-secondary schooling

PART II  PREVIOUS RELATED EXPERIENCES

Have you ever been in a hospital before? Yes____ No____

How do you feel about being in a hospital?
1. don't mind
2. neutral feelings
3. dislike it
4. uncertain

Have you ever had previous experiences with someone who was in a lot of pain? Yes____ No____

How well did you cope (or manage) considering that he or she was in pain?
1. Very well
2. Fairly well
3. Not well
4. Uncertain

Your reason for saying that (1-3)?
### PART III  WIFE'S PREVIOUS AND/OR PRESENT PREGNANCY, LABOUR, DELIVERY AND POSTPARTUM

Para _____ Gravida ______

<table>
<thead>
<tr>
<th>Pregnancy #</th>
<th>Date of Delivery and Hospital</th>
<th>Problems during Pregnancy</th>
<th>Problems during Labour and Delivery</th>
<th>Outcome of Pregnancy for Mother, Baby</th>
</tr>
</thead>
</table>

### Details of Present Labour and Delivery

**Length**

Significant events during labour, delivery occurring to mother, infant?

Medications, anaesthetics administered during labour and delivery?

(From Records)
Did you attend prenatal classes for this
or previous labours? Yes  No

if yes,

How often did you attend?

1. at least \( \frac{1}{4} \) or more of the classes
2. less than \( \frac{1}{4} \) of the classes

Did you stay with your wife during a
previous labour? Yes  No

... delivery?

Had you planned on staying with your
wife during this labour?

... delivery? Yes  No

When did you decide to be with your
wife during this labour?

When did you decide to be/not to be
with your wife during this delivery?

Whose idea was it that you be present for
the labour?

Whose idea was it that you be present for
the delivery? (or not be if appropriate)

<table>
<thead>
<tr>
<th>Husband</th>
<th>Labour</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Who?)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Were you happy with these decisions at
the time? Yes  No

Why did you want (or agree) to come to
the labour?
PART IV  PRESENT LABOUR AND DELIVERY

Did you or your wife make a deliberate choice to come to St. Paul's Hospital? Yes___ No___

How many hours were you present during labour? __________________

What did you do when your wife was in labour? __________________

How well did the labour go for you?  
1. better than you expected  
2. same as you expected  
3. worse than you expected  
4. uncertain what to expect __________________

if 1-3

Can you remember what you thought the labour would be like? __________________

Please rate what kind of an experience this labour was for you. Place a cross in the appropriate box.  

Excellent Experience __________________ Very Bad Experience __________________

What stands out in your mind about the labour? __________________

When did you feel relaxed or calm during this labour? __________________

When did you feel uneasy during this labour? __________________

How much were you able to help your wife during this labour?  
1. helped her a lot  
2. helped her a little  
3. was no help to her  
4. uncertain __________________
What ways do you think that you were helpful?

What ways were you not able to help her?

Were there ways that you wanted to help her more, or less, during the labour? Yes___ No___

if yes, What ways?

How much pain do you think your wife experienced during the labour?

1. an extreme amount
2. a lot
3. a little
4. none
5. uncertain

During labour, how much did you think about the baby?

All the time Never

about yourself?

All the time Never

about your wife?

All the time Never

(For those at the + end, what were your thoughts?)

How would you rate the care that your wife received during labour?

1. excellent
2. good
3. fair
4. poor
How well were you kept aware of your wife's progress during labour?

1. more than enough
2. just enough
3. not enough
4. uncertain

if not enough, what was lacking?

What ways did the nurses help your wife during labour?

What ways could they have helped her more?

What ways did the nurses help you during labour?

What ways could they have helped you more?

Were you present for the baby's birth? Yes___ No___

Why did you attend the delivery?

How well did this delivery go for you?

1. better than you expected
2. same as you expected
3. worse than you expected
4. uncertain what to expect

if 1-3,

Can you remember what you thought it would be like?

Please rate what kind of an experience this delivery was for you.

Excellent Experience [ ] [ ] [ ] [ ] [ ] [ ] [ ] Very Bad Experience
What stands out in your mind about the delivery?

What were your thoughts when you saw the baby?

How well were you kept aware of your wife's progress during delivery?
1. more than enough
2. just enough
3. not enough
4. uncertain

How would you rate the care that your wife received during delivery?
1. excellent
2. good
3. fair
4. poor

What ways did the nurses help your wife during delivery?

What ways could they have helped her more?

What ways did the nurses help you during delivery?

What ways could they have helped your more?

If your wife were to become pregnant again, would you want to go through labour with her? ...through delivery?  Yes___ No___

If no, why not?
What are your feelings about the following statement?

"It is the right of every father to see his baby born."

Please place a cross in the appropriate box.

Strongly Agree | Strongly Disagree

If there were a question about the health of your baby which was detected before delivery, would you choose:

1. to be with your wife during the delivery
2. not to be with your wife during delivery
3. uncertain what you would choose.