THE EXPERIENCE OF MEN WHOSE PARTNERS ARE HOSPITALIZED FOR HIGH-RISK PREGNANCIES: A PHENOMENOLOGICAL STUDY

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The Experience of Men Whose Partners are Hospitalized for High-Risk Pregnancies: A Phenomenological Study

by

Alice Noftall, B.N.,R.N.

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Dedication

This thesis is dedicated to my parents Garland and Sophie Clarke. My father, who did not live to see the completion of my graduate studies, instilled in each of his children the desire to succeed no matter how difficult the task. My mother taught each of her children the value of education throughout their lives.

Abstract

From the moment of conception, up to the birth of the newborn, pregnancy is considered a time of difficult adjustment for expectant couples. While there is an abundance of literature on the experiences of expectant mothers during normal pregnancies, there is comparatively less known about expectant fathers' experiences during this time. Not surprisingly, there is considerably less known about the experiences of expectant fathers during high-risk pregnancies. This phenomenological study used van Manen's human science method to explore the question: What is the lived experience of men whose partners have been hospitalized for high-risk pregnancies? A high-risk pregnancy was defined as one that threatens the health of the mother and/or fetus. Unstructured interviews were conducted on nine expectant fathers in isolation of their partners who were at thirty-two weeks gestation. The analysis of the data led to the identification of four themes: (1) too early: protracted readiness; (2) dealing with uncertainty; (3) coming to terms with the unexpected; and (4) striving for a steady state. The essence of the experience was **keeping the connection**. The findings indicate that expectant fathers, whose partners are admitted to hospital for high-risk pregnancies, desired to be near their partners at this time and that this nearness supplements their own need to feel attached to the fetus.

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CHAPTER 1

Introduction

Pregnancy can be a time of psychological and physiological turmoil that often requires adaptive responses, not only by the expectant mother, but by the expectant father as well. Throughout pregnancy, there are a number of developmental tasks facing expectant parents. Some of the major developmental tasks of pregnancy are those that are concerned with the acceptance of the pregnancy, the attachment to the fetus and realistic perception of the fetus as a person, and the subsequent attachment to the newborn (Kemp & Page, 1986; Mercer, 1990; Rubin, 1984). While achieving these developmental tasks can be challenging for some parents during normal pregnancies, the challenge is much greater for parents with high-risk pregnancies. Pregnancy is considered high risk when there is evidence to suggest that a threat exists to the mother's and/or fetus' health (Kemp & Page, 1986).

It has been estimated that ten to twenty percent of all pregnancies fall in the high-risk category (Kemp & Page, 1986; Mercer, 1990; Penticuff, 1982). In Canada for the year 1994 - 1995, there were 113,680 recorded hospital admissions for complications of pregnancy (Statistics Canada, 1999). In Newfoundland and Labrador for this same period there were 5,872 recorded hospital admissions for complications of pregnancy (Newfoundland and

Labrador Centre for Health Information, 2000). It is not clear whether these statistics reflect the total number of single admissions or the repeated admissions; thus the representative figures could be falsely high. Regardless, the continued presence of high-risk pregnancies into the twenty-first century requires that research efforts be directed toward the challenges facing expectant mothers and expectant fathers.

Expectant mothers and expectant fathers have natural concerns for their unborn children. These concerns can become stronger as pregnancy progresses and delivery is imminent (Glazer, 1989; Mercer, 1990). The threat of endangerment to the fetus becomes more real with time. With high-risk pregnancies, physiologic and/or psychologic factors pose a threat to the mother-infant unit (Kemp & Page, 1986; Mercer, 1990). Parents' fears are heightened and attachment to the fetus is often impeded by feelings of uncertainty surrounding the outcome (Galloway, 1976; Kemp & Page, 1986; Mercer, 1990; Penticuff, 1982; Stainton, 1994; White & Ritchie, 1984). Hospitalization of the expectant mother delays or impedes the achievement of the major developmental tasks of the childbearing family by adding further stress to family members (Bedford & Johnson, 1988; Brown, Rustia, & Schappert, 1991; Galloway, 1976; Mercer, Ferketich, DeJoseph, May, & Sollid, 1988; Merkatz, 1978; Penticuff, 1982; Williams, 1986). It is possible that expectant fathers suffer as well.

When a pregnant woman is hospitalized for a high-risk pregnancy a great deal of the attention, if not all, is focused on the mother and fetus. This is crucial to prevent maternal and fetal mortality. However, the expectant father is often left on the periphery to deal with his own developmental tasks and his anxieties about his partner and the uncertain outcome of the pregnancy. In addition, the expectant father takes on the household responsibilities (Kemp & Page, 1986; May, 1994; McCain & Deatrick, 1994). There is limited research, however, on how expectant fathers deal with the events surrounding high-risk pregnancies. This study explored the experiences of expectant fathers whose partners were hospitalized at thirty-two weeks gestation for high-risk pregnancies.

Background to the Study

Western society's attitude toward childbearing families has been shifting from one where the expectant woman is the sole focus, to one where the expectant father is acknowledged as a real and important part of a woman's pregnancy. It is therefore common practice to refer to the "pregnant family" or "pregnant couple". Around the 1980's, family-centered care with childbirth education became popular among newly empowered expectant mothers and fathers. Prenatal classes were open to both expectant parents. It was at this time that scientists recognized the influence of human emotion on childbirth, and the potential role of the expectant father as the source of emotional support (Simkin, 1996). While most support and education programs do include both the

mother and the father, the principal focus continues to be on the needs of the expectant mother (Diemer, 1997).

During pregnancy, there is interdependency in the need for support between the pregnant woman and her partner. The expectant father is the initial and main source of support for the pregnant woman (Harrison & Hicks, 1983; McHaffie, 1989; Norbeck & Anderson, 1989) and the pregnant woman is the primary source of support for the expectant father (Cronenwett, 1985a & 1985b; Mercer & Ferketich, 1988; Mercer et al., 1988). However, a woman with a high-risk pregnancy is concerned with the changes occurring in her body and her life at this time, and may be unable to give support to the expectant father (Mercer, 1990).

The available support network of the family has changed dramatically over time. The mobility of people in society has created great distances between families and relatives who could otherwise be available to provide support in stressful times. Thus, some fathers whose partners have been hospitalized for high-risk pregnancies, do not always have a readily available support network to call upon for assistance (Cronenwett, 1985a; May, 1994).

There is relatively little research dedicated to exploring experiences of expectant fathers (May, 1982a & 1982b; Valentine, 1982). The man's experience during pregnancy has been a neglected area of research (Antle, 1975; Marquart, 1976; May 1978; Parke, 1996). The responses to and

experiences of expectant fathers to the sudden hospitalization of their partners due to high-risk complications has not been a prolific area of research (McCain & Deatrick, 1994). Consequently, the dearth of available literature does not promote an understanding of the experiences of expectant fathers when their partners have been hospitalized for high-risk pregnancies.

Most of the research involving fathers has looked at the father as a source of support for the mother (Brown, 1986; Chapman, 1991; Donovan, 1995; McHaffie, 1989; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980) and the influence of this support on the outcome of the pregnancy (Bedford & Johnson, 1988; Bryce, Stanley & Enkin, 1988; Nuckolls, Cassell, & Kaplan, 1972; Oakley, Rajan, & Grant, 1990). While these studies show the father as a source of support for the mother, very few studies have been located which looked at the support needs of fathers during high-risk pregnancies. Thus, there has been little reported research capturing the father's lived experience of a high-risk pregnancy.

Rationale

It has already been shown that there has been very little research that examines the experience of expectant fathers whose partners have been hospitalized for high-risk pregnancies. Therefore, there is little scientific evidence to guide nursing practice when nurses are caring for expectant couples with high-risk pregnancies. It is hoped that the data generated from this study

will add to the developing knowledge of what expectant fathers experience during this time and will help health care professionals in their interactions with these individuals.

Purpose

In the last two decades the emphasis for childbearing families has been from a family-centered perspective. Thus, when there is a disruption in the normal process of pregnancy which would endanger the life of the expectant mother, fetus or both, this becomes a time of heightened stress. Up to now nursing care has focused mainly on the well- being of the mother and the baby, and the expectant father has been pushed to the margin. Very little is known about the meaning of this unanticipated and stressful event for the expectant father. The purpose of this study is to explore the lived experiences of expectant fathers when their partners have been hospitalized for high-risk pregnancies. This information will provide nurses and other health care providers with a deeper understanding of the lived experiences of men when their partners had been hospitalized for high-risk pregnancies.

Research Question

This study was designed to address the following research question: What is the lived experience of men whose partners have been hospitalized for high-risk pregnancies?

Organization of the Thesis

Chapter one of this thesis has been an overall introduction to the study. In chapter two the reader will be introduced to a review of the literature which identifies gaps in the literature and provides the reader with insight into the available research in the area of expectant fathers and high-risk pregnancy. Chapter three will focus on the methods used to answer the research question and the justification for the selection of the research method. In chapter four the findings will be presented along with the essence of the study. Chapter five will be devoted to a discussion of the findings in relation to the existing literature. The final chapter will deal with the implications of the findings for nursing practice, nursing education, and nursing research.

CHAPTER 2

Literature Review

There is a paucity of research exploring the experiences of expectant fathers when their partners have been hospitalized for high-risk pregnancies. Related studies will be discussed since they provide insight into the experience of pregnancy for expectant fathers. This literature review is divided into three sections. The first section focuses on expectant fathers and high-risk pregnancy. The second section discusses the attachment to pregnancy by expectant fathers, and the final section deals with social support and expectant fathers.

Expectant Fathers and High-Risk Pregnancy

As pregnancy advances, some expectant couples may become attached to a new growing human life. This life represents a product of their relationship and takes on a very special meaning. Throughout the pregnancy, the couple reaches out to family and friends to support them as they wait for the arrival of a new family member. This is the course of events associated with a normal, full-term pregnancy. When a pregnancy is interrupted, the attachment process and social support needs are also frequently altered. This section of the literature review discusses the impact of high-risk pregnancies on expectant fathers.

In some cases the threat posed by a high-risk pregnancy is serious and can result in a compromise of the health of the mother, the fetus, or both, with a devastating effect on the father and immediate family. Depending on the degree of risk to mother and infant, hospitalization may or may not be required. It is postulated that expectant fathers are more stressed and experience greater uncertainty about the pregnancy outcome during prolonged periods of hospitalization. Several studies were identified from the literature review that focused on expectant fathers during high-risk pregnancies (Maloni & Ponder, 1997; May, 1994 ; McCain & Deatrick, 1994; Miron & Chapman, 1994; Ross, 1993). The findings from these studies are specific to the individuals who took part in the studies. Nevertheless, these findings showed that expectant fathers were profoundly affected, emotionally and physically, by their partners' high-risk pregnancies. Therefore, health care professionals should be aware of these profound effects on expectant fathers and should develop strategies to relieve these symptoms.

Ross (1993), using a grounded theory approach, interviewed nine expectant fathers to determine the experiences of expectant fathers during high-risk pregnancies. Four of the expectant fathers were experiencing their first pregnancy. The expectant fathers described two main roles that they assumed when their partners' experienced high-risk pregnancies and were subsequently admitted to hospital. The primary theme that emerged was the process of

finding a balance between providing emotional care to their partners and sustaining the family's responsibilities. Availability of support, the high-risk condition and the distance from the hospital, influenced the expectant fathers' abilities to balance multiple roles. The coping strategies used by expectant fathers included maintaining a positive attitude, taking one day at a time, having faith in a higher being, and seeking knowledge. The data suggest that expectant fathers were profoundly affected, emotionally and physically, by high-risk pregnancies and subsequent hospitalization of their partners. Expectant fathers expressed fear/anxiety about the well-being of their partners and unborn babies, the possible impact of the high-risk pregnancy experience on their relationships, and their performances as supportive partners. On a physical level, expectant fathers reported alterations in their diets, physical/leisure activities and sleep habits. Similar findings on the difficulties experienced by expectant fathers while trying to balance emotional and physical demands are reported by May (1994), and McCain and Deatrick (1994).

May (1994), in her qualitative study, interviewed thirty expectant fathers whose partners were diagnosed with preterm labor during pregnancy but were not hospitalized. The aim of this study was to describe the impact of the restricted activities of the partners on the expectant fathers. Fifteen of the participants were expecting their first children. The findings revealed that expectant fathers were consumed by shock and worry over the severity of their

partners' conditions, and were concerned that they would not be available if their partners needed them. The expectant fathers also reported experiencing feelings of isolation. In some cases, the isolation was outside their control because there was simply no one to talk to. In other cases, the isolation was voluntary because they did not feel that it was appropriate, or even helpful, to talk to co-workers, friends, or family members about their fears and concerns. Besides the worries/concerns and feelings of isolation, the expectant fathers were generally overwhelmed with having to manage household responsibilities while continuing to work outside the home. Despite these feelings of being extremely busy and in constant demand, the expectant fathers chose to hide their feelings to avoid upsetting their partners. What was particularly challenging for the expectant fathers in this study was maintaining a close emotional bond with their partners while suppressing their own feelings and concerns, as well as balancing the competing priorities of work and home. This study focused on the responses of expectant fathers to their partners' restricted activities. However, the study gives limited insight into the expectant fathers' thoughts and feelings about high-risk pregnancies.

A naturalistic study conducted by McCain and Deatrick (1994) explored the perceptions of twenty-one parents who had experienced high-risk pregnancies and the birth of preterm babies. The results indicated that the basic problem for both expectant mothers and fathers was the emotional

response to a high-risk pregnancy. Three transitional stages emerged during the analysis: (a) vulnerability, (b) heightened anxiety, and (c) inevitability. Vulnerability was reflected in the uncertainty that surrounded the high-risk pregnancy, and the strategies (i.e., seeking medical care and searching for causes) implemented to deal with it. Heightened anxiety was related to continued problems in the pregnancy and treatments, as well as concerns for other children at home. The strategies used to deal with anxiety included compliance with treatment and accepting support. The inevitability stage revolved around accepting the imminence of the delivery. During this stage, the expectant parents engaged in such strategies as "taking-in" information and "taking-in" the newborn. Study findings suggest that a high-risk pregnancy is a time of high stress for expectant parents. It is also apparent that as parents experience high-risk events, there exists a great need to re-organize emotional and physical reserves in order to keep pace with changing circumstances. A feature of this study that may have influenced the responses of expectant fathers was the fact that the expected pregnancy had resulted in a preterm birth. When the outcome has been established, it is difficult to arouse the same feelings that were felt at the time the event was occurring.

Miron and Chapman (1994) used a grounded theory approach to study the experience of eight expectant fathers whose partners experienced miscarriages at four to sixteen weeks gestation. The central theme identified

from the data was "supporting" which was defined as a responsibility the expectant fathers felt towards their partners. The expectant fathers seemed to move through four successive phases: (1) recognizing signs; (2) confirming the news; (3) working through it; and (4) getting on with life. During the initial phase of recognizing the signs, the expectant fathers acknowledged that there was a possibility that something was not right with the pregnancies. However, they harbored their own worries to avoid alarming their partners. That is, they denied the significance of the signs in favor of supporting and comforting their partners. During the second phase, there was confirmation that the partner was experiencing a miscarriage. The partners' physical and emotional recovery became the focus as the expectant fathers searched for ways to support and console their partners. Following the termination of the pregnancy, the expectant fathers attempted to work through their feelings about the miscarriage, while concealing their feelings from their partners. Even as they moved on with everyday living, they continued to worry about future pregnancies. Similar to the study conducted by McCain and Deatrick (1994), the expectant fathers were expressing their responses to an event after the outcome of the pregancy was known. A limitation of this study was that it used a retrospective approach. A disadvantage of using a retrospective approach is that individuals tend to have memory distortion because of changes in the meaning and significance of particular events over time.

Wagner, Higgins, and Wallerstedt (1997) explored experiences of perinatal death for eleven fathers. Two fathers experienced a perinatal death in the first trimester, one in the second, and the remaining four in the third trimester. The findings indicated that the fathers who had experienced a perinatal death in the second trimester displayed as much grief as those who had experienced a stillbirth. Fathers who experienced a perinatal death in the first trimester did not experience as severe a grief reaction as those in the second and third trimesters. The researchers concluded that the severity of grief shown by fathers was a function of the level of attachment formed with the fetus. In the second and third trimesters, the fathers would have felt fetal movements and may have seen the outline of the baby on an ultrasound. Similar to the findings reported by McCain and Deatrick (1994) and Miron and Chapman (1994), the participants in this study spoke about an experience after there was an established outcome. While this study was able to show that there was a likelihood of attachment of the expectant father to the fetus in the first, second, and third trimesters, the research did not report the feelings of the expectant father as his loss was occurring.

A descriptive retrospective study by Maloni and Ponder (1997) described the worries, concerns, stresses, and problems that expectant fathers experienced and the type of support they received when their partners were placed on antepartum bedrest. Fifty-nine men whose partners were recently

prescribed antepartum bedrest were administered the Paternal Bedrest Questionnaire. The researchers did not indicate whether the participants were first-time expectant fathers. The findings revealed that the greatest concerns for the expectant fathers were related to the safety of their unborn babies and their partners, and the management of work and home-related duties. Expectant fathers reported talking with a variety of people about their concerns, but mainly family and friends. Some of the expectant fathers stressed the importance of finding and accepting support from all available sources, as well as adopting a positive attitude toward the situation. Significantly, about twenty percent talked with their partners about their concerns. These findings suggest that men tend to conceal their concerns in order to reduce the worries of their partners. This concealment could be misinterpreted as an ability to cope unless health care professionals take time to talk to expectant fathers about their concerns. Only then would health care professionals have some insight into the concerns that expectant fathers have regarding their partners and unborn babies.

Murphy (1998), using a phenomenological approach, described the experiences of early miscarriage from the perspective of five expectant fathers whose partners had experienced at least one early miscarriage. As with the Miron and Chapman (1994) and Wagner et al. (1997) studies, the Murphy study was selected because it dealt with expectant fathers at a time when there was a sudden interruption in their partners' pregnancies. Seven themes relating to

men's experiences of early miscarriage were identified: (a) early feelings of shock and disbelief, followed by later feelings of anger and confusion; (b) loss of future hopes and expectations; (c) characteristics and differences between men and women, with societal and biological influence favoring women as being more affected by the miscarriage; (d) staff action and attitudes, both positive and negative, following and during the distress associated with admission and diagnostic procedures; (e) questions of what to do and issues related to coping most often centered around comforting partners while denying the miscarriage and continuing on with everyday activities; and, (f) time represented a healing for some fathers while for others it resurrected feelings experienced with a previous miscarriage. These men felt that it was necessary to keep their feelings suppressed in order to support their partners, and that their partners' reactions to the loss were far more intense than the expectant fathers' grief. It is evident that expectant fathers were able to suppress their own feelings during this period of intense stress. It is difficult to know how these suppressed feelings will manifest themselves at a later time. A limitation of this study was that it did not differentiate between first-time expectant fathers and experienced expectant fathers. It is possible that there is a difference in the experiences.

Collectively, these studies on high-risk pregnancy suggest that expectant fathers experience heightened emotional responses when a high-risk pregnancy results in activity restrictions being placed on their partners while at home or

during hospitalization. However, more studies need to be conducted at the time the expectant father is experiencing the hospitalization of his partner for a high-risk pregnancy. Study findings also indicated that expectant fathers tend to suppress their feelings in order to remain supportive towards their partners during high-risk pregnancies or miscarriages. As they struggled to deal with worries and concerns for their partners, they were also overwhelmed with balancing the responsibilities of home and work.

Attachment to Pregnancy by Expectant Fathers

Although this section on attachment focuses mainly on full-term pregnancies, the studies discussed here may have relevance to high-risk pregnancies. Attachment of the expectant parents to the fetus is considered to be one of the major developmental tasks during pregnancy. The establishment of a relationship between a father and a newborn has always been present, but its existence has only been acknowledged in more recent years. The relationship, while it may be identified under a variety of names, is most commonly referred to as "attachment". Attachment is defined as an affectional tie that one person forms to another specific person, binding them together in space and enduring over time (Ainsworth, Blehar, Waters & Wall, 1978). Attachment is viewed as a process during which a commitment is formed; the commitment is affectional and emotional in nature and is advanced when there is positive feedback between partners during satisfying experiences (Mercer,

1990). The attachment process occurs in a linear fashion, beginning during early pregnancy and intensifying in the early postpartum period. When high-risk complications occur during pregnancies, it is reasonable to assume that expectant fathers will feel emotionally vulnerable to the impending loss of their babies, and moving from a peripheral to a central role would pose much greater challenges.

May (1982b) conducted a qualitative study interviewing one hundred first-time expectant fathers to determine their experiences of expectant fatherhood. The findings revealed a characteristic pattern of emotional development experienced by the fathers during the pregnancies. This pattern consisted of three phases: the first phase - the announcement of the pregnancy; the second phase - the moratorium phase; and the third phase – the focusing phase. In the announcement phase, the expectant fathers internalized the reality of becoming a father. While there is no definite mention of the word "attachment", it can be inferred that, as the months pass, expectant fathers begin to become emotionally attached to their babies. It is plausible that expectant fathers move from feeling like an outsider early in the pregnancies to feeling more valued and involved towards the end of the pregnancies. In the moratorium phase, the scene is set for a deeper and growing realization of the prospects of fatherhood as a pending new role. As the mother's body undergoes changes, the expectant father is peripheral to the pregnancy, that is, although the expectant father is aware of the

pregnancy, it has not impacted him, or disrupted his routine. In the focusing phase, there is resurgence. As the pregnancy nears term the expectant father is able to construct more tangible images of family life with baby and mother. This study presents the transition to fatherhood as an evolutionary process taking the entire nine months to unfold. The implication of this study's findings is that when expectant mothers are admitted to hospital for high-risk pregnancies, it is likely to have a heightened emotional effect on expectant fathers who have already become attached to the fetuses. It is realistic to anticipate that the movement from a peripheral to a central role would be even more challenging for expectant fathers.

In a grounded theory study, Jordan (1990) looked at the experiences surrounding the transition to fatherhood by fifty-six first time expectant fathers. The findings indicated that expectant fathers strive to incorporate their newly anticipated paternal role into the existing self by grappling with reality of the pregnancy and child, struggling for recognition as a parent from others, and, plugging away at the role-making of involved fatherhood. In "grappling with reality", the expectant fathers were unable to fully grasp how the pregnancies would alter their lives and their roles. The pregnancy is confirmed but the baby is in utero and, therefore, cannot be seen or felt by the expectant father as real. In the "struggling for recognition" phase, the expectant fathers felt as though they were on the periphery of the pregnancies with the marginal role of

breadwinners and helpmates. These feelings were reinforced by others involved in the health care of their partners who viewed expectant fathers as support persons, not as prospective parents. The mother was the significant link in moving the expectant father beyond this dormant role to a more active role of involvement and sharing. The third of these roles, "plugging away at the role making of involved fatherhood", was an ongoing effort by expectant fathers to develop and take on their new paternal role. While it begins with conception, it was more concentrated as the pregnancy progresses and nears term. The long-term goal for these expectant fathers was to mold themselves toward becoming involved fathers. As the baby grew, the signs of another human life became significantly more real. This was further enhanced when expectant fathers see the forms of the fetuses on ultrasounds, hear the fetal heart beats, and feel the fetuses move. Once the expectant father sees himself as part of the pregnancy, a shift occurs from a "theoretical pregnancy" where one is on the outside, to a "real pregnancy" where one begins to experience an attachment to the fetus. Similar to the study by May (1982b), this study provides insight into the phases of emotional development of the expectant father during pregnancy. These same phases could be used to identify the emotional needs of the expectant father at a time when the pregnancy becomes high risk.

Another study involving expectant fathers during pregnancy was conducted by Donovan (1995). Using a grounded theory approach, Donovan

looked at the social, emotional, and sexual changes experienced by six men during the second trimester of their partners' pregnancies. There was no mention as to whether or not the men participating in the study were first time or seasoned fathers. The following theoretical constructs emerged from the data: ambivalence in the early stages of pregnancy; feelings that their relationship with baby was not real; wondering how "he" would be as a father; trying to cope with the changing roles and lifestyle; and a sense of disequilibrium in the relationship with his partner. Ambivalence was derived from mixed, almost contradictory, expressions such as fear, hope, getting old, and no affinity. The construct of "relationship with baby not real" arose from expressions of no feeling of emotional ties with the baby in utero. The expectant fathers in this period were not able to feel the growing life as were their partners. The next construct to emerge, "how should I be as a father", reflected concepts ranging from the expectant father's own childhood to learning new ways to father. It was in this stage that expectant fathers are likely to look for answers from a deeper, intergenerational perspective. The fourth construct, "coping with the changing roles and lifestyle", concerns the lifestyle changes, physically and psychologically, that the expectant fathers were not only experiencing but also anticipating. In this stage, there were a greater number of issues for the expectant fathers. The central construct arising from this grounded theory study was the disequilibrium felt by the expectant fathers in their relationships with

their partners. The expectant fathers felt isolated from their partners and the pregnancies, while experiencing a need for support and direction from their partners to translate the pregnancies and pending fatherhood into reality. It is reasonable to suggest that when expectant fathers are faced with high-risk pregnancies and all the associated problems, these same needs are felt by the expectant fathers but are more intense. In this study, there was no differentiation between first-time expectant fathers and experienced expectant fathers. Furthermore, the expectant fathers were interviewed only during the second trimester of their partners' pregnancies. It is possible that expectant fathers may have a different view during the thrid trimester of their partners' pregnancies.

There have been a number of studies that have explored the expectant father's attachment to pregnancy, viewing it specifically in terms of the phenomena known as *couvade* (Clinton, 1987; Schodt, 1989). Couvade is a set of pregnancy-related symptoms and behaviors that are experienced by some expectant fathers which disappear almost immediately after their partners have given birth (Clinton, 1987).

In a comparative, repeated measures survey, Clinton (1987) observed the emotional and physical health of eighty-one expectant fathers and sixty-six non-expectant fathers. The instruments used in the study included: The Expectant Father's Preliminary Health Interview and The Expectant Father's

Monthly Health Diary. The findings revealed similar patterns of physical and emotional symptoms for both the expectant fathers and the non-expectant fathers. However, expectant fathers tended to report more frequent colds, unintentional weight gain, insomnia, and restlessness than non-expectant fathers. These health changes experienced by expectant fathers may in fact be allowing the fathers to feel the pregnancies, making them more real, almost as if the expectant fathers were "carrying" the babies. To be able to bring the pregnancies to this level of attachment would then allow the fathers to "give birth" and "become fathers". It is reasonable to suggest that when one internalizes an experience, there is an opportunity to have an ownership versus an observational relationship with the experience, otherwise known as an attachment. It is plausible to suggest that these feelings of nervousness and irritability that often accompany a full-term normal pregnancy could be compounded by the feelings of increased physical and emotional activity for the expectant fathers during high-risk pregnancies.

The expectant father's attachment to the fetus is influenced by the expectant woman's attachment. In a descriptive study, Schodt (1989) explored the pattern of relationships among father-fetus attachment, mother-fetus attachment, and couvade. The sample consisted of one hundred and ten couples attending childbirth education classes. Eighty percent of the expectant fathers were experiencing their first pregnancy. The instruments used in this

study included: The Maternal-Fetal Attachment Scale, The Paternal Fetal Attachment Scale, and The Expectant Fathers Health Inventory. The findings suggested that couvade symptoms were observed among some of the fathers participating in the study, with the most frequently reported symptoms being sleep changes, restlessness, irritability, and weight gain. It was noted that these symptoms occurred during the more advanced stages of pregnancy. These findings are similar to those reported by Clinton (1987).

In summary, the literature reviewed on the attachment to pregnancy by expectant fathers has suggested expectant fathers do in fact develop an attachment to their babies in utero. Initially, they feel very much on the outside of the event and, therefore, it is more difficult for them to establish the attachment to the fetus. Crucial to forming the attachment are a number of variables, among the most significant being the lead given by the partner and the development of the baby. The expectant father looks to both these stimuli to shape the attachment among mother and fetus and himself. There is consistency in the literature to support a sequential phasing or process of attachment (May, 1982b; Jordan, 1990). The previous studies have examined the attachment of the expectant father to a pregnancy without complications. Therefore, there is a need to study the attachment of an expectant father to a pregnancy during a high-risk situation. The findings of the previous studies can prove useful in shaping future research.

Expectant Fathers and Social Support

This section of the literature will define social support and present the findings on social support and pregnancy. While the attachment of the expectant father to pregnancy may occur spontaneously, it may be further facilitated by the presence of social support. However, the effect of social support on the outcomes of pregnancy is, at times, conflicting. While there are any number of explanations for these inconsistencies, one plausible explanation may lie with the operational definitions for social support (Callaghan & Morrissey, 1993).

Social support is viewed as a multi-faceted construct with a variety of interpretations. Norbeck, Lindsey, and Carrieri (1981) define social support as affect, which encompasses the expression of positive affect of one person toward another; affirmation reflecting the endorsement of another person's behavior, perception or expressed views; and aid, the giving of symbolic or material aid to another. Social support is the amount of help actually received, satisfaction with that help and the persons or network providing that help (Mercer, May, Ferketich, & DeJoseph, 1986). Catalano, Hansen, and Hartig (1999) compared social support networks, consisting of friends and relatives, to an informal insurance pool from which individuals may draw surplus help in times of need. In the case of a couple, the pool is sufficient if only one person requires assistance from the pool. However, if both simultaneously need

assistance from the pool for a shared stress, the supply of support could be quickly depleted. While Catalano, et al. use this in relation to unemployment and the incidence of very low birth weight, the same analogy can be applied to couples faced with high-risk pregnancies. Since both parents share the same stressor, there is a likelihood the pool of social support could be quickly depleted because of the increased demands.

There is very little research done on expectant fathers and social support in high-risk pregnancies. The available research has tended to study both expectant fathers and mothers together in uncomplicated pregnancies. However, the findings of these studies have helped to give insight and some understanding of the function of support and how expectant fathers use social support.

Working with a population of three hundred and thirteen expectant couples, Brown (1986) examined how social support and stress affected the health of each of the expectant parents. Instruments used in the study included a Support Behavior Inventory (SBI), a Stress Amount Checklist (SAC), and a Health Responses Scale (HRS). Significant findings emerging from this study were: (a) stress is an important force in triggering illness and support does provide a buffer in the presence of illness or stress such as pregnancy; and (b) partners tend to be the greater perceived source of social support needed by men.

Using a sample population of three hundred and thirteen couples, Brown (1987), looked at how expectant mothers and fathers perceived the significance of certain support behaviors during their pregnancies. The perceptions of social support by the women focused on such factors as understanding and helpfulness; whereas, for the men it focused on issues that were much more concrete, such as work hours/schedules. The findings suggested that women consistently rated the need for social support during pregnancy higher than their partners. Conversely, men ranked the need for acceptance of work schedule, reassurance of their ability as fathers and information about the pregnancies from their partners much higher than women. The findings of this study would suggest that the differences in rating the value of social support are highly dependent on the differing interpretations between genders associated with social support.

Cronenwett (1985a) looked at the social network and the perceived social support of fifty primigravid couples in the third trimester of their pregnancies. A Social Network Inventory (SNI) using the four constructs proposed by House (1981) was one of the measurement tools used to test the variables related to social network and perceived social support. Cronenwett (1985a) reported that men and women did not differ significantly in the number of network members from whom they received informational, instrumental, or appraisal support. However, the number of network members from whom women needed emotional

support was significantly higher when compared to their partners. The emotional support that came from relatives for the men was 81% versus 71% for the women. The source of emotional support from friends was higher for women (24%) than men (15%). Although it is not clear why men lean towards family and relatives, it is reasonable to suggest that it is acceptable for men to seek emotional support from family as opposed to friends because going to friends could make them feel more vulnerable and not bearing up well under the stress. This study did not explore the sources of social support for expectant fathers during the first and second trimesters of pregnancy. Its findings were limited to the third trimester of pregnancy. It is possible that the need for social support may be equally as important during the first and second trimesters of pregnancy.

In summary, the literature review on social support and normal pregnancy, reveals that men do attach an importance to social support during times of stress (pregnancy). It is generally accepted that this support for men is available from within family structures. In addition, the literature does confirm that the expectant father seeks out his partner as his primary source of support.

Summary

Fathers and pregnancy have not always been viewed as a partnership. The use of the terms "expectant father" and "expectant couple" has only gained popularity in the last three decades. Before this time, the father's contribution was felt to be predominantly biological. There was no pressing need to include

the father in the pregnancy. Since the 1980's there has been a pendulum swing, not only in the roles of fathers in pregnancy, but also in the responses and feelings of fathers during pregnancy.

Studies were conducted exploring the emerging trends and transitions with respect to fathers and high-risk pregnancies (Maloni & Ponder, 1997; May, 1982b; May, 1994; McCain & Deatrick, 1994; Miron & Chapman, 1994; Murphy, 1998; Ross, 1993; Wagner, Higgins, & Wallerstedt, 1997); the attachment to pregnancy by expectant fathers (Donovan, 1995; Jordan, 1990; May, 1982b); and the nature and perceptions surrounding social support for the expectant couple during normal pregnancy (Brown, 1986; Brown, 1987; Cronenwett,1985a).

As the role of the father during pregnancy was examined, a number of findings reported that the father does form an attachment to the pregnancy in several ways. Among the more common manifestations is a phenomenon known as couvade. With couvade, the expectant father identifies with the changes of pregnancy as they affect his partner by taking on similar symptomatology. These range from weight gain to irritability. By assuming these changes, the expectant father feels attached to the baby or is able to identify with his partner.

Defining social support in the context of pregnancy has revealed that this is a time of stress. Hence, social support has been redefined, as well, in that the support is given at a time of stress as opposed to crisis. The parameters

commonly associated with social support include persons through whom informational or affectional assistance can be obtained. Studies revealed that there are differences in the sources of support for men and women during pregnancy. Most of the studies have reported that men tend to lean toward their partner and family in the stressful time of pregnancy. Women, on the other hand, will seek support from other sources. Expectant fathers experiencing high-risk pregnancies need support and although they prefer the source to be their partners, they tend to avoid seeking support there as expectant fathers recognize that this is not the time to seek support from, but rather give support to, their partners.

There is an emerging interest in the expectant father, yet the studies completed to date are small in number. None of the studies have explored the lived experiences of fathers during high-risk pregnancies. Thus, this researcher examined the lived experience of expectant fathers whose partners were admitted to hospital between thirty to thirty-four weeks gestation. The aim of this study was to gain insight and a deeper understanding of the meaning of the experience to these expectant fathers which could be used by health care professionals in the provision of family-centered care.

CHAPTER 3

Methodology

In order to address the research question, "What is the lived experience of men whose partners have been hospitalized for high-risk pregnancies?", the researcher chose a phenomenological approach. This method was selected because of its ability to ascertain the meaning of the experience for the individual, and the value placed on the everyday, uninterpreted experiences of the individual. Although there are a variety of phenomenological research methods, the researcher chose van Manen's (1997) method for human science research. The first section discusses phenomenology as a research method. The second section describes how van Manen's methodology was used throughout the study to address this question.

Phenomenology as a Research Method

Phenomenological research is an approach to qualitative research developed from phenomenological philosophy. The focus of phenomenological philosophy is to understand the response of the whole human being, not just to understand an isolated part of behavior (Polit & Hungler, 1997). Phenomenology is an inductive, descriptive method that seeks to describe lived experiences (Morse, 1994) and grasps more fully an understanding of the structure and meaning of human experience (Struebert & Carpenter, 1995). The

nursing profession looks at the person as a holistic and unique individual, and incorporates a holistic approach to nursing practice as a way of preserving personhood. A phenomenological research method is an appropriate method to conduct nursing research as it is concerned with the whole experience as seen by the individual who is experiencing it (Oiler & Munhall, 1986).

The aim of phenomenological research is to describe human experience from the individual's perspective (Struebert & Carpenter, 1995). Phenomenologists focus on what people experience regarding some event or behavior and how people interpret these experiences. Phenomenological research begins in the lifeworld which Husserl described as the world of everyday experience as we "immediately experience it pre-reflectively" (van Manen, 1997, p. 9). Thus, phenomenology can be viewed as a way of questioning and gaining insightful descriptions of some event or behavior from the perspective of the person experiencing it. The aim of this present study was to gain insight and understanding into the lived experiences of fathers whose partners have been hospitalized for high-risk pregnancies.

To guide the researcher to a full understanding of a lived experience, van Manen (1997) identified four existentials which form the basis of phenomenological research: (1) lived space (spaciality); (2) lived body (corporeality); (3) lived time (temporality); and (4) lived human relations (relationality or communality). The lived space (spaciality) refers to the person's

perception of their environment; lived body (corporeality) is the awareness of the physical body in the world; lived time (temporality) is the person's sense of past, present and future; and lived human relations (relationality) refers to the association a person feels with another person. These four existentials cannot be separated and are necessary in understanding a particular lived experience (van Manen, 1997). The principle of "intentionality" is necessary when comprehending the nature or meaning of every day experience. The principle of intentionality is the way people attach themselves to the world and become part of the world. Questioning and reflection are ways researchers obtain meaning from experiences as described by people (van Manen, 1997).

A purpose of phenomenological research is to discover the essence of a particular lived experience. An essence is those elements of phenomena that "make a thing what it is (and without which it would not be what it is)" (van Manen, 1997, p. 177). In order to obtain the essence of a particular lived experience, reduction is necessary. Reduction enables the researcher to come to terms with his/her personal beliefs to develop a closer understanding of the experience. Reduction can be accomplished by bracketing. Bracketing enables the researcher to put aside personal feelings, previous experiences, and knowledge about the experience that is being studied (Baker, Wuest, & Stein, 1992; van Manen, 1997). van Manen suggests that bracketing must be a conscious and vigorous activity for the researcher throughout the research

process in order to control for presuppositions and assumptions. Bracketing prevents the researcher from making judgements and ensures a true description of the lived experience under study. However, while bracketing is beneficial there is a point where one uses previous experiences to broaden or to gain a better understanding of another individual's lifeworld.

van Manen (1997) described six research activities as a guide to phenomenological human science research. The first activity requires the researcher to choose a phenomenon of interest and remain committed to investigating that phenomenon. The phenomenon must deal with some aspect of human experience. It is necessary for the researcher to bracket any biases or knowledge of the phenomenon during this research activity. The second research activity necessitates that the researcher investigate the experience as lived rather than as conceptualized. The third research activity involves reflection on the essential themes which characterize the phenomenon. In this phase the researcher reviews the data carefully and repeatedly. The fourth research activity requires the researcher to describe the phenomenon through writing and rewriting. The fifth research activity requires the researcher to maintain a strong and oriented relation to the phenomenon. Throughout phenomenological research it is necessary for the researcher to consistently remain focused on the question of what an experience is really like in order to remain focused on the phenomenon. The sixth research activity is the balancing

of research by considering the parts that fit together to make up the whole. Thus, phenomenological research brings the researcher back to the phenomenon, which was the starting point for the research.

Turning to the nature of lived experience is both the starting point and the end point of phenomenological research. It is not sufficient to just recall experiences about a particular phenomenon. The experiences must be interpreted to the reader. To do this, the researcher asks the question, "What is it really like for the person who is living this experience?". van Manen (1997) states that "we live this question, that we 'become' this question" (p. 43) until it is exhausted and its nature is made explicit.

Phenomenological inquiry has only one source of credible data, which is, the persons who have lived the experience being investigated. The researcher can access this data from these persons through interviews, observations, various forms of literature, and artistic expression (van Manen, 1997). According to van Manen, it is necessary for researchers to "borrow" the words of participants, and as such, it is best to prompt the participants throughout the interview to describe their experiences and to use silence to facilitate reflection on the lived experiences.

Through analysis, the researcher tries to identify the themes or meaningful ideas that make up the experience. Themes are phrases that try to capture the meaning and give shape to a particular experience, and provide

direction to the researcher to become integrated into another's lived experience. Once themes are identified, the researcher collaborates with the participant to validate that this is what the experience is really like. Other researchers may be utilized to produce deeper insights and understanding.

van Manen (1997) views writing as the basis of human science research. Writing, reading and rewriting enables the researcher to describe the subtle details of the participant's experience. Eventually this process will enable the researcher to view the experience as a whole and not as isolated parts.

Method

Participants

The population for the study was all men in Newfoundland whose partners were hospitalized for high-risk pregnancies. The population was men whose partners had been hospitalized for high-risk pregnancies at the Health Care Corporation of St. John's. In a phenomenological study, a small number of participants is considered adequate for the purpose of the study since the questions are all open-ended and there are indepth interviews. Nine participants were recruited for this study.

The nine participants met the following criteria: (1) they were 19 years of age or older; (2) they could understand and speak English; (3) they were residents of St. John's and surrounding areas; (4) they were co-habitating; (5) they were partners of women hospitalized for a complication of pregnancy at

thirty-two weeks; (6) maternal and fetal health had been stabilized; and (7) they were willing to allow audio taping of the sessions.

Procedure

The nine participants involved in the study were identified by the Patient Care Coordinator, Family and Newborn Services at the Grace Hospital Site, Health Care Corporation of St. John's. A number of potential participants referred to the researcher by the Patient Care Coordinator chose not to participate in the study for various reasons. These reasons included being "too busy" while their partners were hospitalized. This was compounded even further if there was a child at home or it was close to a special occasion, such as Thanksgiving or Christmas. Most of these potential participants expressed a desire to participate in the study as soon as their partners were discharged from hospital. One other potential participant could not participate in the study because his partner delivered the morning of the arranged interview.

The study participants were initially approached by an intermediary, the Patient Care Coordinator, Family and Newborn Services, Grace Hospital Site. The intermediary briefly described the nature of the study and obtained permission for the researcher to contact the potential participant. The names and telephone numbers of those men who expressed an interest in participating were provided to the researcher who either contacted them by telephone or met them when they visited their partners at the hospital. The decision as to how

each was to be contacted was determined by the potential participants. Additional explanation regarding the nature of the study was provided at this time and if the men were still interested, a suitable interview time and location were arranged.

Interviews

The interview was designed to obtain the men's thoughts and feelings regarding their experiences of their partners' hospitalization during pregnancy. All interviews were conducted in a room at the Grace Hospital Site. This location was arranged according to the wishes of each participant. The participants were usually at this site visiting their partners. This location provided comfort, confidentiality, and convenience.

Prior to the initiation of the interview, a detailed description of the study was given to the participants so they could decide whether or not they wanted to continue with the study. This information included the purpose of the study and data-collection techniques, including audio taping and note-taking, during the interview. The consent form was reviewed with the participant at this time and the researcher answered any questions. Participants were also told that they could stop the interview at anytime; however, none chose to do so.

Participants were asked to describe their experiences of having their partners hospitalized for high-risk pregnancies. The participants were invited to start wherever they wished in describing their experience. When necessary, the

researcher used the open-ended questions listed (see Appendix E) to encourage the participants to share their experiences or to clarify ideas. Interview techniques such as probing and reflection were also used. All interviews were audio taped and lasted a minimum of forty-five minutes to a maximum of ninety minutes. The researcher kept a diary which was a reflection of each interview and her own thoughts and feelings. This diary kept the researcher cognizant of the problems of bias. The audio-taped interviews along with the open-ended questions used in the interviews also reduced the element of bias.

A second interview was arranged after the data had been transcribed and an initial identification of themes had been completed. A written interpretive summary of each interview was prepared by the researcher and given to each participant for validation purposes and clarification. Of the nine participants, only one could not be reached as he had left the province. The interpretive summary was confirmed by the remaining eight participants as a meaningful understanding of their experiences. The second interviews occurred eight to fifteen months after the first interviews. All of the partners of the participants had delivered by this time. The partners had all experienced live births and all the children were healthy.

Ethical Considerations

Permission to conduct the study was granted from the Human Investigations Committee, Memorial University of Newfoundland (see Appendix C) and the Research Proposal Approval Committee Health Care Corporation of St. John's (see Appendices A and B). Before the initiation of the first interview all participants were required to give their written consent (see Appendix D). The purpose of the study, as well as procedures of collecting data, and the time required of the participants was explained to them prior to the commencement of the first interview. Participants were assured that they could withdraw from the study at any time. They were also informed of measures to assure confidentiality, such as the use of codes rather than names on the interviews.

Audio tapes and other records pertaining to participants were treated as confidential throughout the study. Members of the thesis committee were asked to review and discuss the interviews in order to provide feedback on the researcher's interview technique. However, only the researcher was aware of the identity of the participants in relation to the raw data. The typist who transcribed the interviews was given a thorough explanation of the need for confidentiality and assured the researcher that confidentiality would be maintained.

The participants were reassured that all written notes and tapes would be destroyed at the end of the study. Although they might not benefit directly from

the study, participants were informed that the information they provided might be of help to nurses and other health professionals who would gain better insight into what it is like for men whose partners have been hospitalized for high-risk pregnancies.

Data Analysis

The data collected from the taped interviews was reviewed by the researcher several times to grasp a sense of the whole. The interview was then transcribed verbatim by a typist. Each written transcript was read several times while listening to the corresponding audio tape, to ensure accuracy of the transcripts and to delineate units of general meaning. The specific approach used to uncover the meaning of each participant's experience was a detailed or line-by-line approach outlined by van Manen (1997). In the line-by-line approach the researcher examined each sentence or sentence cluster and asked, "What does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (p.91). Once the units of general meaning were identified, the researcher applied the research question in order to select the most appropriate ones, which became the units of relevant meaning. The units of relevant meaning formed the framework from which the interpretive summaries were produced for review by the researcher's supervisor prior to being shared with the participants. Every attempt was made to avoid

categorizing or developing concepts, but rather to capture a meaning (van Manen, 1997).

Following the initial reading and initial identification of themes from each interview, the researcher met with the thesis supervisor and the thesis committee to identify and discuss the major themes. Next, the researcher looked for commonalties and differences of the identified themes in each interview. Once the overall themes had been identified, the researcher met with members of the thesis committee. The purpose was to present the themes identified, discuss why the researcher had decided on these themes, and further validate them. When the themes were identified, the researcher began the writing of the themes. Each theme was rewritten several times until the researcher felt the themes accurately described the experience of men whose partners had been hospitalized for high-risk pregnancies. Further discussion with the researcher's thesis supervisor and thesis committee resulted in the identification of the essence.

Credibility

Credibility refers to how well interpreted and truly representative are the descriptions of the phenomenon (Morse,1994; van Manen, 1997). A qualitative research study is credible when the participants recognize the experience as their own (van Manen, 1997). To ensure credibility of this research study, the following measures were used: (1) the research study was supervised by three

faculty members who were proficient in phenomenological methodology and possessed a sound knowledge base in the area; (2) collaboration with the researcher's thesis committee members aided in the discovery of meanings embedded in the text; (3) each participant confirmed that the researcher's analysis was an accurate interpretation of their perceptions and experiences; (4) the researcher's interviewing technique was closely monitored by the thesis supervisor to determine if areas required further exploration. Research bias was also controlled by recording personal views before and during data collection. Frequent consultation with members of the thesis committee also served to keep the researcher focused on the research question.

The Effects of Interviewing Men from the Researcher's Perspective

Throughout the interview process the researcher identified that these expectant fathers were highly stressed about the admission of their partners to hospital for high-risk pregnancies. As reflected in her diary, the researcher believed that although these men were willing to participate, they were hesitant about expressing their innermost feelings. Consequently, the researcher had to make a mental note to herself that: a) the study was about the experience of males as they were responding to a female-related health problem, and b) in this study the males were interviewed by a female researcher in isolation from their female partners. With these two features in mind, the researcher made several observations while interviewing these expectant fathers. One such observation

was that all of these expectant fathers tended at times to trivialize or downplay the severity of their partners' complication of pregnancy. They used terms such as "a little bit of concern", " minor problems" and "a little bit more scary". The selective use of these trivializing phrases gave the researcher a sense that perhaps these expectant fathers did not realize the importance of the complications, or it may have been related to the fact that they were experiencing the event in relationship to how their partners were feeling. However, the researcher felt that these expectant fathers really did understand the impact of the complication and were genuinely worried about their partners and babies. The researcher, therefore, interpreted this trivialization as a veil to cover the emotional turmoil that they were experiencing internally. This could also be interpreted as the participant's way of coping. The researcher learned that it is not easy to interview males on such a sensitive topic at such a vulnerable time. The men did not open up as easily to a researcher as women might open up to a researcher. It took time. Furthermore, the participants implied that the researcher, because she is a woman, should know what they meant or were trying to explain. For example, they would add, "Well, you know what I mean".

Overall, it is hard to predict the exact effect of a female researcher on male participants. Being not only a female researcher, but also a nurse researcher could have influenced their perspective. It could have encouraged

some of the expectant fathers to verbalize their feelings while other expectant fathers may have perceived a female nurse researcher as a barrier to disclosure. There was no evidence to favor one over the other. However, one expectant father stated that he talked to his brother-in-law about his personal life but not in the same depth as he had talked to the researcher. Another expectant father did not reveal his feelings about his partner's hospitalization until the very end of the interview.

In spite of the participants' hesitancy in revealing their feelings, the researcher was able to obtain insight into the depth of their emotions and the impact of the experience on their lives. There was only one expectant father who displayed his emotions during the interview. This expectant father's eyes filled with tears as he talked about leaving his wife at the hospital and returning home alone. He immediately gained composure and apologized for his display of emotion. Initially, the researcher felt uncomfortable and surprised that this had happened. The researcher had not expected this kind of reaction from a man. Through reflection of this incident, the researcher realized that she had acquired the expectation of her society that men are not supposed to cry. Men are supposed to be strong and not show their emotions, especially to a female.

The researcher was careful not to reveal personal beliefs or values that may have influenced the participants' responses, thereby, possibly skewing the interpretation of the data. The orientation of the researcher, that is being a

female and a mother, may have contributed to a conscious awareness of the difficulties facing the participants and their partners (Webb, 1993). While this is how the researcher felt and perceived the whole interview process, another researcher may not feel this way, as everyone is an individual. Hence, the effect of interviewing men from the researcher's perspective was a positive experience.

CHAPTER 4

Findings

The responses to the research question posed in chapter three are presented in this chapter. The findings are presented as follows: first, a comprehensive overview of the study participants' backgrounds is given; second, the themes that were identified from the data analysis are described; and, third, the essence of the lived experience for these men is explored.

Overview of Participants' Backgrounds

All of the men who agreed to participate in this study were involved in their partners' pregnancies. At the time of the interviews, each participant's partner was hospitalized at thirty-two weeks gestational age with a diagnosis of preterm labor, complete placenta previa, or deep vein thrombosis. The length of hospitalization for the partners varied from one week to a month, and at least one participant had a readmission to hospital. Eight of the nine men were first time expectant fathers. The other participant, a father of two living children, had also experienced two previous high-risk pregnancies.

Participants ranged in age from twenty-four to thirty-five years. Two of the nine participants lived in a rural community which required a two to three hours drive to the acute care facility. Although all nine participants were employed, they worked in a variety of settings, ranging from business, to health

care, to construction. Education levels attained by the expectant fathers ranged from completion of high school to post-secondary education degrees.

Thematic Analysis

During the interviews, the expectant fathers described what it was like to experience the hospitalization of their partners due to high-risk complications during pregnancy. Their words suggest that they were struggling to exist in a world filled with new and unexpected events. The following themes reflect the experience of these expectant fathers: (a) too early: protracted readiness; (b) dealing with uncertainty; (c) coming to terms with the unexpected; and, (d) striving for a steady state.

Too Early: Protracted Readiness

Webster's dictionary (1997) defines the word early to mean "occurring before the expected or usual time". The admission to hospital was occurring before the expected time, given that the development of the baby was still progressing. The expectant fathers were not ready for the interruption of the course of pregnancy and the sudden hospitalization. They had not completed the physical and/or the emotional readiness for fatherhood; instead, they were thrust into a situation that looked as though it would be interminable and prolonged. The untimely hospitalization coupled with the need to be ready for

the possible birth of the baby, gave way to the theme of too early: protracted readiness.

The expectant fathers participating in this study expressed an understanding that a normal full-term pregnancy would span a total of nine calendar months. They perceived pregnancy as a healthy time during which they would experience a flow of positive events. As one expectant father described it:

> You're pregnant and you get all these nice little things and enjoy it as you go through and you watch for the kicking and watch for the growing and get your house set up and the room set up and at the end of nine months, you bring home the baby.

The interruption and the unexpected hospitalization at this time posed a new, uncharted experience for the expectant fathers, something to which neither the expectant fathers nor other family members could relate:

> But *[partner's]* mother I think didn't know how to react, something like ourselves. She probably didn't understand a lot. She said, "I had six kids and didn't have a problem at all, like why is this happening now.

The expectant fathers had not entertained the possibility of the birth of the baby this early. The sudden hospitalization caught them off guard, took them by surprise. There was shock and disbelief. They had anticipated that there was still time left for them to complete the necessary preparations for the baby. The surprise was evidenced in statements like: "I guess nobody thinks about it when you first find out that you're going to have a baby, you think, like we do

everything should go by clockwork"; "When she told me her water had broke, I didn't know what to expect, it's too early for me".

Prior to the hospitalization both the expectant fathers and their partners were continuing on with normal everyday activities. There were no signs of difficulty with the pregnancy, again supporting the reaction of surprise:

> *[Partner]* carried on her life as if she wasn't pregnant. Most people like you hear, I suppose their pregnancy has been bad from the beginning, like probably a bit of sickness and whatever. They just spend probably their whole nine months back and forth to hospitals and doctors getting checked.

The expectant fathers were engaged in a normal routine workday. They left for work like they did every day. The phone call to the workplace with the news of the hospitalization took the expectant fathers by surprise:

> I was at work when I was told . . . so I had about an hour to punch and I couldn't leave circumstances at work. I couldn't leave for that hour. One of her best friends was with her at the doctor's office, I couldn't even make it to this appointment. The first one I missed because of work, the time of year and that kind of thing, so I was disappointed that I couldn't come with her right away. That hour that I had to spend, was gee, come on, watching the clock so I could go over and find out exactly what happened.
>
> So what I had to do then was get back as quick as possible cause you know we didn't know what it was. . . . I got on the phone and managed to get the next flight out which wasn't until the next morning. So needless to say I didn't sleep very well that night. . . . Just sort of wanting to get back and sort of feeling like I didn't want to be there now. Let's get out of here as quick as I can.

Because there were no warnings to signal that the baby might be coming too early, the news of the hospitalization left the expectant fathers dazed and unable to think clearly as a result of the unexpected turn of events: "I didn't know what

to think first"; "Very alone and confused, what do I do, you know, how serious is it"; "Like, oh my heavens, didn't know what to think".

This was not the way the expectant fathers had thought that the pregnancy would unfold. It was "not supposed to happen this way", especially for those whose partners "went from day one of her pregnancy to now with no sickness, no aches, no pains". Several expectant fathers described the pregnancy in this manner: "She's always been healthy. She hasn't had any problems at all with her pregnancy up to this point"; "*[Partner]* went so long without anything, her doctor jokingly told her, 'It's a waste of time for me to see you', he said, 'You're just so healthy'"; "It's odd you know because her lifestyle is so much healthier than mine and she's the one laid up now".

Although one of the expectant fathers did have an indication that something might be wrong with his partner's pregnancy, he, too, expressed shock when his partner was admitted: "A week or two ago she was using the washroom every ten minutes, honestly, well jeez is something wrong?". A second expectant father, whose partner had had two previous pre-term deliveries, was also bewildered by the news of the early hospitalization. However, he seemed to be alarmed because this pregnancy was unlike the previous pre-term pregnancies:

> I know she had pain with the other two, she hemorrhaged with the second one, but this was unreal, it makes me wonder. When she told me her water had broke, I didn't know what to expect, it's too early for me.

Interspersed with feelings of surprise, shock, and disbelief, a number of the fathers felt excitement. They cautiously anticipated that the baby might arrive at this time. They longed for the excitement and anticipation that goes with a delivery. Yet, they knew that the pregnancy had not reached its full nine-month span, and they were uncertain about what an early delivery of the baby would mean. These fathers were unsure whether they should feel excited or guarded. The feelings of the expectant fathers were constantly changing. They wanted to be happy but sensed it might be inappropriate to feel this way under the circumstances. Consequently, these expectant fathers vacillated back and forth through the various emotions. As several fathers said:

> I was a bit nervous, thought the baby was going to come right away, no I guess excited, maybe a bit excited but more nervous than excited, it was a shock to us.
>
> It's exciting too, like okay, let's get the labor off, let's go and is it a boy or a girl, we really want to see what it is and oh it's exciting and then you get a knot in your stomach and it's exciting and then it's nervous too.

Often times when there is an event scheduled to occur on a specific date, there are usually any number of preparatory tasks leading up to the event. The successful completion of these tasks contributes to a sense of physical readiness for the actual event. When the planning is interrupted and the event occurs earlier than anticipated, the sense of readiness can be measured against the number of tasks successfully completed up to this time. The early hospitalization of the partner interrupted plans that had been established from

the outset of the pregnancy. The expectant fathers acknowledged the preparations related to the baby, (e.g. crib, room, etc.) as those that were factored into physical readiness. Several participants commented thus:

> We don't have everything ready for the baby yet. We only set up the crib a couple of nights before and we haven't even got a mattress, we need to get a mattress for it. . . . We haven't got any of it done now.

> There's a lot of things to do yet before it is all over because there is absolutely zero home. There's no baby, no baby things whatsoever.

The expectant fathers also spoke of the preparations that were to take place towards the completion of the pregnancy. They spoke of the anticipation that some of the plans would be done together with their partner. As one expectant father said:

> So I went out and picked out the crib and the change table and the dresser and the car seat and all those things. I'm sure *[partner]* is probably a little upset about that, that she couldn't get out and do those things, because she wanted to do those things. We had planned on doing those things and we talked about it before she even came in. . . . When the time came to do them she couldn't participate.

The early hospitalization resulted in the partners being admitted with only their basic toiletries. Because the expectant parents did not know whether this was to be an overnight stay or a lengthy stay, the onus was now on the expectant fathers to attend to their partners' needs. One expectant father commented on their lack of preparedness for the sudden hospitalization:

> Trying to get things ready for her because she was admitted on a short notice. So I stayed with her until 4 o'clock in the afternoon. Then I had to go home and get some clothes ready for her and things ready to go to the hospital and wash some laundry.

The interruption in the pregnancy and the resultant hospitalization brought with it a sense that the ongoing preparations were shattered. Expectant fathers felt as though the early hospitalization tore apart their plans: "All the plans that you had, how you visualized things playing out stops, that's all torn up and thrown away"; "That's all gone out the window"; "Life as you know it is turned upside down". One expectant father described his response to the early hospitalization in this way: "I wasn't expecting her to come in, no, not like this, that's for sure". Several men talked about the suspension of their short-term plans: "We were planning to get groceries on the way home from the doctor's visit. I still don't have them"; "Where were we going to stay for the night?". With their plans and expectations disheveled, these men were now at a standstill, with no interim plans. The expectant fathers were looking for anything that would give them a sense of what to do and in what order to do things. They voiced the need to somehow refocus and formulate new plans. As several participants stated: "I got to build a different plan now, how's this plan going to look, what's the outcome of this going to be?"; "Just trying to make a plan and make sure it's okay with her".

For some of these expectant fathers constructing new plans meant filling the list of things to do, given to them by their partners. The expectant fathers were anxious to do whatever they could: "I had to go out and try to get these things for her and pick up her toiletries that she needed"; "Clothes, as she grew

she needed more. Some new clothes that she didn't have because she was smaller when she came in"; "She's pretty good, she keeps my list updated for me. Most nights I go in she has this little checklist for me". Some of the participants were overwhelmed with the newness of responsibilities. One expectant father elaborated on the difficulties experienced:

> I have to try and get, go to the drugstore, pick up shampoos and all that old stuff. It's just things I never used to do. . . . But for her to tell me to pick up shampoos or now when she gives me these fancy names and to me it's all French because I don't know anything about that stuff.

The expectant fathers were using the nine months as a yard stick to prepare themselves emotionally for the birth of the baby. The nine months was to provide time for the transition from expectant to real father. With the news of the early hospitalization, the expectant fathers had to quickly consider that perhaps as early as tomorrow, fatherhood could be a reality. As one expectant father said:

> We weren't ready to think she was coming in and that was a week and a half ago. We thought then the way the doctor was talking, she could be in labor before the night was out, have the baby, and apparently she could have been. So that made me a bit nervous.
>
> Yesterday, I was really nervous. I didn't know what to expect right? I guess it's typical fatherhood. I haven't been through it, but I was nervous.

Prior to the early hospitalization, the expectant fathers were using the time, in its steady, uneventful progression, to contemplate becoming a father. One expectant father commented thus: " So looking forward to all the stages, but a little bit nervous about the beginning stages". Another expectant father captured

it in this way: "They're not big concerns *[parenting]* and not so much concerns just worry that you're not going to do as good a job *[as a father]* as you could or should".

The early hospitalization created a sense of apprehension and watchfulness about the pregnancy. The fact that the turn of events was occurring too early, created a void in the emotional readiness. It left the expectant fathers feeling wary about what was to take place with this hospitalization and the pregnancy:

> From tonight on, I don't think I can concentrate on much cause my mind will be always, if she's lying in bed along side me how much sleep I'm going to get now is going to be few and far between cause you're wondering if she's sleeping or if she's having any pain.
>
> This time when she goes home, she's going to have to lie around. I'll probably get her sister to come in with her. I'll pay her sister to come in and stay with her if I have to.

The separation from their partners further prolonged the ability of the expectant fathers to prepare for the possible early birth of their babies. There was evidence that the absence of the partners created feelings of emotional disconnectedness. For one expectant father it was related to the fact that he had grown accustomed to his partner's presence: "I don't know. It's different when you're used to five years with [*partner*] there every night. You come home and she's not here". For several expectant fathers, the disconnection was related to a sense of loneliness in the house: "Really lonely, I don't even sleep in the bed since she's been in hospital, I haven't slept in the bed. I sleep on the

couch all the time"; "Come home in the evenings and there is no one there just me". In another case, the partner's presence represented the complete family: "Only thing, like I miss her that is, around the house, looking after the youngsters and I miss the woods. And the youngsters miss her. They cry for her". The partner's absence for several expectant fathers left them in a kind of purposeless quandary: "Especially when I'm home because it's just me in the house, and it's almost like idle time"; "So you just feel a little bit on your own, you'd like to say, why don't you *[partner]* come along with me, or that type of thing". For another expectant father, the absence made him realize the significant companionship and comfort that he derived from his partner's presence in the home: "Oh, it's a lot different, I don't sleep as well when she's not there at night. It makes me realize how much I miss her at home".

Following the admission of their partners to the hospital, the expectant fathers' comments suggested that they remained in a state of emotional turmoil. Several participants described feeling helpless: "I felt helpless. Didn't know which way to turn; didn't know what to do; and there was nobody to communicate with me to say well this is happening or that's happening"; "Helpless, knowing that *[partner]* was in the room and not knowing what was going on". A significant aspect of the event for the expectant fathers was that they felt helpless in relieving the pain and discomfort of their partners. These feelings were captured in the following comments: "It hurts me to know she's in here and there's nothing

I can do about it, nothing I can do for her only just try to talk to her"; "There's not a lot you can do and she sort of has to stay there and you can't"; "You're just there, sitting and twiddling your thumbs. You can't do anything for her"; "You just sit there. Your wife is in bed and every fifteen or twenty minutes . . . she is having contractions, really bad abdominal, heavy, strong abdominal pain".

The expectant fathers had planned to attend prenatal classes as a way of helping them to prepare psychologically for fatherhood. The early hospitalization of their partners interrupted these plans and circumvented the opportunity to attend prenatal classes. Consequently, the absence of prenatal classes interfered with their opportunity to gather new information about their new role. The participants expressed it in this way: "We just started prenatal classes. We've had two classes"; "We went to three classes in the beginning, nutrition, but we've missed the other prenatal classes"; "We went to one class and then last Wednesday, a week ago tomorrow, that's when she started getting sick".

Despite the lack of readiness, the expectant fathers did not remain at a standstill. Instead, they attempted to overcome the obstacles that compromised their emotional readiness. One such way to overcome it was to reflect on past experiences they, themselves, had with children:

> We talked about it, not really ready, but now that they're on the way I mean, everything is in place you know, the nursery is done. At work I'm in a position where financially we're doing pretty good and you know I guess my mental state I'm ready to be a father.

Other expectant fathers chose to deliberately observe their families or friends as they engaged in fatherhood roles. In making his observations, the expectant father was validating his own preparedness for the new role as a father :

> My buddy who is in the same boat as me, he's got a week under his belt. He said, 'look you know there's nothing to it like, everything that you're thinking I thought. You got to be thinking changing diapers and stuff like that, that's all the enjoyment.' He's only into it a week and he says there's nothing to it. They're nowhere as fragile as he thought. A lot of concerns that I had I'm starting to alleviate.

The expectant fathers attempted to find ways to reduce these feelings of helplessness, while simultaneously trying to comfort their partners. One participant talked about using a "keep-busy" kind of attitude:

> I'm trying to do everything I can to comfort her . . .. I feel good that I'm able to help her out, you know, just simply walking down to the fridge, and getting her a glass of milk. That sort of makes you feel like you're doing something. At least, you're not just sitting there, useless.

Other participants used trivializing-type coping strategies, like laughter, to temporarily divert themselves when discussing the seriousness of the event. The laughter usually occurred immediately following an emotionally charged statement or comment such as: "It was 6:30, but she woke up and she was bleeding, and this big holler and screaming, 'come, come quick' [Ha, Ha]"; "Not another soul there *[in the house]* to speak to you or yell at you [laughter]". For others, the phrases such as "minor problems"; "a little bit of worry"; "a little bit of concern"; "a little bit shocked"; "it wasn't too bad"; "a little bit more scary," were ways they attempted to lessen the gravity of the situation.

As the expectant fathers struggled to prepare themselves for what was happening, there was a sense of unfamiliarity. In this extended period of waiting where there was no immediate resolution in sight, coupled with few opportunities to secure an understanding of what was happening, the expectant fathers found themselves no closer to adjusting to events. The absence of predictability about and control over what was happening, contributed to yet another feeling and that was one of uncertainty.

Dealing with Uncertainty

Uncertainty is defined by Mishel (1988) as the "inability to determine the meaning of illness-related events" (p. 225). Uncertainty occurs in situations where individuals are unable to assign specific value to objects and events and/or accurately predict outcomes (Mishel, 1988). The uncertainty experienced by expectant fathers was produced by events that were ambiguous, unpredictable, and unfamiliar regarding the outcome of the pregnancy.

The sudden hospitalization represented an event that transformed a predictable uneventful pregnancy into one with an uncertain outcome. The expectant fathers expressed concern about what had gone wrong with the pregnancy, wondering if the baby would be fully matured and able to survive. The possibilities of a tragic end to the pregnancy, (e.g., stillbirth, imperfect child, etc.) are not usually entertained unless there is some familial history suggesting

such anomalies. However, the nature of this hospitalization [early and sudden] was an event that triggered such thoughts. As several expectant fathers stated:

> If the baby is born, is it going to have any respiratory problems or something like this? Is she going to have to go to the Janeway?
>
> I'm very afraid, I mean anything can happen to the youngster. God forbid anything happens.
>
> Anything could happen, especially the baby, it could be stillborn, which it still could be. I'm not the type of person for that kind of stuff. It was scary that you may not proceed with what I'd call a normal pregnancy.

Given that the expectant fathers had only been focusing on a full-term healthy pregnancy, when the early hospitalization was suddenly thrust upon them, there was immediate concern for the condition of the baby combined with yet another possibility that the baby could have health problems:

> I don't want to have to spend two months traveling back and forth to the Janeway. I'd like to have the baby born healthy and at the right age to come home. Not just spend a month or five weeks in the hospital probably fighting for his life.

In addition to the uncertainty about the baby, there was uncertainty surrounding the health of their partners. For some of the expectant fathers, the uncertainty was manifested by a fear that the partner and/or baby may die: "The baby and *[partner]* just knowing that anything could happen to them"; "But then when I was told what it was and what could have happened to her then I got worried. Cause with a blood clot it can kill you they say".

These uncertainties experienced by the expectant fathers did not exist prior to the hospitalization. The hospitalization and unfamiliarity of events

created feelings of uncertainty for these expectant fathers: "Very nervous because you know . . . being not totally familiar with all these things". The expectant fathers expressed uneasiness with what was happening: "We didn't know whether she was going to lose it or what was going on and we still don't know".

The conflict between what the expectant fathers had understood would be the course of the pregnancy and what was actually happening created feelings of ambiguity. They were no longer able to predict an outcome for their partners, their babies, and themselves. The interruption had now moved the remainder of the pregnancy to a "high risk" category which gave a new meaning to the pregnancy. While the expectant fathers were unable to grasp the exactness of this new meaning, they now perceived the pregnancy as one where the outcome was serious and possibly even dangerous:

> I don't know and where she's in hospital it's got to be something high risk and the pregnancy is a little more *(open-ended)*
>
> What she *[partner]* was asking was 'okay, if I go into labor, what's going to happen, what steps are we going to take and that kind of thing'. So he *[doctor]* talked a little bit about the dangers and that kind of thing. The only concern now is the position of baby A which could be dangerous. The baby is going to hurt himself somehow. (This was a twin pregnancy.)

There was uncertainty regarding the treatment of their partners and its effects on the baby. Even though they had been informed by medical professionals that medications, like steroids and Morphine, would not harm the baby or the mother, the expectant fathers were confused by previous information

that during pregnancy women "should not take anything unless they absolutely have to". The treatments during hospitalization challenged their established way of thinking: "Now . . . where they're treating her with these high-risk medications, Demerol, Morphine, that's a worry too because she wouldn't as much as take a cough drop".

Despite the fact that the partner's condition was diagnosed, at the time of, or shortly after hospitalization, the expectant fathers were unable to make sense of the information that they were given. It was being processed at a time when events were moving uncontrollably fast. The inability to resolve the uncertainty served only to reinforce feelings of uneasiness. The original understandings about pregnancy conflicted with what was actually happening: "Cause with a blood clot it can kill you, they say and you don't know what's going to happen or what kind of two months you're in for". The uncertainty was further heightened when the doctors could not give absolute surety of what was happening:

> That shouldn't be a concern anymore. So, she *[doctor]* said you have to be concerned, it is serious, but you shouldn't be worrying every minute there. It is diagnosed, we are controlling it. The risks of the clot breaking off and getting caught in the heart or lungs is virtually zero.

There was a need on the part of the expectant fathers to quickly formulate a new understanding, but the understanding was slow in coming:

> They *[doctors]* didn't really know what it could be it didn't make a whole lot of sense. Like *[doctor]* said I haven't really seen anyone with this type of pain, and it really didn't make sense to her that she was suffering through this.

Thoughts about their partners and babies were uppermost on the expectant fathers' minds, whether they were at home, at the hospital, or at work. One participant commented on the extent of his concern for his partner: "Even though you're not always here, you're always thinking about it and about her and how she's doing this and that and the other thing". The thoughts were constant, almost unrelenting and typically found their way into the work lives of the expectant fathers. A couple of expectant fathers described how preoccupied they were while at work: "That's always on my mind when I'm at work so sometimes the concentration isn't there. Like I say a little more stressful because your mind is always thinking"; "Actually the first few days back to work, I was nervous working in the meat room because you're around fairly sharp knives and a saw and my mind wasn't there. My mind was out here with *[partner]*". For others this mental pre-occupation, although not a safety issue, nonetheless, was very real: "Trying to get the work done is probably a little different because your mind is not totally with it every day. You kind of wander off sometimes with things".

The energies that accompanied the pre-occupation, resulted in restlessness and an inability to get sufficient sleep, despite being in their own homes. The purposeless energies would be spent in trying to interpret what had taken place earlier in the day. There was a need to make sense of events:

> But when I go home and go to bed, no way. I won't go to sleep, your eyes can be burning. I don't know why this is but I guess the day is, you're rehashing the day or rehashing what's gone on in the last few days.

Although one of the expectant fathers had suggested that keeping physically busy would have been his preferred outlet, he weighed all the options and selected a quiet activity. Thoughts of his partner and the day's events resonated in his mind: "So it's too late to do anything in the house because there are people downstairs. So I'm either sat down or watching TV and of course you start thinking".

Uncertainty triggered ambivalence about the daily communication with their partners. Despite an expressed need for constant contact, the expectant fathers found that some of the communication could be distressing:

> I think about her at work and you know the phone calls. So if I get a phone call from her in the morning, usually I get one in the morning and one in the afternoon and I'm 10 or 15 minutes getting back into the swing of things.

For others, constant communication would be a signal prompting them to expect the worst: "Every time the phone rings I expect it to be something else, hopefully nothing wrong, but you really don't know".

At some point the expectant fathers moved beyond the turmoil associated with the initial hospitalization to a greater need to mobilize themselves in a way that would permit them to come to terms with what was happening. They looked for ways to endure the hospitalization and give meaning to the unexpected event.

Coming to Terms With the Unexpected

When events surface that are unexpected, individuals will attempt to form some meaningful context to help them deal with what is happening. Seeking or finding meaning is foundational for coming to terms with an event (Lazarus & Folkman, 1984). In this study, the expectant fathers were trying to find meaning in their partners' high-risk pregnancies. In order to come to terms with the events as they were unfolding, the participants not only had to endure but also develop a better understanding of these new experiences. The goal was to find a meaningful existence while simultaneously surviving this highly volatile transitional period.

The expectant fathers perceived the hospitalization as something that had to be endured. They were facing events that could not be brushed away but rather needed to be acknowledged, recognized as real, and internalized as an event that was happening to them. By trying to cope with events as they were occurring, participants hoped that they would develop a greater understanding of, and come to terms with, the unexpected. The following excerpts capture this feeling of struggling to endure: "You try your best to work through it and put it right out of your mind as quickly as you can. We didn't dwell on it, and I didn't dwell on it as an individual"; "If it happens, it will happen. It takes a lot for me to get upset"; "It will be over in a little while and things will go back to normal"; "You just plunge along. You take your day's work and do it, and take everything in

stride . . . and just hope for the best and get the answers that you can get and ask the questions that you can ask"; "I think everything will be all right as time goes on, and time is a big healer".

The security of the hospitalization alleviated some of the apprehension surrounding their partners' conditions. One participant commented thus: "Well, if she stayed in hospital, then I shouldn't have any worry". Another participant echoed a similar sentiment:

> I'm glad that she's in here. . . . If she was home, I mean I want her home for my personal reasons . . . but I'm glad she's here for the pregnancy. You know to make sure that nothing goes wrong, to get her through the last few weeks, make sure the babies are healthy, and that kind of thing. She's better off here. I'm sort of comfortable knowing that she's in the best place she can be with the condition that she's got. . . . There is that comfort zone, you know, that there's people here looking after her. (Twin pregnancy).

There was one expectant father, however, who had not realized the necessity for his partner's continued hospitalization. He expressed his frustrations in the following manner:

> I really don't understand why she's in so long. She gets day passes for four hours now. She had a night pass. So, the only thing I see they do now is monitor her once or twice a day and its blood pressure and temp. So, I explained to the doctor I can do that at home and she's more comfortable at home. When you're living in town and you're five minutes from the hospital, I don't think there is anything that would come up in five minutes that would make a difference. If you're in hospital and something happened to *[partner]*, by the time they page for the doctor you got two or three minutes. So it's not a point of adjusting. . . I won't adjust to having her down here because sometimes I get frustrated that she is in hospital and I don't see any need at this point right now.

The hospitalization put extra demands on the expectant fathers due to the atypical nature of what was happening at this stage of the pregnancy. Some of the participants did not have the necessary knowledge to accompany such events as early labor, bleeding, or deep vein thrombosis. Knowledge is the precursor to uncovering meaning. Without this knowledge, there was a void in the understanding of the events.

> I didn't realize whether this was something that is normal, I didn't know the difference. This is our first baby and I've never been around people that close, you know to their pregnancy, only just to go to their house and see them, not to really know what's happening.
>
> I had no idea what it was, like everyone has heard of a blood clot. I've never had to know what it was cause no one in my family had had anything like that.
>
> When I found exactly what the problem was, not really knowing too much about the medical condition.

The expectant fathers searched for answers. Actively seeking information brought with it the possibility of gaining a better understanding of the new situation. There was a thirst for additional information about the pregnancy and what was happening, and this was evident in the following: "I wanted more information"; "I must say I've enjoyed the week that she's in here. The information and feedback that we're getting . . . about pregnancy, just amazing. Makes it exciting"; "So the first thing we thought well you know, we got to find out what does this mean, what are the implications".

There was one expectant father who was not directly involved in the discussions related to the complications of his partner's pregnancy. He did however have an appetite for information. He chose to obtain the information from a distance:

> When they *[nurses and doctors]* come in I just walk out the door. I don't want to be in anybody's way. I got it after a while overhearing the doctors talking to her, I was just outside the door, so I heard that much.

The expectant fathers' understanding of events was enhanced as a result of the variety of technologies that the partners underwent during the course of the hospitalization. Many of the partners required ultrasound, fetal heart monitoring, and biophysical profiles. These tests were tangible opportunities for the expectant fathers to assign meaning and interpretation to the events as they were unfolding. Technology allowed them to see the images of the babies in utero, to hear the babies' heartbeats, and to observe the babies' movements as recorded on paper. The positive impact of the technology on the expectant fathers' understanding of events, was evidenced in statements such as: "That sort of brings it a little bit of reality. You see the changes and things like that *[ultrasound]*"; "I thought it *[ultrasound]* was amazing. We saw the baby, saw his arms, legs and then we got these pictures"; "The first time they put her on the baby monitor and I heard the heartbeat, sounds like it's going awfully fast to me". Technology in one case prompted an expectant father to assign a disposition to his baby: "One little devil *[baby]* is being a little too active". (Twin pregnancy).

Informational support that came from the health care providers also contributed to the expectant fathers' understanding of events. This support was viewed by the expectant fathers as both helpful and sustaining, in the time of crisis: "They *[nurses]* explained everything to you and it was reassuring . . . they always say 'Oh that's good, everything is great and so on'"; "Answered all of our questions . . . in lay terms so that we could understand them; then we got more information, the specialist, the hematologist came in that night"; "The nursing staff in the evenings they'll come in and do the tests and give little bits of information here and there . . . really helpful"; "A couple of doctors . . . came in and explained things better".

The added explanations from health care providers enhanced the expectant fathers' understanding of events. The expectant fathers expressed a satisfaction with explanations no matter how simple they might be. They appreciated the time that the staff took to explain things. One father expressed his appreciation thus: "The nurse said that one must be sitting on your bladder, just little things like that just mean so much and it makes us understand exactly what is going on".

The expectant fathers felt that they had become more knowledgeable and in tune with events as a result of the combined interactions with health care providers and exposure to the technologies. These twofold factors assisted the

expectant fathers in their attempts to understand the events as they were unfolding. As one expectant father commented:

> I told the nurses I could do it *[ultrasound]* as good as they can now. Actually there . . . was an intern or whatever, she did the measurements on the fluid and she measured a bigger number. I told *[partner]* that's not right. . . . I had seen the others do it so many times. I knew she *[intern]* was measuring from the shade of gray and the others were measuring from the shade of black. Every centimeter means there's that much more fluid. I said to get *[doctor]* to measure it.

As the expectant fathers grew accustomed to the hospitalization of their partners, they were less threatened by the unknown and unfamiliar. Though these elements were still very real, the expectant fathers were able to eventually develop an inner strength that co-existed with the unfamiliarity. The feelings of helplessness and insecurity were now subdued so that they could move toward accepting the reality of the situation. In order to achieve a sense of equilibrium, they attempted to look for ways to preserve the routines and relationships.

Striving for a Steady State

In striving to achieve a state of equilibrium during disruptions in routine, an individual will often search for ways to balance time. The individual may simply re-work an approach or adopt an altogether new approach to balance time. In some instances this may involve mimicking strategies used by others to balance time disruptions. Irrespective of the route taken to deal with disruptions in routine, the goal is generally the same . . . to achieve a steady state.

In this study, the unanticipated hospitalization symbolized a disruption in routine for the expectant fathers. At the same time that the expectant fathers described their normal everyday, pre-hospitalization routines, they went on to talk about the ways in which they strived to regain a sense of steadiness in their lives (steadfastness) by balancing time and sustaining relationships.

Prior to the hospitalization of their partners, these couples were experiencing well-established routines at work and at home. In describing these routines, there was a noticeable emphasis on the sharing that was involved in much of the routines. The expectant fathers described the pre-hospitalization relationships with their partners as ones where there were established patterns of regular and frequent contact.

The hospitalization weakened contacts with their partners and interrupted the ways in which they were connected both physically, as well as emotionally. The expectant fathers spoke of the interruptions in the way that they would begin their routine day, as follows: "And now that doesn't happen. You get up in the morning, you eat breakfast by yourself which is something we're not used to doing"; "She calls me every morning to wake me up". When articulating the disruption in the routines, there was an emphasis on the "we/our" aspects of the routines: "We get up in the morning, we do our thing, she goes to work, I go to work and we talk to each other two or three times during the day and we meet home at 5 o'clock"; "That was our routine, you know, beyond our working hours,

most of the time we spent together, everything we did we kind of did together". Some of the routines that were affected were those that had prescribed roles. One expectant father who would have ordinarily been accustomed to having his partner settle the children for bed, now found himself having to take on a new role, one with which he was unfamiliar:

> No, No, I don't be with them *[children]* all day long, I'm only with them in the night time and when I come home from work they're in bed. So I'm hardly ever home, only night time and I work two nights a week. So I'm gone basically all the time from her.

This same expectant father went on to describe that the routine sleeping habits were affected by the partner's hospitalization: "I sleep with the little fellow and she sleeps with the little girl, that's what I got in the habit of doing, until they go to sleep, so they're used to that". For another expectant father, the after-work routine was adversely affected. Catching the evening news, and then retiring for the day was no longer the norm:

> Before, when I'd get home at five o'clock by 7:30 or 8 o'clock I could be asleep watching the news or something . . . I'd have the whole night to sleep or whatever . . . but now I don't. I could come home from work relax and go to the mall, go to the store. You got to put all that on hold . . . you got to put that on hold while she's in hospital.

When describing their routines, the expectant fathers would often include comments on the magnitude or degree to which the hospitalization had now altered their routines. There were feelings of a bombardment of events in a short period of time. There was unpredictability in their everyday routines: "Things have changed so much, you know, from 6 o'clock one morning till 6

o'clock that evening. So, it's a major change in your life"; "There's no routine, now, nothing"; "Actually when I'm home in the night time, I mean, the youngsters are in bed 7:30, 8:00, 9:00, so I'm up watching TV, so I don't know what it's like all day long. But now I do, I'm getting a taste of it". The routines for one expectant father were things he looked forward to: "I miss work, off for a week, I'm usually not off that much". For yet another, the hospitalization prompted him to question the value of routine: "Very untypical I guess. In one sense it slowed me down a little bit because, now lunch time I come here, and then I usually go home and change and I'm back here again".

Changes in routine found the fathers trying to find a normal, manageable timetable of daily routine patterns. The daily routine was now wedged between home, work and hospital-related activities. As several participants described: "How can I get everything done that I want to get done and how can I spend twelve hours at the hospital when I only got five. How can you do that?"; "I don't usually have a lot of time to fool around, so I usually get off work, get changed, get washed up and come on through. I don't even have my supper actually".

The disruption in routine had now created a time schedule that was busier than ever and more difficult to manage. The degrees of the disruption in time are manifested in the following comments: "Everyday is very busy, because you're probably at work and you're probably drove crazy at work all day long. But Saturday comes and you have this checklist of things"; "Then probably as

the week goes on you keep adding, you write down all those things that you have to do"; "It's a lot of driving and cramming everything in"; "Well, it's been really busy actually".

The disruption in time balancing presented the expectant fathers with yet another challenge. They had to juggle the number of tasks to be done and they had to complete the tasks alone. The shift in responsibilities forced the expectant fathers to look at new ways to balance time. The following excerpts captured this accelerated pace: "That's my biggest thing, every day is full, it's a very full day for seven days a week"; "Time is limited"; "You go home and you just, you kind of do chores that have to be done, things that just can't wait any longer, it just got to be done".

One expectant father attempted to balance time by trying to get ahead with things to be done. He tried to accelerate what he had to do, but the pace didn't wane. He never really succeeded at managing his time and he was acutely aware of this:

> You try and balance all things out, so it's like everyday I'm doing something and I want to be doing the next thing and then I want to be doing the next thing and I just can't seem to get things done fast enough to my liking.

There was a runaway feeling with these new responsibilities. This feeling was one that expectant fathers could neither predict nor anticipate. Hence, there was often a feeling of time moving too quickly: "Typical day is very busy, just not enough hours in the day"; "Now I'm not home a minute".

One expectant father felt that there was an immense amount of pressure to get the house in order. He grouped all the chores in such a way that he felt he had to do them all before his wife was discharged. The number of tasks he identified and the time frame within which he was working created a real conflict with time.

> Gardening, housecleaning, trying to get the nursery done. I have a basement apartment and there's always something to be done down there. Basically just the upkeep of the house, that needs to be done. We had done a lot of renovations on the house and half that was in slings when *[partner]* came in. So I'm trying to get that finished off and tidied up before she gets home. It's pretty hectic.

Other expectant fathers were able to describe similar experiences with time moving too quickly:

> You're rushing around, especially on Saturdays, I got to do this and I got to do that. Like today even time is moving on, it's twelve o'clock. I thought I'd be done this. I thought I'd have all this done by now right. It's twelve o'clock and now it's two o'clock and I still haven't got it all done.

> I go to work at 8 o'clock and I work till 5 or 6 and then I leave work and come directly in here and spend the evening with *[partner],* I usually leave about 10 o'clock, so I mean I live in PC, which is another half hour in and half hour home.

For other expectant fathers there was a sense that the attempts to balance time were merely futile efforts where the clock would win out in the end: "fumbling with the clock". One expectant father recognized that he was faced with a tight schedule and that there was nothing he could do about it. He accepted the fact that it was impossible for him to get everything done, so he acknowledged that he would have to do some shifting of tasks:

> Sometimes it's a list so long and there's no way to get all the things done. So you have to try and put this off until Monday night or this one off until Tuesday lunch time and whatever. Try and get all the things done . . . I got to split my time between the hospital and home, trying to get things done.

In contrast, another expectant father expressed that his flexible work hours were an advantage for him. He described the flexibility as one way to lessen the constraints placed on him because of the hospitalization of his partner:

> But we're not sort of rigid, like if she needed something, like my job is flexible enough where I'm in sales that, I can pop out 3 o'clock in the afternoon. It's not like I'm in a 9 to 5 job, and I have to be at work from 9 to 12. So I got a bit of flexibility there which makes it good.

As part of their quest to balance time, the expectant fathers identified the importance of having support from family and friends:

> My brother-in-law, he's not only a partner but also a very close friend. So taking away part of the stress of having to worry about things ongoing in our lives. I think that's how he's very supportive.

The expectant fathers found themselves leaning toward family despite the fact that these family members often had their own responsibilities. Nonetheless, given the nature of the event *[sudden partner hospitalization]* the choices of support were not always open to selection:

> So, I talked to dad, and he got a full-time job now with his cleaning. I had to get him to take care of it for me. Dad's not the best person. He's after having a heart attack . . . so I didn't want to put too much on him . . . so it kind of left me in a position.

The effects of juggling/balancing time, often left the expectant fathers feeling physically and emotionally tired. They found the length of the hospitalization tiring. Their tiredness is captured in the following excerpts: "Three weeks long"; "You know . . . sigh . . . it's hard"; "No I mean, I'm beat out with the youngsters, they wear me out. I put them to bed at 9:00 and I'm in bed 10:30"; "Time is long now". For some of the fathers, they thought that the events might carry over into an even longer period of time: "That's going to be a long two and a half months"; "I got seven more weeks of it to go yet".

When describing their tiredness, there were repeated descriptors such as: "Long, pretty long, drag, flop into bed, and wears you out, just tired". The expectant fathers described feelings of emotional tiredness in the following physical ways: "But there's no relaxation, I guess the relaxation is sitting in the hospital, in a chair in the hospital. It's not really relaxation, it doesn't have the same effect". Evidence of emotional tiredness was expressed as well: "You don't have that relaxation of time with your mind which, I suppose, you do have it. You don't realize that sometimes you're kind of relaxed doing nothing"; "That's a big thing, like there's just no time to yourself, although you're always by yourself and yet I say there's no time to yourself".

As the expectant fathers tried to balance time in the aftermath of major disruptions in daily routines, they acknowledged the importance of restoring some intimacy in their relationships. They sought ways to fill the need for

privacy with their partners. In some cases, this was achieved through the choice of hospital accommodations:

> We talked to the doctor and I said if she got to be in here nine weeks, cause I couldn't spend any time with her. Like after ten o'clock you had to leave because you're on a ward. So the doctor said she would check it out and see if she could get her a private room or even a semi-private room. To get two ladies long term like [partner], who don't have a baby. If you want to open the window you can open it, or if you want to stay up till twelve o'clock laughing, you can stay up till twelve o'clock laughing.
>
> She had the room to herself most of the time, so it was usually only the two of us there. So that was alright for a bit of privacy.

In other cases, a break for both of them from the hospital surroundings for short periods was a reprieve and gave the couples quality time to be alone: "We got out for a couple of times, she went out in the car and we went for a drive"; "Sometimes when the nurses let her go out, we'll go around for a walk and sit down out back somewhere and do something like that. Nothing out of the ordinary".

Several participants talked about accepting the restrictions placed on the joint *[partner and expectant father]* freedom of movement during the hospitalization. The hospital rules made the expectant fathers feel that they no longer had the liberty of going places with their partners without first seeking permission: "The biggest thing with me, like I said earlier was the part where she's in the hospital and can't get out"; "When the nurses let her go out"; "When the days are nice they let us go out"; "A couple of times they gave her a pass to get out for a few hours and we went out. So other than that she stays here".

The connectedness was all the more meaningful when they could participate in an activity to which they both related: "We're playing cards or playing games or whatever when I come in"; "We just drove home. We just wanted to go home and spend a bit of time with the dogs and just enjoy being home and then we just drove back in".

The expectant fathers described their relationships with their partners as being defined by the presence of both in their home. Consequently, the absence of the partners in the home was further exacerbated when they returned home to an empty house. The separation left them feeling like there was no meaning, there was something missing. Their relationship with their partners was based on the partners' presence, not merely on where they lived. One expectant father described it in this way:

> I don't really want to be there, to be honest with you. Even when I do go home at night at ten o'clock or whenever it is, there's an empty feeling when you walk in that house not another soul there to speak to you or to yell at you (laughter) or do anything right. So it's a strange feeling right to walk into an empty house all the time. I've never, since we've been married, I don't think I've been in the house. No I wasn't in the house by myself since we got married, so it's a whole new experience.

Another expectant father felt as if he was leaving a part of himself behind when he left his wife at the hospital at night. There was a emotional wound created when the time came to the leave the hospital following a visit. One expectant father described it in this way :

> You know last night when I was closing the door leaving. I just felt like I'm feeling now, like my eyes were watering. I just sort of felt really alone

> leaving there *(his eyes fill with tears)*. When I was leaving here last night, I was just closing the door and I felt bad leaving her there.

A common response to the partners' absence in the home was for the expectant fathers to substitute with such things as pets and television. The fathers described a need for someone or something to interact with when they were at home alone. They were looking for companionship to reduce the loneliness that they were feeling. As several participants commented: "I moved the TV into the bedroom for company. I'll watch a little bit of TV or something. To kill a bit of time"; "The biggest thing that's helping me through it, is well I got the dogs for company when I go home at night"; "Got a cat. The cat's company"; "I brought the TV in the bedroom, and turn it on until I fall asleep". For others, the value in the presence of friends was expressed. It wasn't the amount of time that he spent with friends, but rather the mere contact and support gained from the visits: "I'll stop in to see our two best friends for a little while, just a bit of company in the evening".

Contact by telephone was the most common means of connecting with the partners while in hospital. Contact via the telephone was a significant remedy to the separation. It served as a form of connection when the expectant couple was trying to make decisions that required input from both. The telephone calls provided the expectant fathers with a closeness, a presence:

> Usually I carry my cell phone with me in case she ever needs me for anything. Like Saturday when I'm running my errands, I'll take my cell phone with me and she can call me. Usually she will call me, like when I'm running errands for her, she'll ask me to pick up this, and this is where

> I'm picking it up, I'll call back and say what color was that supposed to be or what size was that supposed to be.

Likewise, the availability of communications through the telephone, allowed the expectant fathers to be a mere phone call away should the partner's condition change. The telephone was the bridge between time spent at the hospital and time away from the hospital: "Well she got a phone in her room which is a godsend, usually at work every day I'd say she calls me four or five times, or she tries to call me if she can reach me"; "We talk quite often even when I'm not here, or when I'm driving somewhere, I'll call and chat with her while I'm driving. We stay in contact quite a bit". The expectant fathers could telephone their partners as often as they wanted and whenever they wanted. The time of day made no difference to calling their partners yet it made all the difference in that it gave reassurance. Several expectant fathers expressed it this way:

> I call her in the mornings before I go and then usually before I come down. Probably 11 o'clock, I'll call her just to make sure if she wants something before I come.

> I call her mid afternoon or probably 4:30 or so before I go home to see if she needs anything for me to drop in before I go home. Then I'll usually call her before I come here just to make sure, yea, we're pretty well in contact"; "Oh many times, ten, fifteen times a day, just to see how she's doing."

The expectant fathers made themselves available to their partners in case they needed them. They were the ones who were doing the running around. The cell phone or pager would keep their partners from feeling isolated while at the same time it gave connection to the separation. This gave them an

opportunity to experience a sense of togetherness similar to the togetherness they had in their relationship prior to the sudden hospitalization. As several expectant fathers commented: "I carry a beeper with me just in case, so she can get in touch with me"; "I phone her three times a day. I talk to her just as much as I did, probably more now"; "I have a pager and a cell phone that I just got so she can get a hold of me".

Sustaining relationships was also important in terms of the contacts with family and friends. By keeping in touch with family, the expectant fathers had an avenue for some form of support. The two types of support they generally sought were emotional support and tangible support. In some cases the emotional support was merely a phone call away:

> Phone your parents, talk to your parents, talk it out. What helps me relax when something goes wrong like this is my parents. Mom was a nurse at one time. I talk to my mom and then she'll explain it back and eventually you calm down and relax.
>
> I've got a sister who lives a great distance away, in DL, who basically raised me, so she's kind of my mother that I talk to and get all my excitement and stuff out like that, so she gives me a bit of advice.

The expectant fathers expressed that their partners' families, as well as their own families, provided emotional support: "All my family has been very supportive, *[partner's]* family too, visiting, calling". For another expectant father, emotional support came from the daily contact with family and friends. They would ask how he was doing:

> I'd say the most thing I can think about that has helped is the fact of family and friends. That's the major. They seem to rally around you more than

> probably you would a normal day. Some close friends that make sure every day they ask me how things are going or if there is anything they can do for me.

The source of emotional support was sought from not only immediate family, but also from co-workers:

> That's been pretty good to be able to just sit down and talk to somebody and sometimes just ramble on about whatever. So, that was good, that I had a few close friends, and they are there during the work day that you can get all those things off your mind.

The expectant fathers also expressed that, in addition to emotional support, family and friends gave tangible support: "Her mother has been quite good. She's taken home her clothes and cleaned, you know, some of her pyjamas"; "Some of them have offered to cook meals for me. Actually one of my friends brought over a meal the other day"; "Providing meals and cooking meals and coming down and doing little things".

As the hospitalization progressed, the expectant fathers felt that they had successfully managed to remain connected to their partners and the pregnancies. They had endured new, unexpected experiences and discovered ways to maintain an involvement in their partners' pregnancies. They identified such things as their routines, balancing time, and the relationship with the partners as important aspects of their lives that they could and did re-establish to co-exist with the sudden hospitalization.

Essence

Keeping the connection is the essence that flows through the themes of (a) too early: protracted readiness; (b) dealing with uncertainty; (c) coming to terms with the unexpected; and (d) striving for a steady state. Unanticipated events can create a disruption in relationships and the support that is a function of these relationships. When an unanticipated event results in a physical separation between persons, there is generally a need to find ways to keep some kind of connection. When there is an emotional separation triggered by a crisis, there must be a re-attachment. Those affected by the turn of events may try to find new ways, consciously or unconsciously, to reach out for support from other sources.

Initially, the expectant fathers had anticipated that nine months associated with a full-term pregnancy was ample time to plan and get ready for the arrival of their babies. The sudden hospitalization brought this luxury of time to a halt. It left the expectant fathers unprepared for what they had previously thought was to be weeks away. The hospitalization was a signal that events were now happening too early, and as such, they were surrounded by confusion as to whether it was to be a short-term or a long-term situation ending in the demise of the partner and/or baby. This "too early" event sent the expectant fathers scrambling to get ready and to create a sense of order. By being present with their partners at the initial hospitalization, the expectant fathers initiated

efforts to keep the connection with their partners and their babies in utero. The feelings that were aroused at this time, included shock, disbelief, and fear about the outcome for the partner and baby, along with the acknowledgement that they were neither physically nor emotionally ready for fatherhood. These feelings were the primary driving forces that led to efforts to keep the connection.

As time passed, the expectant fathers searched for ways to find meaning in the uncertainties surrounding the complications of pregnancy. The uncertainty was all around them, in every direction, thus supporting a feeling of needing to remain in constant contact with their partners. The more the uncertainty engulfed the expectant fathers, the greater the need to keep the connection. The uncertainty could not be contained. It permeated all aspects of their work lives, their family lives and their social lives. Instead of retreating in this time of uncertainty, the expectant fathers reached out in a number of directions to deal with and, hopefully, resolve it.

The expectant fathers reached a point where they acknowledged that there was a problem. The next challenge was to endure the event as it ran its course. This awareness prompted them to search for answers that would give greater understanding and eventually meaning to the whole event. Mobilizing themselves by actively asking questions or helping out at the bedside during visits were tangible ways in which they moved to meet the goal of coming to

terms with the unexpected. Instrumental in reaching this goal was the necessity to keep the connection.

Once the expectant fathers had worked through the initial feelings associated with a sudden hospitalization they looked for ways to hold on to this steadiness. By balancing time, keeping in touch with not only their partners, but family and friends as well, and maintaining responsibilities associated with routines, the expectant fathers were able to sustain this steadiness. When the expectant fathers were at the hospital they were able to maintain their presence and thereby strengthen the hold on their connectedness. The expectant fathers were trying to put all that had happened behind them and re-focus on the progression of their partners' pregnancies. They attempted to re-establish their relationships through remodeling avenues of communications (e.g., cellular telephone, etc.). One of the most common resolutions to feeling disconnected was for the expectant fathers to spend as much time as possible at the hospital with their partners. Even when there was no news to be had, or no specific reason to go to the hospital, the expectant fathers found that there was a sense of satisfaction of "just being there", keeping the connection. There was a symbolic sense of ease and relaxation when they were together.

Summary

This chapter, in its overview of the participants' background, its description of the themes, and the exploration of the essence of the lived

experience for the participants, outlined the important issues facing expectant fathers who have partners hospitalized for high-risk pregnancies. As in any research, the context allows other researchers to apply the findings to subsequent studies while keeping in mind that the findings are only those for this particular group of expectant fathers. Apart from the gestational weeks of the partners' pregnancies, there were no deliberate efforts to restrict the participation of any particular age group, nationality, or mental status.

The themes were selected based on their mutual exclusiveness to stand alone. The interview data provided a richness that contributed to these efforts to isolate themes. The expectant fathers were interviewed in isolation from their partners. There were free expressions of feelings and thoughts and at times there were signs of emotional pain (crying) that spoke to the genuineness of the expectant fathers' disclosures.

In arriving at the essence of the study all themes were pointing toward a central common thread - keeping the connection. The expectant fathers wanted to be a part of what their partners were experiencing. In order to be a part of what was happening, the expectant fathers had to find ways to keep the connection with their partners. They wanted to share in their partners' pain, to feel their guarded excitement and to be there, whatever the outcome. Every waking moment was focused on their partners and their babies. Whether away

from the hospital, at the hospital, or simply sitting at home, the expectant fathers had a longing to be near their partners.

CHAPTER 5

Discussion

In the previous chapter, the findings to the research question were presented. In this chapter, the findings are discussed in relation to the literature. As already mentioned, one of the early challenges of this study was to locate studies that reported men's views and experiences in pregnancy. The scarcity of available empirical data in the literature has also been acknowledged by others who were attempting to break new ground to discover some of the issues men face in pregnancy-related circumstances, particularly high-risk pregnancies. As would be expected in a phenomenological approach to research, the participants' experiences in high-risk pregnancies were influenced by other aspects of their lived world.

Too Early: Protracted Readiness

This theme described the upheaval brought about by the early, unanticipated hospitalization. There were emotions ignited within the expectant fathers that ranged from shock and anxiety to disbelief. There was concern that something might be going wrong with what was, up to this point, a normal pregnancy. These crisis-like emotions were, in large part, due to the critical nature of the event; that is, the nine months were not finished. Similar emotional reactions in expectant fathers have been reported (Maloni & Ponder, 1997; May, 1994; McCain & Deatrick, 1994; Miron & Chapman, 1994; Murphy,1998; Ross,

1993). The expectant fathers felt as though time had been moved ahead and they had not completed the tasks of getting ready. It is reported that expectant fathers proceed through sequential developmental processes over the span of nine months allowing them time to prepare for the arrival of the new babies and fatherhood (Donovan, 1995; May, 1982b; Jordan, 1990).

During the developmental process, expectant fathers form an attachment with the fetus which is enhanced by feeling the fetus move, hearing the fetal heartbeat and seeing the outline of the fetus on ultrasound (Jordan, 1990). For all the expectant fathers in this study, these avenues for attachment were shattered by the high-risk complications of the pregnancy. The high-risk complication changed the meaning of these avenues. They were no longer used merely for facilitation of attachment and monitoring of the development of the fetus, but were now being also performed to determine the survival of the fetus. Thus, bringing a form of reassurance to the expectant fathers and rekindling some hope that the pregnancy would continue and fatherhood was still a possibility.

When the partners became the center of attention as a result of having to be hospitalized, the expectant fathers felt as though they were isolated from the pregnancies. In normal pregnancies expectant fathers feel similar isolation when their expectant partners near term and become the focal point (Donovan, 1995; Jordan, 1990). Hence, there is a common association between the

feelings of isolation in the expectant fathers and the point in the pregnancies where the partners become the focus.

With the admission of their partners to hospital, all the expectant fathers had to get ready quickly for the possible births of their babies and they had to remain in a readiness mode until the baby's arrival. They needed to maintain a momentum of readiness for a protracted or prolonged period of time. Despite sensing an urgency to get ready, the expectant fathers were at a loss to understand what it was they had to do in order to get ready. There was a time-shifting that permeated all aspects of their lives and it was brought about primarily by the sudden threat of a premature ending to the pregnancies. Although May (1982b) reports that between twenty-five and thirty weeks gestation, the expectant father is directing energies toward physical preparations for the baby's arrival, in this study, the expectant fathers had just begun to think about the physical preparations. They were not in any rush. They anticipated that there was time remaining in which to do these tasks. With the sudden hospitalization, the expectant fathers realized that there was no additional time. The physical preparations, for example, crib, toiletries, that were to be completed at a future date, were now thrust upon the expectant fathers.

Up to this point, the knowledge that they had processed was in relationship to the timely progression of the pregnancies. The expectant fathers understood that the babies needed the total nine months for survival and with

this sudden hospitalization, the survival or well-being of the baby could be compromised. The expectant fathers had not made any changes up to this point with their everyday routines and were caught off guard with the sudden change of events. It was too early to ask for time off work and there was no sign of resolution of the crisis; thus simple, everyday decisions were being hampered by the sudden hospitalization.

Dealing with Uncertainty

The interruption in pregnancy was sudden, unexpected, and came with little warning. In this way, it was fraught with uncertainty. The expectant fathers were now faced with unfamiliar activities and happenings. There was uncertainty about the pregnancies, the partners' health, the babies' health, and their pending role as fathers. In this period of uncertainty, the expectant fathers were constantly trying to make sense of the events. The thoughts of what might be happening was always on their minds, engulfing them wherever they were and in whatever they did. The presence of these ongoing, intrusive thoughts about their partners' status and well-being during high-risk pregnancies are similar to those reported by May (1994), McCain and Deatrick (1994), and Ross (1993).

The expectant fathers thought that they had nine months in which to gather information about pregnancy and fatherhood. The sudden admission of their partners to hospital with complications of pregnancies interrupted this

gathering of necessary information. This gap in information-gathering added to the feelings of uncertainty. It is reported that expectant fathers go through a series of sequential phases during pregnancy which involve a period of learning about pregnancy and their upcoming role as fathers (Donovon, 1995; Jordan, 1990; May, 1982b; Wagner, et al., 1997). It is during these stages that the expectant fathers learn about the developing fetus and begin the attachment process to the fetus, making the fetus a reality.

Routine doctors' visits and the start of prenatal classes had provided the expectant fathers with a foundation for understanding, giving them a feeling of certainty and predictability about the babies and the upcoming births. When these sources of information were halted, the expectant fathers did not have any other sources to call upon and therefore, they were in a state of "flux". With very little knowledge to draw upon, the expectant fathers were no longer able to predict the course of the pregnancy and its outcome (Mishel, 1988).

In addition to the cessation of information-gathering, the expectant fathers could no longer be certain about the information they had already collected. It did not fit the situation or the circumstances that they were now experiencing. The information was of little use to them. Unable to use what information they had, the expectant fathers were now feeling confused and uncertain. Their ability to predict the outcome of the pregnancy left them feeling uncertain about the outcome of the pregnancies and their partners' health.

Coming To Terms With The Unexpected

This theme captures the expectant fathers' attempts to come to terms with the uncertain outcome for the pregnancy. In order to find meaning in what was happening, the expectant fathers had to find ways to endure the events as they were unfolding. They sought new information from sources, such as technologies, health care professionals, family, and friends. Seeking new knowledge has been recognized as one of the strategies used by expectant fathers in high-risk pregnancies as they attempt to come to terms with the whole situation (Maloni & Ponder, 1997; McCain & Dreatrick, 1994; Ross, 1993).

As the expectant fathers became familiar with the hospitalization and the treatments for their partners, they became more knowledgeable about the events surrounding these pregnancies. They were gathering new information along the way that enabled them to find meaning in the events and come to a better understanding of what was happening. They were taking one day at a time in the hope of coming to terms with events. Ross (1993) reports that taking one day at a time is a coping strategy for expectant fathers facing the hospitalization of their partners for high-risk pregnancies.

Eight of the nine expectant fathers accepted the need for the hospitalization of their partners, giving way to a more likely transition toward coming to terms. Of these eight, one expectant father struggled with accepting the hospitalization even though he had had two previous preterm pregnancies.

He felt that this pregnancy was different. Previous experience was not a deciding factor for him in the acceptance of the hospitalization, thus coming to terms for this father was a little more difficult. The one expectant father who had not accepted the hospitalization of his partner was unable to see the reason why his partner should be in hospital when he could look after her needs at home. During the interview, it was clear that he was in a continuum of turmoil in coming to terms with the events and the necessity for his partner's hospitalization.

Striving for a Steady State

As the expectant fathers resigned themselves to the hospitalization of their partners and dealt as best they could with surrounding uncertainty, they were striving for a steady state. They were attempting to survive in a constantly changing and altogether new environment. They found themselves overwhelmed with responsibilities. The expectant fathers had to continue with their own responsibilities plus undertake those that their hospitalized partners were unable to perform. The expectant fathers' daily routines had been disrupted and they had to somehow develop new routines that involved incorporating the hospitalization complete with its levy of uncertainty. This required a balancing of their time and a juggling of responsibilities while at the same time having to spend as much time as possible at the hospital. These findings are comparable to those of Maloni and Ponder (1997), May (1994), and

Ross (1993) who reported that expectant fathers were overwhelmed by "having to do it all".

The expectant fathers were often too exhausted at the end of a day to rest or sleep. Their concentration and attention spans were stretched to their limits. The hands of the clock seemed to dictate the pace of their lives. Similar time pressures, along with lack of concentration, were reported by May (1994) for expectant fathers whose partners were prescribed activity restriction to prevent preterm labor.

Despite this chaos, the expectant fathers did attempt to achieve a steadiness in their daily lives. They valued not only the routines that now seemed lost but also the intimacy they had with their partners before the hospitalization. They tried to align the hospitalization to fit their routines. They spent time at the hospital. They engaged in familiar activities while visiting with their partners. When they left the hospital with their partners on day passes, the expectant fathers and their partners returned home where they could find familiarity and security.

In order to maintain a steady state, the expectant fathers required social support as a way to minimize the intensity of the crisis. Support during a crisis does help lessen the severity or intensity of the crisis (Brown, 1986). Spousal support is recognized as a chief source of support for the expectant father (Cronenwett, 1985a; Wagner et al., 1997). Expectant fathers are more likely to

avoid bringing their own distress to the attention of their partners when they are experiencing problem pregnancies. Instead, the expectant fathers ignore their own needs in favor of supporting their partners (Maloni & Ponder, 1997; May, 1994; Miron & Chapman,1994; Murphy,1998; Wagner et al.,1997). The expectant fathers used support from family first and then from friends in order to keep it all together. These same supports are described by Maloni and Ponder (1997), May (1994), Miron and Chapman (1994), Murphy (1998), and Wagner et al. (1997).

The Essence

The essence of this experience was identified as **keeping the connection**. The expectant fathers went to extraordinary lengths to remain involved with their partners and the pregnancies. Up to the time of the hospitalization, the expectant fathers had already established a place in the pregnancies. As the pregnancies progressed, the expectant fathers were solidifying their presence. There was a connection between the expectant fathers, the partners and even the babies. When the interruption in pregnancies occurred, the expectant fathers sought to establish ways to continue on with the connection to their partners. Integral to remaining a part of the pregnancy was the need to stay physically and emotionally connected with the partner. Through hospital visits, the use of cellular telephones and pagers, alterations in routines, balancing time, and finding supports, the expectant fathers attempted to sustain

the connection. All these strategies kept the expectant couples connected with each other. The focal point of the expectant fathers' day was to remain in contact with their partners, which then ultimately connected them with their babies.

Summary

The four themes discussed in this chapter provide new meaning to holistic family-centered care. Each theme speaks to the impact of the hospitalization on expectant fathers whose partners have been hospitalized for high-risk pregnancies. When the partners were admitted for possible complications, the expectant fathers experienced a cessation in their routines and relationships. Not unlike their partners, the expectant fathers were confronted with a variety of adjustments, some of which were simple, others which were more complex. Metaphorically speaking, the expectant fathers were immobilized. Their worlds were turned upside down, yet they knew that they must maintain stability in the face of unstable events. The expectant fathers were as perplexed and as unsettled as their partners.

The emerging themes provide insight into the considerations that need to be addressed in family-centered care. In shaping the essence of the expectant fathers' experiences as **keeping the connection**, each of the themes acquaints health care providers with knowledge about the major issues facing expectant fathers during the hospitalization of their partners for high-risk pregnancies.

With the knowledge gained from this study, health care professionals who practice family-centered care will be able to move forward with a deeper integration of family-centered care into the care for mothers, babies, and fathers as clients.

CHAPTER 6

Limitations and Nursing Implications

In the previous chapter, the findings of the study were discussed in relation to the literature. This chapter begins by outlining the limitations of the current study, followed by discussion on the implications of the study findings for nursing practice, education and research. It concludes with a brief summary of the study.

Limitations

The participants of this study did not represent the attributes of the general population of expectant fathers whose partners were hospitalized for high-risk pregnancies. Eight of the nine expectant fathers were experiencing their first pregnancy and did not have any other children at home. The other participant had two living children, both born as a result of premature births. The experiences of expectant fathers from other cultural backgrounds, in particular aboriginal groups, was not presented. It is possible that the experience for these expectant fathers may be different and these differences may give rise to additional interpretations.

The sample in this study did not discriminate between expectant fathers living in an urban versus a rural setting, first time expectant fathers as opposed to non-first time expectant fathers or fathers with varying degrees of education.

Age was not a factor. If the criteria for the participants had favored any one of these variables the findings may have been more restricted.

All the expectant fathers in this study were interviewed at the time that their partners were hospitalized. It was felt that this may have been a deterrent to those who might have been otherwise interested in participating but could not because of the level of distress.

Implications

As with most research studies, the findings of this study provide invaluable information that serves to uncover what is obscure, strengthen what already exists, or, shape an altogether new perspective of phenomena. The findings of this study are a composite of all three of these potential research outcomes: the voice of the expectant father during the high-risk experience represents an uncovering of the unknown; the already existent, albeit sparse, research on expectant fathers in normal pregnancies serves to strengthen the direction in which nursing research can move; and the emerging themes have the power to provide insight into the new initiatives needed in family-centered care settings. This study reveals that the expectant fathers' experiences during high-risk pregnancies are not merely an adjunct to the experience of their partners but the expectant fathers' experiences are interwoven with those of their partners.

Nursing Practice

Nursing is built on a foundation that values holistic care for clients, and in this context, views each client as an individual within society, complete with his/her own unique set of needs. Health care providers must recognize the full meaning of family-centered care and incorporate all members of the family when planning and implementing nursing care. The expectant fathers are often left on the periphery to deal with their own worries and responsibilities when their partners are hospitalized for high-risk pregnancies.

In family-centered nursing units, when pregnant women are admitted to hospital with high-risk pregnancies, it is necessary to have structures and supports in place that respond to the needs of all members of their families, expectant fathers included. Health care professionals need to give the expectant fathers a choice whether or not to participate in the nursing assessment of their partners. Nursing needs to identify mechanisms that will allow expectant fathers to actively participate in the care of their partners and babies. There is a need to encourage them to verbalize their feelings about the possible outcomes of the pregnancies. It is unlikely that the expectant fathers will initiate discussion related to their partners' health with health care providers, as it is shown that the expectant fathers tend to ignore their own feelings in order to support their partners in time of crisis. It is important to recognize expectant fathers as part of the pregnancies and not just as visitors. This way of thinking

will serve to help nurses and other health care professionals adopt a stronger, family-centered approach to nursing care.

One of the strategies that the expectant fathers in this study used to come to terms with the unexpected hospitalization of their partners was seeking knowledge. These expectant fathers identified that nurses and other health care professionals provided them with information and explanations. This was evident from the following statement by one of the expectant fathers: "Little explanations like that mean so much". The nurses on the antepartum units need to be informed about this positive feedback so that they know they are meeting some of the needs of expectant fathers. This will encourage them to continue to provide information to the expectant fathers and to recognize their need for information.

The support system of the expectant fathers should be determined by health care professionals. Remembering that the partner is the expectant father's main source of support stresses the importance of providing unrestricted contact for the expectant couple. The need for maintaining the connection with his partner can be facilitated by allowing the couple privacy in order to maintain intimacy in their relationship. Attempts should be made to accommodate expectant fathers who wish to stay overnight with their partners, for example, a room on the unit could be set aside as a family overnight room that the expectant fathers could use as needed. A list of available accommodations and the costs

could also be provided to expectant fathers who must travel long distances from home to be with their partners.

The development of national and provincial guidelines needs to emphasize the presence of the expectant fathers in high-risk pregnancies. By building on research findings such as these, the standards of care in family-centered care can be strengthened. The implications for nursing practice can then be applied. The planning and implementation of programs and nursing care can be augmented.

Nursing Education

There needs to be an emphasis in nursing curricula on the role of men in pregnancy, but more particularly, men in pregnancy that is of a high-risk nature. In developing the curriculum content, experts in the area of family-centered care need to be consulted. Research findings, such as this one and others cited in this study, need to be referenced when developing course content.

Students and educators must be sensitive to the issues that men face when dealing with a typically female-oriented health issue. Cultural, as well as societal biases and barriers need to be addressed. It is important to emphasize that men's emotional responses to stress are not always forthcoming and, in addition, the expression of feelings may be hampered by the fact that these men are revealing their feelings in a predominantly female environment. This may make it more difficult for all involved.

The developmental patterns of men should be well articulated in nursing curricula so that the educator, as well as the student, can interact with and respond to the needs of expectant fathers. The implementation of care must include expectant fathers as well as expectant mothers. Nursing students need to learn the skills that go along with promoting expectant fathers' involvement.

Nursing Research

An important nursing implication arising from this study is the need to encourage and support further research into this area. Funding for research into family-centered care must be a priority among researchers. Nurse researchers need to advocate or lobby for such financial support. Replication of this phenomenological study, or the use of other qualitative methods of inquiry, would provide additional insight into the experiences of expectant fathers. Further research using quantitative methodology, will provide data that allows generalizations across a larger population of expectant fathers. It is important to look at the experiences of both the expectant mother and the expectant father not only as individuals but also as a couple at this time. Further research using comparative analysis of the couples would provide information on the similarities and differences in the perceptions and adjustment patterns of the couples. Consideration must be given to the construct of the family, the relationship between the expectant couple, and how the relationship impacts and is impacted on by high-risk pregnancies. While this study did not address the alterations in

the ongoing sexual relationships of the couples during the time of hospitalization, further research in this area would be useful.

In order to respond to the needs of the childbearing family, research is needed to identify the nature of supports required by expectant fathers during high-risk pregnancies. Such research can then be applied to program development, e.g. support groups for expectant fathers. Research that looks at nurses' perceptions of the role and needs of the expectant father during high-risk pregnancy must be considered as well.

Summary

This phenomenological study on the lived experience of men whose partners were hospitalized for a high-risk pregnancy used van Manen's (1997) method for human science research to explore the question: What is the lived experience of men whose partners have been hospitalized for high-risk pregnancies? Data was collected using unstructured interviews from nine participants whose partners were hospitalized for high-risk pregnancies between thirty and thirty-six weeks gestation. The following themes were identified from the data: too early: protracted readiness; dealing with uncertainty; coming to terms with the unexpected; and, striving for a steady state.

From the themes, the essence of the lived world of these expectant fathers whose partners were hospitalized for high-risk pregnancies was identified as **keeping the connection**. The findings were discussed in relation

to the existing literature on fathers and high-risk pregnancies. Implications for nursing research, education and nursing practice along with the limitations of this study were presented.

References

Ainsworth, M.D., Blehar, M.C., Waters, E., & Wall, S. (1979). *Patterns of attachment: A psychological study of the strange situation*. New Jersey: Lawrence Erlbaum Associates, Inc.

Antle, K. (1975). Psychologic involvement in pregnancy by expectant fathers. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 4,* 40-42.

Baker, C., Wuest, J., & Stein, P. (1992). Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing, 17,* 1355-1360.

Bedford, V. & Johnson, N. (1988). The role of the father. *Midwifery, 4,* 190-195.

Brown, M.A. (1986). Social support, stress, and health: A comparison of expectant mothers and fathers. *Nursing Research, 35,* 72-76.

Brown, M.A. (1987). How mothers and fathers perceive prenatal support. *Maternal-Child Nursing Journal, 12,* 414-418.

Brown, P., Rustia, J., & Schappert, P. (1991). A comparison of fathers of high risk newborns and fathers of healthy newborns. *Journal of Pediatric Nursing, 6,* 269-273.

Bryce, R., Stanley, F., & Enkin, M.W. (1988). The role of social support in the prevention of preterm birth. *Birth, 15* (1), 19-24.

Callaghan, P. & Morrissey, J. (1993). Social support and health: A review. *Journal of Advanced Nursing, 18,* 203-210.

Catalano, R., Hansen, H., & Hartig, T. (1999). The ecological effect of unemployment on the incidence of very low birthweight in Norway and Sweden. *Journal of Health and Social Behavior, 40*, 422-428.

Chapman, L.L. (1991). Expectant fathers' roles during labour and birth. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 21*, 114-120.

Clinton, J. (1987). Physical and emotional responses of expectant fathers throughout pregnancy and the early postpartum period. International *Journal Of Nursing Studies, 24*, 59-68.

Cronenwett, L.R. (1985a). Network structure, social support and psychological outcomes of pregnancy. *Nursing Research, 34*, 93-99.

Cronenwett, L.R. (1985b). Paternal network structure and perceived support after birth of the first child. *Nursing Research, 34*, 347-352.

Diemer, G. (1997). Expectant fathers: Influence of perinatal education on stress, coping, and spousal relations. *Research in Nursing and Health, 20*, 281-293.

Donovan, J. (1995). The process of analysis during a grounded theory study of men during their partners, pregnancies. *Journal of Advanced Nursing, 21*, 708-715.

Galloway, K. G. (1976). The uncertainty and stress of high risk pregnancy. *The American Journal of Maternal Child Nursing, 3*, 294-299.

Glazer, G. (1989). Anxiety and stressors of expectant fathers. *Western Journal of Nursing Research, 11*, 47-59.

Harrison, M.J. & Hicks, S.A. (1983). Postpartum concerns of mothers and their sources of help. *Canadian Journal of Public Health, 74*, 325-328.

Health statistics at a glance [Electronic data file]. (1999). Ottawa: Statistics Canada.

Jordan, P. (1990). Labouring for relevance: Expectant and new fatherhood. *Nursing Research, 39*, 11-16.

Kemp,V.H. & Page, C.K. (1986). The psychological impact of a high risk pregnancy on the family. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 15*, 232-236.

Lazarus, R.S. & Folkman. S. (1984). *Stress, appraisal and coping*. New York: Springer Publishing Co.

Maloni, J.A. & Ponder, B. (1997). Fathers' experience of their partners' antepartum bed rest. *Image: Journal of Nursing Scholarship, 29*, 183-188.

Marquart, R. (1976). Expectant fathers: What are their needs? *American Journal of Maternal Child Nursing, 1*, 32-36.

May, K. (1978). Active involvement of expectant fathers in pregnancy: Some further considerations. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 7*, 7-12.

May, K.A. (1982a). Factors contributing to first-time fathers' readiness for fatherhood: An exploratory study. *Family Relations, 31*, 353-361.

May, K.A. (1982b). Three phases of father involvement in pregnancy. *Nursing Research, 31*, 337-342.

May, K. A. (1994). Impact of maternal activity restriction for preterm labour on the expectant father. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 23*, 246-251.

McCain, G. & Deatrick, J. (1994). The experience of high risk pregnancy. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 23*, 421-427.

McHaffie, H. (1989). Mothers of very low birth weight babies: Who supports them? *Midwifery, 5*, 113-121.

Mercer, R. T. (1990). *Parents at risk.* New York: Springer Publishing Company.

Mercer, R. T. & Ferketich, S.L. (1988). Stress and social support as predictors of anxiety and depression during pregnancy. *Advances in Nursing Science, 10* (2), 26-39.

Mercer, R.T., Ferketich, S. L., DeJoseph, J.F., May, K., & Sollid, D. (1988). Effect of stress on family functioning during pregnancy. *Nursing Research, 37*, 268-275.

Mercer, R.T., May, K., Ferketich, S., & DeJoseph, J. (1986). Theoretical models for studying the effect of antepartum stress on the family. *Nursing Research, 35*, 339-346.

Merkatz, R. (1978). Prolonged hospitalization of pregnant women: The effects on the family. *Birth and the Family Journal, 5* (4), 204-206.

Miron, J. & Chapman, J. (1994). Supporting: Men's experiences with the event of their partners' miscarriage. *Canadian Journal of Nursing Research, 26* (2), 61-72.

Mishel, M.H. (1988). Uncertainty in illness. *Image: Journal of Nursing Scholarship, 20*, 225-232.

Morse, J.M. (1994). *Critical issues in qualitative research methods*. Thousand Oaks: Sage Publications, Inc.

Murphy, F. (1998). The experience of early miscarriage from a male perspective. *Journal of Clinical Nursing, 7*, 325-332.

Newfoundland and Labrador Centre for Health Information. (2000). *Community and Integrated Health Boards Health Status Report 1993-1998*. St. John's: Author.

Norbeck, J.S. & Anderson, N.J. (1989). Life stress, social support, and anxiety in mid- and late-pregnancy among low income women. *Research in Nursing and Health, 12*, 281-287.

Norbeck, J., Lindsey, A., & Carrieri, V. (1981). The development of an instrument to measure social support. *Nursing Research, 39*, 76-82.

Nuckolls, K. B., Cassel, J., & Kaplan, B.H., (1972). Psychosocial assets, life crisis and the prognosis of pregnancy. *American Journal of Epidemiology, 95*, 431-441.

Oakley, A., Rajan, L., & Grant, A. (1990). Social support and pregnancy outcome. *British Journal of Obstetrics and Gynaecology, 97*, 155-162.

Oiler, C.J. & Munhall, P.L. (1986). *Nursing research: A qualitative perspective*. Norwalk, Connecticut: Appleton-Century-Crofts.

Parke, R.D. (1996). *Fatherhood*. Massachusetts: Harvard University Press.

Penticuff, J. (1982). Psychological implications in a high risk pregnancy. *Nursing Clinics of North America, 17* (1), 69-78.

Polit, D. F. & Hungler, B.P. (1997). *Nursing research: Principles and methods*, (6th ed.). Philadelphia: J.B. Lippincott Co.

Ross, M. E. (1993). *The expectant fathers experience of high risk pregnancy and antenatal hospitalization*. Unpublished master's thesis, The University of British Columbia.

Rubin, R. (1984). *Maternal identity and the maternal experience*. New York: Springer Publishing Company.

Schodt, C. M. (1989). Paternal-fetal attachment and couvade: A study of patterns of human-environment integrality. *Nursing Science Quarterly, 2*, 88-97.

Simkin, P. (1996). The experience of maternity in a woman's life. *Journal of Obstetric, Gynaecologic and Neonatal Nursing, 25*, 247-252.

Sosa, R., Kennell, M.D., Klaus, M., Robertson, S., & Urrutia, J. (1980). The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *The New England Journal of Medicine, 303*, 597-600.

Stainton, M. C. (1994). Supporting family functioning during a high risk pregnancy. *Maternal Child Nursing Journal, 19*, 24-28.

Struebert, H.J. & Carpenter, D.R. (1995). *Qualitative research in nursing: Advancing the humanistic perspective*. Philadelphia: J.B. Lippincott Company.

Suplicki, C. (Ed.). (1997). *Webster's dictionary*. New York: Nichols Industries Ltd.

Valentine, D.P. (1982). The experience of pregnancy: A developmental process. *Family Relations, 31*, 243-248.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*, 2nd ed. London, Ontario: The Althouse Press.

Wagner, T., Higgins, P., & Wallerstedt, C. (1997). Perinatal death: How fathers grieve. *The Journal of Perinatal Education, 6* (4), 9-16.

Webb, C. (1993). Feminist research: Definitions, methodology, methods and evaluation. *Journal of Advanced Nursing, 18*, 416-423.

White, M. & Ritchie, J. (1984). Psychological stressors in antepartum hospitalization: Reports from pregnant women. *Maternal-Child Nursing Journal, 13*, 47-56.

Williams, L. (1986). Long-term hospitalization of women with high risk pregnancies. *Journal of Obstetric, Gynaecologic, and Neonatal Nursing, 15*, 17-21.

Appendices

Appendix A: Letter to Health Care Corporation of St. John's

10 Horatio Close
Mount Pearl, NF
A1N 3Y9
January 19, 1998

Ms. Carol Chafe
Director, Women's Health Program
Health Care Corporation of St. John's
Grace Hospital Site
241 LeMarchant Road
St. John's, NF
A1E 1P9

Dear Ms. Chafe:

I am a registered nurse who is a candidate for the Master's Degree in Nursing at Memorial University of Newfoundland. As a partial requirement for this degree I have to conduct a research study. This study is under the direction and guidance of Dr. Maureen Laryea. This letter is to explain the purpose of my study and to seek your approval and cooperation in selecting male participants whose partners have been hospitalized for a high risk pregnancy.

The purpose of this study is to describe the lived experiences of Newfoundland men when their partners are hospitalized for a high risk pregnancy. The ultimate purpose of the study is to contribute to a knowledge base which could be used by health care professionals to address the needs of men who are confronted with their partners' hospitalization for a high risk pregnancy.

This is a qualitative study which will involve two tape recorded interviews with the participants. The interviews will be analyzed by the researcher together with the researcher's thesis committee members who are proficient in qualitative research methodology. During collection and analysis of the data, and following its completion, all materials used for the study will be secured by the researcher. Complete anonymity is assured, and participants themselves will review an interpretive summary of their transcripts to confirm their accuracy. The proposed study will be reviewed by the Human Investigation Committee at Memorial University of Newfoundland.

I am seeking permission for the Patient Care Coordinator, Family and Newborn Services, to make initial contact with the partners of women who are hospitalized for a high risk pregnancy. If the potential participant agrees, I will contact him by telephone to obtain a verbal consent to arrange a date and time for an interview. Written informed consent will be obtained prior to the commencement of the interview.

I will be available to provide further information, and to answer any questions you may have pertaining to this study. I may be contacted at 368-7010 or 737-3648.

Sincerely

Alice Noftall, B.N.,R.N.

Appendix B: Letter of Permission Health Care Corporation of St. John's

HealthCare
Corporation of St. John's

1998 04 20

TO: Dr. M. Laryea

FROM: George Tilley, Senior VP-Corporate Affairs

SUBJECT: Research Proposal

Your research proposal **HIC # 98.58 - "The Experience Of Newfoundland Men Whose Partners Are Hospitalized For High Risk Pregnancy: A Phenomenological Study"** has been considered by the Research Proposal Approval Committee (RPAC) of the Health Care Corporation of St. John's at their most recent meeting.

The committee has approved your proposal to be conducted at the Grace Site within the Health Care Corporation of St. John's. This approval is contingent on the appropriate funding being provided and continued throughout the project and on the provision of regular progress reports at least annually to the RPAC Committee.

GEORGE TILLEY
Senior Vice President, Corporate Affairs

GT/ls

c.c. Linda Purchase, Research Centre

Appendix C: Letter of Approval from the Human Investigation Committee (HIC) Memorial University of Newfoundland

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

1998 03 18

Reference #98.56

Ms. Alice Noftall
10 Horatio Close
Mount Pearl, NF
A1N 3Y9

Dear Ms. Noftall:

This will acknowledge receipt of your correspondence dated **1998 03 09** wherein you provide a revised consent form for the research application entitled "**The Experience of Newfoundland Men Who Partners are Hospitalized for High Risk Pregnancy: A Phenomenological Study**".

At a meeting held on **March 12, 1998**, the Human Investigation Committee granted full approval of the application and revised consent form.

We take this opportunity to wish you every success with your research study.

Sincerely,

Chairman
Human Investigation Committee

HBY\jglo

c Dr. K.M.W. Keough, Vice-President (Research)
Dr. E. Parsons, Vice-President, Medical Services, HCC

Appendix D: Consent Form

FACULTY OF MEDICINE - MEMORIAL UNIVERSITY OF NEWFOUNDLAND
AND
HEALTH CARE CORPORATION OF ST. JOHN'S

Consent To Participate In Bio-medical Research

TITLE: The Experience of Newfoundland Men Whose Partners are Hospitalized for a High Risk Pregnancy: A Phenomenological Study

PROTOCOL TITLE: N/A

INVESTIGATOR(S): Alice Noftall, B.N., R.N. Telephone # 368-7010

SPONSOR: N/A

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time.

Information obtained from you or about you during this study, which could identify you, will be kept confidential by the investigator(s). The investigator will be available during the study at all times should you have any problems or questions about the study.

1. Purpose of study:

   The purpose of the study is to gain a deeper understanding of men's lived experiences when their partners are hospitalized for a high risk pregnancy. By gaining an understanding of the experience, caregivers may be better able to address the needs of men whose partners are hospitalized for a high risk pregnancy.

2. Description of procedures and tests:

   You are being asked to participate in two interviews which will be conducted at a location and time convenient for you. Interviews will be audiotaped (with your permission). The first interview will last approximately 60 to 90 minutes. Your interview(s) will be transcribed word for word. During the second interview, you will be asked to read a written summary of your interview with the researcher to confirm that the description adequately reflects your experiences when your partner was hospitalized for a high risk pregnancy. All identifying data will be destroyed once the study is completed.

3. Duration of participant's involvement:

Interviews should be completed within a three month period.

4. Possible risks, discomforts, or inconveniences:

There are no expected risks from participating in this study. Some individuals may find it upsetting to talk about their experience. You may refuse to answer any questions which make you feel uncomfortable and ask to terminate the interview at any time. During the process of the interview should you become emotionally upset you will have the option of delaying or terminating the interview and support will be offered.

5. Benefits which the participant may receive:

You will not benefit directly by participating in this study. However, your participation may provide useful information to help nurses and other health care professionals support men whose partners are hospitalized for a high risk pregnancy.

6. Alternative procedures or treatment for those not entering the study:

Not applicable.

7. Liability statement.

Your signature indicates your consent and that you have understood the information regarding the research study. In no way does this waive your legal rights nor release the investigators or involved agencies from their legal and professional responsibilities

8. Any other relevant information:

Findings of this study will be available to you and health care professionals upon request. Findings may be published, but you will not be identified. The investigator will be available throughout to address any questions or concerns you may have about the study.

Signature Page

Title of Project:

The Experience of Newfoundland Men Whose Partners are Hospitalized for a High Risk Pregnancy: A Phenomenological Study

Name of Principal Investigator: Alice Noftall

To be signed by participant

I, , the undersigned, agree to my participation or to the participation of (my child, ward, relative) in the research study described above.

Any questions have been answered and I understand what is involved in the study. I realise that participation is voluntary and that there is no guarantee that I will benefit from my involvement.

I acknowledge that a copy of this form has been given to me.

(Signature of Participant) (Date)

(Signature of Witness) (Date)

To be signed by investigator

To the best of my ability I have fully explained the nature of this research study. I have invited questions and provided answers. I believe that the participant fully understands the implications and voluntary nature of the study.

(Signature of Investigator) (Date)

Phone Number

Assent of minor participant (if appropriate)

(Signature of Minor Participant) (Age _____)

Relationship to Participant Named Above

Consent for Audiotaping During Interviews

I, _____, the undersigned, agree to be audiotaped during each interview.

_____ _____

(Signature of Participant) (Date)

_____ _____

(Signature of Witness) (Date)

Appendix E: Interview Guide

Participants will be introduced to the interview with the following dialogue:

I am interested in what it was like for you while your partner was hospitalized for a high risk pregnancy. You can share any thoughts, feelings and ideas you have regarding your experience. I would like you to tell me about your experience in your own words. You are free to talk about whatever comes to mind.

Probes/questions to facilitate the interview:

1. Tell me what it was like for you when _____ (your partner) was hospitalized for her pregnancy?

2. Tell me how you felt when _____ (your partner) was hospitalized for her pregnancy?

3. Tell me what a typical day was like for you while _____ (your partner) was hospitalized for her pregnancy?

4. What did you find helped you most to adjust to _____ (your partner's) hospitalization for her pregnancy? (Specific areas to probe: who was supportive, how were they supportive?)

5. What did you find least helpful?

6. How helpful did you find the nurses and physicians when _____ (your partner) was hospitalized? (Specific areas to probe: information about your partner's condition, baby's well-being and emotional support from nurses and physicians).

7. In terms of your relationship with _____ (your partner) and other immediate family members, did you notice any changes during _____ (your partner's) hospitalization? If so, could you talk a little about these changes (Eg. improvements/ difficulties).

8. Are there any other thoughts or comments that you would like to share with me about your experience while _____ (your partner) was hospitalized for her pregnancy?