CHILDBIRTH EXPECTATIONS IN A COMPLICATED PREGNANCY: THE FATHER'S PERSPECTIVE

By

Diane Bourrier

A thesis submitted to the Faculty of Graduate Studies

in partial fulfillment of the requirements

for the degree of

MASTER OF NURSING

Faculty of Nursing

University of Manitoba

Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

Childbirth Expectations in a Complicated Pregnancy: The Father's Perspective

BY

Diane Bourrier

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

ABSTRACT

Although the presence of fathers during labor and birth has become the norm, little is known about their childbirth expectations. Unmet expectations may lead to dissatisfaction with both the childbirth process and the partner and may later affect perceptions of parenting and marital satisfaction. No studies have focused on fathers' expectations in complicated pregnancies. The potential for unmet expectations may be greater in complicated pregnancies because many fathers expect "normal" pregnancies.

The purpose of this qualitative study was to provide an in-depth description of fathers' expectations for childbirth in complicated pregnancies. Mishel's theory of uncertainty provided an organizing framework for this study. Twenty expectant first time and experienced fathers whose partners were diagnosed with pregnancy complications were recruited using purposeful sampling. Data were collected using semistructured interviews and analyzed by content analysis.

The contextual meaning of childbirth was exemplified by five themes: preparing for complications, being there antepartum, prolonging the pregnancy, trusting in technology, and being there during childbirth. The prenatal period was stressful for many fathers. The diagnosis of prenatal complications required that fathers adjust their expectations. Some encountered difficulty "letting go" of past expectations while others had few expectations. Several fathers held high expectations of technology.

Results of this study have implications for health care providers dealing with expectant fathers prenatally and intrapartum. Consideration should be given to assisting fathers formulate realistic childbirth expectations so that potential negative effects of unmet expectations may be avoided. A philosophy of family centered care should include attention to the concerns of expectant fathers.

ACKNOWLEDGEMENTS

I would like to acknowledge The Manitoba Association of Registered Nurses for their financial support. As well, I would like to acknowledge the following individuals.

Dr. Annette Gupton, my thesis chair, for her expertise, guidance, and words of encouragement.

Dr. Janet Beaton, my internal committee member, for helping me achieve "conceptual clarity".

Dr. Philip Hall, my external committee member, for his suggestions and editorial comments.

Ruth for always "being there"; Sherry for taking a personal interest in this project; and Venetia for listening.

I am indebted to family and friends who supported and encouraged me throughout my years of study. I thank you for your love, patience, and understanding.

Finally, I would like to recognize Dennis who was there every step of the way, whose loyalty, commitment, and love never faltered. This work is dedicated to him.

Table of Contents

CHAPTER ONE

STATEMENT OF THE PROBLEM

The phrase "expectant fathers" often conjures up images of fathers as active participants in the childbirth process. It has become an expectation that they will participate in this important life event (Chapman, 1991). Despite the fact that the presence of fathers during labor and birth has become the norm in many societies (Jordon, 1990a), little is known about their childbirth expectations. No studies have focused on fathers' childbirth expectations in complicated pregnancies even though a significant proportion of pregnancies have complications (Dr. P. Hall, personal communication, June 29, 1999).

Fathers often are expected to assume the role of labor coaches. Yet research has shown that many men do not undertake an active role during childbirth (Chapman, 1992). Most men in Chapman's study adopted the role of witness. This role allowed togetherness, without the pressures of trying to be in control of the labor and birth. All fathers in Berry's (1988) study described participation in childbirth as stressful and Nichols (1993) indicated that the degree of such stress has been underestimated. Berry suggested that the role of labor coach might not be realistic for all men. Some may feel more comfortable observing rather than participating (Nichols, 1993). Expectations that fathers should act as labor coaches should be reevaluated (Chapman, 1992).

Pregnancy may be challenging for the entire family under the best of circumstances (Kemp & Page, 1986). Kemp and Page suggested that the experience could be more stressful when a pregnancy is high risk and that this may alter the family's perceptions. After a review of the literature, May (1994) concluded that a high-risk pregnancy and resulting hospitalization were stressful events for the woman and her partner. May (1994), and Maloni and Ponder (1997) described the impact on expectant fathers of their partners' activity-restricted pregnancies or prescribed bedrest and found that fathers were highly stressed by the situation and in a constant state of worry.

Caring for a father whose partner is diagnosed with a complicated pregnancy can be challenging. Some fathers tend to stand back and seem reluctant to become involved in the labor process. They may require encouragement and direction from nurses. It can be difficult to ascertain their needs and expectations.

This study will address the following research question: *What expectations do expectant fathers have regarding childbirth when their partners experience complications of pregnancy?*

Significance of the Study

According to Sandelowski (1984), childbirth expectations have been raised to such unrealistic proportions that "failed expectations" has emerged as a new diagnostic category. Men in Glazer's (1989) study were concerned that their hopes for childbirth would not be met. "Being able to have the type of birth experience you want" (p. 53) was identified as a stressor by 59% of the men. Broome and Koehler (1986) suggested that unmet expectations could lead to dissatisfaction with both the childbirth process and the partner, which could later affect perceptions of parenting and marital satisfaction.

This study may contribute to nursing knowledge by providing an in-depth description of fathers' expectations for childbirth in complicated pregnancies. This information may help nurses assist expectant fathers formulate realistic expectations so that the potential effects of unmet expectations may be avoided. The results of this study could be used to develop an instrument to measure childbirth expectations in fathers. Such a tool could prove to be helpful in determining who is at risk for "failed expectations".

Definition of Terms

Childbirth Experience: The interactions and events that occur during parturition and the first few hours postpartum.

Expectations: That which a person believes will happen during childbirth (Taylor, 1992).

Pregnancy complications: Any physiologic factors which exist in the mother or fetus that imply a threat to the health of either mother, baby, or both (Kemp & Page, 1986) and which require admission to either an antepartum unit or a community based program.

Assumptions of the Study

This research is based upon the following assumptions:

1. Expectant fathers have expectations regarding childbirth in complicated pregnancies.
2. Expectant fathers are able to articulate those expectations (Taylor, 1992).

Conceptual Framework

A conceptual framework was used to organize and give direction to this study. The framework used was the theory of uncertainty.

The concept of uncertainty reflects a cultural preference for certainty (Mishel, 1990). Certainty is sought, pursued, even demanded. Mishel's theory of uncertainty explains how people construct meaning for illness events. Sorenson (1990) used this theory to explain how expectant women processed pregnancy-related events. A quantitative approach was used by Clauson (1996) and Ashcroft (1995) to quantify uncertainty in women with complicated pregnancies. No research could be found to determine if the theory could explain how fathers construct meaning for pregnancy. This study provided the opportunity to assess its appropriateness to the phenomenon of fathers' childbirth expectations in complicated pregnancies.

There is reason to believe that expectant fathers experience uncertainty about childbirth. When fathers in Taylor's (1992) study were asked to describe what they

expected labor to be like, they mentioned feeling nervous, fearful, and uncertain. They were not always able to articulate how they would react during childbirth. This uncertainty caused some fathers to feel considerable anxiety. Uncertainty can increase feelings of helplessness (Hilton, 1994). Several fathers expressed feelings of helplessness related to their perceived inability to relieve their wives' pain (Taylor, 1992).

Uncertainty is generated by events characterized as vague, ambiguous, unpredictable, or unfamiliar (Mishel, 1984). Complicated pregnancies depict many of these characteristics. McCain and Deatrick (1994) found that the experience of a high-risk pregnancy resulted in a sense of vulnerability when couples realized their pregnancies were "not normal" and labeled as "high risk" by the experts. One reason they felt vulnerable was because they were unsure about the pregnancy's outcome.

Uncertainty, as a perceptual variable, hampers a clear appraisal of events (Mishel, 1983). The inability to resolve uncertainty results in stress (Mishel, 1981). May (1994), and Maloni and Ponder (1997) described the impact on expectant fathers of their partners' activities being restricted during pregnancy and found that they were highly stressed by the situation and constantly worried. The stress of a complicated pregnancy, coupled with the inability to resolve uncertainty, may alter a father's perceptions, and hence expectations of childbirth. For these reasons, the theory of uncertainty may be an appropriate framework for this study.

Mishel (1988) identified three variables that precede uncertainty: stimuli frame, cognitive capacity, and structure providers. Stimuli frame is the primary antecedent and has three components: symptom pattern, event familiarity, and event congruency (Appendix A). These components provide the stimuli that are structured by the individual into a cognitive schema to reduce uncertainty. Stimuli frame components will be used to assess fathers' experience of uncertainty in complicated pregnancies.

Symptom pattern refers to the degree of consistency favoring recognition (Mishel, 1988). For example, symptoms of preterm labor can be vague, imprecise, inconsistent,

and attributed to other conditions. Symptoms must be prominent enough to be included in a symptom pattern (Mishel & Braden, 1988). In some cases of pregnancy induced hypertension, there are no visible symptoms and diagnosis is based on elevated blood pressure and laboratory findings. It can be difficult for fathers to believe that their partners are ill when they look normal. Women with preterm premature rupture of membranes may look and feel fine. Only when symptoms are consistent, predictable, salient, and distinguishable, can a symptom pattern be identified, reducing uncertainty (Mishel, 1988). Because many pregnancy complications lack these characteristics, the potential for fathers to experience uncertainty exists.

A second component of the stimuli frame, event familiarity, refers to whether a situation is habitual, repetitive, or contains recognizable cues (Mishel, 1988). Event familiarity is pertinent to first time fathers as they have no prior experience with childbirth. First time fathers in Taylor's (1992) study stated that they did not know what to expect, nor what was expected of them. Childbirth was described as an "element of unknown" (p. 102). Lack of familiarity with childbirth, coupled with a lack of familiarity with pregnancy complications, may result in more uncertainty for first time fathers than those with past experience.

According to Taylor (1992), fathers who had been present during previous labors stated that previous experience influenced their expectations. Incongruence between past (normal pregnancy) and present (complications of pregnancy) situations could generate uncertainty because of the inability to draw from past experiences. Event familiarity may be lacking for fathers in these situations.

Fathers whose partners had preterm labor in a previous pregnancy reported a sense of resignation when it happened again (May, 1994). Although their previous experience (event familiarity) may have lessened the shock, fathers still worried about their partners and babies. Thus, fathers who are familiar with pregnancy complications also may experience uncertainty.

Because familiarity is developed over time (Mishel, 1988), there may be a need to differentiate between complications that result from a chronic medical condition and those that are time limited or acute. For example, Type I diabetes (chronic condition) may involve more familiar elements than gestational diabetes (acute condition), in which the woman and her partner may face unfamiliar self care regimes such as glucose monitoring and insulin injections. The novelty of an event seems to be the aspect of unfamiliarity that generates uncertainty and as novelty abates, uncertainty decreases (Mishel, 1988).

Event congruency refers to consistency between what is expected and what occurs (Mishel, 1988). The prevalence of myths about childbirth causes some couples to develop expectations that will be incongruent with outcomes (Beatty, Gutkowski, Moleti, & Yeransian-Nassery, 1985). These authors suggested that in high-risk pregnancies, incongruencies between expectations and outcomes were magnified.

The generation of uncertainty through a lack of event congruence can occur when expectations are shattered by unforeseen events (Mishel, 1988). First time fathers in May's (1994) study described the diagnosis of a high-risk pregnancy "as a complete surprise" (p. 248) because they expected a normal pregnancy. Development of complications in a previously normal pregnancy may result in uncertainty for fathers who must readjust their hopes for a "perfect experience". A lack of congruence between events leads to uncertainty about the predictability of future events (Mishel, 1988). A father who predicts that he will adopt an active role in labor may be unsure of his ability to maintain the same degree of participation when a pregnancy becomes complicated.

In summary, despite the fact that the presence of fathers during childbirth has become a common occurrence, research addressing their experiences during pregnancy and birth is "in its infancy" (Lemner, 1987, p. 272). This study provided an in-depth description of fathers' childbirth expectations in complicated pregnancies. Such information could help others to assist expectant fathers formulate realistic expectations

so that the potential consequences of unmet expectations may be avoid. The theory of uncertainty provided a basis for the generation of interview questions. Upon completion of data analysis, themes generated in this study were compared to those included in Mishel's theory for their possible relevance.

CHAPTER TWO

REVIEW OF THE LITERATURE

While there is literature related to fathers' expectations of childbirth, there is none about fathers' expectations in complicated pregnancies. The literature review will be discussed under three headings: (a) fathers' prenatal and intrapartum roles; (b) fathers' expectations for childbirth; (c) needs, expectations, feelings, and concerns of prepared versus unprepared fathers.

Fathers' Prenatal and Intrapartum Roles

Researchers have explored fathers' childbirth expectations using a qualitative approach, with emphasis on the roles they adopt and expect to adopt. Using grounded theory, May (1980) identified three styles of detachment or involvement adopted by first time fathers prenatally (N = 20). The styles identified were:

1. Observer style, in which the man maintains a degree of emotional distance, and sees himself as a bystander (n = 9).

2. Expressive style, in which the man reports a highly emotional response to the pregnancy, and sees himself as a partner (n = 7).

3. Instrumental style, in which the man reports emphasis on tasks to be accomplished and views himself as the caretaker or manager of the pregnancy (n = 4).

Strengths of this study were its utilization of a cross-sectional group and longitudinal approach with all three trimesters represented. Thirty-three open-ended interviews were conducted. Most fathers were interviewed with their wives present. This may have inhibited them from speaking freely. However, May's research was conducted in 1980 and may not reflect contemporary attitudes.

Taylor (1992) used an exploratory design to describe fathers' expectations of childbirth. Taylor did not mention which research method she used, for example, ethnography or grounded theory. Participants (N = 10) were predominantly Caucasian

middle-class married men who had attended prenatal classes. Eight were first time fathers. This small homogenous population may be too biased a sample for generalization.

Taylor (1992) described three roles that fathers expected to adopt in childbirth: caretaker, supporter, and spectator. All fathers expected to assume a support role, in fact they perceived support to be their primary function. Elements of both physical and emotional support were identified. "Being there" for their partners was a common theme. All fathers expected to support their partners by their physical presence. Fifty-five percent of fathers in Nichols' (1993) study identified "just being there " (p. 104) as one of the most helpful things they did for their partners intrapartum.

The caretaker role involved some form of active participation by the father, an advocate function (upholding the birth plan), and a protective function. Four fathers expected to assume both a supporter and caretaker role.

The spectator role referred to fathers being participant observers. All five fathers who expected to assume a spectator role believed they could support their partners by being there. Because of this, Taylor (1992) considered that they had assumed both spectator and supporter roles.

Using grounded theory, Chapman (1992) studied roles adopted by fathers during labor and birth. Strengths of this study are its varied population characteristics and design. The sample (N = 20) consisted of 12 white, 7 black, and 1 Asian father. Thirteen had previous labor and birth experience and 12 had attended prenatal classes. The sample included fathers whose partners had been treated for preterm labor but subsequently had given birth at term, fathers whose partners had labor induced or augmented, and two fathers whose partners had an unplanned cesarean birth. Data were collected using intrapartum participant observations (n = 9) and postpartum interviews of couples (n = 17). The use of triangulation of methods enhances validity of qualitative

data collection (Polit & Hungler, 1991) and improves confidence in the findings (Lemner, 1987).

Chapman (1992) identified three roles that expectant fathers adopted: coach, teammate, and witness. Men assuming the coach role (n = 4) viewed themselves as managers or directors of labor. These fathers had a strong need to be in control of the situation and their partners wanted them to be active, and physically involved. "Teammates" (n = 4) assisted their partners through labor by following the directions provided by their partners and nurses. This role had elements of both physical and emotional support. "Witnesses" (n = 12) were present primarily to observe and be a companion. These fathers provided emotional, but little physical support.

Most men in Chapman's study (1992) adopted the witness role as opposed to that of coach or teammate. Fathers often are expected to take a more active role in childbirth. Chapman (1992) recommended that childbirth classes be redesigned to incorporate alternative labor roles.

Only 10% of women in Chapman's (1992) study had epidural anesthesia for labor. Thus, these results may not apply to settings in which epidural usage is more prevalent as childbirth might be less physically and psychologically demanding when epidurals are used. As fathers whose partners did not deliver a healthy term infant were excluded, paternal intrapartum roles were limited to situations which resulted in a good neonatal outcome.

Chapman (1992) suggested that her study expands the findings of May (1980). Of the three styles May identified, observer style was adopted by many men. Chapman stated that most men in both studies indicated that they desired less physical involvement prenatally and intrapartum.

The work of Taylor (1992) and Chapman (1992) share similarities and differences. The caretaker role parallels that of coach, the support role that of teammate, and spectator that of witness. Results of these studies suggest that discrepancies might exist between

roles fathers expect to adopt and roles they do adopt. Taylor found that 40% of fathers in her study expected to adopt the caretaker role. In Chapman's study, 20% of participants adopted that role. All fathers in Taylor's study expected to play a supportive role whereas only 20% of fathers in Chapman's study adopted the role of teammate. The number of fathers who expected to function in a less physically active role was similar in both studies.

Other researchers have questioned the appropriateness of men as labor coaches. Berry (1988) found that many first time fathers (N = 40) were concerned about their roles as coaches and questioned their usefulness, as they were unable to do all of the helpful things they had planned. They viewed labor and birth as stressful. Nichols (1993) stated that labor might be more stressful for fathers than previously believed. For some, the task of coaching resulted in undue stress and created a situation whereby "demands exceeded capabilities" (Berry, 1988, p. 354). Berry questioned whether expectations for men to be labor coaches are realistic. Her study should be interpreted with caution since a tool with unreported reliability and validity was used and sample size was small.

Conflicting results were found regarding roles men adopted for childbirth. Chandler and Field (1997) conducted a descriptive, exploratory study of first time fathers' childbirth expectations compared with their perceptions postpartum. Eight men were interviewed at approximately 35-37 weeks of their partners' gestation and again 4 weeks postpartum. Six "secondary informants" were only interviewed postpartum. No fathers in their study adopted the witness role as defined by Chapman (1992), but rather "appeared to alternate between coach and teammate" (p. 23). The researchers did not elaborate on these findings. It would have been helpful to have more information regarding where these births occurred as in one of the quotes, a home birth was alluded to. Couples planning home deliveries may not be representative of those delivering in hospital settings. This could account for some of the discrepancies between the roles

adopted by fathers in Chapman's study versus those adopted by Chandler and Field. Also, varying role definitions may explain the differences.

According to Chapman (1991) some men redefine their roles during labor. Using the same sample and design as her previously mentioned study, Chapman found that most men maintained the same roles during childbirth. Two conditions were identified as important for men to maintain a particular labor role: congruent role expectations between the couple, and support of the father's choice by his partner and health care professionals. Men who redefined their labor role during childbirth related their struggles to find other roles. Chapman suggested that satisfaction with labor and birth increases when men enact a role that is comfortable and congruent with their expectation.

In summary, the research suggests that a discrepancy might exist between roles men expect to adopt and those they do adopt. Most men in Taylor's (1992) study expected to adopt an active role in childbirth. In contrast, in Chapman's (1992) study most men adopted the witness role, which allowed togetherness without the pressures of having to be in control. Conflicting results were found regarding the roles men adopted for childbirth. In Chandler and Field's (1997) study, no fathers adopted the role of witness while in Chapman's (1992) study most men adopted that role. Finally, some fathers did not maintain the same roles during childbirth (Chandler & Field, 1997; Chapman, 1991).

Fathers' Expectations for Childbirth

Lemner (1987) reviewed the nursing literature and summarized fathers' perceived needs and expectations for childbirth as follows: (a) to be knowledgeable about labor, delivery, and when to take their partners to hospital; (b) to be informed about the status of baby and mother; (c) to maintain a sense of control during labor; (d) to relieve their spouses' pain; (e) to protect and nurture their spouses; (f) to have behavioral guidelines during labor and birth; (g) to have a birth attendant near; (h) to be reassured that they were good coaches; (i) to be personally nurtured and cared for; and, (j) to receive

personalized care (Gabel, 1982; MacLaughlin, 1980; MacLaughlin & Taubenheim, 1982; Shannon-Babitz, 1979).

A limitation of Lemner's (1987) work is that needs were not distinguished from expectations. In these studies, needs and expectations related to fathers' expectations for themselves and caregivers and did not address their expectations for spouses or the nature of childbirth (Taylor, 1992). Fathers' expectations were described by Taylor within three categories: expectations for themselves, significant others, and regarding childbirth.

Participants in Taylor's (1992) study described expectations for themselves. All fathers (N = 10) expected birth to be a time of intense emotions. Generally, comments reflected a positive affect. However, expectations of labor included feelings such as nervousness, fear, uncertainty, and panic. These findings were validated by Nichols (1993) who noted that fathers stated that birth was more positive than labor. Negative expectations of labor might decrease if fathers were reassured that they do not have to be the primary coach.

Six fathers in Taylor's (1992) study expressed helplessness related to their perceived inability to relieve their spouses' pain. Several studies also cited men's anticipated concerns with seeing or dealing with their spouses' pain (Barclay, Donovan, & Genovese, 1996; Chandler & Field, 1997; Gabel, 1982; Glazer, 1989; Leonard, 1977; MacLaughlin, 1980; MacLaughlin & Taubenheim, 1983; Nichols, 1993). Women have high expectations for partner support during labor (Beaton & Gupton, 1990; Bramadat, 1990; Heaman, Beaton, Gupton, & Sloan, 1992). Heaman et al. (1992) reported that high-risk pregnant women expected to have significantly more pain and difficulty coping with pain than low risk women, yet expected the same level of partner support. How fathers whose spouses have pregnancy complications cope with these demands, particularly if they feel helpless, is as yet unknown.

Fathers were not always able to articulate how they would react during childbirth (Taylor, 1992). This uncertainty caused three fathers in Taylor's study to feel

considerable anxiety. Generally, fathers were able to articulate their reactions during delivery more clearly than during labor. Nichols (1993) stated that some fathers felt uncertain about "what was going on or what to do" (p. 102) while their spouses were in labor. The "need to know" (Barclay, Donovan, & Genovese, 1996, p. 18) to gain control of a process, for example labor, emerged as a category in a study of 53 men's experiences during their partners' first pregnancies. The study utilized focus groups run by male midwives who were also fathers. Labor was labeled the "unknown" (p. 19) and caused fear and anxiety for some fathers. The unknown also emerged as a theme in Taylor's study in which fathers were concerned about how they would react during labor.

Fathers had expectations not only for their partners, but also the nurses and doctors involved in their care (Taylor, 1992). Six fathers believed their wives would have difficulty coping with pain. Although four fathers viewed the nurses' primary role to be that of support for their partners, two expressed a desire that nurses attend to their needs as well. Four expected and believed that they would be kept informed of labor as well as what was expected of them. Fathers in Chandler and Field's (1997) study also believed that health care professionals would keep them informed. For several, this expectation was not met. Fathers believed they would be treated as part of a laboring couple but instead were treated as laboring women whose partners were merely present. Fathers felt excluded and that their presence was tolerated rather than seen as necessary. This concurs with the work of Jordon (1990b) and Barclay et al. (1996). Fathers in Jordon's study felt they were rarely recognized or treated as parents and felt relegated to a supportive role. Participants in Barclay's study felt excluded and separated from the pregnancy process.

Fathers prepared for childbirth either by imagining what was going to happen (n = 5) or imagining the worst possible situation that could happen during childbirth (n = 5) (Taylor, 1992). Four expected childbirth to be "bloody and gory" (Taylor, 1992, p. 65). All respondents believed their partners would have a normal delivery and did not

volunteer expectations related to cesarean birth until asked to do so. Also, they did not express expectations relating to use of medical equipment.

Only two fathers in Taylor 's (1992) study said that they would be disappointed if their wives had to have cesarean sections. The author suggested that fathers placed more emphasis on health of mother and infant than the birth process. This was verified by Barclay et al. (1996) who found that most men expressed greater concern about the neonates than their partners' pregnancies or labors. White (1998) found similar results in a survey of 98 first time fathers. Subjects indicated that their two greatest concerns were the health and safety of mother and child. Concerns relating to their own abilities to handle labor and birth were rated the lowest. These results should be interpreted with caution as the questionnaire used to rank fathers' concerns had only 6 items that were obtained from the literature as being common concerns of expectant fathers.

A limitation of Taylor's (1992) study is its use of a cross-sectional design. A longitudinal approach would be appropriate to determine if expectations change over time. Whether fathers whose partners experienced complicated pregnancies had differing expectations remains unknown as information about risk factors was not provided .

Taylor (1992) stated that most fathers had not discussed their childbirth expectations with their partners. However, three wives stipulated what they expected of their partners. In Chapman's (1991, 1992) studies, couples rarely discussed their expectations. In contrast, Chandler and Field's (1997) couples openly discussed their fears and concerns. Chapman and Taylor suggested that couples' discussion of expectations could facilitate congruence, which in turn could result in a more satisfying birth experience.

In summary, men have childbirth expectations for themselves, their partners, caregivers, and the birth process. It may be preferable that couples discuss these expectations.

Needs, Expectations, Feelings, and Concerns of Prepared versus Unprepared Fathers

The needs and expectations of fathers who did not attend prenatal classes were studied by Gabel (1982) who used a descriptive, retrospective approach to identify the needs of 20 unprepared, blue-collar, black fathers during childbirth. Many fathers (70%) had negative expectations. However, all indicated that attending birth had been moving and valuable. Gabel stated that prepared fathers in other studies felt overwhelmed and wanted more information regarding birth. These issues were not identified by Gabel who suggested that fathers in her study might have had lower expectations of the care they would receive than did prepared fathers in other studies. Another explanation proposed by Nichols (1993) was that unprepared fathers may be unbiased by preexisting expectations.

Most participants in Taylor's (1992) study stated that prenatal classes prepared them for what to expect, and influenced their expectations. However, Taylor suggested that fathers in her study had expectations for childbirth before attending prenatal classes and concluded that variables other than prenatal class participation were important.

The needs and expectations of 11 first time unprepared fathers were ascertained before and after delivery by MacLaughlin and Taubenheim (1983). These fathers wanted: to be knowledgeable about labor; experience a sense of control; be able to protect and nurture their partners; have behavioral guidelines during labor and birth; be reassured that they were good coaches; and, be personally nurtured and cared for. These results were compared to those of a study conducted by MacLaughlin (1980) using the same questionnaire to identify the needs of fathers (N = 20) who had attended prenatal classes. MacLaughlin and Taubenheim concluded that the needs and expectations of fathers during childbirth were similar whether or not they attended childbirth classes.

Most unprepared fathers in MacLaughlin and Taubenheim's (1983) study worked in technical occupations and were of lower socioeconomic status. Prepared fathers in

MacLaughlin's (1980) study were mainly professionals in middle to high socioeconomic status. A panel of psychologists validated the questionnaire, but reliability was not mentioned. Additional information regarding reliability and validity of the instrument would improve result credibility, particularly because the two groups differed demographically. A further limitation of both studies is their small sample sizes.

Nichols (1993) examined the written responses of 44 first time fathers who were asked to describe their feelings about labor and delivery. The responses of fathers who attended childbirth classes (prepared fathers) were analyzed separately from those who did not attend classes (unprepared fathers). The percentage of positive responses from prepared and unprepared fathers about labor was similar. Of all negative responses, 61% came from prepared fathers versus 39% from unprepared fathers. Nichols challenged the opinion that prenatal classes prepare expectant fathers for a positive labor experience, in that prepared fathers may perceive labor as more stressful than unprepared fathers. Childbirth classes may not have prepared fathers for the realities of labor or may not have addressed their needs or expectations adequately.

Two factors that limit generalization are that most respondents were Caucasian and all were in the military (Nichols, 1993). However, Nichols argued that the military demographically represents a heterogeneous microcosm of American society. Use of a written questionnaire instead of interviews might have prevented some subjects from volunteering or prohibited participants from elaborating on their experiences. Face to face interviews might have allowed the researcher to explore unanticipated events. Beal (1994) expressed concern that Nichols used quantitative statistics to analyze a descriptive, qualitative study.

Berry (1988) surveyed first time fathers about their labor and delivery experience. Fathers found that stress increased as labor progressed, reaching a peak during delivery. They were concerned about their spouses' wellbeing and tried to hide their feelings from their partners. Fathers were not prepared for these emotional responses even though 85%

of them had attended childbirth education classes. Similarly, fathers in Chandler and Field's (1997) study found labor to be more work than they had anticipated. Fear and helplessness were dominant emotions experienced during labor. Fathers felt the need to hide their emotions from their partners. In contrast to Berry's findings, Chandler and Field found that as birth became imminent, mounting fears and hidden emotions abated and were replaced by excitement.

Glazer (1989) speculated that pregnancy could produce anxiety for expectant fathers because they might sublimate their needs in favor of the needs of their partners. This was supported by May (1994) who found that fathers whose partners had restricted activities because of preterm labor consistently tried to hide their distress as it might make their spouses feel worse. Only 17% of fathers in Maloni and Ponder's (1997) study discussed with their partners the worries and difficulties they encountered living with partners confined to bedrest.

In summary, needs and expectations of childbirth were similar regardless of attendance at prenatal classes although in one study, negative comments about labor were more likely from men who had attended such classes. Prenatal classes may not prepare fathers for the realities of childbirth or may impart unrealistic expectations. Several studies suggest that fathers have a need to hide emotions from their partners

In conclusion, gaps exist in knowledge about fathers' childbirth expectations. Some of these gaps will be addressed. Studies regarding needs and expectations have not focused on complicated pregnancies. This study included fathers (n = 8) who did not attend such classes and was limited to pregnancies that had been labeled complicated. The sample consisted of varying types of complications, gestational ages, and care settings. Draper (1997) was critical of the lack of a theoretical framework to study expectant fathers and noted that existing studies have focused almost exclusively on first time fathers. This study tested the theory of uncertainty for its appropriateness to the

phenomenon of fathers and consisted of an equal number of first time and experienced fathers.

CHAPTER THREE

METHODOLOGY

Quantitative and qualitative research complement each other as they generate different types of knowledge (Burns & Grove, 1993). Nursing research may be conducted using either approach or a combination (Burns & Grove, 1987). Both methods have strengths and weaknesses.

Quantitative researchers believe that all human behavior is objective, has a purpose, is measurable and that one need only choose or develop an appropriate measurement tool (Burns & Grove, 1993). Polit and Hungler (1991) argued that phenomena such as fear, guilt, and motivation, are difficult to measure accurately and to control in a natural setting. Quantitative research has been described as narrow and deductive and criticized as overly reductionist, failing to capture the human experience in all of its complexity (Polit & Hungler, 1991). A quantitative approach strives to generalize through use of a systematic, disciplined, and controlled process (Polit & Hungler, 1991). Such methods are used to describe, test, and examine cause-and-effect relationships (Burns & Grove, 1987).

According to Burns and Grove (1987), and Polit and Hungler (1991), qualitative research supports the holistic nature of human beings by trying to capture the totality of some aspect of the human experience. Qualitative methods yield rich, in-depth, potentially insightful information but are time consuming (Polit & Hungler, 1991). The method is subjective and includes interpretations shared by the researcher and subjects (Burns & Grove, 1993). However, generalization of results may be questionable as a large, representative sample is impractical (Polit & Hungler, 1991). Others have argued that results of a qualitative study are unique to its own situation and that it is not intended to generalize findings to a larger population (Burns & Grove, 1993).

The approach selected should depend on the nature of the research question as well as the researcher's preferences and philosophy (Polit & Hungler, 1991). The goal of this

project was to describe fathers' expectations for childbirth in complicated pregnancies. Another goal was to explore fathers' perceptions of uncertainty. Although the theory of uncertainty has been used to explain how pregnant women process pregnancy-related events (Sorenson, 1990), its applicability to expectant fathers has not been determined. The qualitative approach is used to: describe a phenomenon which to date has not been studied, generate hypotheses, and develop theory (Polit & Hungler, 1991). The dearth of literature in these areas, coupled with the descriptive nature of this study, suited a qualitative approach.

Heaman, Beaton, Gupton, and Sloan (1992) used the Childbirth Expectation Questionnaire (CEQ), developed by Gupton, Beaton, Sloan, and Bramadat (1991), to describe and compare expectations of high-risk and low-risk pregnant women. That tool has only been used with women. Boyd (1985) cautioned researchers against using the same tool with fathers in that it had been developed to study mothers and suggested that "one must consider reanalysis of instrument data, because the tool may not be reliable or valid when used on a different population" (p. 120). Taylor (1992) suggested that her results indicated that the CEQ was inappropriate to use with fathers but did not explain why. No other appropriate tools have been developed to study paternal expectations.

An ethnographic approach was appropriate to address the issue of paternal expectations. This methodology consists of descriptions of all facets of phenomenon (Morse & Field, 1995). Thorne (1991) stated that nurse researchers have access to sensitive ethnographic data and have provided nursing with useful insights about particular client groups. This study has the potential to sensitize caregivers to the fathers' expectations in complicated pregnancies.

Ethnography

Traditional ethnography describes a group or culture from the emic (insider's) and etic (outsider's) perspective (Fetterman, 1989). Informants are viewed as co-participants,

with initial sampling being purposive and opportunistic, becoming progressively theoretical, that is, directed by logic and aim (Germain, 1993). An in-depth interview is the most important data-gathering technique and can be formal and informal, structured, semistructured, or unstructured (Fetterman, 1989; Germain, 1993). Content analysis is used to induce patterns or themes (Germain, 1993). Fieldwork is an alternative method of data collection which employs observation using all senses (Germain, 1993).

Kleinman (1992) advocated use of miniethnographies for health care research. This approach reframes experiences of health or illness from a solely subjective perspective to an interpersonal realm which connects one's inner world to a social context. Fathers' expectations of childbirth are connected intricately to interpersonal experiences. For example, partners and health care professionals have expectations about fathers' roles in childbirth. These can affect how fathers view their own role. This interplay of subjective and interpersonal experiences forms the "local way of being human" (Kleinman, 1992, p. 129). Kleinman described these local worlds as moral worlds since local patterns recreate "what is most at stake for us" (p. 129). Restricting analysis to these local, moral worlds captures the microcontext. Miniethnography examines a "narrow band in the cultural spectrum of local worlds" (p. 133). Fathers' childbirth expectations represent an example of a specific focus within a local world. Consequently, miniethnography was an appropriate method.

Participants

The population of interest for this study was expectant fathers whose partners were diagnosed with complicated pregnancies that required admission to a tertiary care hospital or to a community based program for women with prenatal complications. Both settings were in a midwestern Canadian city. To be eligible, spouses had to be in the third trimester, 26 weeks or greater, following the assertion that pregnancy becomes

"real" to men at that time (May, 1982). Participants had to be 18 years of age or more and able to read, write, and speak English.

In qualitative research, maximum or theoretical variation is sought to describe experiences as richly and accurately as possible (Morse, 1991). A purposeful sampling approach was used, as detailed by Morse, in which participants are selected according to the study's informational needs. Fathers who were experiencing an intrauterine death or congenital abnormality that was incompatible with life were not approached. The study sampled 20 fathers. Data collection was terminated when saturation occurred. Demographic data were collected to describe the sample (Appendix B).

Procedure

Following approval by the University of Manitoba Ethical Review Committee, formal requests for access were submitted. Subjects were recruited once permission for access had been obtained. The researcher identified potential hospital subjects, while fathers', whose partners were cared for by the community based program, were identified by nurses visiting the families. The investigator did not approach potential subjects until permission from patients had been obtained by the nurses (Appendix C, D, or E).

The community program nurses were asked to introduce the study using a script (Appendix E) and have the women sign a release form (Appendix F). If the program nurses were unable to speak to the fathers, they were instructed to leave a written description of the study (Appendix G) with the mothers, with instructions to write their name and phone number on a piece of paper if they wished to be contacted. A nurse informed the researcher, who then contacted these potential subjects by phone (Appendix H). Mail contact (Appendix I) was not required.

For the hospital group, the nurses introduced the study using a script (Appendix C or D). The investigator tried to discuss the study in person (Appendix J). When this was not feasible, fathers who wanted to hear more about the study were informed of the research by phone (Appendix K).

The study was explained verbally and in writing (Appendix G). Those who agreed to participate signed a consent form (Appendix L). Fathers received a written explanation of the study and a copy of their signed consent prior to data collection.

Data Collection

Data were collected using semistructured interviews. These encourage participants to talk freely about all questions in the topic guide (Polit & Hungler, 1991). The format is flexible and allows the researcher to explore unanticipated or serendipitous events (Germain, 1993; Wilson, 1985). Open-ended questions were used to encourage fathers to elaborate on their expectations (Appleton, 1995). An interview guide (Appendix M) was developed based on the work of Taylor (1992) (adapted with permission), the research question, and the conceptual framework. Questions were developed to determine applicability of the theory of uncertainty to fathers. Interview schedule suitability was reviewed by a panel of experts, two of whom had done research on maternal expectations for childbirth, and assessed during three pilot interviews.

The interviews were conducted after the fathers' partners had been hospitalized or cared for by the community based program for at least three days. The average interview length was one hour (range, 25 minutes - 2 hours). No fathers elected to have the interviews conducted over two sessions. All interviews were tape-recorded, transcribed verbatim, and reviewed by the researcher for accuracy. Unstructured field notes were written at the end of each interview to assist in data analysis (Polit & Hungler, 1997). These notes included details of the situation, personal and theoretical insights, and contextual factors observed during the interview.

Several authors have attested to the need and desire for fathers to discuss their fears and concerns about pregnancy and childbirth without their partners being present (Hott, 1976; Jordon, 1990b; Shapiro, 1987; Starn, 1993; Taubenheim & Silbernagel, 1988). Some researchers have found that men hide their feelings and concerns about pregnancy and childbirth from their partners (Berry, 1988; Glazer, 1989; May, 1994). In Taylor's

(1992) study all fathers, except one, were interviewed with their partners absent. She did not indicate if the interview in which the spouse was present differed substantially from the other interviews. All fathers were interviewed without the partners present to allow them the opportunity to speak without restraint. None of the fathers requested that their partners be present for the interviews. Most of the interviews were conducted in a quiet location in the hospital. Three subjects were interviewed in their homes.

Data Analysis

Descriptive analyses, such as the percentage of first time versus experienced fathers, previous attendance at prenatal classes, marital status, racial background, mean paternal age, years of education, and gestation at interview, were derived.

Content analysis is the primary form of analysis used by ethnographers to induce patterns or themes from their data (Germain, 1993). Research questions directed towards "what", for example, what are fathers' expectations, are appropriate for content analysis (Polit & Hungler, 1991). Germain's guidelines were used. Data were read line by line with the goal of becoming immersed. Labels were assigned manually to units of meaning. A meaningful unit consisted of segments of a line, sentence, paragraph, or larger sections of data. Codes were compared and similar codes grouped into categories. Categories were then compared and grouped into themes.

Trustworthiness

Several authors have argued that qualitative research cannot be evaluated against conventional scientific criteria of rigor, because of dissimilarities in goals and methods of the two approaches (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Sandelowski, 1986; Yonge & Stewin, 1988). Lincoln and Guba (1985) used the term "trustworthiness" to determine scientific rigor. Lincoln and Guba suggested four criteria to establish

trustworthiness in the naturalistic paradigm: truth value, applicability, consistency, and neutrality. Each of these criteria was considered.

Truth value or the credibility criterion is synonymous with internal validity in quantitative studies (Guba & Lincoln, 1989). Study results are credible when there is a match between the constructed realities of respondents and those realities represented by the evaluator and ascribed to various stakeholders (Guba & Lincoln, 1989). Descriptions should "ring true to natives and colleagues in the field" (Fetterman, 1989, p. 21). Guba and Lincoln suggested strategies such as member checks and peer debriefing to promote the truth value of a study.

Member checks or validation was employed in this study to promote truth value. This ongoing process can be informal or formal (Sandelowski, 1993a). Informal validation consisted of seeking clarification or elaboration of meaning from fathers throughout the interviews (Sandelowski, 1993a). Evolving interpretations of the data were shared with fathers and validated. Formal validation is a process whereby subjects can check the accuracy and adequacy of the researcher's syntheses (Sandelowski, 1993a). Sandelowski stated that member checking, which has been hailed as a means to enhance the rigor of qualitative work, may serve paradoxically to undermine trustworthiness. Sandelowski offered compelling arguments against formal member checking that have implications for this study. Stories that subjects tell in interviews are changing constantly; stories previously told may elicit emotions subjects no longer have, regret, or have forgotten. In particular, fathers' childbirth expectations may be time-bound interpretative acts that change. Difficulties arise if subjects want elements of their stories removed or want to change their stories. Participants may be reluctant to disagree with the researchers' interpretations and wish to be "good" subjects. For these reasons, member checking was limited to informal methods in this study.

Couples experiences through parturition vary widely. Personal experience in this area may create bias in a researcher. The researcher's 20 years experience in intrapartum

care supported credibility. Although such prolonged contact fosters awareness of the wide range of situations encountered by couples throughout childbirth, it could also cause bias. Truth can be threatened when one goes native (Sandelowski, 1986). That occurs if the researcher becomes so immersed in the culture that they lose objectivity and cannot observe clearly (Burns & Grove, 1993). These threats to validity were addressed through peer debriefing. This process consists of engaging, with a disinterested peer, in extended and extensive deliberations about results and tentative analyses (Guba & Lincoln, 1989). The researcher's advisor fulfilled this role by reviewing, discussing, and challenging analyses and interpretations (Germain, 1993).

The second criterion, applicability or transferability, may be thought of as parallel to external validity, and refers to the extent to which findings are transferable to other contexts and subjects (Guba & Lincoln, 1989). Two threats to the applicability of research findings are elite bias and holistic fallacy (Sandelowski, 1986). Elite bias is the reliance on informants who are "frequently the most articulate, accessible or high-status members of their groups" (Sandelowski, 1986, p. 32). In order to investigate fathers' expectations, subjects were needed who could articulate their thoughts and experiences (Appleton, 1995). The threat of elite bias was addressed by providing "a rich description of the sample" (Taylor, 1992, p. 36) to assist attempts to generalize study results to other settings (Lincoln & Guba, 1985).

Holistic fallacy can occur if a researcher becomes prematurely convinced that their conclusions are correct (Burns & Grove, 1987). A way to reduce this possibility is to refer back to the interview data repeatedly while developing themes during analysis of results (Appleton, 1995). Quotes help to validate research findings (Sandelowski, 1994). Detailed descriptions and verbatim quotations were used to substantiate categories and themes and enable the reader to determine applicability of the interpretations to their own context. Data that did not support the theoretical statements were provided, as atypical results may prove relevant to future interpretations (Germain, 1993). Polit and Hungler

(1997) argued that conflicting accounts might strengthen a study by providing a comprehensive description of a phenomenon.

The third criterion, consistency or dependability, is parallel to reliability in the conventional paradigm and is concerned with data stability over time (Guba & Lincoln, 1989). A study meets this standard when findings are auditable, that is, a second researcher following the "decision trail" used by the original investigator would arrive at similar conclusions (Lincoln & Guba, 1985; Sandelowski, 1986). The researcher addressed this criterion by recording methodological decisions, interpretations, and procedures so that other researchers could follow and validate the process and its conclusions.

The final criterion, neutrality or confirmability is similar to the conventional criterion of objectivity (Guba & Lincoln, 1989). Neutrality implies freedom from bias (Sandelowski, 1986). Since no one is free of bias, acknowledging subjectivity can help a researcher to maintain neutrality and thus develop a critical perspective (Hanson, 1994). Peer debriefing and acknowledgement of biases assisted this researcher maintain objectivity. Health care professionals may not have recognized that expectant fathers are clients in need of support themselves and not just support persons to their spouses. Partners and caregivers can place unrealistic expectations on fathers.

Lincoln and Guba (1985) recommended that qualitative researchers maintain a reflexive journal to enhance trustworthiness. This personal diary provides opportunity for catharsis, introspection, and insight (Germain, 1993; Lincoln & Guba, 1985). The process of reflexivity allows the researcher to examine feelings and experiences that may influence interpretation and integrates this understanding into analysis of results (Burns & Grove, 1993). Unstructured field notes were written at the end of each interview. These included details of the situation, personal and theoretical insights, and contextual factors observed during the interview.

In summary, several strategies were used to enhance the trustworthiness of the study. These included: informal member checks, peer debriefing, detailed descriptions, verbatim quotations, clear descriptions of the "decision trail", acknowledgment of biases, and use of unstructured field notes.

Ethical Considerations

Written informed consent was obtained from all participants after they were provided with a verbal and written explanation of the study. Issues of confidentiality and anonymity were addressed. Respondents' names were not associated with the interviews. Tapes, transcriptions, and demographic sheets will be stored in a locked container for seven years. Care was taken during the writing of the results to protect the respondents' anonymity. Fathers were identified by pseudonyms.

Fathers were informed that they could withdraw from the study at any point without affecting their partners' care. They were made aware that they need not answer any questions with which they were uncomfortable. The researcher monitored participants' emotional status throughout the interviews. When respondents became emotional, the tape recorder was stopped to give the fathers an opportunity to compose themselves. No serious concerns were identified as a result of fathers' participation in the interview process. There were no perceived risks to participants and the benefits, though minimal to subjects, may benefit other expectant fathers.

Study Limitations

Several limitations are acknowledged. The demographic characteristics of respondents in this study do not represent all expectant fathers. Sample recruitment was limited to one geographical location and consisted of 20 fathers who were 18 years of age or more and able to read, write, and speak English. Only five types of complications were represented; few fathers had past experiences with complicated pregnancies. These

factors may have limited our understanding of the phenomena and generalization of findings. The lack of a longitudinal design did not allow determination of whether fathers' expectations change with the diagnosis of complications, over time, or the addition of other complications.

Summary

This chapter addressed the methodology and research design used to study expectant fathers in the context of pregnancy complications. Strategies to enhance scientific rigor were presented. Finally, ethical considerations and study limitations were discussed.

CHAPTER IV

RESULTS

In this chapter, findings of the study are presented. In the first section, demographic data is summarized to describe the participants. Fathers' perceptions of childbirth, expectations, and complicated pregnancies are discussed in the next section. The final section will elaborate on the five themes that emerged from the data.

Demographic Data

Twenty fathers were interviewed. Most participants were white and married. Three were single, common law, or divorced. Other racial backgrounds included one oriental, aboriginal, and Filipino. Ages ranged from 21 to 38 years, with a mean of 28. Participants had a mean of 13.7 years of education (range, 10-21 years). Partners' gestational ages ranged from 27 to 39 weeks at the time of interview, with a mean of 32 ½ weeks. Three women had a diagnosis of placenta previa, four of pregnancy-induced hypertension (one had progressed to preeclampsia), one "possible chronic hypertension", six preterm labor, five spontaneous premature rupture of membranes, and one deep vein thrombosis. Four women were expecting twins. At the time of interview, 9 women had experienced care exclusively in hospital and 11 had been cared for in both the hospital and home setting.

Only 65% of subjects stated that the pregnancies were planned. The number of first time and experienced fathers was equal. Two had past experience with preterm deliveries. Twelve had attended prenatal classes in this (n = 5) or in previous pregnancies (n = 7). Of the eight who did not attend prenatal classes, three quarters were first time fathers.

Childbirth

Childbirth was described as a process, unknown event, end product, or emotional moment.

Process

Blake, a 31-year-old second time father and student, whose wife was 31 ½ weeks pregnant with twins and diagnosed with preterm labor at 29 weeks, defined childbirth as,

> . . . the actual process in which the, um, the fetus is, uh, born into the world. So it's, um it can mean instantaneous, you know, the second that the baby's born or it can mean, you know, the whole process of labor, delivery, and then, and then post delivery process so it can either be an instantaneously moment or it can more be a description of the longer term.

Unknown Event

Some first time fathers described childbirth as an unknown event that generated feelings of uncertainty because they could not predict what was going to happen. "There are so many unexpected things that come with it," a father said. Kevin, a 21 year old who worked in the public service sector, felt "very, very uncertain" because he did not know what he was going to do during childbirth. Kevin described uncertainty as, wondering "what's going to happen, if you have the right idea about things [childbirth]". He questioned if childbirth was going to be "as easy as I, as I hope or I expect". This inability to predict events was accentuated by a diagnosis of deep vein thrombosis. Kevin said,

> "I don't know if there's going to be any further complications. . . I don't know if that's [deep vein thrombosis] gonna affect the overall outcome. I don't know if that's [deep vein thrombosis] going to be a factor in the labor and delivery. . . . All at once it's a little bit to handle.

The perception of birth as an unpredictable event was not limited to first time fathers. Dennis was a 28 year old professional whose wife had had a previous preterm birth, was 34 weeks pregnant and on bedrest since 27 weeks because of preterm labor. He portrayed childbirth as,

> . . . a phenomenon. I don't think you would ever understand or fully have an understanding of. It's one of those things there's too many variables that can affect any number of results or any number of situations.

End Product

Other fathers spoke of the end product. For them childbirth meant, "Another person I have to take care of, like in a good way," "Having [a] chance to raise a child, watch it grow," "Being a dad," and "Added responsibility".

Emotional Moment

Several fathers spoke of the wonderment of birth. It's "A very special moment," and "One of those wonders of the world". Another said, "It will just be a blessing to see my child born. . . . She means a gift. . . a gift to the family."

Allan, a 32 year old first time father and professional, whose wife was 34 weeks pregnant with twins and in hospital because of preterm labor (diagnosed at 29 weeks), eloquently described birth and death as "profound moments" along a continuum.

> I was in the hospital when my mom died and it was a *very* profound moment because all of a sudden the whole family was in the room and the next minute there was one less of us. So it was a very intense and profound thing. And I'm hoping and think that this [childbirth] might be the same sort of profound and intense moment but on the other end of the spectrum where one minute there is two of you in the family and the next minute there's four.

For fathers in this study, the word childbirth evoked a range of responses. Birth was described as a process, unknown event, end product, or moving experience.

Expectations

Fathers in this study had difficulty defining expectations. Others were reluctant to expect "too much." Fathers described their expectations in terms of what they hoped would happen and/or what they believed would happen.

Challenges

The following quote by Blake succinctly illustrated the challenges of defining expectations.

> It's a very interesting problem, you know, trying to decipher, uh, what expectations are, or what they mean. . . . It's a hard thing to put into words because you don't often think of labor and delivery and childbirth in terms of the father's expectations. . . . you don't often say you expect something to happen. You often say you hope or you want but you don't often say you expect because that almost means that you know, you know what's gonna happen or you're wanting it to happen so bad that it's almost a reality before it happens.

Dennis offered a unique analogy.

> It's impossible to define what you expect. . . . to expect something in childbirth well *never*. . . . It's like saying well I expect if I drop a rock down a maze vertically it's going to take the same path every time. Well forget it you know. . . . what I expect is a childbirth or a labor period of x amount of hours or x amount of minutes, depending on what it takes, and then a baby in the end. That's what I expect out of childbirth.

Several first time fathers talked about "going with the flow" instead of expecting. "If you expect too much then. . . if it's not going right, then you start worrying. . . I don't want to start that so I think we're just kinda, not trying to expect anything. Just go with the flow." Another said, "I'm more of a day to day person, like I go with the flow type of thing, I don't really expect too much."

Hopes and Beliefs

For some, expectations meant hoping for a positive outcome: "My expectations are kinda simple. . . I just hope that we're able to have a healthy baby," "Expectations, uh, that everything will go well, that the baby will come out all right," and "My expectations I guess is hoping that I'll be a good father." Another said, "We're concentrating primarily on the health and welfare of the babies so that we don't have much in the way of expectations about what else we might get. The only thing we're really looking to get out of this is healthy babies."

Hoping for the best did not imply that fathers did not believe that difficulties could arise. Blake expected, "The best or the more positive situation to unfold" while at the same time was cognizant of the fact "that different things could arise". Another said,

"The perfect baby, the perfect everything. . . you can always hope for the best. . . there always might be that problem but just got to look on, on past that." Kevin said:

> I guess hoping and expecting are two different things. . . I would expect that, um, labor is going to be somewhat difficult for, for my fiancée. But, at the same time, I would hope that it goes really well and easy for her but I understand that, that many pregnancies, or many, um, women when they're in labor will take a very long time and it can be very strenuous and in a lot of cases it can be complicated by other, by other physical effects [things].

Fathers had difficulty defining expectations. Some were reluctant to expect "too much." Their responses included hopes and/or beliefs for childbirth.

Complicated Pregnancies

Fathers had many ideas about what constituted a complicated pregnancy. Some fathers classified complications by degrees of seriousness.

What is a Complicated Pregnancy

For many, complicated pregnancies were seen as conditions that could threaten the health of mom, baby, or both. One father's statement reflected that interpretation.

> It's a complicated pregnancy to the point where the mother's being complicated right now. The mother's health. But the baby, uh, appears fine. So I didn't want any complications of course to spread where, uh, the baby wouldn't be getting the proper, uh, blood or oxygen or anything that it needed. And I didn't want that to, in any way, to endanger the life, the life of the child. (Kevin)

For Miles, a 35 year old first time father whose wife ruptured her membranes at 34 plus weeks, there was a difference of opinion between him and the medical staff regarding what constituted a complicated pregnancy.

> Well, that's the term that they [medical profession] use but I mean all it was, was her water broke, it was no big gush, it was just a little trickle of water and so it's been a little trickle here and a little trickle there and with the assessments, fetal assessments, they said no, it's at 6 ½ pounds the baby itself. It seems to be a big baby. . . .there's a lot of fluid in around the baby so it doesn't seem to be a concern right now. I don't. . . . Like I could understand if it was a big gush, then I could see it being a complicated because she's not going into labor yet and they'd have to induce it.

Other fathers viewed a complicated pregnancy as "more than" a condition that could affect the health of mother and/or baby. Real, an experienced 38 year old father and public service sector worker, whose wife was 27 ½ weeks with ruptured membranes since 17 weeks, said,

> A complicated pregnancy deals more [than] with just the physical problems, [also] deals with the family problems. Like the problems extend right up, right into the in-laws and, you know, it's a big thing. . . . people are more stressed out. . . . easier to, uh, to jump off the handle. . . . it's an added factor when you add like personal or job problems. . . . it magnifies other problems so it's complicated in many ways.

Mel, a 30 year old first time father and tradesman whose wife was diagnosed with placenta previa at 21 weeks gestation (now 30 weeks pregnant), also considered emotional stress to be a complication.

> I think in the emotional and stressful sense it's complicated. . . . Like medically, it's, if something were to happen now, like they say, it's nothing, they'd take her in and 15 minutes it's over, everything would be fine. But I think the emotion, emotionally it's complicated.

Walter, a 33 year old self employed man whose wife was 35 weeks with ruptured membranes for 4 days, talked about a previous pregnancy "that was complicated in a different way."

> It was early Sunday morning, it was 35 below, I had to drive her 100 miles and we got about 20 miles from Winnipeg and the car started freezing up and there was no traffic anywhere. And she was just absolutely panicking and I'm trying to keep her calm. So I don't want to act panic, scared. So you gotta put on a big front. To me that's complicated too.

Degrees of Complications

Three fathers referred to degrees or severity of complications. Walter said,

> There's different degrees of complicated pregnancies. . . . I don't think this is a severely complicated pregnancy. It's definitely more complicated than the last one but it's, I'm sure, there's worse you know. . . . The baby's heartbeat's healthy and everybody says the baby's safe where it is. . . . so it's complicated but it's not that complicated.

Dennis stated,

> . . . we've had more tests, more things to make sure it's O.K. and we've had problems earlier. . . . so comparing the two, yea, this one would be complicated. Um. But it's not, I don't think, as complicated as some pregnancies where the women are up and or the wives are up for 8 months in bed. Like it depends on the severity.

Kevin, who acknowledged that his partner's diagnosis of deep vein thrombosis could have been fatal, still remarked, "Being at the hospital all the time makes you think a lot about how some people have it a little harder and that we've had it pretty easy so far I suppose and it could be worse."

This need to compare with something worse was explained by Dennis.

> ...if you compare it to something that's worse, it doesn't seem as bad which is an easier way to compare it to instead of saying oh, you know, friends of ours are no problem or they work right up to the day they have the baby. . . yea if you compare it [to] that, then it looks like a complicated pregnancy. But if you compare it to somebody who either can't have kids or tried to have kids and just can't, then you know it's not, it's not really bad.

Fathers in this study offered a unique perspective regarding complicated pregnancies as their interpretations went beyond traditional definitions. When describing complications, fathers considered the emotional and physical impact as well as degrees of severity.

This section has presented fathers' perceptions of childbirth, expectations, and complicated pregnancies. Their definitions of these key concepts offer a contextual background to understanding the major themes that emerged from the data

Themes

The stories of expectant fathers provided an in-depth description of fathers' childbirth expectations in complicated pregnancies. Five major themes were identified:

1. *Preparing for Complications*
2. *"Being There" – Antepartum*

3. *Prolonging the Pregnancy*
4. *Trusting in Technology*
5. *"Being There" During Childbirth*

Theme 1

Preparing for Complications

The theme, preparing for complications, refers to how fathers adjusted to a pregnancy that was labeled complicated. The process was illustrated by the sub-themes: dealing with the unexpected, using past experiences to prepare, using past successes to prepare, and preparing by readjusting expectations. Strategies used to prepare were depicted by the sub-themes: acknowledging the worst case scenario, seeking the positives, living one day at a time, over-preparing, and seeking and receiving information. The challenges encountered by fathers were described by the sub-themes: not ready, heard stories, and in the dark. The components of preparing are illustrated below.

PREPARING FOR COMPLICATIONS		
PROCESS	**STRATEGIES**	**CHALLENGES**
• Dealing with the unexpected • Using past experiences to prepare • Using past successes to prepare • Preparing by readjusting expectations	• Acknowledging the worst case scenario • Seeking the positive • Living one day at a time • Over-preparing • Seeking and receiving information	• Not ready • Heard stories • In the dark

Process

In general, fathers were not prepared for complications. The process of preparing was immediate and ongoing. Past experiences (or lack of) and successes regarding

childbirth advanced or hindered their abilities to prepare and deal with complications. Some fathers concentrated on readjusting their expectations for the present event while others were concerned with future pregnancies.

Dealing with the Unexpected

The initial reaction to a diagnosis of complications was frequently one of shock and disbelief. The words "totally unexpected" captured the essence of the experience. Kevin said, "Just the whole initial shock. . . was probably the biggest thing . . . just heard blood clot, you know. And, uh, we heard those words before we heard anything else."

"Why us" was a question that plagued fathers and demonstrated dealing with the unexpected. Mel commented, "That was one of the first things, why us, because we wanted a, want a baby so bad." Blake said, "We've, you know, technically done everything right for the last few years to guard against anything, any complications happening." The notion of "not us" prevailed and is exemplified in Kevin's comment. "I never thought that it [complications] would pertain to us. . . I just always, um, felt like, you know, we're in the majority, we're going to be lucky, we're going to have no complications and everything going to be perfect."

Using Past Experiences to Prepare

Experienced fathers prepared for birth by relying on past experiences. In contrast, a lack of experience made it difficult for first time fathers to prepare. One father said, "It's something you can't really prepare yourself for." Fathers did not know what to expect. Fathers commented, "Don't know what to expect," "No idea what it's going to be like," "A lot of inexperience... lot to learn," and "I can only imagine what it would be like." For one father (Colin), his ideas of what childbirth might be like were tenuous. He said, "I have certain ideas of the way it may or [may] not be and, you know, I view those very loose ended in my mind cause I'm sure that some things may be different than I thought."

A lack of familiarity with "normal" pregnancies, coupled with the diagnosis of complications, were issues for several first time fathers. Fathers made the following comments: "Being our first, you don't know what to expect and since it's gone this way with this placenta previa, it's, it's kind of nerve wracking," "All at once it's [complication and first pregnancy] a little bit to handle," and

> I don't know from one day to the other what her stomach's going to look like or the baby moves. Like, um, how much it should move or what's normal, what's not normal. . . . and then yet to boot, you got this side thing, a ruptured membranes.

Familiarity with childbirth lessened the anxiety for some fathers because of the ability to draw from past experiences. Walter said,

> I know a lot more of what to expect. I think if this was, would have been our first pregnancy and we're having the trouble that we're having now. . . I'd be a lot more nervous and a lot more scared. . . . I can keep her a lot calmer now because it seems like I'm reassured in my head. . . . My confidence level is higher now because I've been there before.

Real said,

> I'm sure it's [childbirth experience] helping a lot because it's a difficult pregnancy. So because I've already went, went through the, uh, learning experience of the previous pregnancies, I've got background experience for the normal part of it. But in this situation I'm having to deal with, uh, abnormal circumstances which any experience from previous pregnancies would help get through this.

Familiarity with childbirth decreased Blake's level of uncertainty.

> In the first pregnancy you definitely didn't know what to expect. . . but now, you don't have to sort of worry on every little movement your wife makes because you know that it's not going to harm the babies so. Uh. I would say I probably was more uncertain about, you know, events and things, uh, in the first one just because it was my first. Now that sort of we're theoretically a little more experienced with things then, I'm less concerned about the uncertainty because I know. . . a lot of it's unfounded.

Past experience was reassuring to Jay, a 26 year old laborer, as he prepared for an elective section.

> The first time, [emergency cesarean] I didn't know like, I didn't know they were going to put up the sheet, I figured I'm going to see the whole thing and I didn't

> really want to see the whole thing cause that stuff I don't like seeing. But they put up the sheet so I know they'll put the sheet up again.

The knowledge that his wife was scheduled for an elective cesarean section, was reassuring to Jay. "I'll probably be a little bit more, a little bit more assured because, like I've said, it's all been planned. . . .There's not going to be really any surprises so I'll be a little bit more assured, a little bit more calm." For Jay, there was no uncertainty this time because he believed "everything is [was] going to go according to plan."

A lack of familiarity with a particular event (different labor), complication, or procedure were issues for some experienced fathers. Walter referred to complications as "new territory". Dennis said, "If it happen like last time or a bit longer labor, well then we sort of know what to expect. If it's a totally different type of labor this time, then it's really hard to, you don't know like what happens then. . . .I can't imagine being up for 18 hours." One father described the lack of familiarity as follows:

> Like in a way I know what to expect but this one's a little different because of the, I guess the ways things are going in the pregnancy. . . .The first two I had [with former wife] were premature. And, uh, they were all like natural, you know, there was no inducing or coming to the hospital in advance. . . . With her [present wife] having high blood pressure and swelling, I never really experienced that kind of, you know, thing and. . . like the pain she's been having right now.

Using Past Successes to Prepare

Generally, past successes determined what fathers expected and planned for. Bill an experienced 25 year old father and laborer, whose wife was 34 weeks with twins and diagnosed with pregnancy induced hypertension said, "The other two, they were a breeze. We were expecting this to be easy again. . . The other two were so fast. He [the doctor] was expecting these to go the same, you know, so I never got ready for complications." Blake said, "My wife is nearly 6 feet tall. . . . I thought if anyone is in . . . a good predicament to be in as far as carrying multiples it was her. . . . I thought things would go smoothly, as smooth as a multiple pregnancy could go." Walter said, "She had such an easy first pregnancy. . . that I wouldn't never in a million years dreamed of having to

induce her. . . .All of a sudden, well that's reality. . . . And then, well if that's reality, there's several other things that could be too."

When what is expected (easy, smooth delivery) does not match what occurs (complications), uncertainty can result. This lack of congruence between what is expected and what is experienced, coupled with a lack of familiarity with cesarean sections, was stressful for Bill. "They're talking about C section. . . . I don't know nothing about C sections. . . . Am quite unfamiliar with the procedure so it's scary. . . . This is totally different for me. It's a new ball game. . . .Like labor or pregnancy again for the first time." Bill had difficulty preparing himself for a labor that was longer and more painful. "I can't really picture . . . cause I never really had such a long experience with labor before. . . . It's hard to visualize what I can do." He kept repeating the words, "I don't know."

Lack of congruence was not an issue for Dennis because he had "always thought about the possibility of being early again. . . .I was just wondering at what stage we would threaten to be early." Past experience with a preterm delivery helped Dennis, "Have an idea of what will occur . . . . How to work with the system and the way it works." However, he did not feel that his experiences prepared him for another preterm pregnancy. "I wouldn't say [it's] prepared us, it gives us a better understanding . . . . I don't think you'll be prepared because this one might have some complications, the other one might not. It's really hard to say because you're dealing with life, you never know." Dennis accepted uncertainty as a part of life.

Preparing by Readjusting Expectations

When dreams were shattered by unforeseen events, fathers had to readjust their hopes and expectations for the "perfect experience." Fathers grieved the loss of the "perfect birth." Mel's wife was scheduled for a cesarean birth. He was having difficulty preparing for birth as he remained disappointed about not having a natural birth.

> I wanted to experience it too, you know. I wanted to be there. I wanted to see it all happening. . . .I was . . . looking forward to going to the Lamaze classes and encouraging her in the breathing and doing my part. I wanted to do my part, you know.

For Miles, the diagnosis of a complication meant that his hopes for a natural birth with no induction, epidural, or fetal monitoring might not be realized. He said,

> That's the uncertainty I have like is this going to go the way that we're hoping, the way that we see. . . . You sort of have a picture of here's the delivery date. . . you go and you have the baby, you come out but now it's sort of, it's gonna be maybe early. There might be more complications.

When dreams were "shattered", several fathers experienced a loss of innocence. Comments such as, "No one's immune" and "Not always going to be in the lucky majority" exemplified this loss. "Why us" became "why not" as fathers acknowledged the reality that, "anything could happen".

Fathers adjusted their expectations for the future. Dennis said, "Well if you [wife] want a third. . . we have to be prepared for this, this type of process where you're going to be laid up for a month or two". Comments such as: "Do we chance having another one if we get through this one", "I can't help but wonder if it means it's going to happen again," and "Maybe if this one is too difficult for her, maybe, you know, this will be the last" demonstrated this concern for future pregnancies.

Strategies

Fathers prepared for complications using five strategies: acknowledging the worst case scenario, seeking the positive, living one day at a time, over-preparing, and seeking and receiving information. Each is discussed in the following section.

Acknowledging the Worst Case Scenario

Blake described the essence of this sub-theme.

> I need to be as well informed about all the possibilities, all throughout, all along the way. So whether it's, you know, problems that can develop during the second trimester, third trimester, you know, right up until the time that, you know, labor starts in, right up until after the babies are born, whether they're in NICU for a few days, a few weeks, a couple months. . . . I've thought about, you know, all of those

> scenarios. . . . I need to be prepared of all the, sort of the worst case scenario and then, you know, anything, anything better than the worst case scenario is, doesn't matter, because I'm prepared for the worst case scenario.

Preparing for the worst case scenario meant dealing with the "what ifs." Blake said, "You know, there's all these what ifs. . . .What would we do if, you know if this happened." Walter claimed, "It's always hard to prepare yourself for a what if. . . . There's always unexpected things." Walter's strategy was to prepare for "almost everything." "We've come to terms with almost, with almost everything that could happen. . . . I think we're as well prepared as we could be."

Preparing for all possibilities, did not alter the fact that fathers still expected or hoped for a positive outcome. Blake prepared for the worst but expected "the best or the more positive situation to unfold." Bill was "expecting the worst, and hoping for the best."

In contrast, Jay did not want to hear the worst case scenario. His strategy was to block "out all the bad stuff". He said,

> They tell me. . . . they'd already lost a baby with the same thing [placenta previa]. And then, you know, then they tell me that she can hemorrhage and. Tell you the truth I really don't want to hear that. . . . I don't need to think about those, just dwell on the positive.

Seeking the Positive

This was a strategy described by some fathers and is exemplified in the following quotes. Blake said,

> You have to look positively, uh, at any situation, even if you are having complications, even if things look grim, you still have to, that's just our, you know, human nature is to look, is to look for the positive, that's what keeps you going.

Real clung to positives even when there was little hope of survival.

> The survival rate for. . . under 24 weeks is very low. I mean there's not too much positive. You're looking at the future. You're looking forward to, to make it. That's what's positive if it keeps making it. And the January 2nd fetal assessment, there was actually some amniotic fluid in there which was like very low probabilities of that happening. And at that point it started being a little more positive. And three days later she lost quite a bit so we thought, well that basically

> almost nullified what she gained but then the next time we went, it had built up even more til the 24th week where she had quite a bit and that was also the point where it became feasible, you know, survival rate of any type.

Fathers "looked for" positive signs. Caymin a 27 year old tradesman and first time father whose partner was 28 weeks with ruptured membranes since 24 weeks said, "As the days proceeded. . . she didn't go into labor. . . .She wasn't gushing . . .she's just dripping. . . . So these are all good things." Real said,

> It's almost 28 weeks in four, five days it'll be at 28 weeks. And the survival rate is 85% . . . . All it's vital signs are strong. . . It's a little small. . . . It's had its steroid shots. . . . So we're pretty positive right now cause my wife is showing no signs of infection. She's not leaking more than she can produce with the baby. So I've been really positive for about . . . 3 days.

Living One Day at a Time

Others coped by not looking to the future and living in the present moment. This concept was labeled, living one day at a time. Bill said, "Complications that come around just learn to live with them as they come. Can't make plans for them. So take it one step at a time. You know it's all we can do now." Dennis said, "We usually try to deal with things pretty well as it comes and not worry too much. If you worry about it occurring early, well, you can only worry so much. After that it's not doing anyone any good."

Over-Preparing

Two fathers tried to cope with complications by being "over-prepared". Kevin said, "It could be any time. . . .It could happen at any time, so we're preparing every day." Not only was Kevin "preparing every day," he felt the need to prepare for every possible complication. He said,

> Really anything can happen. Anything you've ever heard about before in any pregnancy in your whole life, um, can happen. . . . For all I know it could be something that nobody's ever heard of or seen before. . . . Try to prepare myself for anything and, uh, it's a little tough because you, you gotta be open-minded about it all and you gotta try to refrain from being pessimistic but at the same time I want to prepare myself a little bit in case something happens.

For Kevin, emotional preparations needed to start with the diagnosis of pregnancy not with the diagnosis of complications. He said,

> The emotional preparation for me I think would have had to start right from the moment I knew that there was a pregnancy. I should have known, you know, something can go wrong. Um. Not that I should have worried about it just that I should have, uh, been a little bit more prepared at that point and it might have been easier to handle now.

Walter prepared by setting "unattainable expectations".

> A person has to set their expectations of themselves almost at an unattainable level because it keeps ya, keeps ya working, eh. If you say, well, if you set your expectations too low, I don't know, maybe won't be prepared for something that's, that you're not, like that you don't realize is gonna to happen. If you set your expectations like so high that they're almost unattainable, seems like anything that happens you can handle it.

Seeking and Receiving Information

Seeking and receiving information were common strategies used to prepare. Resources consisted of: prenatal classes, networking, educational material, tours of the special care nurseries, and fetal assessments.

Prenatal classes. Prenatal classes were not mentioned as a common source of information about complications. The classes helped prepare for "normal" pregnancies. One father claimed that prenatal classes prepared him for the stages of pregnancy; others said they prepared them for labor and delivery. Allan explained how their prenatal instructor helped prepare them. "She [prenatal instructor] had twins and mentioned that she'd been confined to bed for several weeks and was in hospital the last month of her pregnancy. So we were certainly aware that this was one of the pitfalls with multiple birth."

Networking. Networking was a strategy used by a few fathers. The twins and triplet organization was a source of information and support for Blake. He remarked that it helped to talk to "people that have gone through the same thing." Two fathers sought

out colleagues in the health care system to obtain information about their wives' conditions.

Two fathers became informed through their partners. Dev learned about preeclampsia through his wife who was a physician; Allan's wife did a lot of reading which he picked "up vicariously."

Practitioners were considered a source of information. Caymin appreciated the information they received from nurses in the community based program. He said, "They do help out a lot with the questions we have and they answer them, some of them answered them more than we expected. . . .They went all out on it. And that was very good and we liked that." Blake learned about the "tricks of the trade" from nurses. Miles explained how their labor support person prepared them. "She explained to us what to expect at the hospital [assessed for query ruptured membranes] so it wasn't, you know, a complete shock and we didn't go in there, you know, totally ignorant of what was going to happen. That I think makes a big difference."

Educational material. Dev a 26 year old first time father and service sector worker, obtained information about preeclampsia through his wife's medical books. A number of fathers learned more about complications through videos. Walter was angry when the videos they were given were inappropriate.

> This doctor sent over these videotapes to make us watch. And our baby's 35 weeks today. And, uh, [the doctor] sent over these, they might as well have been horror films on these kids that were born at 17 weeks and 20 weeks, not even relevant to our situation *whatsoever*. [the doctor] wasn't there when we watched them, trying to explain nothing. Just sent them and *watch these*. . . . And one, the first one we watched, well OK. The second one we watched, I said, to hell with it, it's just upsetting my wife and upsetting me and I wasn't happy with them. It was totally unrelevant to our situation. I took it out. No, I said, we're not gonna do it.

Tours of the special care nurseries. Prior to a tour of the neonatal intensive care unit (NICU), Blake had difficulty envisioning crucial deadlines in fetal development.

> I didn't really understand, you know, there's so many, you know, crucial deadlines as far as the babies' development or gestational period. . . you know, a 29 week old

> baby is far under, more underdeveloped [than] say a 31 [weeker]. You know how much can two weeks make? I couldn't picture that then.

The tour helped Blake visualize the differences in fetal development and prepare him for a preterm baby.

> One of the nurses showed us, you know, a baby that was 34 weeks but born at 28 weeks. So this baby was less than 2 pounds and that was a big shock. I was expecting a small, small baby but I wasn't thinking of something that, a baby that looked like literally a small baby chimpanzee. . . . And then . . . she showed us another baby that was, uh, more towards where, the stage that our babies are at now. They're about 3, 3 ½ pounds. So that was good. This baby was born . . . at 31 weeks and was now 34, 35 as well. And this baby was about . . . 4 ½, 5 pounds so it's somewhere in between that we could envision where our babies were. . . . In between this 1 ½ pound baby and this 4 ½ pound baby so it kind of gave us a sense of what the development of our babies were so that helped. That helped the preparedness. . . . That was a good experience.

For other fathers, the tour prepared them for the technology involved in a preterm birth. Caymin said, "I know all the little gadgets they use so at that time if they do use any of that, I'm already aware what they are. . . If the baby was born [preterm] I will expect to see that stuff." The tour helped dissipate Walter's anxiety. "She [nurse] picked out one baby . . . that was closest to ours. . . . And she took us through and showed us everything. All the bells and whistles in there. . . . She took so much weight, pressure off me, it's just unbelievable."

Fetal assessments. Fathers marveled at the ability to "see" their babies and felt reassured. Dennis said, "You could see that it was. . . healthy, it was breathing. . . . That makes it more reassuring. . . . Seeing that it was getting bigger based on measurements and seeing the belly grow bigger." Allan said,

> The fetal assessments have proven to be a huge comfort to us because they've always allayed our suspicions and confirmed that everything's going well. And that's nice. Even this bedrest has, it's sort of given us some, uh, objective feedback that what L.'s [wife] doing is helping because you can see on the screen that there's these two wriggling, squirming things.

When Real's wife ruptured her membranes at 17 weeks, the medical profession suggested they "let nature take its course" and offered them "no real hope." They did

have fetal assessments, which helped Real to bond earlier with this baby than in previous pregnancies where bonding started when he felt the babies kick in utero. As gestation increased, the fetal assessments provided positive feedback.

> You see it sucking its thumb and it's heart beating. . . . Those are all positive signs. . . . It should have good lung development because its chest is going up and down. It looks like it's developing properly cause. . . it's tummy's full of amniotic fluid. That means it's actually taking some in and out so I mean if you know those things . . . it will help.

Challenges

The diagnosis of complications was alarming to some fathers because they were "not ready" at home. For many this was the impetus to start preparing or completing preparations. "Hearing stories" and being "in the dark" were sub-themes which did not facilitate preparations.

Not Ready

When confronted with complications, some fathers commented they were not ready. For Rob, a 25 year old student and first time father, this was compounded by the fact that the pregnancy was unplanned. Rob stated, "When this happened, you know, I realized, you know, we got nothing done. You know we got absolutely nothing going right now." Others claimed they were almost ready. James's said, "We were on our way to being ready;" while Miles was concerned that although "The baby's room and everything's [ready] . . . we didn't have our birthing plan made out yet."

Blake focused on being mentally instead of physically ready. He said, "Mentally, I'm prepared you know. Physically we may not be." One father claimed to be "totally ready". Sam was a 29 year old experienced father and laborer whose wife was now 30 weeks, expecting twins and had ruptured membranes since 25 weeks. He stated, "You gotta make sure that you're ready at home." The fact that the twins would likely spend some time in hospital, allowed him the opportunity to complete a few projects. He said, "Want to have that all done. Just want to make sure that everything's just fine before the

babies come home. Which we're luckier than other people I think because the babies are gonna have to spend a little time here." Sam was in denial regarding the seriousness of the situation.

Heard Stories

First time fathers talked about "stories" they had heard. Allan said, "We've heard every conceivable horror story that [there] could possibly [be]. I've heard less about them but L somehow, I don't know, women feel compelled to share their labor stories with pregnant women." Tim, a 27 year old first time father and tradesman who admitted he was blocking thoughts of labor and delivery, was vulnerable to "stories" about the pain of childbirth.

> I always hear the bad stories like the pain and then there's the good ones where it all went so quick I didn't even notice and the drugs. The drugs is always the stuff that's always brought up. Is she gonna get drugs, is she gonna get drugs.

Tim's fears concerning the pain of labor were not ameliorated by this nurse's story. "You know darned well that when it comes [to] natural, [labor] when you're in pain, you're gonna want those drugs and, you know, you can try and withhold but, if you want it, you know, be aware that. . . it might happen."

One experienced father was able to take a wait and see approach about stories he had heard about inducing labor. Walter said,

> I hear it's a little more intense. Pains a little quicker but I've also heard that they can induce somebody and nothing happens too, so probably different for every person. I'm sure it'll be different than normal, like a natural labor. . . .But like I say, whatever happen, happens. You don't know until, until you're there.

In the Dark

A lack of information, as well as inconsistent information and misinformation, precipitated feelings of being "in the dark." Bill, an experienced father, felt "left in the dark."

> I've been here [hospital] but no nurse or doctor has really like talked to me directly. . . . I'd like to have more information. . . . My wife's been asking the nurses [about C sections] . . . but I've never been involved in that.

Bill, who had predicted adopting an active role in labor, was uncertain of his role in this pregnancy.

> This time, I guess I can, you know, still, still I guess just talk to her, be there for her. Not much more. . . . Especially if they're going to be doing C sections, you know. . . . I don't think I can do very much at all. I don't even know if they, do you know if they have masks or oxygen masks or anything like that on there. You know I don't know any of these things, you know, can I talk to her, can she answer me back.

Despite the fact that Bill had experience and had attended prenatal classes in previous pregnancies, he was still "in the dark" regarding pharmacologic methods of pain relief in labor. He explained,

> They always said. . . medication is out of the question. . . . Usually like if you're pregnant you're not supposed to be taking any medication of any kind at all, other than I guess your shot that they give you before you have a C section. Really that's the only thing I ever knew about this whole thing.

Mel was informed about his wife's condition but still didn't know what was happening because the information he received was inconsistent.

> You have so many doctors or different doctors or interns or whoever they are coming in and out and everybody's telling you something a little different. So you don't know what's, what's really going on or what is the right answer until finally her doctor comes in and explains everything to me and you get a better understanding.

Walter's story emphasized the importance of information that was accurate, consistent, and timely.

> When S. [wife] first came in and she was laid up there, we didn't really know what was going on or what was happening or if she was going to go into labor or, or really what we were supposed to be doing because when we left the hospital in X. they said, well we're sending S. in to be induced. And when we got here and [they] said no way, we are not inducing her so we didn't know whether S. should be hoping to have this baby or whether S. should be laying there still and praying to God she doesn't go into labor. Nobody really came and told us all that much right off the bat, eh. But as time went on we talked to more and more people all the

> time. . . and I got it clear in my mind. . . exactly what was going on. . . . My feelings have changed a lot from, from being extremely nervous and kinda in the dark to at least knowing. . . what our situation is exactly. And then once you know exactly where you stand then you know how to deal with it

In summary, preparing for complications was one theme that emerged from the data. The process involved dealing with the unexpected, using past experiences and success, and readjusting expectations. Fathers prepared by: acknowledging the worst case scenario, seeking the positive, living one day at a time, over-preparing, and seeking and receiving information. Some of the challenges faced by fathers included: not being ready, hearing stories, and feeling in the dark.

Theme II

Being There - Antepartum

In this study, being there meant supporting their partners throughout the antenatal period. Fathers described this period as stressful. For Real, being there was perceived as a "Drawn out challenge this time with the complications;" for Walter it meant "having to support my wife for 3 days now instead of just, you know, say a 12 hour labor and delivery."

The themes that emerged from the data were related to various aspects of the stress process. The investigator used Pearlin's (1989) three domains of stress as well as the work of Gupton, Heaman, and Ashcroft (1997) to organize the data. These domains include stressors, stress mediators, and stress outcomes. These domains and related categories and sub-themes are shown below.

BEING THERE - ANTEPARTUM		
STRESSORS	**STRESS MEDIATORS**	**STRESS OUTCOMES**
Situational • Maintaining bedrest • Uncertainty regarding delivery date • Constant worry • Increased workload • Lack of control • Being separated • Protecting partners **Family** • Differing priorities • Altered family dynamics • Lack of support	• Social supports • Coping strategies	• Emotional and physical reactions • Sense of isolation

Stressors

Fathers encountered various stressors as they struggled to be there. These stressors fell into two categories, situational and family.

Situational

Situational stressors refer to those stressors resulting from living with the diagnosis of complications. These stressors were illustrated by the sub-themes: maintaining bedrest, uncertainty regarding delivery date, constant worry, increased workload, lack of control, being separated, and protecting partners.

Maintaining bedrest. Most women in this study were on bedrest. Many fathers played an active role in ensuring that bedrest was adhered to. Fathers were challenged when their partners had difficulty adhering to bedrest. Bill said,

> I can't tie her down. . . . They're wanting her to be on bedrest. . . . She feels uncomfortable when she lies down. She feels uncomfortable when she walks. . . . I don't know what to do. . . . Can't do nothing much for her. Pretty much helpless I guess. Just [let her] do as she wants, that's all I can do."

Uncertainty regarding delivery date. The uncertainty regarding date of confinement was stressful to several fathers. Bill was so concerned about missing the delivery that he had arranged his life so that he was no more than 10 minutes away from the hospital. He struggled to juggle his time between his kids and wife.

> I should be home with the kids knowing that she's not going into labor yet. . . I'm neglecting my kids and . . . at the same time I don't want to neglect her. . . It's just a confused situation . . . as to where to be, who to be with."

Dennis compared the uncertainty of not knowing when to a roller coaster.

> It's that roller coaster of emotion or roller coaster of yes or no. . . . Last Saturday I was feeling O.K., yea here it is cause she was. . . saying there's something wrong. That's when you say, oh, O.K. this is going to be it but then it ended. . . .That's a little stressful because. . . you're on a different mindset and then you have to get back to reality a bit, um, and doing things.

Walter and his wife were awaiting the results of an amniocentesis to see if labor could be induced. Walter described the agony of waiting.

> The hardest thing is just sitting and waiting. We've been sitting and waiting for 3 days with her leaking fluid. . . . That's the hardest part is just sitting and waiting cause it plays on your mind. . . . If you got a long time to sit and wait you keep going over, well is that the right thing to do or is that the wrong thing to do. And it doesn't really matter who comes to talk to you, it's still your, ultimately your decision and you don't, really not 100% sure well is the baby O.K. in mom's belly with no fluid around it. Is that going to be harmful to it? Maybe we should induce her and get the baby out in the world but if you bring the baby out in the world and its lungs aren't fully developed, that's also tough. Just you don't really know which way to go and the more time you got to sit and think about it, you make up your mind and then you'll change your mind. And then you go this way and then you change your mind back again.

Constant worry. Several fathers described being in a state of constant worry. Colin, a 24 year old tradesman and first time father said, "It's not natural to be this unconsciously worried about, you know, your wife and your child all the time." Walter stated he was "always on guard. . . kind of ready for almost anything."

Fathers whose partners were diagnosed with placenta previa worried about hemorrhaging. Jay explained,

> It means I worry cause they said she could hemorrhage. . . .If they don't get the baby out quick enough the baby could die too. And I worry about it, I mean especially at 2 o'clock in the morning when you're on the road, there's nothing on the radio, it's all you can think about. . . . Doctor says bedrest. I tell her don't walk anywhere, you know. She's gotta walk. So I worry.

Mel, whose wife was diagnosed with placenta previa 9 weeks ago, described the effects of prolonged worry.

> Stressed out. Very stressed out. Any little phone call I get at home and I'm jumping you know. . . . Even when I come here [to] visit my wife and she makes a, a funny noise or something. It's like, what's wrong? Are you O.K.?, you know. Just very stressful.

Increased workload. Having their partners confined to hospital or home was a "lot of work" and "lot more responsibility." These stressors are depicted in the following excerpt:

> It's tiring. . . all the work I have to do to keep care of our son and the house and everything else. . . .You don't have a moment. . . . Your day to day activities. . . and priorities change. . . . Yard work . . . doesn't occur until 9 o'clock at night when our son goes to sleep but then my wife is in bed and then I, you know, do another 2 hours work. (Dennis)

Lack of control. The inability to control events was difficult. Tim said, "I can't do anything [about labile blood pressure] except try and calm her down. I try and calm the situation whatever it may be. Um. Otherwise just stand there and watch I guess, like it's, it's hard." The need to "keep things under control" was taxing, as illustrated in this quote.

> I'm always trying to help her keep calm and just, you know, sort of keep things, help keep things under control. Cause I feel that's very related to her contractions. . . . You can do it for yourself a little bit but when you're trying to do it, you know, for your whole family, that's a little bit, that's quite a bit, especially when you got, you know, school or work outside of the household. . . . You're pulling double duty really. (Blake)

Ensuring that everything was under control often meant that fathers' needs were secondary. Walter said,

> I spend all [of] my days just making sure that she's relaxed and calm and everything in her mind is safe. So I don't, I haven't really thought about my own

> feelings too much. So, uh, well I'm scared. I'm really scared. . . . But, well you just put on a brave front and try and keep calm, S. [wife] as calm as possible.

Being separated. This sub-theme was specific to fathers whose partners were confined to hospital. One father described being separated as "the toughest part." James, a 26 year old experienced father and technician said, "I don't get to see her anymore. . . except for when I come to the hospital. It is hard on me because, you know, we haven't been separated for almost a year now." Mel's job had kept them apart for 3 ½ months. They had three days together before his wife was readmitted to hospital for the rest of the pregnancy.

Visiting their partners in hospital was boring, tiring, and time consuming. Miles found the days "very, very long." He described a day in hospital as, "sitting through the whole day and just going. . . from one chair say to the bed and both like just rotating. . . and occasionally going down to the little lounge. . . . After 7 o'clock the restaurant. . . that's closed." Mel summed it up as,

> The routine, you know, like get up [in the] morning, uh, go to work, get home, shower and I'm back here. . . . It's getting tiring. . . [and] it's only been a while. . . . I look forward to coming and seeing her every day and I would come and see her no matter what but it just gets tiring. She knows it too as I got stuff at home I'm trying to do and [the] baby room to finish and everything.

Protecting partners. Many fathers expressed the need to protect their partners. Most did this by not sharing emotions. Bill said, "She's concerned about the kids and everything else. Which I can't take away from her. But at least I can protect her from mine, my feelings." For Mel, being supportive meant not sharing his worries and concerns with his wife. "I'm supposed to be the tougher one and, you know, be the support and tell her everything's going to be O.K." Blake's concerns were typical of several fathers in this study.

> I don't feel I wanna bombard her with any of my stress, you know. I feel that if I'm having any anxiety or stress I don't want to show that to her. I want to show her that I'm strong and that I'm ready to react to any situation that happens and that I'm able to handle my own stress by myself. . . . I haven't really sat down and told

> her, you know, this is how I'm feeling type thing. . . . I've told her very generally how I'm feeling. . . . But I haven't gotten into any in-depth thing because I feel if we do sit down and talk about something in depth, I really will open up, kinda like I am here, and, uh, then it just adds, that could just add to her anxiety as well.

For Tim, not showing emotions was partially related to being male. "It's just the guy thing. It's that. . . you don't want to cry in front of her. . . you wanna try and play that role." When Bill's wife tried to get him to express his feelings he told her, "not to worry about it. Just worry about your own, your own self." He was adamant that to share his concerns would be an "extra burden" and "not fair for her to worry about."

Fathers were asked if there was anything different they would talk to their partners about as a result of having participated in the interviews. Their responses included asking questions about: how she [partner] felt, what she expected, wanted and hoped for. None of the fathers mentioned sharing their feelings. Blake said,

> If she [wife] asks me. . . how are you feeling about it [complicated pregnancy], I'll probably tell her a little bit but I won't , I won't go into any, you know, great depth, emotional depth. I'll keep it very. . . surficial and tell her that, you know, I'm handling it fairly well and, uh, that's about it probably.

Family

Family stressors refer to those which affected the family unit. These included: differing priorities, altered family dynamics, and lack of support.

Differing priorities. Differing priorities between couples caused tension. Blake explains,

> There's a lot of odd jobs around the house that seem to be stressing her. . . . I'm having trouble sort of, I guess, getting them done because. . . I'm prioritizing things a little differently than she is. My focus is on her and. . . playing with our daughter and keeping her active with me. . . .She's [wife] expecting me to still be doing, getting a lot of these things done. And I'm getting that done bit by bit but not as quick as she'd like. So there's some, there is a bit of stress that way. We've had a couple of squabbles in the last month or two, you know, about these kinds of things.

Conflicting demands were another source of stress to Blake.

> I feel that if I'm doing all this household work that's not really meeting. . . my goal of getting my school work done as quick as possible and finishing up my degree. But to my wife. . . that should be more of a priority for me. . . If there's any conflict in our marriage at all, it's that struggle between household work and school work.

Altered family dynamics. Living with a complicated pregnancy often meant that family dynamics were altered. Mel worried about coping with a preterm infant as well as the challenges of a toddler.

> Now it's a different . . . ball of wax because you now have, we now have a son so if this one's early well there's another thing thrown into the loop which adds to the tension which adds to the stress. Um. It goes through your mind of how you're going to deal with this. . . It will be hard if he or she is early and the juggling of the hospital and our son and, you know, the whole family dynamics will change again. . . . Children don't take change too well, especially when it's a new baby so I'm not too sure how our son would appreciate mommy not being around cause she'll probably be at the hospital most of the time so it's, you adjust to it. It's the same as adjusting with her at home now, you know. It's hard for our son to realize she can't get out of bed when he wants, you know. She gets out of bed, she might be up for 5 minutes but then she's back down. Um. So it's adjusting to that whole schedule.

Real described the challenges of being a Mr. Mom and continuing to do things he enjoyed, like refinishing the basement. "I'm used to doing a more constructive, get your work done in a day type of thing. . . . I'm trying to do stuff around the house. . . like refinish the basement. . . . It's a lot to juggle."

Lack of support. A lack of support was stressful for families. Real and his family did not receive the support they needed in a timely fashion. He said, "Til 24 weeks. . . there was really no. . . support programs that kicked in from the medical profession or whatever. . . . The help started coming at 24 weeks cause it wasn't a viable life or . . . wasn't worth. . . using resources for before that." A few fathers were disappointed, even angry, when extended families did not provide the support they had anticipated. Mel said,

> I thought my family would be more supportive. . . . I'm very disappointed in 'em. . . . I'm upset with the way they haven't been in contact with my wife, especially when I was gone for the 5 weeks. I thought my family would be more caring or understanding and even give her the phone calls. . . . If something happens with

> them [his family] I'm there right away or whatever. I help my parents. I help my brothers and the same with my wife. She helps them. . . . I don't know if they understand what we're going through . . . not even phone calls. It's. . . really upset me.

Stress Mediators

In this study, stress mediators consisted of social supports and coping strategies mobilized by fathers to cope.

Social Supports

Supports in this study consisted of tangible and emotional supports. Blake marveled at the support they had received. "For me to be able to go to school. . . and have someone with my wife. . . and looking after our 2 year old, so that H. can remain horizontal as long as possible, that's just been amazing." Real was overwhelmed when a local church, which they did not go to, sent them food. "I tell you right now that once we get through this, we'll be doing the same thing for other people."

Emotional supports cited included: friends, family, and health care providers. In general, fathers did not expect to receive emotional support from their partners. Miles was the exception. He claimed that they were "there for each other."

For several fathers, participating in this study was therapeutic. The interview provided a venue to "let somebody know. . . how I'm feeling" and an opportunity to "lighten the load a little bit." The researcher was viewed as a neutral person "who'll understand . . . some of the things I'm [father] going through." The interview allowed fathers an opportunity to release pent-up emotions and is illustrated in this excerpt.

> Oh, man, I could almost hug you [researcher] right now because it's, I've sat here for 3 days and let nothing out [tape shut off to give Walter a chance to compose himself]. . . . And to let it out to you today was, made me feel really good. Honest to God it made me feel really good. Just nice to let it out sometimes. Even though we're supposed to be big tough men. Sometimes things can get pretty heavy. So all in all I give you an A+.

A minority of fathers openly discussed concerns with their partners. Real and his wife had discussed the possible death of their baby; Dennis advocated sharing all

emotions with his partner. He said, "If you talk about it, it reduces those worries or concerns or fears or that anxiety that you might feel which should result in a more fluid birth."

Coping Strategies

Coping refers to actions taken by fathers on their own behalf as they attempted to avoid or lessen the impact of complications. Four strategies were identified: keeping things in perspective, becoming involved, denying, and monitoring symptoms.

Keeping things in perspective. This strategy was depicted in the following quotes. Dennis said, "It's 9 months so it's not a long time, you know, in the whole scope of things. It's only 9 months that we have to really deal with it." Sam described it as "a small fraction of my life for, for what we get out of the deal you know so I'm taking it in stride." Blake's advice was, "you need to just suck it up and be there. . . as best you can."

Becoming involved. Some fathers coped by becoming more involved. Real's involvement was illustrated by the following quote:

> . . . the visits to the hospital. . . the educational films and the talks with the specialists and the nurses. . . . It's a totally different situation. . . . We've already rushed to the hospital for bleeding, we've rushed to the emergency for ruptured membranes. . . . We go for fetal assessments every week, you know, doctor's appointments. . . . It's not the same as before [previous pregnancies]. . . . It's a continuing thing, you know, a build up as opposed to before which was like all of a sudden, oh, it's time to have the baby and then I really get involved.

Real's involvement gave him strength to be there. He said, "It's going to be a really special baby. . . I feel a real closeness to it. . . . I'm going to name it the name my twin would have been named if it would have survived." The pregnancy also affected the extended family who referred to the baby as "a little fighter."

The diagnosis of complications provided an opportunity for Rob to become more involved. Rob's hectic schedule meant he spent little time with his girlfriend. He said, "I can't watch how she's going through the pregnancy. . . . There's a lot of stuff I miss out

on." When his partner required admission to hospital, Rob took the opportunity to spend time with her and heard the baby's heart beat for the first time. The chance to connect with his baby and partner was important as Rob was still adjusting to the pregnancy, let alone a complicated one.

Denying. One father coped through denial. Sam did not view the pregnancy as complicated even though his partner was 30 weeks, expecting twins, and had ruptured her membranes at 25 weeks. He said,

> I still don't have that idea [that pregnancy is complicated]. They never really told us much about complicated pregnancy, they just told her to be, to not move around too much. They never really said it was going to be complicated or anything, just the longer that she waits, the better.

Monitoring symptoms. Some fathers coped by being vigilant about monitoring their partners' symptoms. Symptoms that became predictable, distinguishable, and salient, resulted in a pattern being recognized by fathers. This ability to "see" a pattern helped dissipate anxiety and decrease uncertainty. James's partner was diagnosed with preterm labor at 31 plus weeks. He described how her contraction pattern became predictable. "About a week and a half ago, I would have been quite upset about it [contractions] but now . . . I've gotten used to it. . . . It's like an everyday thing. . . .You start something new, you get used to it. . . then it becomes routine." For Real, uncertainty ensued when his wife leaked more fluid than normal. "When there's a little bit of leaking here or there, it really doesn't bother us too much because, uh, small amounts are like normal now. . . . A lot of leakage. . . that is pretty scary."

Because of an episode of threatened preterm labor, Colin's wife could distinguish between braxton hicks contractions and "real contractions." "Now she knows what they [contractions] feel like. . . It's nice to know that she knows the difference." Knowing that his partner could distinguish normal from abnormal symptoms gave that father a sense of control. Caymin did not feel in control. His wife was at risk for preterm labor. He was

anxious because his wife did not know what contractions felt like. "We're sort of paranoid about this. . . . She can feel herself groan, is that a contraction?"

Some fathers were alerted to the possibility of complications when symptoms became prominent. One father said,

> That's [swelling] actually the first thing that really made me concerned.. . . . I was probably the one more pushing her to. . . see her doctor and come to the hospital because of those problems. Because I knew that wasn't something normal. . . . I know they say sometimes women swell up a bit but it was getting to a point it was like her feet were like three times the size.

The presence of swelling was not sufficient for Bill. He did not "see" a pattern until he was able to distinguish normal from abnormal symptoms. He said,

> She had a lot of swelling in her feet, her hands, her face. . . she couldn't fit into any of her shoes. And everything's really tight and if you push it, it's like about to burst so. I knew there was swelling in pregnancy. . . so that didn't worry me as much but then when she began having headaches. . . then I think that was the sign that there may be trouble so I sent her in then.

The presence of symptoms was a "constant reminder" to Kevin that "something's still physically wrong." Though he recognized that the condition was "under control," and as a result he felt less anxious, the anxiety still persisted.

> . . . it's not all perfect yet. Uh, it will be a great relief I think when the swelling goes down, when everything is sort of on a regular day-to-day basis where we don't have to face it every day that something is wrong. . . . I mean the treatment (heparin) is still going to go on I suppose for up to 12 months but I would. . . at least have a better outlook on things.

Stress Outcomes

Stress outcomes refer to the manner in which fathers experienced stress. Stress was manifested in emotional and physical reactions and a sense of isolation.

Emotional and Physical Reactions

Fathers expressed a variety of emotional reactions to the diagnosis of a complicated pregnancy, including feelings of shock and disbelief, fear, worry, guilt, hopelessness, denial, uncertainty, disappointment, and resignation.

Stress was manifested in physical reactions. Fathers complained of fatigue when stressors did not abate. Allan found that attending to his wife's needs and working "was a lot of work" and resulted in him suffering from "sleep deprivation." Bill was so stressed that he was having headaches and insomnia. For Dev, "being there" was draining. "You're here every day, you're at work. . . there's so many things going through your head. You're here to support. You don't want to think negative. You want to tell her positive."

Sense of Isolation

For some fathers, stress was manifested by a sense of isolation. Walter's portrayal of "feeling alone" was moving.

> In here [hospital] there's just nobody to talk to. And you keep everything bottled up inside you. . . . I can't talk to my parents, I don't want to upset them cause they're 100 miles away and S.'s [wife] parents are 100 miles away and they're scared as it is. And S. I can't let on any amount of worry to her because she's worried enough and I've got to keep her strong and I got nobody to talk to.

A few fathers expressed the wish that health care professionals, family, and friends acknowledge their feelings and concerns. One father said, "They [health care professionals, family, and friends] pay all their attention to the mother, you know. Which I mean, you know, like is fairly normal but you kind of feel like you're in the corner. . . watching from the corner." Walter referred to fathers as the "forgotten breed" and said he was surprised that someone wanted to study expectant fathers.

In summary, being there antepartum was stressful for most fathers. The stress process was used to illustrate: stressors fathers encountered, mediators mobilized by them, and how stress was manifested.

Theme III

Prolonging the Pregnancy

Most fathers (n = 18) in this study had partners whose pregnancies were preterm. Thus, prolonging the pregnancy became another theme and a primary focus for many fathers as they did their part to prolong gestation. Comments such as: "Do our best to kind of keep them [babies] in as long as possible" and "Do whatever we can if it's within our control to prolong the pregnancy" spoke of fathers' commitments. Elements of "prolonging" included: prolonging through goal setting, strategies to prolong, and prolonging as a stressful event. The core theme, prolonging the pregnancy, and its sub-themes are illustrated below.

PROLONGING THE PREGNANCY
• Prolonging through goal setting • Strategies to prolong • Prolonging as a stressful event

Prolonging Through Goal Setting

Goal setting was one way fathers actualized the concept of prolonging. Dennis said, "We're trying to go as far as we can now so that it reduces the amount of time he or she [baby] would spend in the hospital." For several fathers, the goal was to maximize fetal development. Comments included: "Each passing week is, you know, just a huge step forward in terms of the development of the babies" and "Each week represents sort of a milestone." Other fathers just aimed for a "safer zone."

Fathers set specific goals. Caymin marked the passage of time by putting a star in his date book. "Each day I look forward to marking in that book at the end of the day." For Allan, every Thursday marked another week. Dennis used a combination. "Let's make it to your next doctor's appointment. . . . If we make that then let's make it another week."

For three fathers whose partners were diagnosed with complications ≤ 24 weeks, their initial goals were to reach a stage of viability. Real expressed it as, "Looking at the future. . . looking forward to, to make [making] it." For Real and Caymin, getting beyond 24 weeks meant there was hope of survival. Real said, "Now they're starting to put percentages of, you know, survival. . . . Just that factor changes the whole outlook on it. Like every week that goes by is more positive, once you get over 24 weeks." Caymin claimed that he has gone from fearing the baby might not survive to now not having any thoughts of losing it.

Though Caymin's goal was to make it to 36 weeks, every day without confinement was a "blessing." Real didn't mention a specific goal but claimed that if they got to 32 weeks it meant "just a week in the hospital or so, . . . that's a piece of cake."

Mel described how he felt when the goal of 26 weeks was attained. "They told us if we made it to there, then we'd [baby] be O.K. or our chances are really good then. So at that point there was a relief for both of us."

With the passage of time, the goal to prolong remained but anxiety decreased. Allan described the changes.

> The anxiety has subsided to some extent because with each passing day the risk [of preterm delivery] subsides so we don't have as much concern in that way. But still, if we can extend the pregnancy another week or two that would be better than not. So it's the same concern only, it isn't characterized by the same degree of anxiety or urgency.

As gestation increased, expectations changed. Real explained:

> Every week that goes by the baby is getting bigger and, uh, basically a healthy birth has a lot to do with the weight of the baby so, the bigger the baby, the higher the expectations are, or the hope is that it won't be. . . in [on] the ventilator for a month or. . . have underdeveloped lungs and stuff like that. So I mean as, as time changes, expectations change for the better.

Though fathers hoped to "buy more time", they recognized there was only so much they could do to prolong gestation. Dennis succinctly remarked:

> Nothing I do is going to make my wife go longer other than that support, as long as she's feeling supported, that's the important part of it. Um, you know, you try and do as much to make them as comfortable a possible and from there on in you just let life handle it.

A component of "prolonging" was being able to let go of the goal. After being at risk for preterm delivery for so long, Allan was challenged to adjust his attitude "from one of fearing the birth of the babies to one of now looking forward to it." In spite of reassurances from health care practitioners that "if they [twins] were born today, it wouldn't be long before we could take them home," Allan remained "cautiously optimistic" and persevered in his efforts to extend the pregnancy. Allan was having trouble "letting go."

In contrast, Caymin at 28 weeks claimed to be "getting into happy and planning." Though he still hoped to make it to 36 weeks, he felt reassured that everything was "gonna be fine" and was "just planning the good things, not looking at the worst." It was as if Caymin had dwelled on the negatives long enough and needed to get on with life.

Not knowing what to aim for was distressing for Walter and is portrayed in this quote.

> When we left the hospital in [rural hospital] they said, well we're sending S. in to be induced. And when we got here and [they] said no way, we are not inducing her, so we didn't know whether S. should be hoping to have this baby or whether S. should just be laying there still and praying to God she doesn't go into labor.

Strategies to Prolong

Strategies to prolong gestation included physical and emotional elements. The physical aspects are summed up in this quote. Allan said, ". . . we've sort of had to set out a course of action or plan that's really meant that I [father] do a lot more and L. does a lot less."

Blake concentrated on the emotional aspects. He had observed that when his wife was stressed or emotional she had "more contractions that day." His strategy was to

"help her keep calm and just, you know, sort of keep things, help keep things under control. Cause I feel that's very related to her contractions."

Prolonging as a Stressful Event

Prolonging the pregnancy was perceived to be stressful when fathers felt their partners were in jeopardy. Fathers with placenta previa (n = 3) worried that their partners would hemorrhage and bleed to death. Mel's situation had been exacerbated by the fact that he was out of town for 5 weeks while his wife was home. He worried about her safety; the plan was to readmit her to hospital at 26 weeks.

Two fathers talked about the possibility of losing the baby if their partners started to bleed. This was how Mel rationalized his concerns. "I don't want to sound morbid or anything about the baby. . . if we lost the baby, you know, it happens, but my main concern was her, all along. And still is." A third father whose partner was diagnosed with pregnancy induced hypertension was more direct. He stated, "I'm more worried about my wife because, you know, I hadn't seen the baby yet so, you know, I'm more attached to my wife than the baby."

For Dev, his wife's attempts to "buy time" were stressful because he worried she would "sacrifice her health, uh, to let the baby grow another week. . . .That's my fear is that she's not going to tell them, she's going to sacrifice a bit of her health and hide some of the little problems. . . cause she knows what to look out for to give the baby some time."

In summary, for many fathers prolonging gestation was an integral part of the antenatal period. Fathers actualized the concept through goal setting. Every day or week that gestation was prolonged represented a "milestone." Strategies to prolong consisted of physical and emotional elements. For some fathers, the need to prolong was a source of stress as it placed their partners at risk.

Theme IV

Trusting in Technology

Trusting in technology was another theme that emerged from the data. This theme referred to the trust fathers placed in technology to ensure safe outcomes for their partners and babies. Properties of the theme were illustrated by the sub-themes: we have the technology, high tech versus low tech, technology that is "common", and technology isn't everything and these are portrayed below.

TRUSTING IN TECHNOLOGY
• We have the technology • High tech versus low tech • Technology that is "common" • Technology isn't everything

We Have the Technology

The sub-theme, we have the technology, refers to the trust and confidence fathers had in technology and health care professionals. In the following excerpts, Collin and Blake portrayed the extent of that trust.

> If the baby was born at this point (32 ½ weeks) there likely wouldn't be any complications. So I'm told. . . . Having had the steroids. . . It's likely that the baby could be born, you know although a little underweight, it would still be healthy and functional and normal. . . . Or certainly healthy enough to be within the reach of technology to pick up the rest of the slack.

> If any complications arise, then I'm expecting, you know, the latest and greatest technology and methods to help, you know, bring these kids out. . . . I'm not totally up to speed on all the latest things but I know that this hospital is. . . one of the best maternity hospitals in the city, if not the best. . . . I know that they have everything that's needed as far as technology goes and knowledge and intervention of, you know, being able to quickly diagnose and to intervene. . . . So I'm very comfortable and confident with those things. . . and that the people here are extremely capable of doing, using . . .that technology and performing those intervening methods.

In general, fathers had a high regard for technology. Collin, whose partner had a diagnosis of threatened preterm labor said, "It's pretty impressive that technology has come up with things like this [steroids] . . . . It's things like that that really calm me." Several fathers were reassured because their partners had received steroids to "help the lungs develop faster." Two fathers erroneously thought that steroids helped "speed brain development."

Despite the fact that eight fathers had partners who were of a gestational age of ≤32 weeks, none voiced developmental concerns. The only father who did express concerns was Dev whose baby at 33 weeks gestation was not likely to be developmentally delayed. He said, "I'm worried because it's a bit premature, 33 weeks is, you know, that's almost 2 months away from term. But I guess most babies. . . can still survive at shorter weeks than that. But being normal. . . that's our concern I think."

It seemed to be the perception that we have the technology to ensure healthy, functional, and normal babies as well as safe outcomes for the mother. Mel's wife was 30 weeks with a diagnosis of placenta previa. He said, "If something were to happen now, like they say, it's nothing, they'd take her in [for C section] and 15 minutes it's over, everything would be fine."

High Tech versus Low Tech

Though fathers expressed a profound respect for technology, they also spoke of the benefits of low tech. Blake said, "I think natural is good for almost anything. . . in life on this planet."

In general, fathers were not opposed to the use of technology in labor, if it was required. For Walter, inducing labor was "no different than a machine like a respirator. . . . It's a tool that you use when you need it." Many fathers took comfort knowing that technology was available if needed. Allan said,

> I'm quite content to be here in a hospital surrounded by all of the technology and all of the machinery that'll help out if it's needed as opposed to some women who,

> who I've talked to and feel quite strongly that, that tendency sort of ruins the experience of childbirth because it, it interferes with a natural process. . . . I have not thought in those terms at all. Really, as I say, I'm quite content to be here in a hospital and rely on the people who are trained to help us.

In contrast, Miles and his wife viewed technology as intrusive and in conflict with their wishes for a natural birth.

> It's worried me [Miles] that it [preterm rupture of membranes] might increase the chance of necessity of more interventions. . . . Worried. Yea definitely worried. Sort of scares me the idea of, you know, the use of forceps or fetal monitors and that sort of intrusive type procedures, episiotomies and stuff like that. That doesn't fit too well.

Technology That is "Common"

Several fathers expressed confidence in technology that they perceived to be common or routine and was exemplified in this father's comment about inducing labor. "It's not like it's something that's new, you know. It's been done, lots of women had it done and never had any complications. And as long as like the baby is developed enough." Miles disagreed. For him, the less "medical interference" the better.

Most fathers (n = 15) had thought of the possibility of a cesarean section. Several fathers took comfort in the fact that cesarean sections were frequent procedures. Blake was one of those fathers. He said,

> I have to say I haven't really given it [possibility of section] a whole lot of thought in that if it was a C section then I know the people and the technology here are very capable of delivering C sections *routinely* and it's a very routine thing. I think it's one in two multiples are delivered by C section, something like that. Um. So I'm, it hasn't really fazed me one way or the other. I, yea, I just know that whatever way is the best way and that's what, uh, what nature and the doctors have decided and that's obviously the best way. . . . I haven't given any second guessing or second thought on that yet.

The notion "whatever is best for mom and baby" was mentioned by several fathers. The outcome, not the process, was what seemed to matter most.

Technology Isn't Everything

In general, fathers in this study placed a lot of faith in "today's science and medicines." A few fathers relied on "other" sources as well. Real sought the advice and

support of a midwife and naturopath when the medical profession offered "no real hope." Blake trusted in God as well as technology. "A lot of it's in God's hands. . . you can only do your best to sort of you know, just statistically improve the situation. . . . It means that you're obviously not in control of the big picture." Kevin attributed luck and technology to his success story. "We're very lucky that we had the right care at the right time."

In summary, fathers in this study placed a great deal of trust in technology. In general, fathers did not seem to appreciate the limitations of technology. Fathers were reassured because technology was available if needed. Fathers expressed confidence in technology that they perceived to be common.

Theme V

Being There During Childbirth

The fifth theme, being there during childbirth, was evident across all interviews. Fathers perceived that their primary role was to "be there" for their partners. Several properties described the theme: timing, role expectations, feelings and reactions, pain, expectations for health care providers, failure to "be there", and sharing expectations. These properties are illustrated below.

BEING THERE DURING CHILDBIRTH
PROPERTIES
• Timing • Role expectations • Feelings and reactions • Pain • Expectations for health care providers • Failure to "be there" • Sharing expectations

Timing

Timing refers to when expectant fathers began to think about childbirth. Some first time fathers had just started or not yet begun to think about it. One father had not really thought about birth till he saw a video at 37 weeks. "That's the first time I saw a baby come out of, you know, vagina and I said, 'Oh my God.' (chuckle) Unbelievable. So was kind of like shocked." At 28 weeks, Kevin had not thought about it yet because "I just really don't know what my part in that is going to be." Tim, whose partner was 36 weeks, stated he was

> . . . not at that stage yet. . . . Just kinda, guess, blocking that part out. I just want to get the call, go there, and then come home. Like I just wish it was like. . . buying a car. You go there, you know what you want, that's what I want, and then go home with it and everyone's happy.

Other first time fathers had been thinking about birth prior to conception. Allan had thought about childbirth since their first pregnancy, which had resulted in a miscarriage. "I thought about it, you know, from that point forward. . . . We'd made a conscious decision to have children so from the time we first thought that, decided that we were going to have kids, I thought about the whole process." This was similar to Miles who stated, "I think from day one. . . Day one being the day that we went into the fertility clinic (chuckle)." For others, timing was related to when their partner announced they were pregnant. One father said, "I'm pregnant. Boom, I started thinking about it (chuckle) immediately."

Several experienced fathers did not really think about it till complications arose. Walter said, "When the water broke, that's when I started thinking about being or participating in childbirth." Walter elaborated, "The first pregnancy, I thought about it [childbirth] a lot, like a lot because I didn't really know what to expect. This time, no, it never came into the picture at all." For Bill, the diagnosis of twins prompted him to think about childbirth. Blake continued to expend little energy thinking about childbirth. He said, "My main focus has been. . . my wife's physical and mental wellbeing and doing as

much as I can. I haven't really gotten into the thought process yet of delivery." Real's comments indicated he was more concerned for the baby's wellbeing than thoughts about childbirth. He stated,

> I didn't really consciously think too much about what it would be like, you know. I thought a lot about what the baby would be like. . . . I mean because my wife had two normal pregnancies, deliveries, there wasn't a real cognizant thing to think about too much, you know, until the complications arose then, it really kicked in there.

Role Expectations

Role expectations refer to fathers' beliefs about what they would be doing during childbirth to support their partners. Fathers (n = 3) who were preparing for cesarean births will be discussed separately. Activities for labor and delivery included: coaching, comforting, calming, encouraging, recommending, helping, observing, distracting, and waiting. Three roles emerged from the activities described by fathers and were similar to those described by Chapman (1992): being in charge (coach), being there to assist (teammate), and being there to observe (witness).

Being in Charge

Of the 17 fathers who were preparing for labor and birth, one expected to "be in charge". Walter perceived himself "in charge" of supporting his wife. "She's a strong person but definitely needs help. . . . And I don't think there's anybody in the world more qualified than the woman's husband to help them out." For him, support covered "a big area" and meant keeping his wife "calm, going, focused, and strong". Walter felt his support was critical to his wife maintaining control. His wife agreed. He explained,

> I never. . . understood how hard labor is on a woman . . . . .How much support they need. Not so much support from just anybody, how much support from somebody close by and that, that's my biggest memory of it [last labor experience] is, is just how much support you have to give your wife. . . .Even she [wife] said herself that she could have never gone through it all with just the nurse. She really needed me there.

Being There to Assist

Seven fathers expected to assist their partners by responding to requests for emotional and physical support. Colin said, "I just expect to be there and to do whatever I'm called on to do." Allan was content to "do whatever it is she [wife] needs of me. . . . I'm happy to let her set . . . the stage and then she can write in my part." Blake expected to take on "the same role as I played with the first one. . . . Supporting my wife, at pretty much any request." Dennis expected his partner to direct him through the experience. " I expect her. . . to tell me what she wants [during childbirth] ." It was not clear if that was an expectation based on past experience.

Being there for their partners meant that fathers were not in charge of childbirth. Miles said,

> Coach isn't a good word. . . . I'll be there for her support but I'm not going to be telling her what to do. I don't think she'll want to hear that at the time of when she's going through something painful, she's not gonna want her partner telling her, no, you're doing it wrong, do it this way or try this. I'll recommend stuff but no, I'll just be there as a supporter.

Being There to Observe

Nine fathers expected to adopt the observer role. Fathers in this role did not anticipate playing a physically active role and were there to witness the birth. Emotional support was limited, vague, or consisted of conversation. Kevin exemplified all facets of this role. He said, "I'd like to be there for emotional support. . . . I want to be in the room. And I definitely don't want to miss the experience but, um, I don't really know if I'm going to play much of a part." For Sam, being there meant sitting and reading, talking to his partner, and "waiting for it [baby] to come out."

Fathers who planned to adopt this role were uncertain about what to do. Caymin said, "I guess my job is to coach her on her breathing and that. . . . I think I just gotta be there more or less for my wife and try to make it as easy as possible for her." Dev did not know what he had to do to be considered supportive.

Some believed there was little they could do to help their partners through labor. Caymin wished he could "stop the pain or. . . make it easier for her but, uh, unfortunately I can't do that. Only the drugs can I guess." Dev said, "Basically I'll just be holding her hands. That's what I assume my role is and being calm. That's all I could do. I have no training."

The observer role was not limited to first time fathers. Real was comforted by the fact that a midwife would be present for this birth. He said, "It makes me feel a lot better because of, I don't have to try and . . .be an expert in something I know virtually nothing about, you know. . . . It'll make me at ease. Be able to take. . . more pictures." Real recognized that his own needs might prevent him from being supportive. He said, "The husband's going through his own experiences too, like emotional. It's not any easy thing to do for either parent."

Two fathers suggested that the diagnosis of complications altered how involved they planned to be. Bill, who reported being physically involved in previous births, envisioned a limited role this time. "Show her support and love really that's the only thing I can do." Real elaborated,

> It's going to be a very different situation because there, instead of just a general practitioner and maybe, you know, a baby doctor, it's going to be a whole. . . different surroundings of professionals for any circumstances that occurs because of our premature birth. So. . . if anything, I'll be a bit more off to the sidelines this time than usual."

"Being There" During Cesarean Birth

Two of the three fathers whose partners were having cesarean births had discovered only recently that hospital policy allowed them to "be there". The degree to which they anticipated being supportive was limited by circumstances. Jay said, "The only thing I can really do is just be a comforter. I can't do anything else because everything is out of my hands." Two anticipated being a reporter of events. They expected to give their partners a "play-by-play of events." Both fathers thought they would be able to see the

surgery. Mel said, "Just the thought of seeing them cut, cut my wife. . . bothers me a bit." This did not seem to bother one father who included the topic in his explanation of what a play-by-play meant. He said, ". . . like now they cut you or whatever and now the baby has been taken off."

Feelings and Reactions

In addition to what they expected to be doing during childbirth, fathers had expectations about how they would feel and react. James used the analogy of a roller coaster ride to describe the "the highs and lows" he expected. "Here comes my next child. . . . Here we go, here we go. . . let's go, what's going on here. . . let's get this done. . . it's done."

Fathers were asked to describe how they expected to feel during labor and delivery. Being there for labor evoked intense emotions. Fathers expressed a range of feelings: fearful, nervous, uneasy, tense, scared, worried, panicky, helpless, uncertain, worn out, excited, and happy. Some had difficulty expressing how they expected to feel. Three fathers described their feelings about delivery when asked how they expected to feel during labor. In these situations, rephrasing was required to elicit the emotions of labor. Walter had difficulty expressing his feelings and could not recall past labor emotions because he claimed he was focused on his wife. This need to concentrate on their partners was not uncommon. Dennis described labor as a "concern worried type of emotion where you're focusing on her and what it's going to be like for her more than what it's going to be like for me."

In contrast, fathers did not have difficulty sharing how they expected to feel during delivery. Kevin expected to be overcome with "a whole flood of emotions." Feelings described included: overwhelmed, overjoyed, relieved, excited, and happy. Walter expected to be excited because you're on the " verge of knowing so much." Dev claimed he would feel happy because "the ordeal would be over." Dennis stated, "It's really hard to say what emotion you feel. . . . You're going to feel, you know, a million emotions."

Five fathers claimed they would be worried and anxious until they saw the baby's head or heard it cry. Bill said, "Relief is a big thing. Especially after they're born. . . . Once I see the head, usually there's a relief." Because of the complicated pregnancy, Walter anticipated feeling "a lot more relief this time than last time. . . . The joy's still going to be there but I think. . . a lot of joy's gonna be replaced with just (sigh) so much weight off your shoulders, so much relief." He physically described this relief as taking a "deep breath and say, ooh, let some stuff out of me for a change instead of always being there." How fathers expected to feel during delivery represented a "drastic switchover" from those expected during labor.

Fathers (n = 5) described how they might feel if their babies had complications. Blake said, "I would be nervous. . . . It'd be a stressful time and I would have to sort of really, really suck it up and, you know, focus on trying to give my attention to my wife." Walter stated, "If something's wrong, then emotions would shut off again."

Fathers preparing for cesarean births expressed similar feelings. They expected to feel excited, nervous, worried, relieved, and happy. Mel commented that relief would be a prominent emotion. "The biggest is relieved. . . . Just relieved. Big sigh it's all over." One father worried his partner might bleed or require a hysterectomy. Jay who had previous experience with cesarean births, albeit an emergency cesarean, commented, "All my attention will be on my wife so I don't even really know how I'll, I'll feel myself. . . . I'll probably be a little bit more. . . assured because. . . it's all been planned."

For some fathers, "being there" meant being strong and in control. Blake expected that his emotions would be "under control. . . because they always have been." Walter eloquently illustrated this need to be in control of one's emotions.

> . . . like I say, you can't really show them [emotions], you can't really show always what you're feeling when somebody is, needs that level of support and encouragement. . . . you gotta be kind of like a blank wall and what they need, that's what you try and show. If they need you to be happy and friendly, then you

> be happy and friendly. . . . Just turn yourself off. . . .You have to just be strong as you can be for your wife.

This need to "appear" strong and in control was powerful. Walter expected to appear "calm, very calm" and "strong." "I don't think there'll be a calm bone in my body to tell you the honest to God truth, but it'll look like there is." Two fathers expressed the concern that they might cry at delivery. Mel became emotional and tearful during the interview when he talked about his fears of "breaking down." Their perception was "it's not too manly to shed tears in front of people." Other fathers were concerned they might pass out during the delivery. Caymin mentioned being concerned about "passing out" at least five times.

Pain

"Being there" through the pain of childbirth was challenging for most fathers. Tim was the only one reluctant to talk about pain. He said, "We [he and his wife] don't really talk about that. . . . We don't want to think of there being a problem." Pain in this study referred to physical and emotional pain. Jay vividly recalled "being there" through the emotional pain of his wife's previous emergency section

> It was 3:56 in the afternoon and, uh, it was the hardest thing I ever did in my life cause my, my wife didn't want me to do it [sign consent] . . . . She didn't want to be cut open. And she was crying for me not to be cut open. And the doctor says we have to cut you open cause K. [daughter] had her umbilical cord around her neck and so she give me a sheet and mom's [wife] telling me not to sign it and the doctor's telling me to sign it and, I mean I had to sign it, there was no question about it but it was pretty hard. . . . I was in a lot of pain cause . . . I didn't want my wife to go through that. Everything was supposed to go nice. . . . To put it bluntly, I didn't want to be there cause I didn't want to see my wife go through that ever. . . . My wife was crying and so I started crying and it wasn't very good."

Many fathers (n = 8) spoke of the emotional pain of seeing a loved one hurting. Colin poignantly portrayed this in the following quote.

> I think it will be one of those things where I kinda hurt emotionally cause I see that my wife is hurting physically, you know, she's in pain and. . . anyone that you really love when, when they're in pain whether it's physical or emotional, uh, you can't help but share in it. And I'm pretty sure that emotionally I'll be, I'll be hurting right alongside her.

Real differentiated between physical and emotional pain. "Physically I think that there will be less pain if it's a 5 pound baby compared to a 7 ½ pound baby. . . . That would be physical pain. Emotionally, it will be a, on a higher level I think if it's a preemie."

The physical pain of labor was referred to as "inevitable" and a "life factor." Pain was considered an unknown, uncertain event. Miles explained:

> I imagine it's going to be pretty painful for my partner and hopefully the classes that we've taken will help and hopefully I'll be able to help and I won't panic (chuckle) at the time when it does come I'll know what to do hopefully. . . . I've never experienced this before so it's, uh, it's gonna be a shock. . . hopefully for the next time I'll know a little more and be a little more ready.

Experienced fathers also expressed concerns about how they would deal with pain. Dennis said,

> Ours [last labor] was short, so it's really hard to say after 10 hours or 9 hours of constant labor contractions or constant pain then, yea, that might, um, it might affect me but hopefully that doesn't result in affecting her , you know. Hopefully I can deal with it, um, not result in any anxiety caused on her from an anxiety on yourself. . . . How do you handle it [pain] , well I don't know. . . . You just hope that you react in a reasonable and, you know, caring manner to the whole, whole situation.

Six fathers expressed a sense of helplessness related to their perceived inability to relieve their partners' pain. Dev remarked that seeing his wife in pain would "be awful. . . she's gonna scream." He envisioned feeling helpless as he tried to distract her by talking and joking. Bill an experienced father said, "Just show her support really that's the only thing I can do. I can't make her pain go away and can't give her medications but I guess I can just be there for her."

Pain management ranged from "no drugs" to whatever is "best for baby and mother." Rob said, "childbirth should always be natural. . . unless there are complications. I don't want any drug to go through my baby. . . . I'm not sure how the drugs work. . . or what it is. . . . I think it would definitely make me mad if she wanted to

be put under." When asked if he had shared his wishes for a natural childbirth with his partner, he replied, "Yea. . . I told her it was up to her but said that's what I wanted. . . . She said, well she'll think about it. That's about as far as it got. We haven't talked about it since."

Kevin's hopes for a natural childbirth were wavering.

> I'm starting to think. . . that we're not going to opt for a natural birth because I can see the great deal of pain that she's in now and if it's going to be comparable, I wouldn't even ask of her to go through it without, uh, some help. . . you know a painkiller. . . . So it's changed. . . my outlook on how it'll be. I at first thought. . . she could just cope with the pain. . . . Maybe that sounds a little selfish but, um, I thought that that would be something she would just be able to do and then . . . we'd just be able to say, look it was bad.

Several fathers hoped that childbirth would be as "natural as possible." Dennis commented, "I hope we don't have to go with the epidural just because. . . the least amount of things you need to rely upon, the better I feel." Dennis was cognizant of the fact that if labor was longer this time, consideration would have to be given to "reduce that pain factor." Miles recognized that pain medications might be required, especially if labor was induced. He was concerned that his wife's expectations were not realistic. He said, "Her expectations of it are basically the perfect birth. You go in, have the baby in a few hours, couple of hours to recoup and then go home. . . . I'm expecting we're in for an adventure. . . . I've said to her, like, you know, it might not be as easy as you're expecting and just keep an open mind."

Expectations for Health Care Providers

Fathers expected health care providers to facilitate their "being there". In this study, health care providers included nurses, doctors, and labor support persons.

Fathers' Expectations of Nurses and Doctors

Fathers expected to be kept informed. Blake said, "I expect them [doctors and nurses] to do pretty much the same things that they did for our first pregnancy and that's . . . informing you of what's happening." Tim stated, "Information. Keep me informed.

That's, uh, that's what I definitely need. To know what's going on." Blake expected full disclosure. He said,

> This time. . . there'll be some more extra precautions in their words. . . . They're going to spell out probably more of a worst case scenario this time because it is a high risk pregnancy. So they're gonna be very factual and very honest. . . . The first one, they, because everything was going so smooth, they really didn't feel the need to have to say, well O.K. there's a chance that this can happen, you know, they weren't saying those things. But I expect them to say more of those kinds of things this time around.

Not all fathers wanted full disclosure. Jay explained,

> I just want them to say that, you know, at the end of the day your wife is healthy, the baby's healthy. We'll take care of it, don't worry about it. That's what I want to hear. I know a lot of people want to know everything. For me I don't. I'm happy being ignorant sometimes.

A few fathers expected more of the medical staff because the pregnancy was complicated. Walter said, "My expectations of the medical staff has changed from a normal childbirth to a complicated one." Doctors were expected to be accessible, involved, and present for the delivery. Walter said,

> I want medical people to be more involved in the labor and delivery. . . . When it wasn't complicated. . . I could care less if they come in there [delivery] at all. But now. . . when they say they're gonna be somewhere they bloody well better be there.

Some fathers expected to be treated as valuable consumers of health care. Dennis described it as "that you are our only patient idea" while Allan referred to it as the "business of medical care." Dennis said,

> You want that feeling of we're important to you. That's what I expect. . .They did last time. I'm assuming they're going to again and if they don't, then I'll let them know that we're not getting. . . the care that we deserve or require.

For Allan, the business of health care meant being able to rely on your caregivers to "apply themselves to more than just the medical procedure." He expected them to be "warmhearted, enthusiastic, and encouraging."

As health care consumers, these fathers expected to be treated with respect and as partners in the decision making process. Colin said, " I really dislike doctors and nurses that sort of lord it over you." Though Miles felt it was his right to question the doctor and had done so, he remained uncomfortable. He commented, "You feel sort of worried if you question it, you know, like should I be questioning his authority." Walter relayed an incident whereby he did not feel part of the decision making process.

> The doctor we have right now is very bossy and comes across as being God and I can't stand that. . . . I like somebody that sits down with you, discusses your options, which way this might be better, that might be better. But ultimately leaving this decision up to us, unless it's very, like unless they really feel strongly that this is the only was to go. Well then say that. But I like being talked with not talked to, you know what I mean. Um. Cause when we first came in the doctor we have right now [said] I'm not doing this, I'm not doing this and you're not doing this and this is the way it's gonna be and this [is the] way it has to be. I mean nothing has to be any way. There's always options. And I don't like it when they don't offer them to you. Or at least the chance to discuss it. . . . We should have part of the decision making and it wasn't, wasn't that way this time.

Fathers' Expectations of Nurses

What fathers expected specifically of nurses was variable. In general, first time fathers described a lot of "unknowns" regarding the nurses' roles. Rob said, "I've no clue. I have no idea what they're going to be doing." One father thought the doctor would be present throughout labor and that the nurse would just "assist the doctor." No other specifics were provided. Dev had just discovered that the doctor would not be "there constantly." He described the nurses' roles as providing "medical support" and "monitoring" the situation.

Four fathers expected nurses to be "nearby" and periodically "checking in on us." First time and experienced fathers expressed this expectation. James said, "Making sure, you know, we're okay. I don't expect them to drop everything they're doing, you know, cause she's going into labor. Nobody does that." Bill did not seem as confident just having the nurses nearby. He said, "Just nearby that if something does go wrong. . . I

don't have to run out of the room searching for them." He kept repeating the word nearby. Caymin hoped the nurses would be "checking frequently."

Several experienced fathers described nurses as the "real supports." Blake said, "The doctor you see for 10 minutes at the delivery but it's all the things, support that you get from the nurses up until that very moment [birth] that is the most crucial." Walter expected, "emotional, physical, and every kind of support you can think of, that's what a nurse should give." He expected to be offered "helpful hints" to make his job "a bit easier" and keep him "steered in the right direction." Dennis stated, "You want that, what can we try, what can we do, how is this going to work, when can we expect this, when can we expect that, you know. I expect there to be that wealth of information coming forward."

Nurses were expected to monitor labor for adverse outcomes. Walter stated,

> They got like the emotional support for the parents but then their real responsibility, I think, is to make sure that baby is, make sure the birthing is coming along properly. . . . and if there is [problems] to get proper people in there to handle it right away."

Several fathers hoped that nurses would attend to their needs as well. Kevin said, "Calm me down. . . teach me. . . explain a lot of things that are happening. . . so I could understand and maybe help out a little more. . . Be there [labor and birth] with me." Walter reflected on a previous experience whereby his needs were attended to and expected similar care again.

> She brought me a really nice chair and then she brought me a cup of coffee and a muffin and she would rub S.'s [wife] back and stand and talk to her for a while and give me a little bit of a break.

Fathers' Expectations of Labor Support Persons

Miles thought a labor support person would be helpful for their first birth "because everything's so new." He expected the support person to assist him "be there" with his

wife. Miles wondered if such a support would be necessary in future births as he would know what to do. "Then [next pregnancy] it becomes more of just you and your partner."

The use of support persons was not limited to first time fathers. Real, who referred to their labor support person as a midwife, was reassured because "The midwife will . . . help her [wife] in the right positions and all that kind of stuff. . . . It makes me feel a lot better because I don't have to try and . . . be an expert in something I know virtually nothing about." Real felt the midwife would provide more continuity than a labor and delivery nurse because the midwife would be there throughout the whole process as opposed to having several nurses involved. He expected the midwife to be an advocate. "She will be there to, to help D. personally and give, give options in our decisions." Miles and Real did not expect that the nurses and labor supporters' roles would conflict. Real said, " I don't think our midwife is going to, um, cut into her [nurse] space."

Failure to "Be There"

Fathers hoped to physically "be there" for childbirth. Failure to be there evoked varying responses. Dev said,

> I would feel bad if I chickened out and not show up for the delivery. But I can't see me doing that if I just have to be there. I think I could just force myself just to be there. Close my eyes, look at her and before I know it. . . everything should be over. . . . I would feel undeserving to have the child if I can't be there. If that's all I have to do is just be there and if I can't do that, then I'll feel very low about myself, you know. And I should be there. I will be there.

Sam was very matter of fact. He said, "As long as I tried my best, you know. I don't think I'd feel too bad. Can't help it if it just decides to come you know." Jay was concerned that work commitments would prevent him from being there. He said,

> I'll be upset. . . cause a man, you know, should be by his wife when she's giving birth. And just to be somewhere cause of a job, I don't agree. I mean it's the only thing I know how to do so I really got not choice.

Fathers hoped to "be there" to support their partners. Failure to do so also evoked varying responses. Comments included: "Feel like I let her down," "Feel a little guilty

for not doing the best, or for not doing what I'm supposed to do," and "Wishing that you can go back to do it all over again."

Other fathers were more "forgiving." Allan said, "I'll have to cut myself a little slack and if I come up short, I come up short. I'll be disappointed and I'm hoping that I'll be able to, uh, meet those expectations." Miles tried to prepare for the fact that he might not get it right. He said, "I wouldn't say inadequate but hope I can do the right things (chuckle) at the right times and. . . not to take it personally." Walter was convinced he would meet all expectations. He said, "I don't think there is a question of me not meeting her expectations, because I will."

Sharing Expectations

In general, fathers did not discuss their childbirth expectations with their partners. Several reasons were cited: no time, expecting same, don't have great deal of expectations, don't know what to expect, want to protect partner, fear of failure, and we don't talk much about anything.

For Dennis, sharing expectations made him vulnerable to failure. He stated,

> To me childbirth is a time of crisis when, you sort of validate. . . how you've responded in a crisis. And if you don't respond the way your spouse or your loved one wants, well then how does that make you feel? So you sort of. . . keep inside what you would expect from the other person or yourself. If you don't meet the expectations well no one knows, no one cares, um, you just know that, hey I didn't handle it the way I thought I would you know. I thought I'd do it better.

Walter explained the need to protect.

> It's [childbirth] not really about me. Childbirth's more about the mother and baby than it is the father. . . . I'm just there to help out a bit. Do the best I can. Um. No, I, I, don't think I would discuss what I would expect out of it because I don't wanna, I would never want to make her feel like I expect anything out of it. Um. She's got enough to worry about and enough to do to not ha..., she shouldn't have to worry about my expectations at all so I wouldn't I'd no. I haven't discussed it and I don't think I ever would.

For Dennis, sharing expectations placed unnecessary burdens on others because,

> if you say well I expect it be a good childbirth with a healthy baby, what if it's not? Then you've already told her this is what you expect so how does that make her feel, um, because no matter how much you put it, anything that happens to that baby, I would assume the mother would feel responsible for because it's inside them. And I would not want to put a, uh, burden like that on them if something didn't work out because that's not fair.

A few fathers alluded to the fact that they had discussed expectations. Allan said, "We've talked about it [expectations]. Sure. Not in precisely these [those] terms but we've certainly talked about it. Yea." Miles said, "We have in bits and pieces, we have discussed parts but we haven't sat down, gone through the whole, you know, what we expect of each other and what each other's expectations are." When asked if this was something he was planning to do he replied,

> Now that I think about it, probably, yea. . . . Over the past couple of days, I've, I guess being as the water broke early, [thinking] just of ways how I can talk to her and say, you know it's, some things might have to change here, you know it's, might not be as smooth as you're expecting it type thing.

Three fathers claimed that as a result of the interview they planned to talk with their partners about expectations. None mentioned discussing their own expectations.

In summary, "being there" during childbirth was perceived by all fathers to be their primary role. When fathers began to have thoughts about childbirth was variable. How involved fathers expected to be was represented by three labor roles. Only one father expected to enact the coach role. The remaining fathers expected to be there to assist or observe. Fathers expressed feelings and reactions about being present for childbirth. "Being there" through the pain of childbirth was a pervasive topic. Fathers had expectations regarding how health care providers could facilitate their "being there." Failure to be there physically or emotionally for their significant others evoked varying responses from the men. Finally, most fathers did not share their childbirth expectations with their partners.

Summary

The stories of 20 expectant fathers experiencing complicated pregnancies have provided a beginning understanding of their perspectives. In this chapter, the contextual meaning of childbirth was described. Five core themes, which captured the essence of fathers' experiences, were then described. These themes were: preparing for complications, being there antepartum, prolonging the pregnancy, trusting in technology, and being there during childbirth.

CHAPTER V

DISCUSSION

In this chapter, a discussion of the findings is presented in four sections. In the first section, results of the study are discussed and related to other empirical and theoretical literature. In the second section, research findings are connected to the conceptual framework, the theory of uncertainty. Implications for practice and recommendations for future research are presented in the third section. The chapter concludes with a summary of the study.

Preparing for Complications

A sense of shock and disbelief was a common reaction to the diagnosis of a complication amongst first time and experienced fathers. This is similar to May's (1993) study where first time fathers were taken by surprise when their partners were diagnosed with preterm labor. In contrast, fathers with previous preterm experience reported a sense of resignation (May, 1993). In the current study, only two fathers had previous preterm experience, of which one expressed a sense of resignation when it occurred again. The other father did not report feeling resigned but he was experiencing a different complication this time with a new partner. Because of the risks inherent in preterm labor and the incidence of recurrence in another pregnancy, couples are frequently given instructions regarding signs and symptoms of preterm labor. Thus, a sense of resignation "when it happens again" may be more prevalent in situations of preterm labor than in other conditions as couples have been prepared. One father in this study was not surprised by the recurrence of preterm labor in this pregnancy because he had anticipated and mentally prepared himself. The supposition that a sense of resignation may be unique to the recurrence of preterm labor in another pregnancy requires further investigation.

Several fathers worried that similar complications would recur in future pregnancies. This concern was not limited to specific conditions and continued despite reassurances (when medically appropriate) to the contrary. Several men worried about their partners' safety. It may be helpful for fathers to know if their partners are also concerned for their own health or instead are concentrating on the well being of their babies as this information may avoid misunderstandings between couples. Interventions that address these issues may be helpful. Consideration should be given to resolving these issues before future pregnancies are contemplated.

"Why us" was a question that plagued fathers. This response is common during times of loss. For many fathers in this study, the diagnosis of complications meant dealing with "shattered dreams". Affleck and Tennen (1991) cited the work of Affleck, Tennen, and Rowe which suggested that many victims of misfortune answered the question "why me", in a way that brought "order and purpose to an otherwise senseless event" (p. 7). This need to achieve order and purpose was evident when fathers accepted the reality of their situations and stated "why not us".

A lack of experience with "normal" pregnancy made it difficult for first time fathers in this study to prepare for childbirth. This may have been exacerbated by the fact that most of these fathers (75%) did not attend prenatal classes. However, though fathers in Taylor's (1992) study claimed that prenatal classes prepared them for what to expect, they appeared to have expectations for childbirth before attending classes. Taylor questioned the role of prenatal classes in formulating those expectations.

Because experienced fathers used past successes to predict future pregnancies, they were not prepared for the possibility of complications. This is somewhat similar to two experienced fathers in Taylor's (1992) study who expected this birth to be similar to the first. There is a need to encourage fathers to recognize the uniqueness of each pregnancy and birth to avoid setting them up for failure if the next pregnancy and birth does not match previous experience.

Several experienced fathers claimed that past birth experiences helped them cope with complicated pregnancies. For some, the ability to draw from past experience seemed to decrease their anxiety and uncertainty while others were not able to make this transition. In some cases, the more unfamiliar and different the present circumstance was from past situations, the more anxious fathers seemed to be. This begs the question – Is there a difference between experienced and inexperienced fathers regarding the amount of stress and anxiety they feel when confronted with complications? What effect does a negative birth experience have on future expectations? For one father in this study, a past negative childbirth experience remained unresolved and appeared to "color" many of his concerns and expectations for the upcoming birth.

In this study, the diagnosis of a complicated pregnancy resulted in several first time and experienced fathers having to deal with "shattered dreams". Some adapted by altering their expectations while others were having difficulty "letting go".

Preparing for the worst case scenario was a sub-theme evident in this study and that of Taylor's (1992). In both studies, it seemed to be the perception that if you were prepared for the worst, you were prepared for anything. One father in the current study became angry when presented with all possibilities. Another wanted to prepare "from the moment" pregnancy was confirmed! The challenge faced by health care practitioners is to differentiate the "nice to know" from the "have to know" while remaining sensitive to individual needs and desires for information.

Other fathers prepared by ensuring that everything was ready at home. Fathers who focused primarily on the physical preparations seemed to be less likely to discuss mental preparations. This may have been compounded by the fact that several of these fathers stated that the pregnancies were unplanned.

It was not surprising that few fathers mentioned prenatal classes as a source of information about complications. This is not their mandate, nor should it be. This is not to suggest that these classes do not have a role in preparing fathers who are experiencing

complications. These couples need to understand the normal aspects of pregnancy, as well as the specifics of their complications (Heaman, 1998).

In general, fathers in this study seemed to be able to access the information they required. Only a minority seemed to want more or indicated that information regarding complications was not readily available. However, since it was not the intent of this study to assess informational needs, further study via a needs assessment is required.

Fathers who participated in a tour of the special care nurseries reported positive benefits. This is similar to the results of research by Griffin, Kavanaugh, Fraga Soto, and White (1997). In that study, a qualitative approach was used to describe expectant parents' reactions to a prenatal tour of the neonatal intensive care unit (NICU) during a high-risk pregnancy. Benefits of the tour included that it: decreased fears, inspired hope for the newborn's prognosis, provided reassurances about the care delivered in a NICU, and prepared parents for what to expect in the unit. In the current study, fathers specifically mentioned seeing a preterm baby whose gestational age was similar to their baby and being exposed to "all the bells and whistles" as helpful. The fact that Griffin et al. (1997) interviewed couples, not just fathers poses the question - Do men and women perceive different benefits? Men are often intrigued and immersed in technology and may be more likely to be impressed by the high tech of a NICU and thus more apt to mention technology as a benefit and may be less likely to "notice" the emotional and physical care being provided.

In this study, fetal assessments provided "objective feedback", "positive feedback", hope, when there was "no real hope", a chance to bond, and "huge comfort". Fetal assessments were more than "reality boosters" (Jordon, 1990b, p. 13). These findings suggest that there may be some value to encouraging fathers to attend at least one fetal assessment. Some fathers cited that work commitments prevented them from attending and others claimed they were not invited. Health care providers can play a key role in facilitating their attendance.

The sub-theme "heard stories" was evident in other studies. Fathers in Barclay et al.'s (1996) study referred to these stories as "unsolicited information" (p. 19) that were often not welcomed and resented. This is similar to the fathers in this study who seemed disturbed by negative stories they heard. First time fathers seemed to be more vulnerable to these stories. This concurs with Taylor (1992) who stated that first time fathers were influenced primarily by indirect experiences such as what they had been told by others. However, in Taylor's study, fathers did not seem bothered by these stories. Stories that appeared to have the most influence on fathers were generally from the same generation as them and were perceived to be credible sources. These findings suggest that it may be important to encourage fathers to discuss these stories so that any inaccuracies could be corrected and myths dispelled. Perhaps if health care providers encouraged fathers to talk about their birth experiences and gave them the opportunity to "work through" any unresolved issues, the negative and inaccurate stories could be curbed.

A few fathers did not feel they were adequately informed. It is not unusual to find that during times of stress, information that is provided is simply not heard. Health care providers need to make a concerted effort to include fathers when information is being provided. Having both parents "hear " the same information may decrease the possibility that information may not be heard. Some experienced fathers lacked knowledge about childbirth. This finding suggests that health care providers should not assume that because a father has experience, he possesses the knowledge.

Being There – Antepartum

Fathers reflected on the meaning of complications. Several fathers used the medical model to define complications and described risks in relation to their partners and/or babies. In contrast, high risk pregnant women in Corbin's (1989) study tended to focus on risks related to their babies rather than risks to their own health. When making

decisions regarding treatment modalities, it was the needs of the fetus that were given priority. "Women want healthy babies and will do what they believe is necessary to achieve that end" (p. 336). Some fathers in the current study claimed they were more concerned about the health and safety of their partners than that of their babies. It is possible that other fathers shared this attitude but did not feel comfortable acknowledging it. One father admitted that he was more attached to his wife than to his baby because he had not seen the baby yet. These results are supported by the findings that prenatally a father's relationship with his baby is not real (Donovan, 1995) and does not become real until sometime after birth (Jordon, 1990b). Generally, the father has an established relationship with his partner and may only be beginning to bond with his baby.

Some fathers viewed a complicated pregnancy as "more than" a condition that could affect the health of the mother-baby unit. For them, it was crucial that the emotional component be considered. Some even differentiated between emotional and physical complications. These interpretations go beyond traditional definitions and have the potential to create misunderstandings if caregivers fail to understand the father's perspective. Caregivers may prevent such misunderstandings by becoming sensitive to the issues relevant to fathers as well as being aware of their own biases. Mismatched perceptions were noted between caregivers and high risk pregnant women in Stainton's (1992) study. Those women focused on the possibility of becoming a mother to their infant while health care professionals focused on the actual or potential problems posed by their medical condition. Caregivers often misinterpreted this "mismatch" as denial by the mothers about the seriousness of their situation. Findings of the current study suggest that the potential for "mismatch" exists with fathers as well.

Not all fathers agreed with the medical interpretation of what constituted a complicated pregnancy. For one father, this difference of opinion was a source of conflict. The dearth of literature regarding fathers in the context of complicated pregnancies does not permit comparisons with men. However, Corbin (1987) studied

women with pregnancies complicated by chronic illnesses and found that conflicts arose between women and their physicians when there was a lack of shared meaning regarding the nature and/or degree of risks. Findings of the current study suggest that shared meaning may be relevant for men as well. Ford and Hodnett (1990) found that high risk pregnant women interpreted risk using a subjective component and that their appraisal of pregnancy risk could be independent of, even divergent from, the risks as determined by medicine. One father in this study did not deem the pregnancy complicated as determined by medicine while others used varying definitions of risk that did not concur with medical definitions.

Fathers coped with the diagnosis of complications by comparing their partners' complications to those of others who were less fortunate. This need to compare with something worse was depicted in the phrase "it could be worse", which is an expression used frequently to "make sense" of unpleasant events. Affleck and Tennen (1991) reviewed literature regarding the search for meaning in threatening circumstances. They found that people in a variety of circumstances are apt to compare themselves with others who are less fortunate and even derive comfort in doing so. These authors reported on their work with mothers who were dealing with the crisis of having a newborn in intensive care and found that mothers coped by making downward comparisons. These mothers selectively compared their infants to others in the unit on dimensions that made their own child's condition seem relatively less severe. Some fathers in the current study also used downward comparisons to deal with the diagnosis of complications.

For most fathers in this study, supporting their partners throughout the antenatal period was stressful and demanding. This concurs with Maloni and Ponder's (1997) study where fathers whose partners were diagnosed with prenatal complications and were prescribed bedrest described being supportive as "never-ending" (p. 185).

When describing the lived experience of "being there" in the antepartum period, fathers in this study identified many stressors. Several described being in a state of

constant worry about their partners and/or babies. They reported being "always on guard", "jumping" with every phone call, or "unconsciously worried. . . all the time". Fathers whose partners were diagnosed with placenta previa worried they would hemorrhage. Other researchers substantiated this sub-theme. Maloni and Ponder (1997) found that 66% of fathers worried about the physical or emotional health of their partners or fetuses. In a study by May (1994) which described the experience of fathers whose partners were on activity restriction at home for preterm labor, the "constant worry" related to concerns for their partners' safety. Because fathers worried about their partners being alone, they went to extraordinary means to ensure that they stayed in contact with them. The worry was ameliorated only when their partners were not alone. This worrying continued until the gestational age of the fetus was such that activity restrictions could be relaxed.

In this study, fathers were stressed by having to take on multiple roles and tasks. This is consistent with other studies. Fathers in Maloni and Ponder's (1997) study identified "doing it all" as the most difficult aspect of having a partner on bedrest while fathers in May's (1994) study reported being overwhelmed by having to do it all.

Fathers in this study believed they needed to protect their partners by not sharing emotions. Only a minority of fathers discussed their concerns with their partners. This is consistent with other studies. Fathers in May's (1994) study tried to protect their partners by trying to hide their distress for fear of causing them additional anxieties. Only 17% of fathers in Maloni and Ponder's (1997) study reported talking with their wives about their concerns. This need to protect is not unique to high risk situations as men in Jordon's (1990b) study were also hesitant to share feelings and concerns about pregnancy in front of their partners for fear of causing their mates additional stress.

Several fathers referred to a lack of supports. This is consistent with the findings of May (1994), and Maloni and Ponder (1997) except that in those studies fathers were referring to lack of support from health care professionals while in the current study only

a minority of fathers voiced that concern. Fathers perceived that their partners were being asked to comply with a home regimen that involved minimal assistance from the health care system (May, 1994). Over half of the fathers in Maloni and Ponder's (1997) study reported receiving no help from health care professionals. In the present study, all women who were at home received care from a team of specially trained public health nurses. Other sources of stress described by fathers in this study, but not previously identified included: maintaining bedrest, uncertainty regarding date of delivery, and being bored.

Fathers initiated behavioral and cognitive actions to mediate stressors. Concurrent with other studies (Maloni & Ponder, 1997; May, 1994), tangible and emotional supports were cited. In this study, cognitive actions included "putting things into perspective" and becoming involved. Maloni and Ponder (1997) cited reframing the problem, putting the problem in perspective, and believing in God as cognitive actions undertaken by fathers in their study.

For several fathers, participating in this study was a cathartic experience. One father was so eager to participate that he initiated the first contact with the researcher. He felt that the researcher would understand some of the things he was going through. Most fathers in Jordon's (1990b) study remarked that the investigator was someone with whom they had been able to share their experiences and feelings.

A unique finding of this study was the sense of control fathers experienced by diligently monitoring their partners' symptoms. In some situations, this sense of control dissipated their anxiety and decreased feelings of uncertainty. Researchers Affleck and Tennen (1991) found that mothers who closely monitored the care their infants received in the neonatal intensive care reported a sense of control over outcomes. Since control is a powerful motivator for men and women in our society, there is reason to assume these results may hold true for fathers as well.

Stress was manifested by a range of emotional reactions and concurs with those reported by other researchers who studied fathers in the context of complicated pregnancies (May, 1994; McCain & Deatrick, 1994). Reactions specific to this study included: guilt, hopelessness, denial, and disappointment.

Other researchers confirmed the sense of isolation reported by fathers in this study. No fathers in May's (1994) study reported knowing or talking to other fathers in similar situations. They avoided discussing their situation with co-workers. In another study, 20% of fathers reported having no one to talk to about the difficulties they encountered (Maloni & Ponder, 1997). A sense of isolation was not limited to the context of complicated pregnancies. Other expectant fathers have expressed feeling forgotten (Barclay et al., 1996), alone (Jordon, 1990b), and left out (Donovan, 1995). The comment, "They [health care professionals] don't usually worry about us" (Barclay et al., 1996, p. 18) says it all. Donovan claimed we all contribute to this feeling of isolation by focusing on the mother and her fetus. This is echoed by Jordon (1990b) who stated that expectant fathers are victims of "societal benign neglect" (p. 15).

Diemer (1997) found that wives were the most frequent source of support for expectant fathers. Mercer and Ferketich (1988) studied 75 men whose partners were hospitalized for a pregnancy complication (high risk men) and compared them to 147 men whose partners were experiencing a normal pregnancy (low risk men). They found that 68% of high risk men reported their partners as part of their support network compared to 79% of low risk men. Fathers in this study, and Maloni and Ponder's (1997) rarely mentioned their mates as providers of support. Are fathers less likely to turn to their partners for support in situations of complicated pregnancies? If so, who supports fathers in these times of stress? Women in high risk situations have high expectations for partner support. Most high risk women in Mercer and Ferketich's (1988) study considered their partners to be a part of their support network. Donovan (1995)

questioned how fathers can be expected to take on supportive and nurturing roles without an acknowledgement of their needs or the provision of supports to fulfill those roles.

The stressors, fatigue, and sense of isolation reported by fathers in this study and others, have the potential to create a situation whereby demands may exceed capabilities and resources. Mercer and Ferketich (1988) found that high risk men reported significantly higher levels of anxiety and depression and less perceived support than low risk men with almost a third of high risk men having depression scores indicative of clinical depression. Ensuring that fathers are also treated as clients may preserve family functioning. Failure to do so violates the philosophy of family centered care. The time has come to put words into action through actual changes in practice.

Prolonging the Pregnancy

Prolonging the pregnancy was a powerful motivator for fathers in this study. Fathers did what they could to achieve that goal. No references to this theme were found in the literature. However, pregnant women in high risk situations spoke of prolonging gestation. Women actualized the concept by focusing on small daily or weekly goals (Gupton et al., 1997; Schroeder, 1996) and viewing each day as "one more day of growth" (Coster-Schulz & Mackey, 1998, p. 349). This concurs with the reports of fathers in this study.

Fathers in this study coped with the possibility of preterm delivery by looking to the future. Similarly, women also coped by looking to the future, however, women on bedrest "were profoundly oriented to the future" (Schroeder, 1996, p. 256). Men in the current study were consumed with the present and were "always doing" while women on bedrest endured the present and were "always waiting" (Schroeder, p. 256).

As time passed and pregnancy landmarks were reached, men in this study experienced less anxiety. This concurs with studies that have explored men's and

women's lived experiences within the context of complicated pregnancies (May, 1993; Monahan & DeJoseph, 1991; Schroeder, 1996).

The need to "let go" of the goal to prolong gestation requires further exploration. According to Sather and Zwelling (1998), being high risk for so long can make it difficult for a woman to "let go" of the anxiety associated with a high risk pregnancy. The authors suggested that at some point a woman must move from the developmental tasks of a high risk pregnancy, with it's inherent uncertainties, back to normal tasks of pregnancy such as investing in thoughts of mothering. Must fathers at some point also shift their focus from prolonging gestation, a task inherent in high risk situations, to anticipating birth, a task of normal pregnancy? If this process is important, when does it usually occur?

Several fathers viewed attempts to "buy time" as potentially dangerous to their partner's health. In contrast, women are determined to do whatever is necessary to achieve healthy babies (Corbin, 1989). The task is to discover how to best meet the needs of expectant fathers and their partners when such divergence exists.

Trusting in Technology

Most fathers in this study had a profound respect for technology. This finding offers support for the argument that science and technology is a core value of our society (Davis-Floyd, 1990). The underlying assumption seemed to be that because of technology, these fathers could expect healthy, functional, and normal babies. These findings parallel the opinion of Davis-Floyd who stated that there is a prevailing cultural belief in our society that it is only through the combination of technology and skilled technicians that we can expect "perfect products" (p. 184). Thus, technology creates expectations for the perfect baby and the illusion of certainty (Sandelowski, 1993b).

The internalization of this technocratic model is not without its problems. What happens if technology fails fathers and does not deliver perfect babies? In the current study, many fathers held high, at times unrealistic expectations, of modern technology.

Thus, fathers were at risk of "failed expectations" (Sandelowski, 1984, p. 237). The possibility of unmet expectations was enhanced by two factors. Steroids were viewed as the panacea for preterm labor. Some fathers misunderstood the action of steroids and thought it helped "speed brain development" and enhanced lung development when actually it has no effect on brain development. Second, no fathers voiced developmental concerns despite the fact that eight fathers had partners who were of a gestational age of ≤ 32 weeks. It is possible these fathers did recognize the implications of preterm delivery but like women in Stainton's (1992) study were focusing on the possibility of fathering a baby instead of focusing on actual or potential problems posed by preterm deliveries.

In this study, technology was related generally to what might be used for the baby. This is not surprising when one considers the number of babies who were at risk of preterm delivery. Only one father voiced concerns about "intrusive procedures" such as episiotomies. This is similar to Taylor's (1992) study where no fathers expressed expectations relating to use of medical equipment such as electronic fetal monitoring and forceps. In contrast, women in Beaton and Gupton's (1990) study produced a "lengthy list" (p. 137) of treatments and procedures they expected to have during childbirth while high risk women in Heaman et al.'s (1992) study expected more medical interventions than did low risk women. One explanation for these differences may simply be that women, not men, experience those interventions and thus have a vested interest in seeking out this information. Another reason may be because several fathers in this study had not started or only begun to think about childbirth and may not have had the opportunity to formulate clear expectations regarding interventions.

Most fathers in this study had thought of the possibility of a cesarean birth. This seems reasonable as all women had been diagnosed with complicated pregnancies and thus were at increased risk of an operative delivery. In contrast, no fathers in Taylor's (1992) study mentioned expectations related to cesarean sections until probed by the

researcher. However, it is unknown if any of these women were experiencing a complicated pregnancy.

Several fathers expressed confidence in technology that they perceived to be common or routine. For many, these words convey thoughts of a procedure that is relatively risk free. A cesarean section, though a common procedure in North America, is a major operation that carries substantial risks for both mother and baby (Enkin, Keirse, Renfrew, & Neilson, 1995). Elliott (1998) questioned if the high prevalence of cesarean sections has led to its acceptance as simply another way to give birth. The findings of this study offer some support for that viewpoint.

For several fathers in this study, the notion "whatever is best for mom and baby" prevailed. Other researchers have suggested that fathers are more concerned with outcomes as opposed to the birth process (Barclay et al., 1996; Taylor, 1992; White, 1998). Many women in Beaton and Gupton 's (1990) study had developed "highly detailed and romanticised birth fantasies" (p. 138) which could set them up for failure if the script did not match reality. It is this researcher's experience that some men seem to "let go" of expectations for a particular type of birth experience more readily than women when faced with the reality of childbirth. Because of a diagnosis of complications, one father had begun adjusting his expectations while his partner was still expecting "the perfect birth".

For a minority of fathers in this study, technology did not have all the answers. These fathers may be part of a growing number of people who exert "countercultural efforts to withstand the tendency to assimilate technology into nature" (Sandelowski, 1993b, p. 38) and who seek to "invert our core value system" (Davis-Floyd, 1990, p. 187) by placing science and technology at the service of nature, themselves, and others.

Being There During Childbirth

Fathers' perceptions of "being there" during childbirth encompassed expectations. The original intent of this study was to conceptualize expectations from a cognitive perspective, that is, that which a person believed would happen. Instead, fathers described their expectations in terms of what they thought or believed would happen (cognitive) and/or what they hoped would happen (affective). Taylor (1992) encountered similar difficulties. In her study, fathers often used cognitive and affective aspects interchangeably when describing their expectations for childbirth.

Several fathers portrayed childbirth as a profound, intense, or spiritual experience. In contrast, four fathers in Taylor's (1992) study described childbirth as "a 'bloody and gory' experience" (p. 65). In the current study, thoughts of childbirth conjured images of the unknown and were not limited to first time fathers. The "unknown" was prevalent in other studies (Barclay et al., 1996; Taylor, 1992). Thoughts of labor caused fear and anxiety for some first time fathers in Barclay's et al. study and was labeled the "unknown" (p. 19) while in Taylor's study the unknown related to fathers being unsure of how they would react during labor. Taylor did not indicate if this theme was limited to first time fathers.

Fathers in this study had role expectations for labor and birth. Three roles emerged from the activities fathers anticipated doing during childbirth and parallel those described by Chapman (1992) and Taylor (1992) respectively. Being in charge paralleled the coach role and caretaker; being there to observe, that of witness and spectator; and being there to assist, that of teammate and supporter.

In this study, being in charge was the least common role (n = 1) fathers expected to adopt. One explanation may be that fathers could not envision or did not want to "be in charge" of a labor that could potentially become complicated as well. Another explanation may relate to the fact that three quarters of first time fathers did not attend prenatal classes and may not have been exposed to information regarding labor roles.

Being in charge was not the prevalent role that fathers in Taylor's (1992) study expected to adopt or that fathers in Chapman's (1992) did adopt. Findings from the current study, Taylor's and Chapman's, complement Berry's (1988) results and provide further evidence that the coach role may not be realistic for all fathers.

In this study, 53% of fathers expected to be there to observe. This is similar to Chapman's (1992) study where 60% of fathers adopted the role of witness (observer). Further support for the observer role was found in Nichols's (1993) study in which 55% of fathers identified "just being there" (p. 104) as one of the most helpful things they did for their wives during childbirth. In contrast, no fathers in Chandler and Field's (1997) study were "there only to witness the birth. . . . All of the fathers wanted to be at the birth to support their wives" (p. 23). This is similar to five fathers in Taylor's (1992) study who assumed supporter roles, in addition to that of spectator roles (observer). These apparent contradictory findings may result from differing interpretations of the observer role. In her research, Chapman (1992) claimed that all roles provided support. Furthermore, she described the role of witness (observer) as one that allowed "togetherness without the pressures of having to be in control of the labor and birth experience" (p. 117). Fathers in this study, Chapman's, and Taylor's hoped to provide support by virtue of "being there."

In the current study, 41% of fathers expected to be there to assist while all fathers in Taylor's (1992) study expected to adopt that role. One explanation for these divergent results may be that all fathers in Taylor's study had attended prenatal classes while in this study only 60% of fathers had attended classes. Participants in Taylor's study claimed that prenatal classes prepared them for what to expect during childbirth while in the present study some fathers had only recently started or not yet begun to think about childbirth. Fathers who attended prenatal classes (prepared fathers) were more likely to describe providing physical comfort measures and psychological support during labor than unprepared fathers, content that is generally included in childbirth classes (Nichols,

1993). Another reason for fewer fathers in this study expecting to be there to assist may be because all fathers were experiencing complications, in fact two experienced fathers anticipated enacting less active labor roles this time because of the complications.

The fact that 41% of fathers in this study expected to be there to assist while in Chapman's (1992) study only 20% of participants adopted that role, suggests that a discrepancy might exist between roles fathers expect to adopt and roles they do adopt. This supposition is supported by the work of Chapman (1991), and Chandler and Field (1997) who indicated that some fathers alternated labor roles during childbirth. However, the present study did not examine this factor

Previous researchers (Beaton & Gupton, 1990; Bramadat, 1990; Heaman, Beaton, Gupton, & Sloan, 1992) have indicated that woman have high expectations for partner support during labor. In the current study, it is not known if fathers' partners had similar expectations. What is clear is that at least half of fathers did not expect to be active participants during childbirth and thus, may not have been able to provide the type of support their partners expected, creating a situation conducive to failed expectations.

Fathers expressed a lot of intense, negative emotions about labor. The predominant feeling expected by most fathers in Taylor's (1992) study was that of helplessness. Prior to labor, fathers in Chandler and Field's (1997) study were confident of their abilities to support and comfort their wives. However, labor proved to be "more work than anticipated" (p. 19) and resulted in fathers experiencing fear and helplessness. Research by Nichols (1993) presented a somewhat different picture. In that study, 59% of fathers, regardless of attendance at prenatal classes or not, expressed positive emotions about labor while 41% expressed negative emotions.

In general, comments regarding birth reflected a positive affect. Several researchers have reported similar results (Chandler & Field, 1997; Leonard, 1977; Nichols, 1993; Taylor, 1992). Birth was primarily characterized by positive or very

positive feelings (Nichols, 1993) and described using "a myriad of positive emotions" (Chandler & Field, 1997, p. 22).

Fathers in this study expressed a need to appear strong and in control at all times. Being supportive meant hiding your feelings from your partner and just turning "yourself off". The possibility of showing emotions by crying or passing out was disturbing for some fathers. Researchers Berry (1988), and Chandler and Field (1997) also reported that fathers had a need to hide their fears and anxieties during childbirth so as not to worry their partners. These findings provide further evidence for Berry's conclusion that childbirth is stressful for fathers.

Fathers were concerned about seeing and dealing with a partner in pain. This finding has been reported in other studies (Barclay, Donovan, & Genovese, 1996; Chandler & Field, 1997; Gabel, 1982; Glazer, 1989; Leonard, 1977; MacLaughlin, 1980; MacLaughlin & Taubenheim, 1983; Nichols, 1993; Taylor, 1992). In this study, fathers expressed a sense of helplessness related to their perceived inability to relieve pain. The assumption seemed to be that only pharmacologic measures would work. This was supported by Taylor (1992) who stated that fathers expected some pain to be relieved by analgesics. However, pain control through nonpharmacologic measures was "laden with uncertainty" (p. 93).

According to Chapman, (1992) fathers who adopted the witness role believed that there was little they could physically do to help their partners through the pain of labor. Though this was also noted in the present study, it is not clear if that finding was limited to the witness role. Because fathers in Chandler and Field's (1997) study were often dissatisfied with their own performance and felt that they had not provided adequate support for their partners, the question regarding which fathers perceived a limited role for themselves regarding pain relief remains unanswered, as no fathers in that study adopted the role of witness.

The need to be informed was prevalent in this study and supports a growing body of research regarding its importance for expectant fathers (Barclay et al., 1996; Chandler & Field, 1997; Chapman, 1991; Lemner, 1987; Taylor, 1992). Some fathers in this study expected the nurse or labor supporter to provide ongoing information to assist them in being supportive. However, for many fathers in Chandler and Field's (1997) study, the expectation that nurses or midwives would show and help them support their partners was not realized. Instead, fathers reported caregivers taking over their support role. This was disconcerting for these fathers as they believed they were "part of a couple experiencing labor" (Chandler & Field, 1997, p. 23). It is important that health care providers and fathers share congruent role expectations in order to avoid setting fathers up for failed expectations. However, fathers have the responsibility to share what those expectations are to ensure that they are met.

Fathers' roles during childbirth are being debated in the midwifery literature. Though only one father in this study expected to have a midwife at their birth, this number will likely increase in Manitoba when the midwifery model is available to all consumers. Traditionally, midwifery has meant "being with woman" (Draper, 1997, p. 133) not with man. Where does a father's presence "fit" within this model? Draper, via personal communications with the author Sandall (1966), cited a qualitative study of midwives' experiences. A clear distinction was made between midwives who wanted a close relationship with the woman and saw the man as peripheral and those who wanted to empower the mother and her existing relationships and saw themselves in addition to the man and woman dyad. Thus, fathers who expect to be actively involved in labor or a couple who considers themselves to be a "laboring couple" (Chandler & Field, 1997, p. 23) may be setting themselves up for failed expectations if they do not choose a midwife who shares their views.

Fathers expected the nurses' primary role to consist of monitoring the progress of labor and observing for signs of adverse outcomes. Though several fathers in this study

expected nurses to provide support, it seemed to assume a secondary role. In contrast, four fathers in Taylor's (1992) study viewed the nurses' primary role to be that of support. All fathers in the current study were experiencing a complicated pregnancy. It is within this context that these results must be viewed. When one considers the positive outcomes of one to one supportive care that is provided by a trained professional (Hodnett, 1995), it is concerning, but not surprising, that more fathers did not expect support to be the nurses' primary role. The expectation that fathers "fill the gaps in care" (Enkin, Keirse, Renfrew, & Neilson, 1995, p. 194) needs to be addressed if we are to provide evidenced based practice. Given the realities of health care reform, this is an ambitious endeavor.

Two fathers spoke of health care as a business. Although only two men made reference to that fact, the finding is noteworthy and may be a reflection of the current philosophy of health care in Canada. Another explanation may relate to their background experience or gender. One father dealt with health care professionals through his job. Men may be more likely to view health care in terms of "running a business" while women may place more emphasis on the caring aspects.

The finding that fathers did not tend to discuss their childbirth expectations with their partners is consistent with other studies (Chapman, 1991, 1992; Taylor, 1992). The present study offered some insights regarding why fathers did not share expectations and included: expecting same, don't know what to expect, and wanting to protect partner. Chapman and Taylor suggested that discussion of expectations between couples could facilitate congruence of expectations, which in turn could result in a more satisfying birth experience. Fathers and mothers are at risk for the guilt, anger, and disappointment that can result when the labor and birth "script" does not match reality (Broome & Koehler, 1986). The question remains - Can fathers be convinced of the value of sharing *their* expectations?

Shapiro (1987), a clinical psychologist, who based his thoughts and ideas of expectant fathers on his clinical observations, experiences as a father, and interviews conducted with 227 expectant and recent fathers from all walks of life, offered this perspective. While men are encouraged to participate fully in pregnancy and birth, their feelings – fear, anger, and uncertainty – are unacceptable to society, for fear they might upset expectant mothers. The author contended that expectant fathers have neither the support systems nor the cultural sanctions for what they experience. Shapiro concluded by stating that unless these fears are recognized by the father, his partner, and society, the expectant father cannot be a full partner in the birth process.

Health care professionals may have perpetuated this belief by not ascertaining what "being there" means to fathers. Health care professionals often expect fathers to "be there", participate, and be supportive and may not provide the means to achieve those goals. Aberrant behavior is often frowned upon and to adopt a very passive role during childbirth may be viewed with suspicion. Nonattendence is not encouraged. It may be difficult for fathers to become full partners unless their needs are acknowledged and addressed.

Discussion of Findings Related to the Theory of Uncertainty

The conceptual framework for this study was Mishel's (1988) theory of uncertainty. This model consists of three variables, stimuli frame, cognitive capacity, and structure providers, which precede uncertainty and offer information that is processed by the client. The original intent of this study was to focus on the primary antecedent variable, stimuli frame, and its components: symptom pattern, event familiarity, and even congruency. During analysis, it became apparent that the variable, structure providers, and its components, credible authority, social support, and education, had relevance to this research, and will be discussed. The third variable, cognitive capacity, refers to the information-processing abilities of people and was not assessed.

According to the theory of uncertainty, components of the stimuli frame are structured by an individual into a cognitive schema to create less uncertainty (Mishel, 1988). Symptom pattern, one of the components of the stimuli frame, refers to the degree to which symptoms are present with sufficient consistency to form a recognizable pattern. The ability to identify a pattern decreased uncertainty. The data offered support for this premise. When symptoms such as contractions and leaking of amniotic fluid became predictable, routine, and/or normal, several fathers reported feeling less anxious and uncertain. A symptom pattern implies control over symptoms (Mishel & Braden, 1988). The ability to detect abnormal symptoms and to distinguish normal from abnormal symptoms gave fathers a sense of control. Fathers did what they could to "control" symptoms. For example, Blake tried to control the amount of stress his wife was exposed to because he felt that her emotional well being was "very related to her contractions" while Tim tried to control his wife's blood pressure by controlling the environment.

Event familiarity, a second component of the stimuli frame, refers to whether a situation is habitual, repetitive, or contains recognizable cues. The data also supported this premise. Event familiarity was pertinent to first time fathers because they lacked familiarity with "normal" pregnancies as well as complicated ones. The role of event familiarity in experienced fathers is not clear. Some of them dealt with the diagnosis of complications by drawing on past experiences with "normal" pregnancies while other fathers did not seem to be able to make this transition. Some fathers who were having difficulty with this transition had recently been confronted with the diagnosis. According to Mishel (1988), familiarity of events is developed over time and through experience. Thus, not only is there a need to differentiate between experienced and inexperienced fathers, but it may be necessary to differentiate between those fathers who have lived with the diagnosis for a period of time and those who are newly diagnosed.

The novelty of an event seems to be the aspect of unfamiliarity that generates uncertainty and as novelty abates, uncertainty decreases (Mishel, 1988). This was noted

in this study and was not limited to experienced fathers. For example, in situations of ruptured membranes a certain amount of leakage became accepted as the "norm". It was only when there was more than the revised standard of normal, that anxiety and uncertainty ensued. Dennis, who had previous experience with preterm labor, did not seem to find issues of uncertainty problematic, in fact, he seemed to accept uncertainty as a part of life. It could be argued that past experience had prepared him for what to expect and thus decreased his level of uncertainty. Another explanation is that the experience and expression of uncertainty may not be the norm for all men. The theory of uncertainty assumes that people structure stimuli into cognitive schema. Individual variations, preferences, and cultural norms, need to be considered.

Event congruency, the third component of stimuli frame, refers to consistency between what is expected and what is experienced. Incongruencies between what is expected and what happens leads to uncertainty. In this study, the sub-themes "readjusting expectations" and "using past successes to prepare" supported that premise. Ensuring that expectations are realistic is one strategy to maximize event congruency.

Structure providers are those resources that are available to assist people interpret the stimuli frame (Mishel, 1988). In the model, structure providers are education, social support, and credible authority. These structure providers are proposed to reduce uncertainty both directly and indirectly.

The first structure provider, credible authority, refers to the degree of trust and confidence clients have in health care providers. Mishel and Braden (1988) proposed that credible authority directly reduced uncertainty when health care providers assumed power and authority that were evaluated as highly credible. In this study, the sub-theme "we have the technology" suggests that technology as well as the health care providers who used that technology were held in high prestige and endowed with power by several fathers. Further research is required to ascertain if credible authority, as conceptualized by Mishel (1988), can include technology.

Credible authority indirectly influenced uncertainty by its positive association with the stimuli frame (Mishel, 1988). In this study, credible authority, in the form of health care providers assisting fathers to determine symptom patterns, and familiarity of events are examples of indirect influences (Mishel & Braden, 1988). Health care providers enhanced event congruence when they provided a framework for the interpretation of events (Mishel, 1988). Thus, the enhancement of predictability through the promotion of realistic expectations may indirectly avoid or minimize uncertainty.

Two other structure providers, education and social support, can influence the perception of uncertainty (Mishel, 1988). Social support refers to people who help clients have a clearer view of symptom patterns and assist them with familiarity of events (Mishel & Braden, 1988). Social support functions as a means of avoiding uncertainty by establishing a network where each member depends on another member for their expertise to handle various situations (Mishel, 1988). In this study, health care providers functioned as structure providers. Fathers rarely mentioned networking with other fathers in similar situations and have implications for practice. Education via information helped some fathers prepare and cope with complications. In other circumstances, a lack of information, inconsistent information, or misinformation precipitated feelings of being "in the dark" and in some cases resulted in fathers feeling uncertain. "Hearing stories" were not conducive to preparing for complications.

In summary, the antecedents to uncertainty were supported and exemplified with qualitative data and sub-themes from the interviews with expectant fathers. The theory of uncertainty was an appropriate framework for this study (Appendix N). Testing of the theoretical model of uncertainty in the context of fathers lived experiences during complicated pregnancies is warranted since the antecedents to uncertainty were supported by this study. The only variable not investigated was cognitive capacity as it was beyond the scope of this study.

Nursing Implications

Having an in-depth understanding of fathers' experiences during complicated pregnancies may help nurses improve the quality of care for expectant fathers. Nurses can play a pivotal role in creating a supportive environment for fathers and ameliorating some prenatal stressors. Given the sense of isolation described by fathers in this study and sense of relief they felt when given an opportunity to vent, it is important that nurses continue to make themselves available to listen to the concerns and frustrations of fathers. Merely acknowledging to the father that he might be experiencing a stressful time may be all that is required to communicate to him that his concerns, and not only that of his partner, are important.

Fathers in this study expressed a need to share their concerns and burdens in a neutral environment. Nurses need to provide opportunities for this to occur. Fathers might benefit from a forum that allows them to discuss their concerns with other fathers in similar situations. Though prenatal classes are one way for fathers to meet others in similar situations, several fathers in this study were not able to attend prenatal classes once their partners were diagnosed with complications. Only one father reported networking with the twin and triplet organization. Nurses may want to assess the need and feasibility of establishing formal support groups for men as have been done for pregnant women with complications (MacMullen, Dulski, & Pappalardo, 1992; Synder, 1988). No literature could be found regarding such groups for men. However, benefits of formal support groups for high risk pregnant women included: sharing with others who have "been there", reassurance that their reactions to their high risk pregnancies were common, and being able to resolve feelings about their pregnancies (Snyder, 1988). These benefits are similar to those of a support group for expectant fathers that included increased confidence and comfort knowing that others shared their concerns (Taubenheim & Silbernagel, 1988). Fathers often developed a strong support system by

the end of the program. This is extremely valuable since fathers in the present study reported a lack of support systems to deal with pregnancy related issues.

Study participants described the stress of the antenatal period as pervasive and demanding. Nurses can play a key role in ensuring that fathers' needs are met so that they will have the emotional and physical energy to support their partners and complete necessary tasks (Maloni, 1994). Active listening and conducting a psychosocial assessment may validate the stressors a father is experiencing and allow the nurse to offer appropriate suggestions to promote coping (Maloni, 1994). Some interventions might include, providing anticipatory guidance, offering assistance with problem solving (May, 1994), and encouraging and facilitating the fathers' presence at fetal assessments and tours of the special care nurseries.

Findings of this study suggest that nurses must be cognizant of the fact that just because a father is experienced does not mean he knows what to expect about childbirth. It is important that fathers' informational needs are assessed. Reviewing the father's past birth experiences may offer insights regarding areas to concentrate on. Since experienced fathers in this study used past successes to predict future outcomes, it is important that the uniqueness of each birth is stressed.

Given the fact that three quarters of first time fathers did not attend prenatal classes, nurses need to explore creative means to provide information as these fathers may not be available when their partners receive prenatal instructions. Findings of this study suggest that if videos are used, they need to be pertinent to the situation and that time is allowed for the couple to discuss any questions that might have arisen from seeing the videos.

Since fathers in this study were often instrumental in ensuring that the medical regime was adhered to, nurses need to ensure that fathers are informed about their partners' medical conditions. Fathers who seem misinformed or have unrealistic expectations regarding fetal outcomes or therapies such as steroids, might benefit from

having a neonatologist or clinical nurse specialist visit them to present a more realistic "picture".

Fathers were reluctant to share concerns with their partners. Some fathers were more concerned about the health and safety of their partners than that of their babies because of differences in emotional investment. A reluctance to talk about such issues could result in difficulties in relationships if women interpret this as a lack of concern for their babies. Fostering open communications between partners may sensitize them to the unique stressors and challenges that each is encountering and help reestablish a sense of support for each other. Open communication may assist partners to appreciate differences between them.

Based on the findings of this study and others, childbirth educators need to continue to de-emphasize the coach role and present alternative roles in a non biased manner. It should be emphasized that all roles have the potential to provide support. Chapman (1991) suggested that the labor roles adopted by fathers are an extension of a couple's methods of relating. It has been suggested that health care providers and childbirth educators should support that dyadic relationship by encouraging fathers to adopt a role that is a natural part of the couple's patterns of interacting, rather than a new and artificially induced role (Chapman, 1992). Fathers may need assistance to determine an appropriate role. The importance of selecting an appropriate role was emphasized by Chapman (1991) who found that fathers who redefined their role in labor either disengaged from the experience and remained disengaged or continued to search for their place.

Findings of this study suggest that experienced fathers who adopted an active role in a previous "normal" pregnancy may expect to enact a less active role when complications ensue. Since the diagnosis of complications is usually unpredictable, information regarding role modifications should be a component of "regular" prenatal classes. Even if fathers do not encounter complications, an experienced or inexperienced

father who expected to adopt an active role may feel less pressured to maintain that role if he has been given "permission" to adopt alternative roles. Two couples in this study planned to have labor supports. It is important that all couples are aware of these supports so they can exercise some options about childbirth.

Nurses need to prepare fathers for the "work of labor" to avoid setting them up for failed expectations. They need to know that they may feel helpless when they see their partners in pain. Nurses can empower them with strategies. One strategy is to include discussion groups during prenatal classes so experienced fathers can share with first time fathers. Several authors suggested that men lack role models to emulate as attendance at birth is a relatively new phenomenon (Barclay et al., 1996; May, 1980; Shapiro, 1987; Taylor, 1992).

Given the finding that fathers in this study expected to enact different labor roles, nurses need to assess how involved fathers plan to be so they may facilitate those expectations where possible. Chapman (1991) found that fathers who had health care providers (nurses, midwives, and physicians), who through their activities supported the labor role the father had adopted, were more likely to maintain that role and not have to struggle to find their place during labor.

Fathers had expectations of nurses. It is important that nurses ascertain what those expectations are. This may provide an opportunity to clarify or correct any misunderstandings regarding the roles of labor and delivery nurses and may be a relief for the father who thought he was on his own. Also, clarification of these expectations could facilitate congruence of expectations and promote a more satisfactory experience for the nurse and couple (Taylor, 1992).

The promotion of "realistic" expectations is challenging. In this study, expectations for the perfect birth, perfect baby, and belief that we have the technology to conquer all, coupled with the reluctance of fathers to share expectations with their partners, are concerning because fathers may be setting themselves up for failure by

ascribing to unrealistic expectations. Fathers need to be encouraged to appreciate the limits of technology and to explore a range of circumstances and possibilities. However, nurses must recognize their limitations and realize that some will continue to pursue unrealistic expectations despite their efforts. Expecting perfection through state of the art technological advances goes beyond the scope of individual nurse client interactions and would require us to "invert our core value system" (Davis-Floyd, 1990, p. 187). Sandelowski (1984) suggested that even proponents of alternative methods are at risk for unrealistic expectations when they expect to attain "psychological perfection" through natural means.

Fathers in this study were reluctant to share expectations with their partners. According to Chapman (1991), fathers are more likely to maintain a specific labor role if role expectations between couples are congruent. This emphasizes the need for couples to know what each expects of the other so a resolution of discrepant expectations can be pursued. Taylor (1992) and Chapman (1991, 1992) suggested that discussion of mutual expectations could facilitate congruence of expectations, which in turn could result in a more satisfying birth experience. Fathers and mothers are at risk for the guilt, anger, and disappointment that can result when labor and birth "script" do not match reality (Broome & Koehler, 1986). Nurses could set the stage. Perhaps if women were made aware of the experience of labor from the father's perspective and how he feels under the weight of the expectations placed upon him (Beaton & Gupton, 1990), communication between partners would be facilitated.

Nurses could provide a forum for exploring the expectations that couples have for themselves and each other. Open dialogue about expectations sensitized couples in Chapman's (1992) study to the other's potential needs during labor and birth and increased their abilities to interpret each other's responses during labor. Such sharing could be facilitated during prenatal classes. Since not all couples in the current study

attended prenatal classes, a concerted effort needs to be made to reach expectant couples in other settings such as during doctor's visits, hospitalization, and home visits.

Fathers wanted to "be there" to support their partners. Nurses need to facilitate this by supporting fathers in their efforts. During labor, the nurse can "set the father up for success" by monitoring his physical and emotional well being, role modeling various techniques, offering suggestions, and providing encouragement. Because most fathers were concerned about "being there through the pain", nurses should not assume that because a father is experienced he requires less monitoring and interventions than an inexperienced father might.

Fathers did not expect one to one care. They expected nurses to be nearby and periodically "checking in". This may have been their expectation because they assumed it was the norm. Given the realities of health care, this often is the norm. At times nurses assume that couples wish to be left alone during labor. These assumptions should be verified. The lack of one to one supportive care is perpetuated by consumer demands for a pain free labor. Generally, a woman who is "comfortable" with an epidural does not need the same intensive, supportive care as a woman who is using nonpharmacologic methods to manage her pain. Thus, the prevalence of epidurals means that nurses are often expected to care for more than one woman in labor.

It might be argued there would be less of a need or demand for epidurals if couples were assured that they would receive one to one supportive care in labor. For some fathers, the assurance that he would not be the primary support person would be a relief. This would have implications for continuing education workshops such as doula training and nonpharmacologic methods of pain relief. The resurgence of interest in natural childbirth, consumer demand for intense, supportive care, and research regarding the benefits of one to one supportive care in labor, are positive steps towards achieving that goal.

Finally, there is a need to acknowledge fathers as individual clients, rather than just support persons for their partners. According to Jordon (1990a), the nurse's advocacy needs to be broadened to include both parents, considering each as an individual client as well as an interdependent couple, with efforts to not compromise either parent for the sake of the other.

In summary, several recommendations for nursing arise from this study. These recommendations can be used to: sensitize nurses to the unique needs of fathers; improve the quality of care for expectant fathers; and promote realistic expectations so that potential negative effects of unmet expectations may be avoided.

Recommendations for Future Research

Previous research regarding complicated pregnancies and birth has concentrated on women's perspectives. However, to gain a "holistic perspective on the high risk childbirth experience" (MacMullen, Dulski, & Pappalardo, 1992, p. 24), fathers need to be studied. This study represents a beginning understanding of the father's perspective and an attempt to fill that gap.

The next logical step that needs to be undertaken in a program of research regarding fathers is the development and testing of a research instrument to measure childbirth expectations in men. Though such an instrument exists for women (CEQ), Boyd (1985) cautioned researchers against using the same tool with fathers in that it had been developed to study mothers. This tool could prove to be invaluable in determining who is at risk for "failed expectations". It would also facilitate comparisons of expectations between complicated and uncomplicated pregnancies and allow comparisons between partners.

This study was based on a small, relatively homogeneous sample of married, white, and well educated fathers. Racial background included one oriental, aboriginal, and Filipino. Three were single, common law, or divorced. Three quarters of first time

fathers did not attend prenatal classes. Five types of complications were represented. Two fathers had previous experience with preterm labor; no spouses had prenatal complications related to chronic medical conditions. These limitations could be addressed through research that includes more divergent populations and situations. The experience may be different for fathers with less education and different racial backgrounds. Future research could include a larger percentage of first time fathers who had attended prenatal classes. A more representative sample of diagnoses and the inclusion of fathers who have had past experiences with complications other than preterm labor might offer a different perspective. A father whose partner's complication is related to a chronic medical condition such as Type I diabetes may have an experience different from one who is dealing with a condition such as gestational diabetes.

Since pregnancy has been described as a developmental process in fathers, the third recommendation is the utilization of a longitudinal approach to deepen our understanding of their perspectives. Research is required to ascertain the developmental tasks of a "high-risk" pregnancy for fathers. Is uncertain fatherhood an element of that process? Other research questions that could be addressed using this approach are: Do expectations change when a pregnancy is labeled complicated, over time, or once the event, for example childbirth, has occurred?

A fourth recommendation for future research would be to explore labor roles. Is there a difference between fathers who are experiencing complicated pregnancies and those who are not regarding the labor roles they expect to adopt? Is there a link between previous labor roles and the roles fathers expect to adopt during complicated pregnancies? Is there a difference between fathers who attend prenatal classes and those who do not regarding the roles they expect to adopt? Do women have an effect on the roles men hope to adopt? In situations of complicated pregnancies, are fathers more likely to alter their labor roles during labor?

Research questions regarding expectations abound. Who is at greater risk of encountering unmet expectations? Are experienced fathers more likely to be biased by preexisting expectations, which may increase their odds of encountering unmet expectations or are they more likely to have realistic expectations because they've "been there"? Is there a tendency for first time fathers to view their expectations "loose ended" which may decrease the odds of unmet expectations because they may be more receptive to changing situations? What other factors affect how fathers adjust to "shattered dreams"? Is there a role for post birth debriefing in altering future expectations? All of these questions have implications for future research.

Draper (1997) was critical of the lack of a theoretical framework to study expectant fathers. The theory of uncertainty has been used to explain how expectant women process pregnancy-related events and to quantify uncertainty in "high risk" situations. According to Clauson (1996) the exploration of the uncertainty and stress experienced by fathers of hospitalized high-risk women is a potential area for future research. Based on the results of this study, future research should not be limited to hospital situations but include home settings as well. Fathers whose partners were diagnosed with placenta previa felt relieved once their partners were being cared for in hospital versus being cared for at home. The home setting may be even more anxiety provoking if there are a lack of supports such as home care.

A final recommendation is further research to address issues identified by fathers in this study. Fathers identified many prenatal stressors. The development and testing of nursing interventions designed to meet the needs of these fathers are warranted. Should our interventions be targeted at a specific group? In other words, is there a difference between experienced and inexperienced fathers regarding the amount of stress and anxiety they feel when confronted with a diagnosis of complications? Fathers placed a lot of trust in technology. Is this theme unique to men or an element of women's experiences as well?

In summary, this study represents a beginning understanding of the father's perspective in the context of a complicated pregnancy. Several recommendations for future research have been proposed.

Conclusion

The purpose of this study was to provide an in-depth description of fathers' expectations for childbirth in complicated pregnancies. An ethnographic approach was selected. The theory of uncertainty provided an appropriate conceptual framework for this study. A purposeful sample of 20 fathers was recruited from the antepartum unit of a tertiary care hospital and a community based program for women with pregnancy complications. Data were collected using semistructured interviews and analyzed by content analysis.

The contextual meaning of childbirth was exemplified by five themes: preparing for complications, being there antepartum, prolonging the pregnancy, trusting in technology, and being there during childbirth. The prenatal period was stressful for many fathers. In some situations, this stress was exacerbated by a sense of isolation. The stories of expectant fathers suggest that health care providers should become sensitive to the unique needs and concerns of these fathers. A diagnosis of prenatal complications required that fathers adjust their expectations. Some encountered difficulty "letting go" of past expectations while others had few expectations. Several fathers held high expectations of technology. It is important that health care providers assist fathers formulate realistic childbirth expectations so that potential negative effects of unmet expectations, such as dissatisfaction with childbirth and their partner, may be avoided. A philosophy of family centered care should include attention to the concerns of the "forgotten parent".

REFERENCES

Affleck, G. & Tennen, H. (1991). The effect of newborn intensive care on parents' psychological well-being. Children's Health Care, 20, 6-14.

Appleton, J. V. (1995). Analysing qualitative interview data: Addressing issues of validity and reliability. Journal of Advanced Nursing, 22, 993-997.

Ashcroft, T. (1995). Antecedents of uncertainty in women experiencing complications of pregnancy. Unpublished master's thesis, University of Manitoba.

Barclay, L., Donovan, J., & Genovese, A. (1996). Men's experiences during their partners' first pregnancy: A grounded theory analysis. Australian Journal of Advanced Nursing, 13 (3), 12-24.

Beal, J. (1994). Critique of paternal perspectives of the childbirth experience. Nursing Scan in Research, 7 (2), 17-18.

Beaton, J., & Gupton, A. (1990). Childbirth expectations: A qualitative analysis. Midwifery, 6, 133-139.

Beatty, J., Gutkowski, M. V., Moleti, C. A., & Yeransian-Nassery, L. (1985). Anger generated by unmet expectations. Maternal-Child Nursing Journal, 10, 324-326.

Berry, L. M. (1988). Realistic expectations of the labor coach. JOGNN, 17, 354-355.

Boyd, S. (1985). Study of the father: Research methods. American Behavioral Scientist, 29, 112-128.

Bramadat, I. (1990). Relationships among maternal expectations for childbirth, maternal perception of the birth experience, and maternal satisfaction with childbirth in women undergoing induction, augmentation and spontaneous labor. Unpublished doctoral dissertation, University of Texas at Austin.

Broome, M., & Koehler, C. (1986). Childbirth education: A review of the effects on the woman and her family. Family & Community Health, 9(1), 33-44.

Burns, N., & Grove, S. (1987). The practice of nursing research. Toronto: Saunders.

Burns, N., & Grove, S. (1993). The practice of nursing research (2nd ed.). Montreal: Saunders.

Chandler, S. & Field, P. (1997). Becoming a father: First-time fathers' experience of labor and delivery. Journal of Nurse-Midwifery, 42 (1), 17-24.

Chapman, L. L. (1991). Searching: Expectant fathers' experiences during labor and birth. JOGNN, 4, 21-29.

Chapman, L. L. (1992). Expectant fathers' roles during labor and birth. JOGNN, 21, 114-120.

Clauson, M. ((1996). Uncertainty and stress in women hospitalized with high-risk pregnancy. Clinical Nursing Research, 5, 309-325.

Corbin, J. (1987). Women's perceptions and management of a pregnancy complicated by chronic illness. Health Care for Women International, 8, 317-337.

Coster-Schulz, M. & Mackey, M., (1998). The preterm labor experience: A balancing act. Clinical Nursing Research, 7, 335-362.

Davis-Floyd, R. (1990). The role of obstetrical rituals in the resolution of cultural anomaly. Social Science and Medicine, 38, 175-189.

Diemer, G. (1997). Expectant fathers: Influence of perinatal education on stress, coping, and spousal relations. Research in Nursing & 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.

Draper, J. (1997). Whose welfare in the labour room? A discussion of the increasing trend of fathers' birth attendance. Midwifery, 13, 132-138.

Elliott, J. (1998). Just another way to give birth? Pre & Post Natal News, 6 (4), 2.

Enkin, M., Keirse, M, Renfrew, M., & Neilson, J. (1995). A guide to effective care in pregnancy & childbirth. Oxford: Oxford University Press.

Fetterman, D. (1989). Ethnography step by step. Newbury Park: Sage.

Ford, M. & Hodnett, E. (1990). Predictors of adaptation in women hospitalized during pregnancy. The Canadian Journal of Nursing Research, 22 (4), 37-50.

Gabel, H. (1982). Childbirth experiences of unprepared fathers. Journal of Nurse-Midwifery, 27(2), 5-8.

Germain, C. (1993). Ethnography: The method. In P. L. Munhall & C. O. Boyd (Eds.), Nursing research a qualitative perspective (2nd ed.) (pp. 237-268). New York: National League for Nursing Press.

Glazer, G. (1989). Anxiety and stressors of expectant fathers. Western Journal of Nursing Research, 11(1), 47-59.

Griffin, T., Kavanaugh, K., Fraga Soto, C., & White, M. (1997). Parental evaluation of a tour of the neonatal intensive care unit during a high-risk pregnancy. JOGNN, 26, 59-65.

Guba, E., & Lincoln, Y. (1989). Judging the quality of fourth generation evaluation. In A. Egon, E. Guba, & Y. Lincoln (Eds.), Fourth Generation Evaluation (pp. 228-251). Newbury Park: Sage.

Gupton, A., Beaton, J., Sloan, J., & Bramadat, I. (1991). The development of a scale to measure childbirth expectations. The Canadian Journal of Nursing Research, 23(2), 35-47.

Gupton, A., Heaman, M., & Ashcroft, T. (1997). Bed rest from the perspective of the high-risk pregnant woman. JOGNN, 26, 423-430.

Hanson, E. (1994). Issues concerning the familiarity of researchers with the research setting. Journal of Advanced Nursing, 20, 940-942.

Heaman, M. (1998). Psychosocial Impact of High Risk Pregnancy. Clinical Obstetrics and Gynecology, 41, 626-639.

Heaman, M., Beaton, J., Gupton, A., & Sloan, J. (1992). A comparison of childbirth expectations in high-risk and low-risk pregnant women. Clinical Nursing Research, 1, 252-265.

Hilton, B. A. (1994). The Uncertainty Stress Scale: Its development and psychometric properties. Canadian Journal of Nursing Research, 26 (3), 15-29.

Hodnett, E. (1995). Support from caregivers during childbirth. [Computer software]. In M. Keirse, M. Renfrew, J. Neilson, & C. Crowther (Eds.), Cochrane database of systematic reviews (Disk Issue 2). London: BMJ Publishing Group.

Hott, J. (1976). The crisis of expectant fatherhood. The American Journal of Nursing, 76, 1436-1440.

Jordon, P. L. (1990a). First-time expectant fatherhood: Nursing care considerations. NAACOG'S Clinical Issues in Perinatal and Women's Health Nursing, 1, 311-316.

Jordon, P. L. (1990b). Laboring for relevance: Expectant and new fatherhood. Nursing Research, 39(1), 11-15.

Kemp, V. H., & Page, C. K. (1986). The psychosocial impact of a high-risk pregnancy on the family. JOGNN, 15, 232-236.

Kleinman, A. (1992). Local worlds of suffering: An interpersonal focus for ethnographies of illness experience. Qualitative Health Research, 2, 127-134.

Lemner, Sister C. (1987). Becoming a father: A review of nursing research on expectant fatherhood. Maternal-Child Nursing Journal, 16, 261-275.

Leonard, L. (1977). The father's side: A different perspective on childbirth. The Canadian Nurse, 73(2), 16-20.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills: Sage.

Lucy, S. (1994). Obstetrical anesthesia statistics. Winnipeg: St. Boniface General Hospital, Department of Obstetrical Anesthesia

MacLaughlin, S. (1980). First-time fathers' childbirth experience. Journal of Nurse-Midwifery, 25(3), 17-21.

MacLaughlin, S., & Taubenheim, A. M. (1983). A comparison of prepared and unprepared first-time fathers' needs during the childbirth experience. Journal of Nurse-Midwifery, 28(2), 9-16.

MacMullen, N., Dulski, L., & Pappalardo, B. (1992). Antepartum vulnerability: Stress coping, and a patient support group. Journal of Perinatal Neonatal Nursing, 6 (3), 15-25.

Maloni, J. (1994). Home care of the high-risk pregnant woman requiring bed rest. JOGNN, 23, 696-706.

Maloni, J. & Ponder, B. (1997). Fathers' experience of their partners antepartum bedrest. Journal of Nursing Scholarship, 29, 183-188.

May, K. (1980). A typology of detachment/involvement styles adopted during pregnancy by first-time expectant fathers. Western Journal of Nursing Research, 2, 444-453.

May, K. (1982). Three phases of father involvement. Nursing Research, 31, 337-342.

May, K. (1994). Impact of maternal activity restriction for preterm labor on the expectant father. JOGNN, 23, 246-251.

McCain, G. & Deatrick, J. (1994). The experience of high-risk pregnancy. JOGNN, 23, 421-426.

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

Mishel, M. H. (1981). The measurement of uncertainty in illness. Nursing Research, 30, 258-263.

Mishel, M. H. (1983). Parents perception of uncertainty concerning their hospitalized child. Nursing Research, 32, 324-330.

Mishel, M. H. (1984). Perceived uncertainty and stress in illness. Research in Nursing & Health, 7, 163-171.

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

Mishel, M. H. (1990). Reconceptualization of the uncertainty in illness theory. Image: Journal of Nursing Scholarship, 22, 256-262.

Mishel, M. H., & Braden, C. J. (1988). Finding meaning: Antecedents of uncertainty in illness. Nursing Research, 37, 98-127.

Monahan, P. & DeJoseph, J. (1991). The woman with preterm labor at home: A descriptive analysis. Journal of Perinatal Neonatal Nursing, 4 (4), 12-20.

Morse, J. (1991). Strategies for sampling. In J. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 127-145). London: Sage.

Morse, J., & Field, P. (1995). Qualitative research methods for health professionals. London: Sage.

Nichols, M. (1993). Paternal perspectives of the childbirth experience. Maternal child Nursing Journal, 21, 99-108.

Pearlin, L. (1989). The sociological study of stress. Journal of Health and Social Behavior, 30, 241-256.

Polit, D. F., & Hungler, B. P. (1991). Nursing research: Principles and methods (4th ed.). Philadelphia: Lippincott.

Polit, D. F., & Hungler, B. P. (1997). Essentials of nursing research: Methods, appraisal, and utilization (4th ed.). Philadelphia: Lippincott.

Sandelowski, M. (1984). Expectations for the childbirth versus actual experiences: The gap widens. Maternal-Child Nursing Journal, 9, 237-239.

Sandelowski, M. (1986). The problems of rigor in qualitative research. Advances in Nursing Science, 8, 27-37.

Sandelowski, M. (1993a). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science, 16(2), 1-8

Sandelowski, M. (1993b). Toward a theory of technology dependency. Nursing Outlook, 41, 36-42.

Sandelowski, M. (1994). The use of quotes in qualitative research. Research in Nursing & Health, 17, 479-482.

Sather, S.& Zwelling, E. (1998). A view from the other side of the bed. JOGNN, 27, 322-337.

Schroeder, C. (1996). Women's experience of bedrest in high-risk pregnancy. Image: Journal of Nursing Scholarship, 28, 253-258.

Shannon-Babitz, M. (1979). Addressing the needs of fathers during labor and delivery. The American Journal of Maternal-Child Nursing, 4, 378-382.

Shapiro, J. (1987). The expectant father. Psychology Today, 36(1), 36-42.

Sorenson, D. (1990). Uncertainty in pregnancy. In M. McCormick (Ed.), NAACOG'S Clinical Issues in Perinatal and Women's Health Nursing (pp. 289-296). Philadelphia: Lippincott.

Stainton, C. (1992). Mismatched caring in high-risk perinatal situations. Clinical Nursing Research, 1, 35-49.

Starn, J. (1993). Strengthening family systems. AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4(1), 35-43.

Snyder, D. (1988). Peer group support for high-risk mothers. MCN, 13, 114-117.

Taubenheim, A. & Silbernagel, T. (1988). Meeting the needs of expectant fathers. Maternal Child Nursing 13, 110-113.

Taylor, K. M. (1992). Childbirth expectations: The father's perspective. Unpublished master's thesis, University of Manitoba.

Thorne, S. (1991). Methodological orthodoxy in qualitative nursing research: Analysis of the issues. Qualitative Health Research, 1, 178-199.

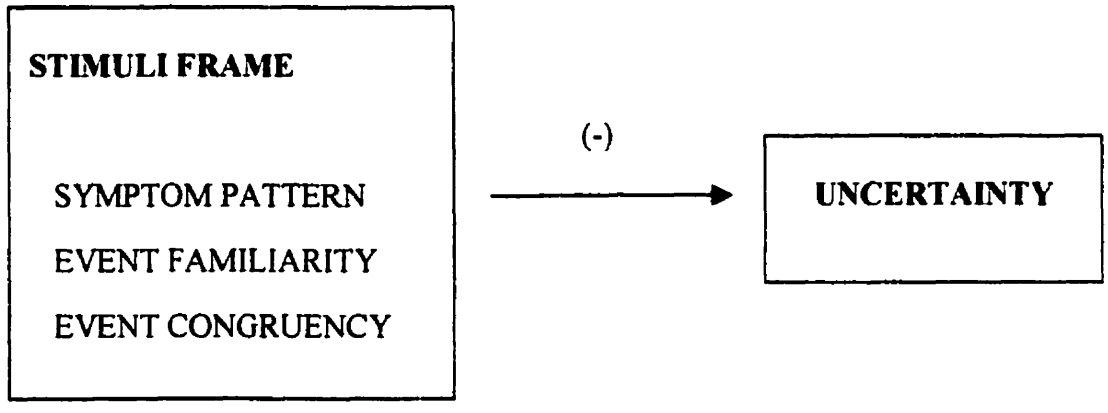
White, M. (1998). Men's concerns during pregnancy, part 1: Reevaluating the role of the expectant father. International Journal of Childbirth Education, 13 (2), 14-25.

Wilson, H. (1985). Introducing research in nursing. Menlo Park: Addison-Wesley.

Yonge, O., & Stewin, L. (1988). Reliability validity: Misnomers for qualitative research. Canadian Journal of Nursing Research, 20, 61-67.

APPENDIX A

Portion of the model of perceived uncertainty in illness (Mishel, 1988, p. 226)



APPENDIX B

Study ID # ___

Demographic Data

1. Age: _____

2. Education: Circle the last year of education completed:

   Grade School through High school

   1 2 3 4 5 6 7 8 9 10 11 12 13

   Vocational or Community college University

   1 2 3 4 1 2 3 4 5 6 7 8 9

3. What type of work do you do? _____

   _____

   Full time _____ Part time _____

   Unemployed at present _____

4. Mark the response that most accurately reflects your **total family income** for last year before taxes:

   ___ below $10, 000

   ___ $10,000 to 19,999

   ___ $20,000 to 29,999

   ___ $30,000 to 39,000

   ___ $40,000 to 49,999

   ___ $50,000 to 59,999

   ___ $60,000 to 69,999

   ___ $70,000 to 79,999

   ___ $80,000 to 89,999

   ___ $90,000 to 99,999

   ___ above $100,000

5. Racial Background:

   _____ White

   _____ Black

   _____ Aboriginal / Metis

   _____ Oriental

   _____ Other _____

6. What is your marital status?

   _____ Single

   _____ Married

   _____ Common Law

   _____ Separated

   _____ Divorced

   _____ Widowed

7. At the present time, is your partner in the hospital or on the antenatal home care program? _____

8. What is the reason that your partner is on the antenatal home care program or in the hospital? _____

   _____

9. How many days has your partner been in the hospital since she was diagnosed as having a complicated pregnancy? _____

10. How many days (if any) has your partner been on the home care program? _____

11. How many weeks pregnant is your partner? _____

12. Was this a planned pregnancy? _____ yes, _____ no.

13. Have you ever attended childbirth education classes? _____

    If yes, was that this pregnancy? _____

    In previous pregnancies? _____

    How many classes did you attend? _____

APPENDIX C

Script for Contact with Potential Hospital Subjects when the Researcher will have In-Person Contact with Potential Subjects

A nursing study is being conducted about fathers' expectations for childbirth when their partners are having complications of pregnancy. You are a potential participant. Would you like to hear more about the study?

If potential subject says yes

I'll let the nurse researcher know and she will come and speak with you.

If potential subject says no

The father will be thanked.

APPENDIX D

Script for Contact with Potential Hospital Subjects when the Researcher will have Telephone Contact with Potential Subjects

A nursing study is being conducted about fathers' expectations for childbirth when their partners are having complications of pregnancy. You are a potential participant. Would you like to hear more about the study?

If potential subject says yes

I'll let the researcher know and she will contact you by phone. If you will give me the number you wish to be contacted at I will give that number to the research nurse.

If potential subject says no

The father will be thanked.

APPENDIX E

Script for Contact with Community Clients

A nursing study is being conducted about fathers' expectations for childbirth when their partners' are having complications of pregnancy. Your partner is a potential participant.

If potential subject (father) is present

Would you like to hear more about the study?

If potential subject (father) says yes

I'll let the nurse researcher know and she will contact you by phone (or mail if that is subject's preference). I need your wife/partner to sign this form before I can release the phone number (or address) you wish to be contacted at.

If potential subject says no

The father will be thanked

If potential subject (father) not present

May I leave an " Invitation to Participate" for your husband/partner to read?

If the woman says yes

I'll check with you at the next visit to see if your husband/partner is interested. If your husband/partner is interested you (woman) will be asked to sign this form before I can release the phone number (or address) your husband/partner wishes to be contacted at.

If the woman says no

The woman will be thanked

APPENDIX F

Release Form for Community Clients

I, _____ , give permission for the nurse to release to Diane Bourrier (nurse researcher) the phone number (or address if that is subject's preference) my husband/partner can be contacted at.

Signature:_____

Witness:_____

Date:_____

APPENDIX G

Invitation to Participate

You are invited to participate in a research project about fathers' expectations for childbirth when their partners experience complications of pregnancy. This research is being conducted by Diane Bourrier RN, a graduate student from the Faculty of Nursing at the University of Manitoba. Participation in the project is entirely voluntary. Refusal to participate will not influence the care your partner receives. Fathers who have partners with complicated pregnancies at St. Boniface General Hospital or in a community based program will be invited to participate.

The interview will be done at a time and location that is mutually agreeable. The interview involves questions about what you expect labor and delivery to be like and what it means to have your partner diagnosed as having a complicated pregnancy. You will be asked to fill out a brief form asking for background information about you and your partner's pregnancy. You may refuse to answer specific questions; you may withdraw from the study at any point.

The interview will be audiotaped, last about 1 to 1 1/2 hours, and may be conducted over two sessions if mutually agreed. All of the information will be kept confidential. Only the researcher will have access to your name. You and your partner's name will not be associated with the interview. Only the researcher, her thesis committee, and the typist will have access to the interviews. All data will be stored in a locked container for seven to ten years and then destroyed.

Any specific details which might identify you or your partner will not be included in the results of the study. A summary of the results will be provided to those requesting it. Although you will receive no direct benefit from being in the study, it may be helpful for you to talk to another person about childbirth at this time in the pregnancy. Any questions or concerns may be directed to Diane Bourrier at 233-0552 or her advisor, Dr. Annette Gupton at 474-6220. Thank you for your consideration.

APPENDIX H

Telephone Contact with Potential Community Participants

Hello, my name is Diane Bourrier. I am a graduate student in the Faculty of Nursing at the University of Manitoba. I received your phone number from one of the nurses in the community based program that deals with women who have complications of pregnancy. I am doing a study about fathers' expectations for childbirth when their partners' are having complications of pregnancy.

When the father has not received the "Invitation to Participate"

Would you like to hear more about the study? (If the answer is no, the father will be thanked and the contact ended. If the answer is yes, the study will be explained using the "Invitation to Participate".

"Do you have any questions? Are you interested in participating?" (If the answer is yes, an appointment will be made for the interview; if the answer is no, the father will be thanked and the contact ended).

When the father has received the "Invitation to Participate

Do you have any questions about the study? Are you interested in participating? (If answer is yes, an appointment will be made for the interview; if answer is no, the father will be thanked and contact ended.

APPENDIX I

Mail Contact with Potential Community Participants

Hello, my name is Diane Bourrier. I am a graduate student in the Faculty of Nursing at the University of Manitoba. I received your address from one of the nurses in the community based program that deals with women who have complications of pregnancy. I am doing a study about fathers' expectations for childbirth when their partners' are having complications of pregnancy. I have enclosed an "Invitation to Participate". If you are interested in hearing more about the study or wish to participate I can be contacted at 233-0552. I thank you for your consideration.

APPENDIX J

In-Person Contact with Potential Hospital Participants

"Hello, my name is Diane Bourrier. I am a graduate student in the Faculty of Nursing at the University of Manitoba. I am doing a study about fathers' expectations for childbirth when their partners' are having complications of pregnancy. Would you be willing to read this written explanation about the study?" (If the answer is yes, he will be given a copy of the "Invitation to Participate" and given time to read it; if the answer is no, the father will be thanked and contact ended).

"Do you have any questions? Are you interested in participating?" (If the answer is yes, an appointment will be made for the interview; if the answer is no, the father will be thanked and contact ended).

APPENDIX K

Telephone Contact with Potential Hospital Participants

"Hello, my name is Diane Bourrier. I am a graduate student in the Faculty of Nursing at the University of Manitoba. I received your phone number from one of the nurses on the antepartum unit. I am doing a study about fathers' expectations for childbirth when their partners' are having complications of pregnancy. Would you like to hear more about the study?" (If answer is no, the father will be thanked and contact ended. If the answer is yes, the study will be explained using the "Invitation to Participate").

"Do you have any questions? Are you interested in participating?" (If the answer is yes, an appointment will be made for the interview; if the answer is no, the father will be thanked and contact ended).

Appendix L

Consent Form

I voluntarily agree to participate in this study. Diane Bourrier has informed me that this is a study to determine fathers' expectations for childbirth when their partners have complicated pregnancies.
Diane Bourrier, a graduate student from the Faculty of Nursing at the University of Manitoba, is conducting this study. She may be contacted at 233-0552 during the course of this study. Her thesis chairperson, at the Faculty of Nursing University of Manitoba, is Dr. Annette Gupton who may be contacted at 474-6220.

I understand that to participate means that:

- I will be interviewed by Diane Bourrier.
- The interview may be conducted over two sessions, if mutually agreed. The interview(s) will take approximately 1-1 1/2 hours in total.
- The interview will be held at a time(s) and location(s) that is mutually agreeable, and they will be audiotaped and transcribed.
- I will also be required to complete a form asking for background information about myself and my partner's pregnancy.
- All of the information I provide will be kept confidential. My identity (and my partner's) and the information I provide will be kept anonymous. Only the researcher, her thesis committee, and the transcriber will have access to the interview(s).
- All data will be stored in a locked container for seven to ten years and then destroyed.
- I can inform the researcher that I do not wish to answer a question.
- I also understand that I am free to withdraw from the study at any time. My decision will not affect the care my partner receives.
- There is no danger of physical or psychological risks from participation in this study.
- I receive no benefit from being in the study, though it may be helpful for some men to talk to another person about childbirth at this time in the pregnancy.
- I will be provided with a copy of this signed consent.
- I will be provided with a summary of the results if I request them.

I understand that this study has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba and may be published.

Signature:_____
Researcher:_____
Date:_____

I would like to receive a summary of the research results:
No____ Yes____
If yes, please indicate your mailing address below:
Name:_____
Address:_____

APPENDIX M

Interview Schedule

1. As you know, I am interested in learning about your expectations for the childbirth experience. What does childbirth mean to you?

Probes:

a) What thoughts and feelings come to mind?

2. What previous experience have you had with childbirth? How does your previous experience (or lack of) make you feel about this upcoming event (childbirth)? (This is to assess event familiarity.)

3. _____ (wife/partner) has been diagnosed as having a complicated pregnancy. Can you tell me what that means to you?

Probes:

a) What were your thoughts, concerns, or feelings when you first learned that ____(wife/partner) was experiencing a complicated pregnancy?

b) What are your thoughts, concerns, or feelings at the present time?

c) Do you perceive your wife/partner as having a complicated pregnancy?

4. Some men have used the word "uncertainty" to describe childbirth. Would you say this is true in your situation? (This is to assess the concept of uncertainty.)

5. Can you describe _____(wife/partner) symptoms to me. (This is to assess symptom pattern.) How does _____ (wife/partner) symptoms (or lack of symptoms) make you feel?

6. What previous experience have you had with complicated pregnancies? How does this previous experience (or lack of) make you feel about _____ (wife/partner) pregnancy? (This is to assess event familiarity.)

7. When did you start to think about what the childbirth experience would be like for you?

8. Can you describe for me what you think the experience of childbirth will be like?

9. What role do you expect to play during: labor, delivery (or the cesarean birth), and immediately after the birth?

Probe:

a) What do you expect to be doing during: labor, delivery (or the cesarean birth), and immediately after the birth?

10. What do you expect from the doctors and nurses during labor, delivery (or the cesarean birth), and immediately after the birth?

Probes:

a) What will the doctors and nurses be doing during: labor, delivery (or the cesarean birth), and immediately after the birth?

11. How do you expect to feel emotionally during childbirth?

Probe:

a) Please describe these emotions during: labor, delivery (or the cesarean birth), and immediately after birth.

12. Have you discussed your expectations for childbirth with _____ (wife/partner)?

13. What are _____ (wife/partner) expectations for childbirth? How do her expectations compare to yours?

14. Do you think _____ (wife/partner) has certain expectations of you?

Probe:

a) What are these expectations? If father does express expectations go on to question #15

15. Can you describe for me how you think you might feel if you can not meet _____ (wife/partner) expectations.

16. Can you describe for me how you think you might feel if you can not meet your own expectations for childbirth.

17. Have you thought about how _____ (wife/partner) diagnosis of _____ (complication of pregnancy) might alter the use of interventions/medical technology in labor and birth (or during the cesarean birth)? How do you feel about that?

Probes:

a) Interventions for pain control, fetal monitoring

b) Interventions for delivery, for example delivery by cesarean

18. You have described for me what you think the childbirth experience will be like. Have any of these expectations changed since _____ (wife/partner) has been diagnosed as having a complicated pregnancy? How does that make you feel? (This is to assess event congruence.)

18. Is there anything else you can add about your expectations for childbirth that we have not discussed?

APPENDIX N

Portion of the model of perceived uncertainty in illness (Mishel, 1988, p. 226) exemplified by data and sub-themes.