Moratorial fathering: enduring sustained uncertainty in the transition to premature fatherhood

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Abstract

In comparison to the extensive focus of research on the maternal experiences of premature birth, empirical evidence exploring the experience of premature fatherhood is limited. Unless healthcare professionals understand the process of transition to premature fatherhood, they may not be able to effectively support fathers during the admission of their baby to a Neonatal Intensive Care Unit (NICU) and following discharge home, and the provision of high quality family-centred care may be compromised.

The aim of this study was to generate an explanatory theory that provides an interpretative understanding of how fathers experience becoming a parent of a preterm infant. The social and psychological processes involved in becoming a preterm father were examined using Constructivist Grounded Theory. The study recruited seven fathers following the admission of their preterm infant to a NICU in the South-East of England over 18 months. Data generation involved: eight hours of intensive interviews with seven fathers following admission to the NICU through a process of purposive and theoretical sampling; and five hours of intensive interviews with three of the seven fathers following discharge home. Data generation and analysis were undertaken concurrently by initially coding using “gerunds”, followed by focused coding. Memo writing during the constant comparative method enabled the conceptualisation of premature fatherhood and the construction of a substantive grounded theory.

The findings suggest that fathers of preterm infants are enduring sustained uncertainty. The study offers a substantive theory grounded in the data that is located in, and further expounds, formal theories of uncertainty. It provides new insights into the social process of transition to premature fatherhood, which requires preterm fathers to manage the sustained uncertainty of premature birth by eliciting strategies that enable them to endure this unfamiliar, ‘novel’ and stressful situation.

Keywords: Fatherhood, Neonatal Intensive Care, Moratorial Fathering, Negotiating Boundaries, Surveyancing, Constructivist Grounded Theory

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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed: _____

Dated: _____

Chapter One Introduction

This study explored the transition to parenthood for fathers of a preterm infant in the Neonatal Intensive Care Unit (NICU) and their on-going experience following discharge home. The contextual factors that inform this social process are considered and a theoretical model for neonatal clinical practice and education in understanding the needs of preterm fathers during this time is presented. The choice of research topic stemmed from personal and professional observations and experiences in a number of roles: as a mother of preterm twins; over twenty years' experience as a neonatal nurse; and over fifteen years' experience as an academic in higher education. During this time it has become increasingly evident to me that preterm fathers continue to be mainly overlooked both in clinical practice and in the research literature.

The majority of literature on parent's experiences of having a preterm infant on a neonatal unit focuses on parental experiences collectively and the mother. The lack of research involving fathers of preterm infants has been highlighted by professional and service user organisations over the last decade. In 2013 the Council of International Neonatal Nurses (COINN) set up a specialist forum of healthcare professionals interested in providing evidence based support for fathers following the premature birth of their infant. The paucity of research in the parenting literature involving fathers of preterm infants indicates that healthcare professionals may be unaware of the specific needs of these service users during a stressful and traumatic time in their lives. Each family member's unique contribution should be acknowledged and supported and 'when nurses are unable to be attuned to the emotional needs of fathers, those needs may go unmet – which can potentially be harmful' (Pohlman 2009:E11). This chapter introduces the research setting for the study and the context of neonatal care which frames men's experiences of premature fatherhood.

1.1.The research setting: neonatal care services

Neonatal care is highly technical and has developed rapidly over the past thirty years, resulting in improved outcomes for sick and very premature babies[1] (Department of Health (DH) 2009). Approximately 95,000 babies born each year will receive some kind of neonatal care (National Health Service (NHS) England 2015). During the last ten years there has been a sixteen per cent increase in the number of live births (Centre for Maternal and Child Enquiries (CMACE) 2011), with one in nine of these infants requiring neonatal care due to prematurity, low birth weight or a medical condition requiring specialist treatment (Royal College of Paediatrics and Child Health (RCPCH) 2017:7). This increased need for specialist neonatal care in England has resulted in the development and implementation of quality measures for ensuring the provision of high quality care to babies and their families (Burger, King and Tallett 2015). Since 2013 neonatal services have been 'delivered within 11 operational delivery networks (ODN) to ensure that the baby receives the right care in the right place at the right time' (NHS Improvement 2017:11). Neonatal care incorporates a pathway of care including: intensive care; high dependency care; special care; transitional care; outreach care; and transport. The three types of neonatal unit are defined by the level of care they deliver: neonatal intensive care units (NICU) provides the range of medical care for babies more than 22+6 weeks gestation with some units additionally co-located with neonatal surgery and other specialised services; local neonatal units (LNU) can provide care for babies more than 26+6 weeks gestation; and special care units (SCU) provide care for babies more than 30 - 31+6 weeks gestation (DH 2009).

The delivery of neonatal care services in England is costly and labour intensive, with research by BLISS (2015a) highlighting a significant shortfall in government funding for neonatal care and a shortfall of 2,140 neonatal nurses. The report suggests that 70% of NICU's experienced occupancy levels higher than the recommended 80% and nearly a third of units offered no psychological support to families. Comparable findings are reflected in the research undertaken in Wales (BLISS 2016) and Scotland (BLISS 2017). The considerations of having an overstretched and under-

[1] A full-term pregnancy is defined as the completion of 40 weeks and a term infant more than 37 weeks gestation. Admission to a NICU is often due to prematurity. A preterm infant, defined as an infant born below 37 weeks gestational age, will require admission periods of several days, weeks or even months.

resourced neonatal workforce are particularly pertinent as there are 'increasing numbers of pregnant women with conditions who require a more complex package of care and interventions' (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) 2017:vii).

The research setting for the study is a NICU in the South-East of England providing a range of medical and surgical care for babies more than 22+6 weeks gestation and is subject to the same national funding and workforce constraints as outlined above. Therefore, cognisance of the national landscape for neonatal care services provides the context in which fathers in the study experience the transition to premature fatherhood.

1.2. Parental experience of neonatal care services

The last ten to fifteen years have seen an increased focus on parents' needs from government policies such as the publication of the Toolkit for High Quality Neonatal Services (DH 2009) and the Specialist Neonatal Care Quality Standard (National Institute for Health and Care Excellence (NICE) 2010) and research commissioned by professional and service user organisations such as the UK's main preterm baby charity BLISS (BLISS 2015b). The first English survey of parents' experiences of neonatal care received feedback from 9000 parents (Picker Institute Europe 2011) related to four key themes integral to family-centred care: information; communication; support; and involvement. Nearly half of parents said that they did not receive enough information following admission to neonatal care. Parents were largely positive about the neonatal staff and their communication with them, although a third of 'parents reported fewer positive experiences related to receiving conflicting information or not receiving enough written information' (Picker Institute Europe 2011:2). Parents were largely positive about their involvement in their baby's care and felt prepared for discharge home. However, 'parents were least positive about the care and support they received once their baby had been discharged home, with nearly half not receiving enough information and guidance about the long-term development of their baby' (Picker Institute Europe 2011:3).

A subsequent survey of parents' experiences of neonatal care in England included responses from 6000 parents (85% mother, 12% both parents and 2% father) (Picker Institute Europe 2015). Parents reported positive experiences related to:

visiting their baby and being involved in their baby's care; having confidence and trust in the staff caring for their baby; being helped by staff to feel confident in caring for their baby; and feeling prepared for discharge home. Parents reported least positive experiences in: 'not being offered emotional support or counselling services; not being given enough written information about their baby's condition and treatment and parent support groups; and not being given information about help with expenses related to their baby's stay in the neonatal unit' (Picker Institute Europe 2015:4). Although the results from both surveys are comparable and highlight continued areas for improvement, there has been an increase in the number of parents (47% to 62%) suggesting that they had received enough information about the long-term development of their baby following discharge home.

The participation of fathers in these surveys appears to be less than that of mothers and suggests that the results need to be interpreted in light of the dominance of the maternal perspective. This challenges the representativeness of *parental* experiences and whether differences between mother's and father's experiences of neonatal care are known.

1.3. Supporting preterm parents during the NICU admission

Premature birth is considered to be a stressful event, with the effect of the physical characteristics of the preterm infant (birth weight, gestational age and clinical condition) and the subsequent need for a longer period of hospitalisation, linked to higher stress levels and negative emotions in parents (Ionio et al 2016). These factors have been considered to affect the quality of parent-infant interactions, increasing the risk of negative consequences of premature birth on both the infant and parents. It is recognised that premature birth is a major life event with parents experiencing distress and disruption during the transition to parenthood (Franck et al 2005; Reid et al 2007; Turan et al 2008).

There have been a number of models and programmes that have been developed to encourage greater parental involvement in their preterm infant's care (Gooding et al 2011, Amy, D'Agata and McGrath 2016) and to support parents during this stressful experience. Interventions for parental support include: family-centred care (Lee et al 2014, Voos et al 2015); developmental care (Altimier and Phillips 2016);

skin to skin/kangaroo care (Ludington-Hoe 2013) and the Creating Opportunities for Parent Empowerment (COPE) programme (Melynk et al 2006). The Prem Baby Triple P programme includes positive parenting; responding to baby; survival skills; and partner support and is suggested by parents as supporting the unique transition to premature parenthood (Whittingham et al 2014). The Family Integrated Care (FIC) model developed in Canada (O'Brien et al 2013) has been adopted by some units in the UK (Patel et al 2018). The model promotes parents providing most of their baby's care (being present on the unit at least 8 hours a day) with the neonatal staff acting in a supportive and teaching role. Overall, positive outcomes (such as improved weight gain, reduced length of hospital stay and reduced parental stress) are provided by those interventions that enhance greater involvement of parents in care giving activities, alongside education and information on parenting a preterm baby. Digital technologies such as webcam (Kerr et al 2017) have been introduced in a few UK units to provide parents with the opportunity to remotely observe their baby. Technologies such Skype and FaceTime have been used in other countries (Epstein et al 2015, Hutcheson and Cheeseman 2015). A mobile app has been developed in one London NICU to support Family Integrated Care (Banerjee et al 2018). Evaluation of the impact of digital technology, suggests that most parents considered the technology in a positive way.

However, the majority of these models and programmes, by their nature, are focused on the mother. For example, kangaroo care[2] is often referred to in the literature as kangaroo *mother* care. Family-centred and family-integrated care both incorporate an element of there being a family presence on the NICU, which in reality often means a mother's presence, as fathers are often limited and constrained by work commitments. The webcam technology in the UK is only available to the mother on the postnatal ward and fathers are therefore excluded from having unlimited access to this facility of staying in touch with their baby. The results from the study therefore aim to contribute to a developing evidence base for providing true family-centred care that acknowledges fathers' unique experiences (DH 2009, POPPY 2009).

[2] Also known as skin-to-skin care where the baby, wearing just a nappy, is placed on the parent's naked chest to promote bonding, attachment and physiological stability

1.4. Supporting preterm parents following discharge home

The premise of parental engagement and involvement during the NICU admission has been advocated by BLISS (2005) and the British Association of Perinatal Medicine (BAPM) (BAPM 2017). Increasingly the focus has turned to also exploring parental experience following discharge home (Adama, Bayes and Sundin 2016). Discharge planning from the NICU begins on admission and is an important process for ensuring parents feel confident in their abilities to care for their infant at home (Aloysius et al 2018). The discharge process promotes opportunities for parents to become increasingly independent from healthcare professionals in providing for their infant's needs (Deierl et al 2018). Parents on the day of discharge have mixed emotions at leaving the 'safety' of the NICU (Murch and Smith 2016) feeling unprepared and anxious at no longer having the constant reassurance of monitoring equipment and availability of healthcare staff for advice (Aydon et al 2018). They are, however, also excited at the prospect of being in control and developing a family routine at home. Implementing a discharge planning tool can enhance parent's feelings of being prepared (Ingram et al 2016) and should incorporate timely and clear communication and information sharing strategies between parents and NICU professionals. The availability of ongoing information and community resources is also highlighted as integral to reducing parental anxiety (Ingram et al 2016).

The literature on parental experience following discharge has highlighted the on-going needs of preterm parents. Although both parents were included in the British, Australian and American studies presented above, the presentation of the findings suggests a dominance of the maternal perspective. Two of the studies have acknowledged this as a limitation. Aydon et al (2018)[3] suggested there was a difference in how mothers and fathers gathered information with fathers more frequently gaining information 'second hand' from their partner and additionally acknowledged the importance of including fathers and addressing their specific and unique needs. Ingram et al (2016) identified that mothers in their study were more involved in data collection than fathers and advocate for recognising that fathers are important and should not be ignored. The evidence base for supporting parents

[3] Australian study interviewing 20 sets of parents (28 to 32 week gestation infants) pre and post discharge highlighted the importance of effective parent staff communication; parents feeling informed and involved; and parents being prepared to go home

during the preterm experience acknowledges that this support should extend beyond the NICU admission and include the transition to home. The study therefore interviewed fathers both during the NICU admission and following discharge home.

Summary

This chapter outlined the context of neonatal care and the research setting for the study. The next chapter presents the theoretical context in which fatherhood is situated and the results of a non-committal literature[4] review on the experiences of preterm fathers. It highlights how preterm fathers' voices are largely absent and why the study is timely. Reference to the parenting literature illuminates the problematic nature of the transition to premature parenthood for men and informed the methodological decisions taken in the study (discussed in chapter 3).

[4] The literature review was undertaken to establish the research problem, rather than to define an existing theory of premature fatherhood and prove or disprove this theory from the findings of the study (discussed in more detail in chapter 3)

Chapter 2 Theoretical context of premature fatherhood

2.1. Introduction

This chapter presents empirical knowledge of the transition to parenthood for men, situating this in relation to the problematic context of premature birth. Pregnancy, paternal-foetal relationship, paternal role and transition to parenthood provide the theoretical context in which premature fatherhood is situated. A review of the literature on experiences of preterm fathers is presented which: established the research problem; and informed the methodological decisions discussed in the next chapter.

The transition to parenthood, as a developmental stage in the life course, can be experienced as a stressful event which results in considerable physical, psychological, emotional and relational change for both parents (Entsieh and Hallström 2016). This developmental stage to parenthood can be considered as having two dimensions: the biological transition of being a father; and the social transition of fathering (Draper 2003). Fathers experiencing the safe delivery of their baby at term have completed the biological transition to fatherhood and began the social transition to fathering. In contrast, preterm fathers are transitioning to parenthood during the baby's admission to a NICU.

2.2. Pregnancy: preparing for fatherhood

Pregnancy highlights the gender differences in the transition to parenthood; the mother experiencing physical and emotional changes very early in the pregnancy, with the father comprehending the changes much more slowly. The transition to motherhood begins with confirmation of the pregnancy and has both biological and social dimensions (Draper 2003). However, fathers' evolving comprehension of the impending transition to parenthood takes longer, with the degree to which a man feels prepared to become a father influencing the extent of their prenatal involvement. A seminal study suggests fathers' evolving comprehension of the impending transition to parenthood and behavioural and emotional involvement in

their partner's pregnancy incorporates three phases (May 1982[5]); an announcement phase; a moratorium phase; and a focusing phase and three paternal styles: observer; expressive; and instrumental.

The announcement phase occurs following the confirmation of a suspected pregnancy, with the man demonstrating little behavioural or emotional involvement. The moratorium phase is experienced by men as adjusting to the reality of the pregnancy by withdrawing emotionally and with associated feelings of ambivalence, and feeling a sense of unreality and disconnection from the baby. Men during this phase actively hold back from emotional and behavioural involvement, appearing to need to be emotionally distant in order to secure adequate time to adjust. For most men in May's study (1982), this phase lasted from 12 to 25 weeks and its completion often coincided with their partner's physical changes of pregnancy becoming more obvious. The focusing phase begins around 25 to 30 weeks and is a transition that is defined by the man making preparations for the birth. During this phase they begin to acknowledge and define their future status as a father by imagining what their baby might look like and envisaging their role as a father.

The period of preparing to be ready for fatherhood incorporates a variable amount of time. During the moratorium phase, the extent of ambivalence and emotional distance needed to adjust to the potential change in status[6] from a husband to father and from a couple to a family varies between individuals. It can be argued that men transitioning effectively to the focusing phase are more likely to be more emotionally prepared for the father role during the birth and in early parenthood. Men who need more time in the moratorium phase to adjust may experience less time in the focusing phase and therefore have less time to redefine the situation and prepare emotionally for the birth and subsequent transition to fatherhood (May 1982).

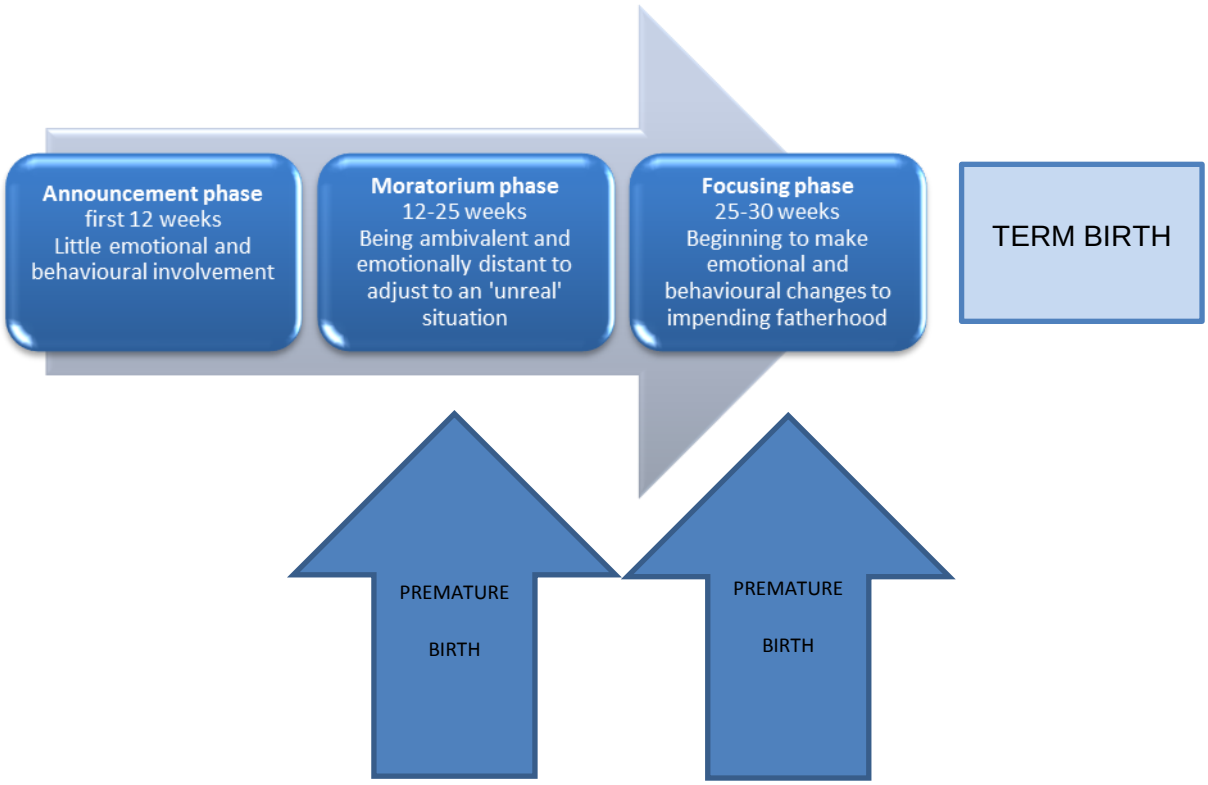
Appreciating the period of adjustment needed by men to comprehend the transition to fatherhood (described as a transition space by Villamor, Guzman and Matienzo 2015) provides a sensitising concept that situates how men experience premature birth. The study explores the sudden and unexpected transition to fatherhood

[5] 'A field study including 20 intensive interviews with expectant couples, short field interviews with 80 additional fathers, participant observation in prenatal classes and clinics and content analysis of popular literature' (May 1982:337)

[6] In early pregnancy, father status prominence and content influences the parenting dimension of foetal bonding (Habib and Lancaster 2006)

following the premature disruption of the pregnancy and the admission of the baby to NICU. Depending on the gestational age of the baby, preterm fathers will be experiencing the transition to parenthood during the moratorium phase (12 to 25 weeks) and at the beginning of the focusing phase (25 to 30 weeks) (figure 2.1). Premature birth therefore reduces the time available for men to prepare emotionally and behaviourally for the birth and the transition to fatherhood.

Figure 2. 1 Development of father involvement in pregnancy (May 1982)



2.3. The paternal – foetal relationship

Family formation in terms of life course theory suggests that having a baby is a stressful life event which requires the couple to psychologically and sociologically adjust in order to fulfil the tasks of parenthood (Luz et al 2017). Parental attachment and parenting alliance are considered to be important aspects in the adjustment to parenthood with the parental role beginning during the pregnancy (Habib and Lancaster 2010). Attachment theory traditionally has focused on the perspective of the child in being able to form a secure relationship with an attachment figure that is the bidirectional interaction between the child and parent (Bowlby 1969, Ainsworth

1989). This relates to the aspect of attachment theory which highlights the infant and child's dependence on a significant other(s). Historically, attachment theory was therefore not considered to be relevant to parents as they are not dependent on their child.

However, the reciprocal social and psychological interaction between the parent and infant/child forms the basis of attachment theory (Walsh et al 2013). Parental attachment, understood through attachment theory, has been the subject of more recent conceptualisation (Walsh 2010, Redshaw and Martin 2013). It has been recognised that parents will exhibit observable behaviours that promote the development of a secure attachment in their child, and which are borne out of parent's emotional and cognitive perception of the needs of their child.

The role of attachment theory in considering parental-foetal attachment has been debated due to the fact that the interaction with the foetus is one way i.e. from parent to foetus. The more valid term of parental-foetal relationship has therefore been suggested (Walsh et al 2013, Cunen et al 2017). Paternal 'antenatal attachment, father emotional well-being and quality of the couple relationship during pregnancy' has been found to influence father's attachment to their infant at 6 months and 12 months (Condon et al 2013:25). In this study, three quarters of the men scoring lower measures when their infant was 12 months, scored lower on the paternal antenatal attachment questionnaire (at 23 weeks gestation) suggesting that men begin to form an attachment to their unborn child during the pregnancy. Although the findings from this study require replication to substantiate and refine causality rather than association, the importance of continuity during the pregnancy and the first year of the infant's life is significant.

Increasingly the importance of considering how men develop their new identity as a father has shifted the focus of studies to include pregnancy[7] in order to clarify when the transition to fatherhood begins (Habib and Lancaster 2010). This cross-cultural longitudinal cohort Australian study (*n=115)* investigated the change in identity and attachment to the foetus across the first and third trimesters for first-time fathers. Identity measures such as status prominence (proportioning a segment of a pie chart to each of their identities) and father status content (rating the degree on a

[7] Studies exploring father identity have traditionally focused on the period of late pregnancy or following birth

Likert scale from ‘very unlike me’ to ‘very like me’ for being a caregiver, breadwinner, playmate, mother’s helper, mother’s emotional support) were used. Paternal-foetal attachment was measured by the Paternal Antenatal Attachment Scale (PASS) which assesses feelings, attitudes and behaviours towards the foetus. In this study, contrary to expectations, father status prominence and father status content did not significantly change across the two trimesters (Habib and Lancaster 2010). This suggests that father status prominence may be assigned high proportional importance in the first trimester once the pregnancy is viable or this result could be due to methodological challenges of participation in a research study e.g. the Hawthorne effect or the social expectations of defining their anticipated father role. In terms of the father status content, emotional supporter, playmate and caregiver were assigned greater relevance than helper, with breadwinner achieving the lowest status content. Conversely, although unremarkable, paternal-foetal attachment had increased, reflecting the transition over the pregnancy. In considering attachment as part of the context of the transition to parenthood, this aspect of the psychological preparation of men for fatherhood beginning during the pregnancy is a further sensitising concept in situating the preterm experience for men in the study.

2.4. Transition to fatherhood

Life course trajectories involve transitions which can result from different triggers and result in ‘changes in internal roles and external behaviours and/or relationships’ (Palkovitz and Palm 2009:9). Change may be related to ‘critical or disequilibrating events, to disruptions in relationships and routines, or to ideas, perceptions, and identities’ (Meleis et al 2000:7).The essential properties of transition experiences have been identified as ‘awareness, engagement, change (both a result of and results in), difference, time span and critical points and events’ (Meleis et al 2000:5). The concept of transition has been developed in the social science and health disciplines and has been defined as involving ‘a complex interplay of adaptive activities to manage situational alterations’ (Kralik, Visentin and van Loon 2006:325) and in which an ending of a previous familiar life is inevitable and a disrupted biography that affects self and identity is likely to occur (Meleis et al 2000). Individual’s responses to change may occur over time and may be convoluting in nature, rather than being linear with an identifiable beginning and an end. In order

to attempt to control both self and the situation, individuals will engage in time work to modify the personal experience of time (Barken 2014).

The change in status from being a partner to additionally becoming a parent is realised following the birth and having time with the baby at home. A metasynthesis (*n=23 articles 1999-2010*) of the transition to term fatherhood identified a number of themes: feelings of risk and uncertainty, exclusion, fear and frustration, ideal and reality, issues of support and experiencing transition (Steen et al 2012). A more recent metasynthesis (*n= 8 articles 2000-2013*) identifies this as 'complex and multidimensional' with men wanting to support their partner during the birth but experiencing feelings of vulnerability, confusion and distress (Johansson, Fenwick and Premberg 2015:17).

A longitudinal qualitative study of first-time fathers (*n=17*) reflects the common biographical profile (i.e. white, middle class) of the majority of participants in the few studies on men's transition to fatherhood (Miller 2011) and is recognised as a limitation. In anticipating fatherhood, men attend antenatal preparation and gather information in order to be an involved father (Draper 2003) and anticipate that parental instincts will be present after the birth of the baby (Miller 2011). Motherhood and fatherhood when presented as binary dimensions of parenthood are framed within societal and cultural traditions which influence each parent's agency. From this perspective, mothers are viewed as the primary caregiver, with fathers being involved in care giving whilst balancing the economic provider aspects of their identity. Shared involvement with care giving activities can be seen to be 'evenly distributed, rather than equally distributed' (Miller 2011:1102), during the antenatal period and in the first few weeks following birth. As a consequence of returning to work following paternity leave, fathers exhibit more of a choice in the level of their involvement in caring activities. This and their perception that their partner is more able to meet the needs of their baby through spending more time with them, influences the amount of time and type of caring activities they engage in (Miller 2011).

2.4.1. Antenatal education

Within contemporary society the transition to parenthood is marked more clearly for women, medically, socially and politically and is manifest in the biological changes

occurring in her body (Draper 2003). Following confirmation of the pregnancy, the woman will access antenatal services for the duration of the pregnancy (NICE 2008). Monitoring the pregnancy, labour and birth may subsequently result in her experience becoming framed within the more medicalised approach of obstetric intervention, particularly in the event of any adverse changes (Draper 2003). Women are more likely to be receptive to both health advice and accepting of opportunities for social support. Attendance at antenatal classes has been shown to provide opportunities for women to develop social support networks and prepare them for their transition to motherhood (Teate et al 2011). Wearing maternity clothes provides an outward sign of the anticipated transition to motherhood and the provision of maternity leave endorses the status of motherhood. Although changes to policy means that both parents are now eligible to share the entitlement to paid leave, the numbers of men taking up this option have been small (Department for Education 2014).

Fathers experience the transition to parenthood differently to women, with definitions of this transition being re-evaluated in the context of contemporary societal norms and values (Draper 2003). Fathers in the UK are assumed to have an active presence during the pregnancy, labour and birth. However, these stages to parenthood are all occurring in and happening to his partner's body. In contrast to the woman's transition to motherhood which has both biological and social dimensions to it, men's transition to fatherhood is more socially aligned. There are no visible signs that he is anticipating becoming a father. The social support available to fathers is limited for a number of reasons. By its nature, the institutional support of formal antenatal provision is frequently 'mother centric' and often offered during the day, which may prohibit those fathers in employment from attending. In addition, fathers may anticipate that the antenatal provision is unlikely to address their needs due to the focus on the mother. The importance of antenatal education for fathers is acknowledged (Deave and Jonson 2008) and highlights the importance of providing tailored education related to: changes in relationship and role; understanding the mother's experiences; appreciating the risk of father's experiencing distress and depression; enhancing father's understanding of infant communication; and emphasising the importance of supportive coparenting (May 2013).

Antenatal education has been shown to play an important part in preparing both mothers and fathers for parenthood; however, a premature birth may preclude the availability of this education for preterm fathers. Depending on the gestational age of the baby, preterm fathers may have received some antenatal education or none. They will therefore have limited knowledge on which to base their understanding of the process of labour and birth. Additionally, the social support gained during attendance at antenatal classes may be absent or reduced because of premature birth.

2.4.2. Social support

Transition to parenthood involves a biographical reorientation which is facilitated by the type and density of social support (Giudici and Widmer 2017). The quantity and quality of available social support not only supports the transition to parenthood but also positively influences children's social and emotional development (Bennett 2017). This social connectivity can include three types of associations: informal (based on the parents' own social networks including friends, families, and neighbours), semi-formal (community groups and social events organized within a community by a volunteer organization), and formal (professional - or needs - based services) (Moran, Ghate, and van der Merwe 2004).

The types of social networks that individuals engage in have also been shown to contribute to the decision-making process of family formation (Lois 2016) and the intentions of participating in paid work for mothers and fathers (Giudici and Widmer 2017)[8]. Giudici and Widmer (2017:443) identified that the effects of 'personal networks on participation in paid work during the transition to parenthood were gendered: the density of emotional support was important for women and the density for practical support was significant for men'. Although the differences in Swiss family policies need to be acknowledged and the intentions prenatally and practices postnatally of paid employment of each parent was the focus of this study, the findings further support the view that it is the type of network support, in addition

[8] Longitudinal analyses of 235 couples before birth using a network instrument and face to face interviews with 74.3% of the original sample one year after birth. The density, degree of overlap between partners' networks, geographical distance between network members, and types of relations were explored to investigate how personal networks influence the practices of participating in paid work of men and women becoming parents

to the amount, that influences parental behaviours during the transition to parenthood.

2.5. Paternal role

Historically, father involvement, considered as conceptualising fathering, has been explored in terms of the amount and type of interaction and involvement a father has with his child(ren). A commonly used model measured paternal participation in three dimensions: interaction; accessibility and responsibility (Lamb 1987). The first dimension of interacting relates to the direct care taking activities with the child, with the second category, accessibility, relating to the father being physically and psychologically present, but not directly participating in care-giving activities. The third dimension of responsibility focuses on the father being concerned for the child's welfare, thinking about the child and making plans whilst undertaking other activities.

A process model identified the properties that determine parenting: characteristics of the father; characteristics of the child; and sources of stress and support (Belsky 1984). At the time, the process model emphasised the importance of the quality of the marital relationship in supporting parenting. However, since then the relevance of exploring co-parenting i.e. parenting alliance has received greater inquiry and better predicts and explains paternal involvement (McBride and Rane 1998, Luz et al 2017). The influence of having a father role model has also been articulated (Stubley, Rojas and McCroy 2014).

Over time, reference has been made to engagement, warmth and responsiveness, control and direct care when considering the paternal role (Fagan et al 2014). A mixed methods study used identity theory to explore fathers' involvement (*n=89)* with their preschool children (Rane and McBride 2000) and found that the centrality of the nurturing role was more indicative of father involvement than centrality of parent status. Mothers' hours of employment and their appraisal of the fathers' nurturing role served as a contextual factor in how fathers perceived the centrality of the nurturing role. This finding lends credence to the importance of defining statuses and roles in considering fathers' identity hierarchies. In addition, it supports the suggestion that a father's role and identity is symbiotic with their partner's roles and identities. The cautionary note regarding research on father involvement is that it has mainly been focused on white middle class fathers. An American study

focusing on teenage fathers from African American and Latino descent however, also identified that relationship quality and co-parenting predicted father involvement (Varga et al 2017).

A framework for conceptualising the dimensions of men and fatherhood has been expressed in a Fatherhood-Masculinity model (Pleck 2010). This model defines fatherhood as a parental status and includes: being a father to biological or social children or both; the timing of fatherhood; how many children he has; and the spacing of his children. These dimensions influence a father's parenting behaviours and his self-conception of what it means to be a father. It is suggested that contemporary fathers are more engaged in the expressive, emotional and caring dimensions of parenting, leading to the suggestion of a new construction of fatherhood (Stubley, Rojas and McCroy 2014).

To some extent it can be seen that there are changes to contemporary fathering involvement but hegemonic masculinities may act to constrain these. The term 'involved fathering' evolved during the 1980s in recognition of the importance of the father role in providing emotional and practical care and fulfilling a co-parenting role compared to the traditional 'breadwinner role' (Dermott 2008: 28). A small UK mixed methods study (*n=15*) collected data both antenatally and postnatally from men who had planned to have a baby and the results support the concept of men choosing to be involved fathers (Machin 2015). Fathers in this study struggled initially in the early weeks to 'bond' with their baby and co-parent due to practical and biological factors such as breastfeeding, lack of interaction from the baby and reduced time for becoming a competent primary caregiver. Fathers identified low levels of father-focused support from healthcare professionals during a time when they found the transition to fatherhood emotionally challenging. Fathers returning to work following paternity leave found it difficult to address the work life balance that now needed to incorporate an involved father role. This tension, along with having to accept being a secondary parent, rather than being able to co-parent, can lead to reduced levels of well-being and psychological distress (Giallo et al 2013). The degree of childcare provision has been debated with reference to an 'exclusive mothering' discourse and 'shared parenting' discourse (Vuori 2009:45)[9].

[9] Research based on Finnish family expert publications and political social policies

During the process of preparing for parenthood, men will create 'possible selves', a term that engenders the idea of future roles that may be enacted (Markus and Nurius 1986). In anticipating these possible selves, fathers will consider the requisite goals and expectations associated with them. This consideration will contribute to him defining his future fathering role and may include attributes associated with being, for example, an effective provider, competent caretaker and engaged fully in the father role (Cowan et al 1985). Unlike mothers, fathers over time evidence little continuity in either their ideal or feared possible selves (Morfei et al 2001). This discontinuity may be a reflection of the wider social perceptions of the role of fathers. Contemporary ideologies of fatherhood reflect the role of fathers that encompass both the instrumental and affective aspects of parenthood (Stubley, Rojas and McCroy 2014). The identification of men as caring and nurturing has been framed in terms of presenting a challenge to their masculinity (Morfei et al 2001). However, 'intimate fathering' acknowledges the fluidity of enacting a parenting role, with men considering their father role as 'being primarily about the negotiated, individual relationship between father and child' (Dermott 2008:93). From this perspective, juxtaposing motherhood and fatherhood is unhelpful and supports the importance of considering fathering in relation to, rather than distinct from, mothering.

2.5.1. Gendered caring

Masculinity traditionally referred to the male gender status: being biogenetically defined as male which is socially and culturally constructed to represent the binary orientations of male and female. Within the male gender status, the orientation to masculinity varies in terms of personality characteristics and the attitudes and beliefs attributed to being a man; in other words, notions of the extent to which a man is perceived as 'being masculine'. However, rather than considering gender to be static, it is proposed as a dynamic and agentic process, constructed through social interactions and offers a theoretical framework in understanding men's health (Courtenay 2000). Connell's theory of hegemonic masculinity (Dolan and Coe 2011) framed an understanding of the construction of masculine identities in the transition to fatherhood from father's and healthcare professional's perspectives. Men experienced marginalisation and a lack of control and power during childbirth, but this relative vulnerability was accepted and managed through guidance by healthcare professionals on how to meet the situational demands. Men did display

hegemonic masculinity by not disclosing emotions, fears and concerns to others. The expression of the 'masculine' trait of being emotionally strong and resilient can be seen to be premised on situational, interpersonal and individual contexts. During pregnancy and childbirth, hegemonic masculinity in men's parenting has been explored from a psychosocial perspective and highlights the complexity of 'imaginary positions inherent in fathering influenced by personal experience of being fathered, parental alliance and social and cultural discourses' (Finn and Henwood 2009:559).

When evaluating the gendered aspect of providing care for family members who are unwell, men use problem-focused coping strategies and evaluate their caregiving on tasks completed successfully rather than how well they have provided care or the effect of that care on their spouse (Barken 2014). This 'take charge' attitude has been suggested as being characteristic of men's caregiving (Barken 2014:712). Older men, in attempting to control and provide effective care for their partner can be seen to use a task oriented, managerial approach reminiscent of their approach to paid work (Calasanti 2010). Men cope with care-giving by blocking emotions (potentially leaving stress unexpressed), focusing on tasks and keeping busy (Charmaz 1994).

With respect to the influence of gender on seeking health advice, it is suggested that health promotion strategies for men should focus on enabling them to 'problem solve and gather information about a topic' rather than providing opportunities for them to talk about feelings (Kaye, Crittenden and Charland 2008:12). 'Although people orient their behaviours to gender ideals, what these actions are can vary by context. That is, even if a group of traits are thought to be feminine or masculine, the ways in which women or men behave depends upon the situation' (Calasanti 2010:721).

With this in mind, it can be suggested that premature birth, considered as a stressful experience, may be managed differently by mothers and fathers. Folkman and Lazarus (1980) suggested two coping strategies for managing stress: problem-focused strategies address the situation; and emotion-focused strategies regulate the individual's response to the situation. Work contexts are more likely to elicit problem-focused coping with emotion-focused coping demonstrated more in health contexts. Gender becomes significant only in 'problem-focused coping when men

use this more at work (possibly related to nature of job) and in situations that have to be accepted and require more information' (Folkman and Lazarus 1980:219). A large and diverse Spanish study (*n=1566 women and 1250 men*) demonstrated gender differences in stress and coping, with men's coping style being more problem-centred and less emotion-focused (Matud 2004). Gender was considered as a sensitising concept during the process of data generation and analysis in this study and is discussed further in chapter 6.

2.6. Premature fatherhood

The parental experience of premature birth has attracted research from the disciplines of sociology and psychology. The important role a father plays in the life of their child in terms of providing psychological, social and emotional long-term benefits is recognised (Dermott 2008, Lamb 2010, Ramchandani et al 2013). The gradual increase in the number of research studies focusing on the experiences of fathers have mainly included fathers of term infants, with fewer studies involving fathers of preterm infants. A non-committal literature review was undertaken on commencing the research process for this study in order to establish the research problem, confirm a gap in the literature and inform the research proposal. Ongoing reference to the extant literature on premature fatherhood informed the methodological processes throughout the study (see appendix i).

2.6.1. Initial non-committal literature review

An initial review of the literature highlighted few American, Swedish and UK studies focusing on preterm fathers' experience. These studies typically included small numbers of participants (*n=5-21*) (Lindberg, Axelsson and Ohrling 2007, Arockiasamy, Holsti and Albersheim 2008, Sloan, Rowe and Jones 2008, Lee et al 2009) and most used a phenomenological approach (Jackson and Ternestedt 2003, Lundqvuist, Hellström-Westas and Hallström 2007, Pohlman 2009, Craethern 2011, Hollywood and Hollywood 2011). Most were undertaken during the NICU admission and did not consider the experience of the father following the discharge of his infant home (Jackson and Ternestedt 2003, Rowe and Jones 2010, Deeney et al 2012 are exceptions).

These qualitative studies provide a rich description of the lived experiences of fathers with a preterm infant on a NICU; how they experience feelings of shock and

loss of control (Lindberg, Axelsson and Ohrling 2007, Lundqvuist, Hellström and Hallström 2007, Arockiasamy, Holsti and Albersheim 2008, Lindberg, Axelsson and Ohrling 2008, Sloan, Rowe and Jones 2008, Pohlman 2009, Binder et al 2011, Craethern 2011, Hollywood and Hollywood 2011); feeling an outsider (Jackson and Ternestedt 2003, Lindberg, Axelsson and Ohrling 2007, Lundqvuist, Hellström and Hallström 2007, Lindberg, Axelsson and Ohrling 2008, Arockiasamy, Holsti and Albersheim 2009, POPPY project 2009, Binder et al 2011, Craethern 2011,Hollywood and Hollywood 2011); concern for their partner and infant (Jackson and Ternestedt 2003, Feeley, Gottlieb and Zelkowitz 2007, Lindberg, Axelsson and Ohrling 2007, Lindberg, Axelsson and Ohrling 2008, Lee et al 2009, Craethern 2011); and their evolving identity of being a father (Lindberg et al 2007, Lundqvuist, Hellström and Hallström 2007, Lindberg, Axelsson and Ohrling 2008, Sloan, Rowe and Jones 2008, Craethern 2011).

In the UK, studies have focused on fathers' experiences during their infant's hospital admission (Jackson and Ternestedt 2003, Craethern 2011, Hollywood and Hollywood 2011, Deeney et al 2012) with only two studies including the period of time following discharge (Jackson and Ternestedt 2003, Deeney et al 2012).

The findings from non-UK studies need to be interpreted within the cultural context, as the differences in these countries' healthcare practices changes the context within which fathers experience becoming a parent (Feeley, Gottlieb and Zelkowitz 2007, Lindberg, Axelsson and Ohrling 2007, Lundqvuist, Hellström and Hallström 2007, Arockiasamy, Holsti and Albersheim 2008, Sloan, Rowe and Jones 2008, Pohlman 2009). In Sweden, for example, fathers can receive compensation of 80% of their salary to look after a sick child and therefore fathers of preterm infants can stay on the unit for the full duration of their infant's admission (Lindberg, Axelsson and Ohrling 2007, Lundqvuist, Hellström and Hallström 2007). Conversely, in the United States, fathers often need to remain at work in order to pay for the medical treatment required by their preterm infant, resulting in fathers fulfilling their role as bread winner and family protector, rather than being present on the NICU during their infant's admission (Arockiasamy, Holsti and Albersheim 2008).

2.6.2. Review of the literature during the research process

2.6.2.1. Effect of gestational age

There are few studies specifically exploring the effect of gestational age on parent experience and parent-infant interaction. Stefana et al (2018) in their Italian mixed methods study explored fathers' emotional experiences of premature birth (*n=20*) and suggested two clusters: 'fathers-of-preterm-infants' (more than 32 weeks) who engaged in their infant's care; and 'preterm fathers' (24-32 weeks) who were less engaged with their infant's care. The findings of this study[10] are considered in light of the policy of not allowing Italian fathers to be present at premature births. Tooten et al (2013) demonstrated a correlation between lower gestational age of the baby and greater parental negative experiences, with these negative experiences found to be the same for mothers and fathers.

However, a Dutch longitudinal study (*mothers n=217, fathers n=204*) comparing parent-infant interaction and parent perceptions between term, moderately preterm and preterm infants concluded that premature birth per se does not lead to difficulties in long term parent-infant interaction (Hoffenkamp et al 2015). Using a validated semi-structured interview schedule at one month and 15-minute videotapes of parent-infant interaction, the study examined the extent to which parent, infant and contextual factors of prematurity predicts later parenting behaviour. Negative parent-infant interaction was predicated more on parental perceptions than on the clinical condition of the baby and the complications of prematurity. The study did find that preterm fathers demonstrated less sensitive interactions with their infant at 6 months compared to preterm mothers and to fathers in the other two groups (Hoffenkamp et al 2015). These findings suggest the presence of a complex interplay of parent, infant and contextual factors during the preterm experience (rather than the preterm baby alone) that influences parental perceptions and experiences.

[10] 'Feelings related to becoming a father; confused memories; seeing the baby for the first time; touching the baby for the first time; first impressions of the baby in NICU; involvement in infant-care activities; and development of feelings towards the infant from birth to discharge' (Stefana et al 2018:4)

2.6.2.2. NICU experience

Hugill et al (2013)[11] completed a three year focused ethnography study in one UK NICU to explore the early experiences of fathers following admission to the NICU. Emotion work as a 'conceptual perspective was used and three themes were identified: emotional withdrawal and control; stereotyping; and mixed feelings' (Hugill et al 2013:655). Preterm fathers in this study felt unsure of how to react to the unfamiliar situation in terms of the normative display of emotions (*feeling rules*)[12]. Their emotionality stemmed from the desire to be emotionally strong for their partner and baby and was based on logic and rationality attributed to men's emotional distance from the birth process. Preterm fathers experienced mixed often opposing feelings and unexpressed emotions, leading the authors to suggest that preterm fathers engage in 'silent emotion work' (Hugill et al 2013:661). Although limited to one NICU and only capturing the early experiences of preterm fathers, this study highlights how men's 'emotional reactions are influenced by the attitudes and behaviours of their partner and healthcare professionals and by perinatal events and perceptions (both their own and others) of father responsibilities' (Hugill et al 2013:662). A Norwegian study also found that preterm fathers (*n=8*) strived to be the emotionally strong partner and experience feelings of being a spectator (Hagen, Iversen and Svindseth 2016). Logan (2018) suggested similar findings from interviewing seven fathers of very preterm infants.

In their Canadian qualitative study, Feeley et al (2013) identified barriers to fathers (*n=18)* being involved with their preterm baby: infant (the medical condition and physical attributes of the infant and multiple births); interpersonal (personal beliefs concerning the primacy of the mother and father role); and NICU environmental factors (particularly the technological aspects). Employment, domestic and childcare responsibilities presented conflicting demands and challenged time management. Social support during this time was considered to be a facilitator in enabling involvement with the baby along with familiarity of hospitalisation.

[11] In-depth interviews with ten fathers (27-35 week gestation infants), a survey of NICU staff (*n=87*) and field notes from 260 hours of observation and 206 hours informal conversations with parents and healthcare professionals

[12] Feeling rules are defined in Hochschild's (1983) social theory of emotion as the way in which an individual knows whether to express or suppress an emotion and are determined by norms and values and the social context. Theodosius (2006) proposes how unconscious emotional processes are also relevant to social interaction and further develops an understanding of emotion management

Therefore, although the physical environment of the NICU acted as a barrier, open visiting, meeting other parents and support and role modelling from neonatal nurses facilitated fathers' involvement with their preterm baby. In another study, facilitating engagement of fathers in providing direct care giving activities to their infant promoted confidence in the paternal role (Blomqvist et al 2012).

The social support provided by neonatal nurses has been highlighted in other literature. O'Brien and Warren's (2014) quantitative Irish study found 86% of fathers (*n=58*) received a high level of information, emotional, appraisal and care-giving functional nursing support. A French mixed methods study (Koliouli and Gaudron 2018) reports the dimensions of social support to fathers (*n=48*) by healthcare professionals to include attention, accessibility, empathy and information-sharing. Communication is additionally suggested as being instrumental in facilitating paternal involvement. Hugill (2014) suggests understanding the quality of the relationships between fathers and healthcare professionals would support the development of specific ways to support premature fatherhood. The judgements made by fathers and healthcare staff about each other can influence their interactions and father experience (Hugill 2014). The implementation of a fathers' peer support group in one large Australian NICU (Thomson-Salo et al 2017) was found to reduce paternal stress. Facilitated by a male neonatologist, the weekly evening meetings provide time and space for men to talk about traumatic experiences of the birth and NICU. Sharing feelings and receiving support from other men provided fathers with the opportunity to cope with the preterm experience during the NICU admission.

An American qualitative study *(n=10 mothers and 8 fathers interviewed at least 2 weeks post discharge*) explored paternal social support needs (Hyung 2018) and also highlighted the primacy of support from nurses as well as peer fathers and partners. Fathers' needs for information, to be included in communication and encouraged in enacting their paternal role were met by nurses. Tandberg, Sandtro and Vardal (2012) in their Norwegian quantitative study, evaluated whether mothers and fathers (*n=82*) experienced stress and nurse's support differently but highlighted no significant difference in the experience of nurse's support between mother and father. However, fathers experienced increased stress at discharge

compared to their baseline[13]. The stress and anxiety experienced by preterm fathers has highlighted the need to reliably measure the support needs of fathers (Mahon, Albersheim and Holsti 2015).

A survey based German study (*n-111*) highlighted how parenting dimensions (such as self-esteem, self-efficacy and confidence) were similar to mothers (Garten et al 2013). Fathers received care and support from the neonatal staff, but identified that they would welcome father-specific information about preterm babies and practical care advice. A qualitative Norwegian study (*n=6*) interviewed fathers on two occasions on NICU and presented the essence of their experiences as: starting fatherhood while facing existential issues (seriously ill partner and baby); connecting the family; becoming familiar with your infant; and becoming a father in a public area (Vaerland, Vevatne and Brinchmann 2017).

2.6.2.3. Experience following discharge home

Lundqvist, Hellström-Westas and Hallström (2014) in their follow-up study described fathers' lived experiences as a process of reorganizing life with three subthemes: *struggling to endure; experiencing empowerment; and building a secure base*. Following discharge home, fathers initially experienced exhaustion and being under prepared for the sole responsibility of their preterm baby and the need to balance his own and partner's needs with that of his baby and other children. Experiencing empowerment described the gradual return to their 'normal social life with family and friends, maturing in their parental role and sharing childcare with their partner' (Lundqvist, Hellström-Westas and Hallström 2014:127). In building a secure base, fathers retained memories of the time on NICU but now felt reassured that their preterm infant was developing as expected and that they had established ordinary family life. Benzies and Magill-Evans, (2015:81)[14] found that fathers described fatherhood as the 'best job in the world and a bigger job than ever imagined'. Fathers experienced personal growth in their transition to fatherhood but proffered suggestions for implementing specific interventions by healthcare professionals for

[13] Two self-reporting validated questionnaires were completed: Nurse Parent Support Tool and Parental Stressor Scale (measures parental perception of stressors from the NICU physical and psychosocial environment)

[14]Follow up study of 85 late preterm fathers taking part in the Father-Interaction Programme interviewed after discharge

preterm fathers that developed individual knowledge, skills and confidence in fathering.

2.6.2.4 Cultural influences

The relevance of cultural influences on fathers experiencing premature birth is acknowledged in a study using a narrative inquiry approach[15] (Adama, Sundin and Bayes 2017). The findings from this study acknowledged the traditional 'breadwinner role' of the father in Ghanaian society. Men in this study experienced a lack of engagement of healthcare staff in enabling them to care for their preterm infant and they were excluded from discharge preparations. Overwhelmingly, fathers experienced the NICU context as completely focused on the needs of his partner and infant to the exclusion of himself (Adama, Sundin and Bayes 2017:279).

An Iranian phenomenological study identified three themes from semi-structured interviews fathers *(n=6)* of preterm infants during the NICU admission: abandonment and helplessness; anxiety and confusion; and development and self-actualization (Dadkhahtehrani et al 2018). The shock of experiencing their baby's early birth led to uncertainty about the present and future health outcomes of their baby and resulted in feelings of guilt and blame. Conversely, preterm fathers also recognised positive outcomes that included experiencing empathy for their family, an increased ability to problem solve and accepting changes in their responsibilities to the family (Dadkhahtehrani et al 2018). The findings from this small study evidenced cultural differences in terms of fathers experiencing a lack of financial support to cover medical costs and the lack of information and support from staff perceived to be uncaring.

The influence of the NICU culture on preterm fathers (*n=8*) is evident in a Brazilian study where fathers felt constrained by extremely restricted access due to prescriptive visiting hours (Marski et al 2016). Fathers' experiences after discharge were considered under three themes: fatherhood boundaries (physically distant from and lack of information about their preterm baby); responsibility for the child (affirming the preterm father role after discharge); social network and support

[15] Infants were 26-36 weeks gestation and 9 fathers were interviewed at one week, one month and four months following discharge home

(extended family support and receiving much needed information from healthcare professionals).

Lee et al (2013)[16] compared an intervention group of preterm fathers *(n=34*) receiving tailored support (booklet and nursing guidance) with a control group (*n=35*) receiving routine neonatal care during their time on NICU. This historical comparison study reports increased fathering ability and decreased stress in the intervention group and suggests interventions for preterm fathers should include informational, emotional, instrumental and esteem support. These studies have been included to illuminate how the culture of the NICU and the social context of parenthood can influence the experience of men transitioning to premature fatherhood. This is discussed further in chapter 7 when considering the limitations of the study.

2.6.2.5. Systematic literature reviews

A systematic review of 14 qualitative studies (Provenzi and Santoro 2015) presents five themes that characterise preterm fathers' experiences: emotional roller-coaster (shock, loss of control, concern for their partner); paternal needs (obtaining information, involvement in infant's care); coping strategies (hiding feelings, going to work); self-representation (feeling detached, observer, protector); and caregiving engagement (fear of infant vulnerability, supporting maternal role). Ireland et al. (2016:172) in their systematic narrative review (*n=27* papers) highlighted aspects of preterm fathers' experiences: 'stress and anxiety; information sharing (linked to stress, knowledge and parenting self-efficacy); gender roles (equal parent in caregiving activities); and emotions (being strong, feeling confident in the ability of neonatal staff to care for their baby)'. Preterm fathers' experiences have also been framed in terms of 'unequal parental involvement, work constraints and challenges with information sharing' (Walmsley and Jones 2016:293).

Summary

This chapter situated premature fatherhood in the context of expected parenthood and gender and presented a review of the extant literature on preterm father's

[16] Methodological limitations include: timing of data collection, reliability of the fathering ability scale and Taiwanese postpartum practice of others taking on main childcare responsibilities for 4 weeks to allow the mother to recover

experiences. Qualitative research approaches dominate the preterm father literature, mostly focus on the NICU admission, and findings need to be interpreted acknowledging cultural influences and the inclusion of different gestational ages. However, a synthesis of the research on preterm father's experiences can be seen to align with the dimensions of parenthood (Fagan et al 2014): emotional (shock, loss of control, stress, anxiety, 'silent emotion work', post traumatic growth); cognitive (uncertainty, concern for partner and baby, needing information, communication); social (feeling an outsider, fulfilling employment and domestic responsibilities, health professional support), and motor/physical behaviours (involvement in infant caregiving activities, supporting mothering). The influence of social support by healthcare professionals and other preterm parents in contributing positively to preterm father's experience is a prevalent theme.

The initial literature review framed the principal research question for the study:

How do fathers experience becoming a parent of a preterm infant following their infant's admission to a Neonatal Intensive Care Unit and following discharge home?

Secondary research objectives include: to explore contextual factors that inform the social process of becoming a father of a preterm infant following admission to a NICU and discharge home; and to increase knowledge of father's experiences to generate a theoretical model that may inform neonatal practice and education regarding the role of healthcare professionals in supporting fathers during this transition. First time fathers and those that have already experienced the transition to fatherhood prior to the birth of their preterm infant will have different perspectives on the transition to fatherhood and therefore both have been included in the study.

The next chapter provides the ontological and epistemological considerations that influenced the choice of Constructivist Grounded Theory (CGT) as a methodology for the study. In order to provide evidence for evaluating the research findings (presented in chapter 5) and the substantive theory (presented in chapter 6) in terms of congruence with CGT methodology, the strategies used throughout the research process are also discussed in the next chapter in terms of credibility, originality, resonance and usefulness (Charmaz 2014).

Chapter 3 Methodological framework

3.1. Introduction

The choice of methodology for examining how fathers experience the process of transition to premature fatherhood took into account several personal and professional attributes and experiences, in addition to the sociological focus of inquiry. The personal experience of being a mother of preterm twins and the professional experience of being a neonatal nurse provide an understanding of neonatal care but also present a potential for bias in data generation and analysis. As an academic teaching a post qualification neonatal course, it is hoped that the study's findings will contribute to the empirical evidence on premature fatherhood, to inform both neonatal clinical practice and neonatal nurse education. A further consideration in choosing the methodology, stemmed from reflecting on personal values and beliefs that led me to consider how important it was to use an empathetic and participant focused mode of inquiry. In essence, the choice of methodology was informed by personal ontological and epistemological perspectives (influenced by personal and professional attributes and experiences), as well as by the nature of the research question.

Grounded theory (GT) is a prevalent qualitative research methodology in nursing and the central tenet of GT acknowledges that individuals' patterns of behaviour (the unit of analysis) can be conceptualised by exploring the process of how problems are managed and resolved (Andrews 2017). The participant's 'main concern' (Glaser and Strauss 1967) or problem is unknown at the beginning of the study and emerges using the GT methodology. The substantive grounded theory conceptualises the patterns of behaviour and explains how the main concern is processed. GT therefore provided a mode of inquiry for the study which would result in the development of a theoretical model that could offer a contribution to the empirical evidence on premature fatherhood to inform both neonatal clinical practice and neonatal nurse education.

From its origins in sociology, GT has evolved into three acknowledged versions: Classic (Glaser 2015); Straussarian (Corbin and Strauss 2015); and Constructivist (Charmaz 2014). This chapter presents the development of these versions of GT

and the areas of similarity and divergence between them. The personal epistemological, ontological and theoretical perspectives that informed the choice of methodology are critically examined; acknowledging how sequentially each of these perspectives informs the development and decisions taken about the next. The epistemological and ontological perspective therefore influences the choice of methodology and methods (Crotty 2006) and these philosophical considerations are discussed within a context of providing the justification for using Constructivist GT (CGT).

3.2. Grounded theory methodology

Describing and exploring the experience of the transition to premature parenthood required a qualitative research approach. There exists a range of approaches available to answer a qualitative research question such as phenomenology, ethnography, case study (Crotty 2006). In recognising that there exist different perspectives of the same phenomena, qualitative (interpretive) inquiry expects the researcher to present the different participant's voices, reflecting their different perspectives (Petty, Thomson and Stew 2012). The study, in exploring the social process of the transition to premature fatherhood, required the use of a methodology that could account for this variation in interaction (Chenitz and Swanson 1986). Additionally, in order to answer the research question, the methodological approach would need to explain the fundamental patterns (social-psychological processes) inherent in the transition to premature fatherhood. GT was therefore chosen as the methodology for the study because the method enables the exploration of a social process and generates an explanatory theory that will enhance the understanding of a social and psychological phenomenon.

GT is a methodology that uses a systematic process to generate theory grounded in the data (Charmaz 2014, Corbin and Strauss 2015). The methodology brings together the 'depth and richness' of qualitative inquiry with the 'logic, rigour and systematic analysis' of quantitative approaches and provides a 'completeness of method' (Walker and Myrick 2006:548). An evaluation of whether GT was appropriate for the study was considered using the three criteria suggested by Birks and Mills (2011): there is a paucity of knowledge about the area of study; the study

aims to generate a theory with explanatory power; and the area of study involves a process that can be explicated by grounded theory methods.

3.2.1. Origins of grounded theory

The foundation of GT is acknowledged as emanating from a seminal text by sociologists Glaser and Strauss (1967). In *The Discovery of Grounded Theory* (1967) Glaser and Strauss presented a method of generating sociological theory. Although GT was initially presented as a research method for sociologists, this research methodology has become increasingly popular with other social scientists, notably in healthcare and business. Its relevance to other disciplines stems from the fact that the GT methodology enables general concepts to be identified, theoretical explanations can be developed which extend beyond that which is already known and new insights into various experiences and phenomena can be gained (Corbin and Strauss 2015).

Trained at Columbia and Chicago respectively, Glaser and Strauss (1967) sought to provide an alternative methodology to grand theory and quantitative methodology, and the perceived 'unscientific' qualitative methodology, endorsed by these universities at that time. Methods of social research had up until that point emphasised the verification of theories, either testing existing theories or testing an incomplete new theory. Glaser and Strauss (1967) argued that sociologists were being constrained by the continued focus on the verification of research and that this was at the expense of generating theory which had become a secondary concern. They proposed that generating theory, 'hand in hand with verifying it' (Glaser and Strauss 1967:2) should be the main goal of research. Employing systematic methodological strategies in qualitative research, they suggested GT as a way of generating sociological theory. Set within the historical context of a polarisation between inductive qualitative research and deductive quantitative research, Glaser and Strauss (1967) proposed generating theory grounded in qualitative data, challenging the criticism that qualitative research lacked scientific, analytical integrity. Recognising that there has since been the development of differences in approach to GT, the fundamental research process of GT has been highlighted as: 'gather data, code, compare, categorise, theoretically sample, develop a core category, and generate a theory' (Walker and Myrick 2006: 550).

3.2.2. Emergence of different versions of GT

Philosophical assumptions may naturally encourage the evolvement of GT research design 'into new methodological spaces' (Birks and Mills 2015:5). This view helps to explain the emergence of several iterative versions of GT, such as dimensional analysis by Schatzman, Constructivist GT by Charmaz, and situational analysis by Clarke (Morse et al 2009). Methodologically, GT has been influenced particularly by the second (post-positivism), third, fourth (representation) and fifth (legitimation) of the eight moments of qualitative research (Denzin and Lincoln 2011). Glaser and Strauss developed GT in the second moment (1945 to 1970), when philosophically post-positivism assumed the existence of a reality that could be discovered by a detached objective observer. In the third and fourth moments (1970 to 1995) qualitative researchers, such as Charmaz, questioned the representation of research: the effect of the researcher's relationship with the participants; the place of the researcher in the text; and how the researcher constructs the text which is grounded in the data. Clarke's (2005) work on situational analysis developed during the fifth moment of qualitative research, adds legitimation (how the quality of research outcomes can be measured) and praxis (the extent to which grounded theory contributes to societal change) to representation.

One key criticism of the work of first generation grounded theorists is the absence of attention to the philosophical position informing the GT methodology. The initial focus of early work was in explicating GT methods, and the philosophical position taken by Glaser and Strauss is not explicit in their seminal text (Glaser and Strauss 1967). Glaser subsequently has been dismissive of specific philosophical or disciplinary positions being applicable to GT (Kenny and Fourie 2015), although he is generally cited as 'a critical realist researching within the post-positivist paradigm' (Annells 1996 cited by Birks and Mills 2015:5). The philosophical position of Strauss arises from pragmatism (Corbin and Strauss 2015). It has also been suggested, however, that GT can transcend philosophical constraints and has the ability to embrace the epistemological stance of the researcher in their application of the methodology (Urquhart 2013).

A philosophical divergence between Glaser and Strauss may to some extent have contributed to the emergence of their different perspectives on grounded theory soon after the publication of their seminal text. Glaser (2004:2) refers to classic grounded theory defined as 'a set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area'. He contrasts qualitative data analysis and GT viewing the latter as being about generating concepts rather than being concerned with providing accurate descriptions. Following the constant comparative method, he emphasises emergent discoveries 'and the generation of a substantive or formal theory' (Glaser 2004:4). The philosophical position of Strauss (Strauss 1987) informed the integration of symbolic interactionism as a theoretical perspective to GT. In proposing a coding strategy, Corbin suggests that Strauss added a way to identify, elaborate and integrate concepts, in addition to the basic tenets outlined in *The Discovery of Grounded Theory,* rather than proposing a new version of grounded theory (Corbin and Strauss 2015).

Walker and Myrick (2006) propose two main differences in Glaserian and Straussarian GT, that of emergence and verification. Considering the issue of emergence, they suggest that the divergence between Glaser and Strauss stems from the differences in how the process of data analysis is undertaken, specifically the procedures used for coding. Their critique contrasts the two-step approach of coding (substantive and theoretical) defined by Glaser (1978, 1992), with the three-step approach of coding (open, axial and selective) suggested by Strauss (1987) and Strauss and Corbin (1990). Glaser's response to Strauss' version of GT is based on his critique that this 'new' version of GT forces the data rather than enabling the emergence of theory from the data (Glaser 1992). The development of the conditional/consequential matrix by Strauss and Corbin (1990) as a coding strategy is seen by Glaser as being applied to the data rather than emerging from them. Instead, Glaser proposed coding 'families' to be used to facilitate the consideration of the relationships between theoretical codes (Glaser 2005).

A further divergence between Glaserian and Strausserian versions of GT is that of the use of literature (Kenny and Fourie 2015). Glaser (1992) supported the delayed use of literature to the constant comparison stage of the study, which contrasts with

Strauss and Corbin's (1990) view that literature can be used appropriately during each stage of the study. However, Glaser and Strauss (1967:3) did originally suggest that the researcher must 'have a perspective to be able to abstract categories from the data', but that GT research does not commence with a theory derived from previous research which needs to be proven or disproven. GT is therefore not considered to be a method of verification but one of discovery (Chenitz and Swanson 1986).

3.2.3. Defining the elements of GT

The aim of GT methodology is to inductively generate a grounded theory that provides 'relevant predictions, explanations, interpretations and applications' about a substantive area (Glaser and Strauss 1967:1). Glaser and Strauss (1967:39) identify two elements of theory: categories (and their properties); and hypotheses (the 'generalised relations among them'). They suggest that 'categories and their properties are concepts indicated by the data' (Glaser and Strauss 1967:36) and the process of conceptual abstraction will render them independent from the original data, whilst continuing to have fit and relevance for the substantive area of study. Constant comparison of differences and similarities in the data generates categories and their relations. Hypotheses appear unrelated to begin with and then through the emergence of abstract categories and hypotheses their interrelations form the 'core of the emerging theory' (Glaser and Strauss 1967:40).

Coding facilitates the emergence of meaning through observing for patterns in the data and provides the scaffolding for the iterative process of defining and refining the categories and core category integral to the grounded theory. Coding strategies[17] enhance the researcher's analytical capability to question the data (Saldańa 2013) and those used in the study included initial and focused coding (Charmaz 2014). Glaser (1978:57) emphasised the importance of continuously asking the question 'what is this data a study of' during data analysis and initial coding tasks the researcher to look for action and processes in the data to initiate 'an analytic accounting of them' (Charmaz 2014:111). By using gerunds[18] the

[17] The coding strategies used in the different versions of GT (see 3.1.2) include open, axial and selective coding and conditional/consequential matrix in Straussarian GT and coding families in Classical GT. The coding strategy discussed here is proposed by Charmaz

[18] The verb form of a noun which explicates action

researcher is able to explicate action and processes in the data rather than structures, topics and themes (Charmaz 2014). Codes can be used to label the concepts that explain incidents in the data. These incidents can be recurring actions, experiences, phrases, explanations and the codes 'identify conceptual reoccurrences and similarities in the patterns of participants' experiences' (Birks and Mills 2011:93). From initial coding, the researcher engages with focused coding as part of the emerging analysis. Focused coding involves selecting those initial codes that have conceptual relevance to become substantive codes.

The process of developing theoretical sensitivity enables substantive codes to become categories that 'explicate ideas, events or processes in the data' (Charmaz 2014:89). Theoretical sensitivity guards against the proclivity of analysing data from a single professional perspective (Glaser and Strauss 1967, Strauss and Corbin 1990) and can be developed through: 'in-depth reading of the literature; personal and professional experience; using the constant comparative method of data analysis' (Noble and Mitchell 2016:34) and 'dancing with data'[19] (Hoare, Mills and Francis 2012). Background assumptions and disciplinary perspectives 'serve to illuminate certain possibilities and processes in the data' (Charmaz 2014:30). These sensitising concepts serve as a useful starting point to commence a GT study and along with guiding interests and disciplinary perspectives can act as 'points of departure for developing ideas' (Charmaz 2014.31). Reading the literature is aimed at enhancing sensitivity (using the literature as conceptual levers to develop concepts) without forcing the data into an extant theory.

Generating a grounded theory is a process that takes time and patience and may be jeopardised in the excitement of initial coding (Russell 2014). To ensure that the emerging theory is grounded in the data, constant comparative analysis and memoing are integral methods used in GT. Utilisation of these methods throughout the research process explicates patterns in the data as conceptual categories and coherently explains the patterns of relationships between them. The constant comparative method (CCM) generates abstract concepts and theories by 'comparing data with data, data with code, code with code, code with category, category with category, category with concept' (Charmaz 2014:342).

[19] A coined term suggested as explaining the process of developing theoretical sensitivity

Writing memos facilitates successive analyses of data and the abstraction of categories and their properties during the research process. In this way, thoughts, ideas, contrasts, comparisons, differences, connections, analytical directions serve to inductively and reflexively inform theory generation. Therefore, memos are considered to be 'analytic notes' (Charmaz 2014:163) and instrumental in effecting the CCM. The chronological recording of memos captures nuances in the emerging data and provides further evidencing of nascent codes, categories and concepts. Memos explicate the cyclical process of studying and analysing the emerging data (Giles, de Lacey and Muir-Cochrane 2016) and can be presented in several forms depending on the stage of the research process: a methodological journal for recording analytical decision-making; an analytical memo during initial and focused coding; a theoretical memo during identification of categories and abstract conceptualisation of the phenomena (Chenitz and Swanson 1986, Charmaz 2014).

Memoing directs further data generation by theoretical sampling and involves the process of abduction. Theoretical sampling is a strategy to explicitly refine categories and their properties and is not a process for 'sampling until no new data emerge or to find a negative case' (Charmaz 2014:197). Abduction develops new, useful and imaginative explanations and moves beyond induction to consider theoretical explanations for 'surprising or puzzling data' (Charmaz 2014:200). This process of creative reasoning includes the deductive process of returning to the data, or generating further data, to confirm the credence of these new theoretical interpretations. Theoretical saturation is a consequence of theoretical sampling and is beholden on the 'properties of the category being saturated rather than the data' (Giles, de Lacey and Muir-Cochrane 2016:E40). Diagramming is useful in crystallising categories and concepts during data generation and analysis and the grounded theory should be presented as a visual representation of categories and their relationships.

So far, this chapter has discussed the origins, emerging versions and defined the elements of Grounded Theory. The next section presents the theoretical perspective of symbolic interactionism that is commonly associated with GT.

3.3. Symbolic interactionism

The study used the theoretical perspective of symbolic interactionism (Blumer 1969). This perspective has its roots in pragmatism, an approach valuing theories and beliefs that have practical application and acknowledges 'how meanings emerge through practical actions to solve problems' (Charmaz 2014:263) and is considered to be the chief theoretical perspective associated with Straussarian GT. There are three basic tenets that are generally accepted as positioning the concept of symbolic interactionism: 'human beings act toward things based on the meanings that the things have for them; the meaning of such things is derived from or arises out of social interaction with others; and these meanings are handled in and modified through an interpretative process' (Blumer 1969:2).

This approach 'views human actions as constructing self, situation and society' and therefore provides a way of understanding actions and events (Charmaz 2014:262). The relevance of SI is in appreciating that the meaning of becoming a preterm father is understood not only from the position of what it means to the individual, but also acknowledging that this meaning develops through social interaction with others. Preterm fathers have become a father earlier than anticipated. Through the nature of the encounters with others, the meaning of premature fatherhood is not only formed but is modified through interpretative processes. Comprehending the meaning of premature fatherhood subsequently influences men's actions in the unfamiliar, novel and stressful situation of the NICU.

The theoretical perspective of SI assumes social interaction as an active process. The complexity of social life is premised on understanding the ongoing social interactions of human beings that influence their actions. This relativist position acknowledges the agency of individuals who interact, interpret and act within situations (Birks and Mills 2011). Interaction is 'dependent on language, symbols and meanings which are shared and occur within social, cultural and historical contexts of the situation' (Charmaz 2014:266). The interaction provides the conditions in which the individual then attributes meaning to his or her situation followed by action. Individuals need to 'deal with the world of their objects and toward which they develop their actions' (Blumer 1969:11). Objects in this sense are seen to be social, physical and abstract. Individuals attribute meaning to these objects, which 'forms, sustains and transforms them' and result in changes to the

action of the individual which are aligned with the changes to 'their world of objects' (Blumer 1969:12).

To facilitate an understanding of the actions/behaviours of preterm fathers, their world of objects needs to be identified in order to 'develop a familiarity with what is actually going on in the sphere of life under study' (Blumer 1969:39). This approach mirrors the directive of GT in exploring the 'main concern' of the participant, as opposed to forcing prior theories and professional perspectives onto the area of study (Glaser and Strauss 1967). Individuals are seen to 'build up separate worlds with different life situations in which individuals possess different beliefs and conceptions for handling these situations' (Blumer 1969:38).

Individuals in a given situation will act according to the meanings attributed to the situation and these meanings develop from social interaction with others (Blumer 1969). How the participants in the study defined, labelled and named premature fatherhood prompts their actions within this situation. In essence, the problematic situation of premature fatherhood has arisen because it is unanticipated and outside of the participants 'existing normative framework' (Shibutani 1986:268). Symbolic interactionism provides 'an abstract theoretical framework of premises and concepts for viewing social realities' (Charmaz 2014:262), in this instance premature fatherhood.

In the study, appreciation of these factors enabled engagement with data generation and analysis to take account of these given situations and facilitated the space for men to share their individual experiences. Prior to data generation, the co-construction of knowledge that would occur in sharing this space during the interviews with participants was appreciated. My epistemological and ontological position found resonance in a mode of inquiry that acknowledges how the researcher is part of data generation. This subsequently framed the choice of the Charmazian version of GT and the theoretical perspective of SI for the study.

3.4. Epistemological and ontological considerations in choosing Constructivist GT

Grounded theory methods may be used across different research paradigms, however the epistemological and ontological position will affect which assumptions the researcher holds and how the methods are used (Charmaz 2014). Positivist

leanings of original GT led to the development of Constructivist GT as 'a middle ground between positivism and postmodernism[20] (Allen 2011:29). The assumption that 'social reality is multiple, processual and constructed', Charmaz (2014:13) views the researcher as being part of the research situation and requires him/her to demonstrate reflexivity about the actions and decisions taken during the research process. This approach requires the researcher to explore processes and the specific social context of the participant and to generate a theory or pattern of meaning.

The epistemological positioning of the study is one of constructivism and relativist ontology. This philosophical position holds that there are multiple realities rather than an objective truth which can be discovered through social scientific inquiry (Crotty 2006, Cresswell 2013). The study explored the contextual backdrop of the transition to premature fatherhood, enabling the participants to share their meanings, understanding, feelings and actions. It proposes useful interpretations of the transition to premature fatherhood, acknowledging that meaning is co-constructed by the interaction between the participant and researcher (Crotty 2006, Charmaz 2014).

The experience of becoming a father of a preterm infant is a unique experience and how this is understood by each individual is valid and worthy of respect. Cultural and social aspects of the NICU environment, and personal attributes, characteristics and histories of the father, his partner and baby frame the experience of fatherhood. To address cultural, social and personal encounters required a research design which views knowledge as not being discovered or created but constructed through the interaction of human beings and their world (Chenitz and Swanson 1986). Rather than there being a true or valid interpretation of premature fatherhood, the study proposes useful interpretations and an explanatory theory conceptualising the meaning of premature fatherhood set within social, cultural and historical perspectives (Charmaz 2014).

I considered the participants as agents in the research process (Carter and Little 2007) appreciating the role of both participant and researcher in constructing a meaningful understanding of premature fatherhood and the researcher as 'part of

[20] 'Postmodern perspectives view all knowledge as socially and culturally constructed' with truth being 'located only in the values and interests of particular groups' (Allen 2011:26)

the constructed theory' (Charmaz 2014:260). The Constructivist GT methodology enabled men's' voices to be heard and understood within the context of premature birth. Of considerable importance is that the substantive theory provides professionals with an understanding of how men manage the preterm experience. In this way, preterm fathers are contributing to and influencing both neonatal clinical practice and neonatal nurse education.

The study reflects the respectful appreciation of the participants' meanings attributed to their experiences and that 'entering the participant's world of implicit meaning is a privilege in which you may experience precious shared moments' (Charmaz 2014:98). Sensitive and respectful exploration of how the participant made sense of their experience of premature fatherhood framed data generation and analysis. Constructivist GT accords with personal values and beliefs regarding the nature and purpose of research inquiry, with the approach of Charmaz (2014) seen as being 'collaborative, inductive and iterative' (Allen 2011:28).

Theoretical perspectives can be used to sensitise researchers to the issues inherent in the data and embracing a symbolic interactionist perspective contributed to reflexivity (Charmaz 2014). Constructivist GT provides 'a systematic approach to social justice inquiry which facilitates the exploration of inequalities such as race, class, gender, age and disability' (Charmaz 2014:326-327). Although the study did not begin with the premise of exploring gender inequalities per se, a 'gender lens' provided the opportunity to consider issues inherent in the data and explore the transition to premature fatherhood from the perspective of men. Constructivist GT supports the exploration of the meaning of the preterm experience to men and their actions to it, but it also acknowledges structural components of men's' lives that influence their actions in experiencing this novel and unfamiliar situation.

It is acknowledged that there are currently considered to be three main versions of grounded theory: Classic; Straussian; and Constructivist and that there are particular areas of convergence and divergence between them. Through personal reflection undertaken during this grounded theory study and constant referral to the grounded theory literature (including grounded theory studies), a personal understanding of the differing approaches gradually crystallized. The contentious areas of divergence between the versions of GT include: differing coding practices; polar philosophical positions; and the use of literature (Kenny and Fourie

2015:1271). It is suggested that it is in the doing and practice of grounded theory that an understanding is reached on how the differing coding practices and the use of literature permeate from the philosophical position of the researcher. Early in the study, a personal resonance with the constructivist version of GT was acknowledged. In reviewing the other two versions of GT, particularly centred on the coding procedures, an appreciation of the personal congruence with constructivist GT developed.

3.5. Evaluating the quality of a grounded theory study

It is imperative that transparency is assured in providing evidence of methodological congruity during the research process. Standards used to evaluate qualitative research traditionally stem from those used to evaluate quantitative research such as validity, reliability and generalizability. There has been a gradual appreciation over time of considering evaluating qualitative research in a more flexible way which recognises the relevance of different methods and is dependent on each specific research study (Cho and Trent 2006). From this perspective, applying set standards to qualitative research may be unhelpful and that using a 'structure of methodological best practices: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics and meaningful coherence' better serves this purpose (Tracy 2010:838). Others have synthesised the variance of viewpoints in assuring 'validity' of qualitative research and provide primary criteria (credibility, authenticity, criticality, integrity) and secondary criteria (explicitness, vividness, creativity, thoroughness, congruence) with the appropriateness of these seen to be directed by the 'interpretive perspective and research design' of the study (Whittemore, Chase and Mandle 2001:528).

Concerns regarding the critical evaluation of qualitative research, versus the scientifically validated ways of judging quantitative research, were a prime driver for the development of GT in the first place (Glaser and Strauss 1967). Glaser (1978:4) suggested the criteria of 'fit, work, relevance and modifiability' in evaluating a GT study. Cho and Trent (2006:327) propose a holistic 'process view of validity' which suggests that this is continually addressed throughout the research process. Prior to evaluating the quality and outcome of a research study, the auditable methodological process and findings of the research need to be transparent and

clearly articulated. This reflects the traditional two main areas for evaluating research: the process and the product. However, in evaluating GT methodology it is recognised that the process and theory building procedures (the science) are inherently bound up in the product, the substantive or formal theory (the art) (Charmaz 2014). Consequently, evaluating the quality of the study is inherent in the methodology and enables the reader to appreciate the methodological techniques undertaken and decisions made during the research process (presented in the next three chapters of the thesis). Assuring the quality of the study is framed by the Constructivist GT methodology and uses the criteria suggested by Charmaz (2014:337) of 'credibility, originality, resonance and usefulness'.

3.5.1. Credibility

In order to begin to provide an evaluation, it is helpful to consider the defining features of a grounded theory methodology and where these have been addressed in the study (table 3.1). This is particularly relevant following the discussion relating to the emergence of different approaches of GT outlined in sections 3.1.3. Defining the core features of GT minimises the risk of methodological incongruence and contributes to the evidence of rigour and trustworthiness.

Table 3. 1 Defining features of GT methodology (Charmaz 2014:7)

Methodological features	Evidence in thesis
Concurrent data generation and analysis	Chapters 4 and 5
Constructing analytic codes and categories from data	Chapters 4 and 5
Constant comparative analysis	Chapters 4,5 and 6
Advancing theory development during data generation and analysis	Chapters 2, 4,5 and 6
Memo-writing	Chapter 4
Theoretical sampling	Chapter 4
Conducting a literature review when developing an independent analysis	Chapters 2 and 6

The importance of adhering to best practice principles for assuring credibility was addressed throughout the research process. Four methods for assuring credibility in GT are considered in this section (Chiovitti and Piran 2003).

Let the participants guide the process: The degree to which the participants were enabled to guide the research process is discussed chapter 4. Broadly the active participation of participants in the study is evaluated during several stages of the research process: research design; ethical approval process; and data generation. Parents provided feedback on the research design and participant information and supported the development of the research protocol and meeting the criteria for securing ethical approval for the study. Intensive interviews utilising an interview agenda guided the initial interviews in the study. Intensive interviewing 'focuses the topic while providing the interactive space and time to enable the participant's views and insights to emerge' (Charmaz 2014:85). The interview agenda was therefore used reflexively during each interview and, following participant responses, revised accordingly over the course of the study.

For example, one of the ending questions for the first interview from the interview agenda (appendix v) was removed following early interviews. The question asked the participant, in light of their experience of premature fatherhood, to articulate what they would say to someone who is expecting to have a preterm baby. From the participant's non-verbal and verbal responses to this question, it was recognised that this question did not resonate with them and they were puzzled by it. In their experience, the expectation of experiencing a premature birth was not anticipated and therefore this question was irrelevant. On reflection, using an interview agenda that contains irrelevant questions supports topic control by the researcher rather than the participant (Chenitz and Swanson 1986). It results in the foreclosure on the interview providing an opportunity for the participant to explain how they perceive and address the transition to premature fatherhood.

Check the theoretical construction generated against participants meanings: GT methodology tasks the researcher to engage with the participant's meanings

through the systematic constant comparative method (CCM)[21]. Interviewing the participants on several occasions provided the opportunity for me to clarify and deepen understanding of how the participants constructed their experience of premature fatherhood. It has been acknowledged that prolonged engagement with the data, CCM, memoing, coding and categorising memos increases the likelihood that 'the theory will be well integrated and clear' (Glaser and Strauss 1967:230). In addition, 'the researcher should provide sufficiently clear statements of theory and description so that readers can carefully assess the credibility of the theoretical framework he offers' (Glaser and Strauss 1967:232). This detail is presented in chapters 4 and 5.

Use participants actual words in the theory: The interviews were transcribed verbatim and all aspects of the interview described, including the actions and emotions of both participant and researcher. Self-transcription (although time consuming) was considered to be an integral part of the data analysis process for the study (Chenitz and Swanson 1986). Memos completed after each interview provided a way of capturing emotions, body language, unexpected as well as expected participant responses. Concerns and areas for further exploration were noted and directed theoretical sampling (Charmaz 2014) to include men who had previously experienced fatherhood. The authenticity and vividness were addressed by attentive listening to each individual participant, accurate transcription, memoing and providing participant quotes to illuminate categories and the emergent theory (Whittemore, Chase and Mandle 2001).

Articulate the researcher's personal view and insights about the topic of study: It is acknowledged that the theory of the study is grounded in the data which has been constructed with, and is a representation of, the participants and researcher (Charmaz 2014, Corbin and Strauss 2015). In appreciating the philosophical origins of GT in pragmatism, the theoretical perspective of symbolic interactionism with its emphasis on language, meaning and action, facilitated an 'interpretative rendering' (Charmaz 2014:339) of becoming a father of a preterm infant. Rather than

[21] 'A method of analysis that generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with code, code with code, code with category, category with category and category with concept' (Charmaz 2014:342)

presenting an accurate report of the individual participants' interview accounts, reflexivity engenders making theoretical sense of the process of transition to premature fatherhood.

3.5.1.1. Theoretical sensitivity

The potential for prior knowledge to 'force the data' was considered throughout data generation and analysis. Entering the data generation stage of the study with sensitising concepts provided the intellectual tools to remain open to what was being said or not said by the participants during the interview. It is imperative during data generation to pay attention to the quality of the data in relation to depth and scope, in order to evidence the credibility of the study. Obtaining sufficient, suitable and quality data instils confidence in the robustness of the research findings and was established by using a questioning guide identified by Charmaz (2014:33) (box 3.1).

Box 3. 1 Questions to evaluate whether data is rich and sufficient

Have I collected enough background data about persons, processes and settings to have ready recall and to understand and portray the full range of contexts of the study?
Have I gained detailed descriptions of a range of participants' views and actions?
Do the data reveal what lies beneath the surface?
Are the data sufficient to reveal changes over time?
Have I gained multiple views of the participants' range of actions?
Have I gathered data that enable me to develop analytic categories?
What kinds of comparisons can I make between data? How do these comparisons generate and inform my ideas?

My professional background as a neonatal nurse and lecturer provides familiarity with the context of neonatal intensive care and this sensitivity is suggested as contributing to the authenticity of the study. It is essential that the interviewer feels confident and comfortable interviewing in the research topic area (Chenitz and Swanson 1986). My disciplinary perspective and background assumptions supported the framing of the research question and the emergence of 'guiding empirical interests to study' (Charmaz 2011:16). Prior to commencing data generation, personal assumptions were articulated and defined which were

influenced by the preliminary literature review, experience of working as a neonatal nurse and personal experience of having premature twins (table 3.2).

Table 3.2 Personal assumptions prior to data generation

Personal assumption	Source
Fathers may welcome the opportunity to talk about their feelings in the interviews. However skilled facilitation may be required to enable them to talk about sensitive situations that may make them feel vulnerable and exposed. They may conversely provide a strong (masculine) voice that misrepresents their underlying feelings. Therefore, questions will need to be framed that facilitate the articulation of their feelings relative to the context and conditions that frame their language and expression at that time.	Preliminary literature review Personal correspondence with a neonatal colleague completing a PhD with a similar focus
Fathers may articulate feeling out of their depth and struggle to understand their role in the process of birth and admission to NICU. Sensitive facilitation may be required to enable the participant to fully articulate their concerns and provide an opportunity for exploring an alternative perspective on this situation	Preliminary literature review Experience of working with families as a neonatal nurse Personal experience of having premature twins
Employment commitments and the technology, equipment, environment of NICU may be talked about in the interviews. These concepts are a consistent feature in the literature and what these mean will need to be considerately explored with each participant	Preliminary literature review
Midwifery and neonatal staff may be considered as important sources of support and advice. Rather than accepting this situation as expected, occasions in which this may not be the case will need to be considered. This may result in the situation in which professional concerns may come to light that require the researcher to compromise participant confidentiality and refer issues surrounding staff conduct to senior nursing staff	Preliminary literature review Experience of working with families as a neonatal nurse Personal experience of having premature twins
Fathers may articulate feeling torn between their partner and their baby. Following the premature birth of their baby the mother is not in a position to be able to accompany the baby to NICU and the father then has to make a decision to either stay with his partner and visit the NICU together several hours after the birth or accompany his baby to NICU immediately following the birth. The meanings attributed to this situation may be different for each participant and so how the decision to stay with either his partner or baby is made will need skilful exploration	Preliminary literature review Experience of working with families as a neonatal nurse Personal experience of having premature twins

Identifying a baseline position of my researcher perspective guarded against describing categories using incidents primed by my professional experience as a

neonatal nurse and facilitated the process of being able to conceptualise patterns of behaviour in the data and the abstraction of categories to build the theory. However, early in data analysis it became clear that professional perspectives and assumptions were being used in the interpretation of the data. The importance of developing theoretical sensitivity is in how it will mitigate against the risk of applying pre-existing theoretical schemes to the data, a danger coined by Glaser as 'forcing the data' (Glaser 1992). Memoing and supervisor's critical feedback preserved the development of theoretical sensitivity during the process of conceptual abstraction.

3.5.1.2. Reflexivity during data analysis

The iterative approach inherent in GT ensures the researcher stays close to the data and challenges any assumptions or presuppositions that the researcher may inadvertently bring into play. This also requires a degree of courage and trust in the process that the constant comparative method will result in the emergence of codes and categories and the building of a substantive theory. As a developing grounded theorist, this trust in the process was integral to adhering to the methodology.

I found conceptual abstraction a particularly challenging aspect of GT methodology. I experienced challenges in letting go of the data and subsequently presented detailed descriptions of data (Chenitz and Swanson 1986). Remaining immersed in the data, concentrating on description and remaining true to the narrative, fearful of losing the participant's voice, initially constrained my ability to theorise and utilise abstraction to identify categories and their properties and how these related to the developing theory. This dichotomy was resolved in part by using gerunds during data analysis which captured the participant's experience. Engaging in reflexivity during academic supervision meetings, memoing and the CCM provided integral processes for affirming methodological congruence and adherence to the GT method. Reading other grounded theory researcher's experiences provided reassurance that these challenges were not unique and reaffirmed that in experiencing this process, the outcome would be a crystallisation of a working knowledge of this methodology (Sbaraini et al 2011, Ralph et al 2014, Russell 2014, Birks and Mills 2015).

During the course of the study I also encountered feelings of inadequacy which I recognised as 'imposter phenomenon' (Ramsey and Brown 2018), a consequence

of my developing academic researcher identity (Hutchins 2015). This resulted in a period of time during the study when conceptualisation slowed considerably and was only resolved through consistent memoing and returning to the data. Memos were used throughout the research process to promote the progression of theoretical sensitivity and resolve the issues of professional bias. Post interview memos explicated my initial interpretations and assumptions of the patterns in the data. A methodological journal (see box 3.2 for an excerpt example) recorded how personal, professional and experiential history influenced the methodological decisions taken throughout the research process and illuminated how personal anxieties were affecting this process. Supervision by two academic supervisors further enhanced reflexivity during each stage of the study by challenging and refuting my assumptions and articulation of emerging categories as the research study progressed. Attendance at GT special interest group meetings provided collegiate exploration of the various forms of GT and a forum to share experiences of undertaking a GT research study.

Box 3. 2 Excerpt from methodological journal during early data analysis

Identifying headlines and saturating the data 3.11.15
Prior to this supervision meeting I was very conscious of the fact that I was doubting the process I had gone through to arrive at the concept of **realising fatherhood** through **diminishing self** and **deferring to others** set within a framework of **unoriented fatherhood**. I realised that I wanted to identify an abstraction of what was happening in the data and during the meeting it was highlighted that the data I had currently were insufficient to undertake this level of abstraction. I was jumping the gun and in doing so had made a theoretical leap without clearly demonstrating the audit trail of the analytical process taken to arrive at this point. The process of 'dancing with the data' was reinforced, the importance of the inductive method and returning to the data again and again. The importance of constant comparative analysis was also stated in comparing across transcripts rather than just focusing on individual transcripts. The process of abstraction begins with constant comparative process. I need to line up participants and look for patterns also looking for what is missing. Everything is data- trust the process. Use gut feelings and insights and challenge these with the data. Do these marry up with the data? If not why not? I need to interrogate the data. What I have been doing is taking them at face value rather than digging deeper, explaining the process that is going on rather than the outward evidence of this. Suggested that I have feelings as a concept and then code everything about feelings from all participants.

Think about what are the headlines and complete a memo ending with a question – so what now, what does this mean?
What do we know already about men's' experiences of pregnancy and transition to term fatherhood?
What are the participants feeling?
What are the participants doing - activities?
It is a strange and alien situation but is this the NICU or becoming a father?
What about the physical space – territory?
What about stereotype – gender? Should this be linked to feelings?
What about the biography of the participant – age, married, not married, other siblings, prior experience of babies
What about time?
What, where, when, how and why?

The above methodological strategies enabled my views and insights to be considered as an integral part of data generation and analysis and as such subject to the techniques and procedures inherent in the process of generating a grounded theory. They are offered here as the context for considering the credibility of the research process presented in the next chapter and the development of the grounded theory (discussed in chapter 6).

3.5.2. Originality

The use of storyline as an analytical technique in grounded theory was originally suggested by Strauss and Corbin (1990) as a way of conceptualising the core category. Glaser (1992) was dismissive of this methodological strategy considering it to force the data to fit into a prescriptive framework. However, a storyline can be seen to present the unique research process for each grounded theory study. It articulates the theoretical conceptualisation of a phenomenon through the creative integration of 'concepts, categories and relationships in the data' (Birks et al 2009:408). In building the case for how the grounded theory has been generated from the data, gaps and inconsistencies are highlighted and direct the researcher back to the data (Charmaz 2014). In essence, a storyline can explicate how a grounded theory provides a novel contribution to knowledge and offers new insights into a specific substantive area. The storyline for the study therefore begins in the next chapter and culminates in chapter 6 with the presentation of the grounded theory.

3.5.2.1. The literature review

Glaser (1998) recommends the researcher goes into the field and finds out the main concerns of the participants, rather than beginning with preconceived hypotheses from the available literature (Glaser 1998). The timing of the literature review in GT has therefore been the focus of some debate. First generation grounded theorists stated that a literature review on the substantive area of study should not be undertaken prior to commencing the research study. The argument is knowledge of the research literature relating to the topic of study potentially precludes the emergence of theory that is grounded in the data. Glaser (1998:67) contends that the researcher needs to be 'as free and open as possible to discovery and to the emergence of concepts, problems and interpretations from the data'. The relevant literature will not be known prior to data generation and only becomes known during the process of theory development. From this perspective, concepts, interpretations and connections from prior reading of the literature and then developing a pre-conceived problem, jeopardise not only the fit and relevance, but the originality of the emerging theory.

However, Charmaz (2014) considers it prudent to learn about the situation before entering as a researcher. Not doing so risks the integrity and quality of the researcher's conduct and it could be argued is disrespectful to the participants. It may jeopardise the ability of the researcher to have the skills to elevate conceptual description to theoretical integration and a grounded theory. An understanding of the situation can be gained from personal and professional experience and from the literature and promotes the ability through CCM to be open to appraising emergent categories.

By virtue of their disciplinary background, seminal grounded theorists were already cognisant of the contemporary 'grand and middle range' sociological theories relating to social life and it could therefore be argued that they held prior knowledge and were sensitised to the intricacies and nuances of social processes. Sociologists therefore can identify patterns in the data in relation to social life despite a lack of knowledge relating to the specific unit of analysis. Having said that, Glaser and Strauss (1967) contend that there are too few sociological theories to cover the broad and diverse areas inherent in social life, and therefore this sociological knowledge has its limits.

The literature review is therefore contentious at the beginning of a GT study and its role premised on the identification of there being a specific research question or area of research interest (Yarwood-Ross and Jack 2015). The research question was deliberately broad to encompass all elements of the social process of becoming a preterm father. A non-committal literature review (chapter 2) was undertaken in order to evaluate the extent of current knowledge relating to premature fatherhood, define the research problem and to meet the organisational requirements of doctoral research study. In this instance as Glaser (1998) advises, using this literature as data was acknowledged as providing a point of departure rather than a pre-existent theory (Charmaz 2014). Recourse to the literature (perceived as data) was undertaken during data generation and constant comparative analysis to facilitate the abstraction of concepts and advance theory development (Charmaz 2014). The on-going review of the literature (chapters 2, 4 and 6) was used 'to enhance theoretical sensitivity, as data during analysis, and as a source of theoretical codes' (Birks and Mills 2015:22). The position of the theory of premature fatherhood is positioned in relation to extant theory (chapter 6) and offers evidence of how this theory provides new insights for explaining the social process of becoming a father of a preterm infant following admission to a NICU and discharge home.

3.5.3. Resonance and Usefulness

The fittingness (Glaser and Strauss 1967, Chiovitti and Piran 2003), usefulness (Glaser and Strauss 1967) and resonance (Charmaz 2014) of a study can be explicated by defining the scope of the research in terms of the sample, the setting, and the level of theory generated (substantive or formal) and describing in what way the literature relates to the emergent categories in the theory. The grounded theory should provide clear categories that 'fit' by being 'readily applicable to and indicated by the data' and 'be meaningfully relevant to and be able to explain the behaviour under study' (Glaser and Strauss 1967:3). The theory should make sense to the participants and was assured by the methods inherent in GT and receiving feedback from participants (member checking).

Member checking is used in qualitative research as a validation tool for the trustworthiness of results (Carlson 2010) or to enhance interpretative

understandings (Birt et al 2016). In critiquing the purpose of member checking in a number of qualitative paradigms, Thomas (2017) suggests there is no evidence to support its use in research focused on theory development. In addition, the dilemmas inherent in asking participants to verify transcripts[22] has led to a cautionary note if including this as part of the research process (Carlson 2010). In acknowledging these considerations, transcripts were not made available to the participants. However, a summary of the theory of premature fatherhood and suggested ways healthcare professionals might support preterm fathers was made available and this provided the opportunity for participants to comment on how this interpretive rendering of premature fatherhood resonated with them.

Dennis (2018:113) suggests researcher positionality in the interactive space of the interview, enables participant's 'truth claims to be validated'. From this perspective, validity comes from the study's interactive research activities rather than external acts and is considered 'relational validity' (Dennis 2018:117). My interaction and engagement with preterm fathers during the interviews were premised on generating a sensitive and caring interpretive understanding of premature fatherhood. This took the form of displaying genuine interest in and respect for the emic perspective. Listening intuitively and reflexively sought to enhance the ability to theoretically conceptualise meaning and give voice to preterm father's experiences that offer practical insights for men and practical applications to neonatal clinical practice and education. The social and theoretical significance of this grounded theory for preterm fathers, neonatal practitioners and neonatal educators is outlined in chapter 7.

Summary

This chapter has presented the epistemological and ontological position of constructivism and relativism, the theoretical perspective of symbolic interactionism and Constructivist GT methodology that guided the study. The chapter discussed the considerations for evaluating how best practice principles were used to assure quality and how these informed the research process presented in the next chapter.

[22] For example, complete transcriptions with grammatical errors causing embarrassment to participants; participants perceiving their 'performance' during the interview in a negative way; the ethical considerations of participants being left with upsetting or negative feelings; managing feedback from participants who significantly edit the transcript

Chapter 4 Research process

4.1. Introduction

Ten intensive interviews with seven fathers meeting the inclusion criteria facilitated data generation; seven of these were arranged following the infant's admission to NICU and three following the infant's discharge home. All the interviews were transcribed verbatim and data analysis progressed through initial and focused coding, memoing and constant comparative analysis to generate categories and their properties of the substantive theory. Sensitising concepts highlighted during a preliminary review of the literature influenced the framing of the interview agenda and provided some ideas and directions to explore such as: feelings of shock and loss of control; feeling an outsider; concern for his partner and infant; and the evolving identity of being a father.

4.2 Defining the unit of analysis

Specifying a concept and maintaining a focus on this, is one aspect of GT which is commonly missed by many novice GT researchers (Birks and Mills 2015). Specifying the unit of analysis[23] is seen as integral to generating theory, and comparing the unit of analysis with other units highlights the 'distinctive elements or nature of the case studied' (Glaser and Strauss 1967:25). In this instance, the case study being explored would then be compared with both similar and different situations.

The unit of analysis for this study is fathers' experience of becoming a parent of a preterm infant in a particular situational context, during admission to NICU and following discharge home. Specifying the unit of analysis relied on professional knowledge and a preliminary review of the literature. The decision of when to interview fathers was informed by guidance from service user feedback[24], the literature, and motivated by wishing to capture father's real time experience of the process of transition to fatherhood during their baby's admission and following

[23] Examples of traditional units of sociological analysis given by Glaser and Strauss (1967) are those of taxi-dance halls, ghettos, high schools i.e. the focus is on the situation which is problematical, rather than the individuals.

[24] An online resource (*Ten briefing notes for researchers*) was hugely beneficial when considering the first step of involving service users in the research study design (INVOLVE 2012). In addition, as part of their *make it clear* campaign, the online resources regarding plain English provided valuable information when designing the participant information.

discharge home. One way of understanding term father's experiences of the phases of transition to fatherhood is in terms of their emotional reaction; identifying their role as a father; and redefining self and the partner relationship (Chin, Hall and Daiches 2011). The experience of term fatherhood was therefore used as the alternative unit of analysis. The transition to fatherhood is deemed to occur over time and through the experience of pregnancy, labour, birth and the postnatal period (Villamor, Guzman and Matienzo 2015). In the context of the study, interviewing the participants over a period of time provided the opportunity to explore their experiences during the phases of transition to premature fatherhood.

Fegran, Fagermoen and Helseth (2008) identified three distinct phases for parents experiencing NICU: the acute critical phase (birth and immediate period of time after this); the stabilizing phase (baby's condition gradually improves); and the discharge phase (the period of time associated with discharge from hospital). The literature also highlighted the importance of fathers' experiences following their baby's discharge home (Jackson and Ternestedt 2003, Deeney et al 2012). The initial period following birth and during the first few weeks of admission to NICU is a crisis event for fathers, but this is the time when the father may not be at work and is more able to be with his infant and partner. However, normally a father will then have to return to work for the duration of his baby's admission. This change in the father's parenting role and their involvement in the discharge process is another phase of transition to premature fatherhood that was highlighted in the literature and supported by service user feedback: '*I agree that an interview should be conducted after discharge as this was a particularly difficult/challenging time*' (member of BLISS *Fathers' Voices*[25]). Cognisance of the transition phases of fatherhood supported the decision taken to interview on three occasions.

4.3. Ethical approval process

The risks and benefits to the participants required careful evaluation through an ethical approval process that was anticipated, and proven, to be lengthy. This process involved the university research ethics and governance committee; the

[25] *Fathers' Voices* is part of BLISS, the main UK charity working to provide the best possible care and support for all premature and sick babies and their families. The charity commissions its own research and is currently supporting £7.5 million of research in neonatal care. It also actively supports those planning research studies involving parents of premature and sick babies, with a dedicated section on their website for Health Professionals and research (BLISS 2015).

NHS Research Ethics Committee (REC); and the local NHS research and development office (R&D). However, before the ethical approval process was embarked upon, public engagement was obtained in line with good practice (NIHR 2006).

Service users were involved in the initial research design phase (INVOLVE 2012[26]). To gain service user engagement in the first instance the local parent's forum was attended. The membership of this forum includes parents who have had a preterm baby on the local NICU and nursing and medical staff from the local NICU. The forum provides opportunities for parent consultation on procurement of equipment for the NICU, on nursing and medical research studies and the results from both clinical audits and parent feedback. At the meeting attended to present the study, the attendees included just one father and following the presentation of the research study and distribution of the participant information sheet (PIS), the women were the only ones that provided feedback on the study design. They raised concerns regarding the interviews, which they perceived as fathers '*sitting and chatting and having a cup of tea*' with me soon after the birth of a preterm baby, with the inference that the father should be with his partner and baby at this time. The responsive suggestion of ensuring that the mother was present when information about the study was provided and consent gained reassured the forum members that the importance of including the mother would be acknowledged and this would provide transparency during recruitment to the study.

These concerns did have significant personal resonance, which centred on appraising the ethical principle of non-maleficence in terms of the father spending time away from his family to take part in the interviews at a critical time in his family's life (Wilman et al 2015). Following a period of reflection, these mothers' comments were then evaluated in the light of the notion of the centrality of women in pregnancy and childbirth. It also affirmed how the participant's partner's views may affect recruitment. Respectful consideration of how research is understood by parents and nurses informed the design of the study, particularly regarding the consent process. Recruitment needed to be managed sensitively, remaining cognisant of the

[26] INVOLVE, is funded by the National Institute for Health Research (NIHR) and acts as a national advisory group to support public involvement in NHS, public health and social care research

acknowledged importance of promoting family dynamics while ensuring that the focus of the research inquiry was not lost.

Participation in research is enhanced if consideration is given to a number of elements. The stressful NICU environment has been shown to affect parental perceptions of time when deciding to be involved in neonatal research (Hoehn et al 2009). The importance of providing enough time for parents to give consent, demonstrating effective communication, acknowledging parental stress and fostering trust between parents and the researcher has been highlighted (Hoehn et al 2009). One further element highlighted by Hoehn and colleagues (2009) was that of parents citing absence of their partner as the reason for not feeling able to consent to taking part in the research study. Research into parental decision-making in the neonatal period focuses mostly on gaining consent for involvement of the infant in clinical studies. However, the presence of both parents during consent for non-therapeutic neonatal research increased the likelihood of a positive response (Korotchikova et al 2010).

These elements were integral to the design of the study. In addition, recognising that the first three days of an infant's admission to NICU is a shock and stressful for parents (Provenzi and Santoro 2015), consent for inclusion in the study and the first interview were conducted after the third day and within the first two weeks of NICU admission. The philosophy of family-centred care is promoted in NICU and underpins neonatal nursing practice in engaging parents in care giving interventions (Lee et al 2014, Voos et al 2015). The primacy of both parents as the constant in their child's life is acknowledged and as such each is recognised as having an important contribution to make. The initial design for the study therefore sought to reflect the importance of involving both parents during recruitment in line with the NICU philosophy of family-centred care and recognising the dynamics of parental relations.

Specific feedback from fathers was obtained from *Fathers' Voices*[27], a national father's forum. BLISS were contacted during the early stages of the study and with their consent provided the contact details of members of *Fathers' Voices.* The

[27] *Fathers' Voices* is part of BLISS, the main UK charity working to provide the best possible care and support for all premature and sick babies and their families. The charity commissions its own research and is currently supporting £7.5 million of research in neonatal care. It also actively supports those planning research studies involving parents of premature and sick babies, with a dedicated section on their website for Health Professionals and research (BLISS 2015).

members of this forum are all fathers who have had premature babies and they provided constructive comments on the study protocol, letter of invitation, PIS and consent form. Their feedback included: refining the PIS with consideration given to using plain English; clarification on interview timings if the baby is only on NICU for a few weeks; the process for the situation if a baby dies; and clarification on the risk assessment procedures. The importance of public engagement has been reinforced (Macfadyen et al 2011) and involving fathers in the research design stage reaffirmed the value of the research focus and increased the likelihood that other fathers would be interested in participating in the study.

The six key principles of the Economic and Social Research Council (ESRC) (2015) guided the methods undertaken in the study (table 4.1)[28].

Table 4. 1 The methods taken to meet the ESRC's six principles

The six key principles of the Economic and Social Research Council (ESRC)	Evidence for meeting the six key principles
Research participants should take part voluntarily, free from any coercion or undue influence, and their rights, dignity and (when possible) autonomy should be respected and appropriately protected. There is a very fine line between sensitively promoting participation in a research study and inadvertently applying undue influence. This was particularly salient when contacting the participants for the discharge interview.	Recruitment process (section 4.3:73) Arranging interviews at a convenient venue and time Potential participants were initially approached by the nurse caring for the baby and the timing of this was sensitively decided upon by senior nursing staff who were aware of the baby's clinical condition. As the nurses on the NICU are experienced in caring for families who are being approached to take part in both nursing and medical research studies, they were able to ensure that the potential participants were made aware that the care of their baby would not change if they took part in the study or not. Enabling the participant to direct the interview When communicating with a participant by mobile phone, it was important to pick up on any tones in their voice that might indicate that continued consent may be tenuous.

[28] Building on the Nuremberg Code of 1947, the Declaration of Helsinki was signed by the World Medical Association in 1964 and has undergone several revisions (1975, 1983, 1989, 1996, 2000, 2008, 2013). It outlines the set of ethical principles that should guide all research involving human beings. The four ethical principles of autonomy, justice, beneficence and non-maleficence have been considered during every stage of this research study, from the preparation for submission to the Research Ethics Committee (REC), during data generation and analysis and dissemination.

The six key principles of the Economic and Social Research Council (ESRC)	Evidence for meeting the six key principles
Research should be worthwhile and provide value that outweighs any risk or harm. Researchers should aim to maximise the benefit of the research and minimise potential risk of harm to participants and researchers. All potential risk and harm should be mitigated by robust precautions.	Preliminary literature review identified the gap in this area Enabling the participant to direct the interview Researcher attentiveness to participant's words, actions and meanings to minimise harm Participants were reminded during each interview that they did not have to respond to any questions they did not feel comfortable with answering. Respectful pauses and a gentle and sensitive interview style promoted a safe and secure 'space' for the participants to explore very personal and emotive thoughts and feelings.
Research staff and participants should be given appropriate information about the purpose, methods and intended uses of the research, what their participation in the research entails and what risks and benefits, if any, are involved.	PIS developed with service user consultation Continuous verification of participant's continued consent to be involved in the study Opportunities provided at the end of each interview for the participant to ask the researcher any questions
Individual research participant and group preferences regarding anonymity should be respected and participant requirements concerning the confidential nature of information and personal data should be respected. Anonymity and confidentiality of records and data were protected in accordance with the Data Protection Act (1998), the University of Brighton guidance (2010) and the Confidentiality NHS Code of Practice (DH 2003).	Each participant was given a pseudonym Any names of partners, children or places used by the participant were anonymised when transcribing the interviews Electronic data securely stored for 10 years and then deleted and rendered irretrievable.

The six key principles of the Economic and Social Research Council (ESRC)	Evidence for meeting the six key principles
Research should be designed, reviewed and undertaken to ensure recognised standards of integrity are met, and quality and transparency are assured.	Assuring quality of the study is discussed in section 3.5:52. Attendance by the researcher at regular supervision meetings throughout the study Presentation by the researcher at the annual Brighton Doctoral College Postgraduate Research Student Conference Participation in the school's grounded theory specialist interest group When communicating with a participant by mobile phone, it was important to pick up on any tones in their voice that might indicate that continued consent may be tenuous.
The independence of research should be clear, and any conflicts of interest or partiality should be explicit	The study was subject to the University of Brighton research governance procedures and audit

4.3.1 The research governance process

Public engagement through the two advisory forums and collaboration with the Trust medical and nursing neonatal research staff provided key advice when developing the study design. Initially the research protocol stipulated that the mother would be present during the recruitment process and one of the exclusion criterions was no consent from the mother. However, during the REC ethical review meeting this latter point was challenged and it was stipulated that the father could and should act autonomously to give his consent and that this process need not include the mother.

However, feedback from *Fathers' Voices* had not raised any concerns regarding involving the mother. These points were confidently raised in response to the REC member's scrutiny of the research study but were not totally accepted. The dichotomy of being required to demonstrate public engagement in the research study design and then this subsequently being disregarded was perturbing. However, in acknowledging the REC as having expertise in reviewing numerous research studies, their recommendations were accepted and, as Walker and Read (2011:17) suggest, highlighted how the gatekeepers involved in the ethical review

process are ‘autonomous and powerful’. This was subsequently not found to be an issue during recruitment to the study.

4.3.2. Managing vulnerability

The tension between autonomy and non-maleficence, the participant’s vulnerability and the right to choose was acknowledged during the study. At every stage of the research process, the participant’s vulnerability was thoughtfully considered, and this was particularly significant during recruitment for the first interview. It is known that the initial period following birth and during the first few weeks of admission to NICU is a crisis event, with the baby’s clinical outcome unknown and time spent with their baby and partner important (Provenzi and Santoro 2015). Therefore, asking the participants to take time away from their family to be involved in an interview could be seen, at one level, as doing harm. However, the importance of ensuring that the voices of vulnerable people are heard, acknowledges how research can be an instrumental way in which this can occur (Liamputtong 2007).

At the beginning of the study, it was therefore anticipated that the benefits of the study to the participants may be nebulous and it was considered unlikely that participants would receive direct benefit from participating in the research study. However, authors have tentatively suggested that there might be benefits for research participants. Walker and Read (2011:16) in their qualitative research study into the preferred place of death for hospice patients proposed that some of these benefits included ‘having the opportunity to talk about this sensitive issue; having their views listened to and valued; and having the opportunity to contribute to research that might improve patient services as well as future medical and nursing training on end-of-life care’. Fathers participating in other research studies have suggested that in being listened to they felt valued and that their experience matters: ‘a positive and validating experience’…. ‘it makes me feel like people care’ (Arockiasamy, Holsti and Albersheim 2008:221). Macfadyen et al (2011), in their experience of involving fathers in research, found that fathers appreciate being able to talk without the presence of their partner and can offer suggestions on how neonatal services and facilities can be improved. Craethern (2011), in her phenomenological study of fathers’ lived experience of having a preterm baby, found that the participants were all eager to be part of the study and welcomed the

opportunity to be able to talk about their experiences. It was therefore anticipated that this would also be the case in my study.

The participants articulated the importance of having the opportunity to talk about their experiences suggesting: *men don't really talk about their feelings as such so it's nice to know that other people are feeling the same….*(Harry interview 1); *you know just talking… having this conversation makes sense ….I can understand probably why I am where I am…… because when you listen to yourself say it all ……*(Tim discharge interview). The opportunity provided by the interview to hear their own story appeared to benefit the participants on many levels. Being able to take time out and talk about the stressful and emotive situation they found themselves in seemed to help them to clarify and understand what was happening. The participants experienced feelings of being marginalised and without a defined role at the birth of their preterm baby and during the first few days of admission to the NICU. The focus was on their partner and baby, which is endorsed by health professionals and family and friends. For health professionals this focus is predicated on meeting the physical and clinical needs of the mother and baby. However, the participants all recognised the importance of ensuring that fathers' voices are heard and appeared to welcome the opportunity to talk about their experiences.

During the interviews the participants were asked to describe their experience of becoming a father of a preterm infant. Talking about personal experiences may invoke feelings and emotions that may be difficult for participants and cause discomfort and distress. A distress protocol was adapted for use during the study (appendix vii) and the process for managing this distress was made known to the participant prior to the interviews and included in the PIS and consent form. Some participants did become emotional during the interview, and the distress protocol was adhered to. However, no interview needed to be stopped. If during the interview it had become apparent that the participant may benefit from a referral to another professional, such as a counsellor or psychotherapist, then this would have been sensitively discussed with the participant at the time. If the participant had requested to see another professional, then a referral to the neonatal unit counsellor would have been made for an appointment which normally can be arranged within seven days and usually much sooner. Prior to the interviews, to ensure non-maleficence,

the nurse and medical staff caring for the participant's infant were also made aware that the interview was taking place and were then available for support during or after the interview if the participant had needed it.

4.3.3. Outline of the research process

In May 2014, the NRES Committee for the East of England – Essex (REC reference 14/EE/0170) gave a favourable ethical opinion of the research study subject to a few conditions. Confirmation that the resubmitted documents complied with the approval conditions of the REC was received in November 2014 (appendix ix). The research governance manager at the NHS Trust participating site granted NHS Permission (R&D approval) in May 2015 (IRAS 123953). Recruitment to the study commenced in July 2015. A summary of the study can be seen in table 4.2.

Table 4. 2 Summary of research process

Date	Event
October 2011	Registration and induction to MPhil/PhD
January - June 2012	Attended and successfully passed research method module Research Plan Approval (RPA) meeting
March 2014	University Faculty Research Ethics and Governance Committee approval
May 2014	Favourable ethical opinion by NRES Committee for the East of England – Essex subject to conditions
November 2014	Confirmation that the resubmitted documents complied with the approval conditions of the NRES Committee for the East of England – Essex
May 2015	NHS Permission (R&D approval)
July 2015	Data generation commenced Four interviews
July - November 2015	Data analysis Two interviews (one discharge home interview)
May 2016 – July 2016	Two interviews
October 2015 – April 2016	Preparing four chapters to be included in the transfer document
April 2016	Successful transfer from MPhil to PhD
February 2017 – April 2017	Two discharge home interviews
December 2017	Allocation of new supervisor following change of supervisor circumstances
April 2016 – December 2017	Preparing a draft thesis and submitted to supervisors for review in December 2017
January – June 2018	Editing of thesis following supervisor feedback
July 2018	Submission of final thesis

Research training included attendance at modules, workshops and events provided by the University Researcher Development Framework (URDF) and membership of the Grounded Theory Special Interest Group (SIG). The research methods module was successfully achieved during the first year of study. Attendance at specific sessions provided by the URDF included obtaining ethical approval; grounded theory methodology; interviewing as a research method; Unit 2 preparing for RPA; and Unit 3 preparing for transfer. Membership of the University's Grounded Theory Special Interest Group (SIG) provided a forum to continually extend knowledge of this methodology. The SIG provided opportunities to attend sessions including: creativity; writing a story line; a presentation and Skype session with international grounded theorists; and a presentation and discussion on grounded theory and symbolic interactionism. Annual presentations at the Brighton Doctoral College Postgraduate Research Student Conference provided a valuable resource for sharing research knowledge. Regular meetings for academic supervision supported the progress of the study.

4.4. Access to and recruitment of participants

Recruitment for the study commenced with initial sampling from a NICU in the local Neonatal Clinical Network (NCN), with the decision to choose this NICU being essentially a pragmatic one[29]. Adhering to the ethical principles of justice[30] and autonomy[31] it was imperative that potential inclusion in the study should be open and fair to all. To reduce the risk of coercion, access to participants was negotiated through the nursing staff who acted as gatekeepers. The 'goodwill' demonstrated by gatekeepers and the relationship between the researcher and gatekeeper has been shown to 'facilitate, constrain or transform the research process by opening and/or closing the gate' (Sanghera and Thapar-Björkert 2008:543). The goodwill of the nursing staff was dependent on the extent of their clinical workload, competing demands in recruiting for other medical research studies and their professional

[29] The NICU has a consultant research lead and the unit is actively engaged in medical research studies. Permission to conduct the study had been gained from the consultant research lead and the neonatal nurse matron and an honorary NHS Trust contract secured. These processes were facilitated by personal knowledge of the NICU through previous employment as a senior neonatal nurse.

[30] The bioethical principle of justice includes the two elements of equality and equity

[31] The bioethical principle of autonomy is to respect an individual's right to act independently without coercion

judgement in identifying participants. Fathers were approached by staff if they met the following criteria:

Inclusion criteria**:**

- Father aged 16 years and over and who is in a relationship with the infant's mother at the time of the infant's birth
- Preterm infant born between 23 and 35 weeks gestation
- Preterm infant admitted to the Neonatal Intensive Care Unit with the length of stay anticipated to be at least a week

Exclusion criteria:

- Diagnosed congenital anomaly of the baby
- Poor prognosis of the baby and unlikely to survive the neonatal period (first month of life)
- Maternal ill health

I was invited by the Consultant Neonatologist Research lead to publicise the study by presenting on nursing staff team away days and at Clinical Governance meetings attended by senior nursing and medical staff. Engaging and supporting nursing staff during the recruitment process was facilitated by securement of an NHS Trust honorary contract. Being present on the NICU afforded the opportunity to gently remind nursing staff about the study, whilst acknowledging the context of their competing clinical responsibilities.

The attitude of nurses to neonatal research has been shown to influence whether or not they actively promote a potential participant's engagement with the research process (Singhal et al 2004). During several occasions of being present on the NICU it became clear that staff were inadvertently preventing access to potential participants by suggesting valid reasons for why it may not be appropriate to inform the father about the study. These reasons were embedded in the staff perceiving the father to be vulnerable and exercising a protective role, rather than enabling the father to act autonomously in deciding to take part in the study or not. Over one hundred envelopes containing the invitation letter and PIS were handed out by nursing staff and therefore the integral role of nursing staff in facilitating access to potential participants is respectfully acknowledged. The participants were given a

minimum of twenty-four hours to consider whether they would like to take part in the study.

4.5. Interviewing as the method of data generation

The process of data generation will inevitably affect their content. The relationship between the researcher and participant is complex, with the participant sharing their personal experiences and the researcher attending to and analysing action and process (Charmaz 2014). Ethical and methodological dilemmas arise when undertaking qualitative research and centre around the issues of research control, power relations and knowledge ownership (Karnieli-Miller, Strier and Pessach 2009). There appears to be no correct or optimal relationship in qualitative research between the researcher and participant, with many variations evident in the literature (May 2011). The relationship and the role of participant and researcher are dependent on the methodology and discipline and it has been suggested that there appears to be polar points of view on how the social research interview should be conducted (May 2011). This ranges from a more detached relationship that assumes more reliable data to full engagement in the interview relationship.

Qualitative research utilises informational, intensive and investigative interviewing strategies but constructivist grounded theorists normally use intensive interviewing (Charmaz 2014). The interview can be viewed as facilitating the provision of an interactional space in which the participant shares their experiences with the researcher as well as a 'research space' (Murphy, Wilkes and Jackson 2016:16). Viewed as a 'flexible and emergent technique, intensive interviewing results from interviewer and interview participants' co-construction of the interview conversation' (Charmaz 2014:58). The interview as a data generation method enabled the gathering of 'rich data to provide solid material for building a significant analysis' (Charmaz 2014:23). The intensive interview facilitates the in-depth exploration of the participant's understanding of their experiences and provided an opportunity for me to respectfully seek clarification and further elaboration of ideas and issues raised by the participant at the time.

The interviewer should have flexibility, intelligence and emotional security in order to skilfully facilitate the intensive interview particularly if sensitive topics are likely to be raised (Chenitz and Swanson 1986, Petty 2017). Flexibility during the interviews

was demonstrated by me being comfortable with silences, not suggesting answers and facilitating the participant to end the interview when they needed to. During the interviews probing appropriately and sensitively was integral to enabling the participants to explore their experiences in a way that was acceptable to them, supported by responding respectfully and non-judgementally to their responses. The neonatal unit environment is a sensitive context in which clinical deterioration can occur very quickly in a preterm infant's health. Prior to the interviews, verification that it was still appropriate to conduct the interview as planned was assured. The nurse and medical staff caring for the participant's infant were aware that the interview was taking place and were available for support during or after the interview should the participant have needed it. During the study one of the participant's very premature twins had died five days before the interview took place. This was the first interview of the study and the opening question from the interview agenda resulted in the participant talking extensively for twenty-five minutes with the whole interview lasting nearly two hours. The participant talked freely about his emotions relating to the death of his son… *they brought him in the incubator and they disconnected all the lines and they took him out of the incubator put him in our arms and when we were ready they disconnected him from the ventilator and they took out his tube… I don't think that until we had him in our arms that I really felt like..actually this is my son.* The interview allowed for an empathetic space, facilitating the participant to talk freely about his experiences and enabling him to direct and end the interview in the manner of his choosing.

Demonstrating sincerity, empathy, communicating warmth and putting the participant at ease was affirmed by one of the participants during the interview. He was defining the characteristics of the nurses he preferred to care for his baby and touched on how he judged people on first meeting them *….in life you either bond with someone or you make an instant….so for instance when I met you I …I ….as a person you automatically judge that person you do …you think what is that person like you either like that person…* The practical considerations given to facilitating the interviews are outlined in table 4.3 and are framed by attentiveness and responsiveness to the participant's unique situation and emotional needs (Morris 2015).

Table 4. 3 Practical considerations of facilitating interviews

Communication	This was facilitated via mobile phone. Following giving consent to be part of the study, it was verified with the participant that this would be the preferred means of communication. This strategy worked well during the study, with a text or phone call on both sides confirming interview dates and times and any changes to arrangements.
Dress code	In order to adhere to the local Hospital NHS Trust infection control policies and be permitted to enter the NICU nurseries, the researcher wore clothes that facilitated being bare below the elbow. The researcher's attire was professional, in addition to being comfortable and cool. When conducting the discharge interviews at the participant's home, consideration was given to presenting a professional image and being respectful of the fact that I had been invited into their home.
Punctuality	It was imperative that I arrived for the interviews in good time. During the baby's stay on NICU, arriving early provided the opportunity to make sure that the participant was still able to be interviewed and time given to preparing the room. Depending on the time of day arranged for the interview influenced how much time was needed to ensure punctuality. Car parking around the local NHS hospital during the day is limited and personal knowledge of the hospital facilitated being able to park and have the required coinage for payment to be on time. The discharge interviews were conducted in the participant's home and having the postcode for the address resulted in punctual arrival for the interviews.
Venue	The R&D office lead had suggested that if a suitable venue for the interviews on the NICU was unavailable, a quiet room could be used at the Clinical Investigation and Research Unit (CIRU) in the local NHS Trust hospital. Following several unsuccessful attempts to book a room at the CIRU due to lack of room availability, the interviews during the baby's hospital stay were conducted on the NICU. Finding a quiet venue in the NICU at fairly short notice was a constant challenge, with the matron's office, a parent's room (containing a folded up sofa bed and chair) and a consultant's office being used. When staff offices were used, confidential and sensitive information was removed for the interview, the telephones were muted and a do not disturb sign attached to the door. The chairs were positioned facing each other but not too close with a table to the side for the digital voice recorder, glasses of water and a box of tissues. The participant's partner and the nurse caring for his baby were informed of the venue in case the father was needed.

Digital voice recorder	All the interviews were digitally voice recorded using a small inconspicuous voice recorder with an inbuilt microphone. The quality of the recording for all the interviews was excellent and ensured that an accurate transcription of the interviews was achieved.
Interview agenda	An interview agenda (appendix vi) was adapted from Charmaz (2011: 30-31) and included open-ended initial, intermediate and ending questions. During the first few interviews it was utilised, however, as my confidence increased in both interview technique and in exploring the topic, it was used more infrequently. A notepad and pen were available for all the interviews, but this was rarely used. The focus instead was on listening intensely with careful consideration given to body language and non-verbal communication. The first and second face to face interviews were conducted on the NICU to reduce the potential risk that accompanies lone working. The third interviews were conducted in the participant's home and strategies put in place to minimise the risk of lone working in this situation (lone working policy appendix vii).

The interviews were arranged at a day and time convenient to the participant. Careful planning and consent for each interview enabled the participant to be in control of his engagement with the study. Conducting the interviews on the neonatal unit during a scheduled visit by the participant to see his infant reduced the burden of taking part in the first and second interviews. However, it is acknowledged that the time taking part in the interviews is time the father could have been spending with his infant. It was anticipated that interviews would be cancelled at very short notice due to the dynamic changes that can occur in a preterm infant's health. Sensitivity and flexibility with arranging and conducting interviews during the study was demonstrated. There were several occasions when the participant arrived later than arranged, or the interview was postponed or on one occasion the participant did not turn up. There were valid reasons for these unexpected changes. Participant biographical information using pseudonyms (NMC 2015) is presented in table 4.4.

Table 4. 4 Participant biographical information

Participant	Age	Marital status	Employed	Gestational age	First time father	Ages of other children	Interview 1	Interview 2	Interview 3
Frank	45	Married	In between jobs	24/40 twins -one infant died at 1 week of age	Yes	N/A	July 15	Interview arranged but participant had to cancel	Interview arranged but participant unwell
Arthur	29	Engaged	Full-time employed	31/40	Yes	N/A	July 15	Unable to arrange	Declined
Tim	36	Engaged	Full-time employed	30/40	Yes	N/A	July 15	Unable to arrange	November 15
Harry	30	Engaged	Full-time employed	33+6/40	Yes	N/A	July 15	Unable to arrange	Declined
Eric	35	Married	Self-employed	28/40	No	6 and 4 years	November 15	Unable to arrange	Declined
Robert	35	Married	Full-time employed	30/40	No	10years	May 2016	Unable to arrange	April 2017
Harrison	38	Married	Full-time employed	24/40 twins -one twin had died earlier in the pregnancy	No	6 years	July 2016	Unable to arrange	Feb 2017

There are limitations to intensive interviews (Morris 2015). The interviewee may present information that they perceive the interviewer has asked for or which portrays them in a certain way. In the study, a careful, concerned and compassionate attitude was displayed during the interviews which facilitated the participants feeling comfortable enough to share thoughts and feelings that they suggested they had not shared with anyone else. All the participants appeared to be able to talk frankly about their experiences, thoughts and feelings. Below are excerpts from memos completed following the interviews which captured the immediate reflections on how the interviews went (table 4.5).

Table 4. 5 Reflection on interviews

Memo: reflection on Frank's interview
I had an overall sense that this father was very engaged with the research process. He came across as a very intelligent, intense man who as we progressed through the interview it became clear that he had been carefully considering the things that he would say in the interview that may be helpful to other fathers. He had very recently experienced the death of one of his twins (5 days ago) but still really wanted to continue to be part of the study.
Memo: reflection on Tim's interview
I had an overall sense that this father was very happy to be open about his feelings and experiences using language that I would anticipate he uses in everyday life. He expressed feelings of becoming a father in terms of loss of previous lifestyle (luxuries and time), recognising that he was selfish, fearful of responsibility, that he would be a good enough father and also excitement. This seemed to consider realigning his expectations of being a father with the reality of now being a father. He expressed that the birth was terrifying, and he was more concerned about his partner rather than the baby. Once his partner was ok he visited the baby. He acknowledged the situation and himself being managed by the professionals and needing to trust them, letting them steer him but recognising how disempowering this was and how this created vulnerability and dependability
Memo: reflection on Tim's discharge interview
I had an overall sense that this father was very happy to be open about his feelings and experiences using language that I would anticipate he uses in everyday life. His baby was on the unit for 10 weeks and had a number of readmissions in the first few weeks following discharge. He sees his role as facilitating the world of his partner and baby and to some extent resents this, he expressed feelings of extreme stress, being the provider and being excluded, experiencing being so stressed and in a scary space not known before. I had a feeling of disquiet during and following this interview. This seems to be from two main concerns: one is his articulated concerns regarding the 'scary space' he finds himself in currently; and the other is to what extent was this interview a cathartic almost therapeutic situation. This interview overall was predominantly presenting the negative aspects of becoming a father and this seems to be understood in terms of having to be the provider, being left out/almost abandoned feeling stressed/depressed and there was a sense that he was finding being at home with his son far more difficult than being on the unit. However, towards the end of the interview he recognised through talking why he was experiencing these feelings and articulated the healthy ways in which he was dealing with his stress. The second concern was that as a professional I needed to provide some advice with regard to the second schedule of immunisations which were due in a few weeks. His son had had a seizure which occurred in the 24 hours following the first schedule of immunisations. His partner naturally was inclined not to have the second schedule of immunisations but I felt I needed to advise them to speak to the health visitor/GP and I also suggested that it was important that his son as a preterm baby had his second schedule of immunisations

Memo: reflection on Eric's interview
This participant has had 5 premature babies, 2 of which died in the first few days of life last year. These babies died of cystic changes resulting in a very quick deterioration following birth. The X-rays of these babies have been sent to centres of excellence around the world and has not been seen before. At the time of the interview the same cystic changes had shown up on this baby's third X-ray. A high dose course of steroids had just been completed and it was a matter of a waiting game to see if his baby continued to do well. I did not really have to use the interview agenda as he was happy to just talk through his experiences.

The apparent willingness of the participants to share their experiences is evidenced by the openness of the participants in expressing their experiences, such as: *..if I'm really honest not giving a monkeys about the baby* (Tim interview 1); *that's the most difficult thing I think in reconciling that to yourself it's sort of saying you know as much as there's this really tiny thing that's completely dependent on me in a really dangerous risky fragile place whatever there's still this other bit of me that's still completely self-centred and really only concerned with my own needs* (Tim interview 1); *I guess….being yeah men don't really talk about their feelings as such so it's nice to know that other people are feeling the same* (Harry interview 1); *I hadn't thought about the name idea that's actually a bit sad yeah no this is one thing I expected my children to be baptised in a church with all my friends and family around not in an incubator at 4 am with some priest who I don't know* (Frank interview 1).

There are other limitations of the intensive interview that have been considered. Intensive interviews can take up large amounts of time and effort to organise and transcribe. It is recognised that a one hour interview can take six to eight hours to transcribe (Morris 2015) and this proved to be the case. However, the process of listening to the interview, transcribing it, listening to the interview again and amending the transcript proved to be an essential part of being immersed in the data (Charmaz 2014). From a social constructivist perspective, the interview is not just the content of the interview, but also takes note of what the participant has not articulated, the body language and non-verbal communication of both researcher and participant. The interview is therefore 'a site of exploration, emergent understandings, legitimation of identity and validation of experience' (Charmaz 2014:91). Completing reflective memos following each interview facilitated the possibility of emergent meanings.

4.6. Reflexivity

In assuming that 'social reality is multiple, processual and constructed' (Charmaz 2014:13), research is considered to be a construction, and the researcher, as part of the research situation, is required to demonstrate reflexivity about their actions and decisions during the research process. A number of definitions of reflexivity exist which have been broadly framed within three main areas: as a methodological consideration for qualitative research; as a social activity undertaken by everyone; and as an individual activity of self-consciousness (Doyle 2013). The subject of qualitative health research often focuses on participant's experience of illness and healthcare and can mean that emotive and potentially distressing stories are related during the research process. As the interview may be seen as a social interaction in itself, the behaviour, values, and beliefs of the researcher can influence the conduct of the research process.

In the study, there existed a potential conflict of roles between being a nurse and a researcher. During the process of conducting emotional interviews there is the potential for a 'blurring of roles' (Ashton 2014:27). This was planned and prepared for during the development of the research proposal. Memos following emotional interviews (table 4.6) and a methodological journal facilitated an exploration of the personal emotional response to what the participants were saying and how this contributed to the construction of meaning in the data generation process (Valentine 2007). These personal responses were considered as data and therefore incorporated into the data generation and analysis process (Glaser and Strauss 1967).

Table 4. 6 Examples of memos following emotional interviews

Reflective memo on the nurse as a researcher
This first interview was particularly challenging. The participant had experienced the birth of his twins at a very early gestation and the interview was conducted less than a week following the death of one of the twins (Frank-interview 1). Despite his recent bereavement, this participant was very keen to be involved in the research study and the interview lasted nearly two hours. During the interview, distressing and emotional concerns were raised by the participant and I was very conscious of sensitively and thoughtfully responding, whilst carefully maintaining reflexivity during the interview. Later, reflecting on my emotional response to that interview, I recognised that I had physically 'held' this participant's story for a number of days as a feeling of physical chest pain. I found myself hearing echoes of the participant's voice

and I came to realise that I was experiencing the conflict inherent in the role of the nurse as researcher. As a nurse listening to the participant's concerns, I would have responded in very active ways to care for and meet the needs of the participant. As a researcher I realised that I was listening rather than caring as a nurse. However, I invoked aspects of the nurse's role by subsequently asking the participant at the end of the interview if there was anything that we had discussed during the interview that he wanted me to take back to any of the neonatal staff.
During this interview it became apparent that the participant had not yet had a cuddle with his six day old son even though the baby's clinical condition had not precluded this from happening (Harry-interview 1). He appeared to have foregone his 'entitlement' to a cuddle with his baby, deferentially giving this time to his partner. Reflexively my initial response as a neonatal nurse was to take action to inform the nurse caring for this family advocating for the participant to be able to have his first cuddle with his baby. However, as a researcher, I consciously resisted this and instead sensitively explored with the participant what had prevented him from holding his baby up to that point.

Reflexivity has been described as 'the researcher's scrutiny of the research experience, decisions, and interpretations in ways that bring him or her into the process' (Charmaz 2014:344) and involves 'accounting for oneself in the research' (Cutcliffe 2003:137). A number of strategies have been presented as facilitating transparency to enhance the trustworthiness of qualitative research. One of these is the use of reflexive journals which should include personal as well as methodological presuppositions and decisions. Another strategy is to make a priori knowledge and values explicit and this involves the ability to be self-aware (Cutcliffe 2003). However, drawing on the psychology literature, the extent to which a researcher can demonstrate self-awareness is questioned. Cutcliffe (2003) cites the work of Luft (1969) who presented a model of self-awareness as the 'Johari window' and argues that this supposes that an undefined amount of personal values and beliefs may remain in the unconscious. In addition, it is recognised that the concept of self, including self-awareness, self-consciousness and values and beliefs are continually revised in response to interactions and experiences during everyday life. Therefore, the suggestion that a researcher can display total self- awareness which is a given for all time is contested.

Empathy and transference in the research interview can impact on reflexivity (Cutcliffe 2003). The notion of empathy as the ability to put yourself in another's shoes in order to understand their lived world is utilised in therapeutic contexts as

well as research contexts. Within the research context, the researcher is exploring the participant's understanding of the experienced phenomena, acknowledging their feelings and how they make sense of it. The expression of emotions and feelings may be transferred from the participant to the researcher and this transference may not be obvious or acknowledged. The researcher then leaves the interview having been affected by the interview process. In acknowledging the origin of any feelings experienced, the researcher contributes to the credibility, authenticity, or trustworthiness of the findings by attributing these feelings to the participant and not to themselves. The emotional consequences of interviewing participants about sensitive issues have been acknowledged in the literature (Ashton 2014, Petty 2017). In the study an unexpected emotional impact was experienced during transcription of the interviews, a finding echoed in the experiences of research assistants (Ramjan et al 2016).

The concept of tacit knowledge and its importance in the inductive process has also been acknowledged (Cutcliffe 2003) and whether the interaction of tacit knowledge, creativity and intuition can be articulated through reflexive activities. Cutcliffe (2003:145) concludes that excessive reflexivity 'might inhibit intellectual entrepreneurship' as the focus is more on the researcher accounting for themselves rather than using their creative, analytical and interpretative skills during the research process. Cucliffe (2003) embraces using tacit and intuitive knowledge and endorses the tenet of using theoretical memoing and suggests articulating the researcher's background and interest in the substantive area prior to commencing a qualitative research study. Engward and Davis (2015) successfully used this strategy in a doctoral thesis in which the author wrote a prologue to contextualise how the research evolved. The influences of being a woman, neonatal nurse and mother of preterm twins on the researcher role were acknowledged through the supervisory process, memoing and maintaining a reflective journal, to ensure that the interpretation of feelings originated, as far as possible, from the participants; and acknowledging how tacit and intuitive knowledge played a role in generating categories.

Doyle (2013) draws on psychoanalytic theories to articulate the influence of the capacity to think on reflexivity and critiques the positions of relational psychoanalytic theories, such as that of Bion, to explain the process of how human beings 'make

sense of the world through the relationship between self and other' (Doyle 2013:249). These psychoanalytic theories have been extrapolated from observing parent-infant relationships and seeking to understand the process of how human beings develop the ability to think and learn and adapt this understanding when faced with differing experiences during life. The concept of the parent's mind as being a 'container' for the baby's experiences has been suggested (Doyle 2013:250). Acting as a container, the parent's mind holds the baby's experiences and then can think about these, process them and make sense of them. This relationship enables the baby, infant, child and young person to develop their own capacity to think and this positioning of how life and relationships are experienced are referred to as states of mind.

These states of mind are not static but affected by interpersonal and intrapersonal factors during social interactions (Doyle 2013). The concept of a containing relationship can be seen in different situations and contexts throughout life and has some resonance with the research interview. The interview can be viewed as a relational communication between the researcher and participant in which both parties consciously or unconsciously may be affected by the sharing of an experience. This can lead to the perception that the interview has shifted focus to include both the researcher self and the participant self and can have the potential to lead to a 'muddled and blurred merger of selves' (Finlay 2005:289). The capacity to think is essential in counteracting this and entails 'both a quality and state of mind and, simultaneously, a practice in which to actively engage' (Doyle 2013:251).

Reflexivity therefore needs to be present in every aspect of the research process and should not be limited to simply presenting the researcher's self - knowledge as a disclosure of self, without due regard to thinking about aspects of self in relation to the context, purpose and focus of the research study (Doyle 2013). Reflexivity should also to be evidenced in interview interactions, as states of mind can change during a social interaction and this can provide the researcher with the opportunity to remain attuned to these changes. This provides assurance 'that the capacity to think is regained' with this process being seen as reliant on 'authentic contact with other and authentic contact with self' (Doyle 2013:252). Reflexivity is therefore framed not only within the emotional and personal experiences of the researcher

and participant, but also relies on the capacity to think about and analyse these experiences in relation to the research study.

The importance of engaging in reflexivity about preconceptions assures methodological rigour and keeping a methodological journal supported the articulation of any 'dilemmas, directions and decisions' experienced during the research process (Charmaz 2014:165). Keeping a journal advanced memo writing and supported the illumination of any researcher attributes that may have influenced data analysis. This was particularly relevant as the research subject is within the context of my own professional discipline.

The impact of gender on interviewing has been examined in relation to gender identities being framed within masculine or feminine discourses. Pini (2005) appraises several research studies undertaken by a female researcher interviewing male participants which highlight the influence of masculine and feminine discourses on the research process. Women researchers have documented actively moderating their femininity in terms of appearance when interviewing participants in order to foreclose any potential sexual advances. Conversely, women researchers have also highlighted how gender differences may enhance the research process, as women are perceived to be unthreatening and good at listening (Grenz 2005) which may facilitate opportunities for men to share sensitive experiences (Chiswell and Wheeler 2015). Closer scrutiny of gender differences in the interview process therefore renders a more complex interpretation of the process and suggests other social attributes may be at work, other than gender alone.

Pini's (2005) own research explored women's involvement in leadership in the Australian sugar industry and following completion of the study, she re-read and re-analysed her data focusing on the interview process itself. From this she suggests that it was not just the research topic that had an impact on the interview, but the context within which the topic was framed. She argues for moving away from a simplistic exploration of the gender of the interviewer and interviewee, towards examining how the influencing factors of who, whom, what and where interact in order to provide a more critical and reflexive stance of the research process. There is some evidence to suggest that male participant preferences for researcher gender are not specific and may be influenced more by the research subject (Yager, Diedrichs and Drummond 2013).

The gendered dynamics of the interview process was an aspect that had been considered from the beginning of the study. Childbirth and neonatal care are set within a female dominated context. The majority of midwives and nurses are female and increasing numbers of medical staff are female. Poulton (2012) presents her reflections on being a female researcher studying football hooliganism and defines three key concerns she experienced when undertaking gendered research: gaining access; entering and developing rapport within the subculture; and doing gendered research in the hyper-masculine field. She argues that it is imperative for the researcher to consider the 'positioning, practices and performances of the gendered self in the gendered field' (Poulton 2012:9). Although an ethnographic study, the advocacy for avoiding 'gender blindness' has relevance for the study. The perceived hostile response to this study when it was presented at the Parent's Forum resulted in a period of time of critical reflection on the justification for interviewing fathers at a critical and sensitive time in the lives of their family. This reinforced the notion of childbirth being the domain of women, with men being outsiders in this process. The tension between the needs of the mother to have their partner with them and the needs of the father to be able to take part in the study was acknowledged. It was important to ensure that the participant's agreement to take part should not result in adding to the family's emotional burden or contribute to tensions within the parent's relationship at a stressful time in their lives.

4.7. Data analysis

The theoretical perspective offered by symbolic interactionism enhanced both 'methodological direction and theoretical insight' for the study (Charmaz 2014:279). I experienced the challenge of remaining theoretically sensitive during data analysis, being open to the data and not foreclosing on emergent concepts which is a common experience for researchers new to GT (Reay, Bouchal and Rankin 2016). Following initial data generation and analysis, feelings of 'drowning in data' and being unable to make analytical sense of what was happening were experienced (box 4.1). Feeling overwhelmed and tolerating ambiguity has been identified as a condition relating to the researcher (Chenitz and Swanson 1986) and fosters the required analytical skills to move from description to explanation involving conceptualisation, abstraction and becoming theoretically sensitive (Charmaz 2014). The sensitising concepts of action, meaning, process, agency, situation,

identity, and self were found to be useful throughout data analysis and in building the theory. The constant comparative method in a grounded theory study mitigates against pre-conceived ideas and assumptions. Initial coding requires immersion in the data and is the process for initially describing and understanding what was happening in the data. Focused coding is a process that is engaged with during further analysis and conceptualisation leading to theoretical sensitivity and abstraction of the data.

Box 4. 1 Considering context, conditions, consequences

Corbin and Strauss suggest that the context is a broad term that includes many things: events, the set of circumstances or conditions that make up any situation, the meaning given to these (a goal, problem), the action and interaction persons take to manage or achieve desired outcomes and the actual consequences that result from their action (2015:155). It seems that concepts can be conditional factors, action-interaction or anticipated/actual consequences/outcomes (concepts= action, conditions, consequences) (2015:156).

Context: this is becoming a father of a preterm baby admitted to a NICU. I have identified it as **realising premature fatherhood** as it is the reality of the birth of the baby-confirming the outcome of the pregnancy and the process of coming to know what it is to be a father of a preterm baby. What else could it be - fearing the unknown, experiencing premature fatherhood, comprehending premature fatherhood, becoming a father of a preterm baby

Conditions: answer to the questions why, when and how come. **Perceived reasons given for why things happen and the explanations given for why they respond in the manner that they do through action-interaction – cue words such as because, since, due to, when**

Why – no reason other than the sudden and unexpected birth of a preterm baby, no warning, some experienced pre-warnings but still a shock when it occurred, admission to NICU required as a preterm baby

When – occurs at birth with the pregnancy for first-time fathers described as being unreal and not tangible, experienced father suggested the bond occurs after birth

How come – baby not tangible not real in pregnancy, sudden unexpected situation of being a father to a baby that is in danger and not with the mother, preparation for baby disrupted, NICU - entering the rigmarole, sitting yourself in the rollercoaster for the duration, no choice and even if you had a choice this would absolutely be the choice you would make, being discharged home and realising responsibility

Actions-interactions: what meaning in the form of a problem, goal was given to these conditions or set of events? What particular action-interaction was taken to manage the problem or reach that goal?

During the birth first-time fathers were staying out of the way of the professionals but supporting their partner, concern was for the partner rather than the baby, conflicting loyalties at birth not sure where I should be, experiencing empty room-being left behind, visiting the NICU and being overwhelmed by strange, alien environment, being reassured by seeing baby, speaking to staff, seeing the monitors (for Eric the monitor was a locus for warning of a deterioration in his baby's

condition), big shift – everything is sort of shone in a different light really, fear of the unknown, feeling disconnected (guilty, distressed) – Frank didn't feel like a father for a week and refrained from even touching his son as he did not want to interfere with the best care, and Harry anticipated feeling like a father when his baby was discharged home, forming a connection, comprehending losing his baby, promoting mothering, supporting and promoting the mother-infant dyad, staying with partner, being close to baby and mother, deferring to professionals, being in a half-way house, cosy blanket, slow-time in order to adjust to being a father , comprehending the NICU process, business of fitting everything in – texts, visits, meal times, quiet times

<u>Consequences</u>: are anticipated or actual outcomes of action and interaction. Actual or anticipated consequences can be to self or to others and can be physical, psychological or social and can generate emotions and spur further action or change the direction of action-interaction.

Being in shock – go with the flow, herded like sheep, own momentum, witnessing, limiting self, deferring to others, being stressed, high anxiety, not able to celebrate birth, coping with relatives, juggling day to day living, going to work, social chatting with staff, not rocking the boat, holding the losing hand, being a spare part, being lonely, being supernumerary.

I am not sure how to move on from this because I seem to be rigidly stuck and am struggling to apply the matrix. It feels like forcing the data and I need an approach that is more flexible. I will therefore continue memoing and interrogating the data to see if I can move on. I will refer back to Charmaz and also consider sensitising concepts from SI: Action, Meaning, Process, Agency, Situation, Identity, Self to interrogate the data

Conceptual levers such as emotions/feelings, space, time, status passages and rites of passage were consequently used to interrogate the data to elicit categories and their properties. The transition to parenthood is different for the mother and father (Draper 2003) and can be understood by acknowledging the context of the biological and social transition to parenthood. Both the physical and social transition to motherhood begins earlier for the mother with the physical changes of pregnancy. The transition to fatherhood is for the most part a social transition realised gradually through different time lines: pregnancy, birth and early fatherhood, with the physical manifestation of becoming a father confirmed at birth. The context which frames this transition for fathers is the social process which incorporates both comprehending the sudden and unexpected physical reality of having a preterm baby and the process of coming to know what it is to be a father of a preterm baby during the admission to NICU and following discharge home.

4.7.1. Initial coding

In accordance with Charmaz (2014) data analysis commenced with line-by-line coding using gerunds. This technique facilitated staying close to the data and fostered theorising rather than summarising (table 4.7) and presented opportunities to remain open to seeing processes and actions. The importance of developing theoretical sensitivity during the coding process is integral to GT and enabled me to define preterm father's experiences in abstract terms.

Table 4. 7 Example of initial coding

Excerpt from transcribed interview (Robert's - interview 1)	Initial codes
it is a struggle because you're just putting your feelings aside ..you know I found it hard I knew I had a daughter but I didn't see it that I had a daughter I didn't feel like I had a daughter all I came up to see you know when {name of partner} *came home we'd come back up and we'd be coming to see a baby in a box you know I didn't have I've struggled to get a connection with* {name of daughter} *because I was constantly making sure that* {name of partner} *was getting cuddles*	Struggling on Remaining strong Rationalising the situation Feeling a cognitive and emotional disconnect Juggling responsibilities Distancing from baby caused by technology Struggling to form a connection Championing mothers' needs Keeping an eye Fathering role on hold

4.7.2. Memoing

Memoing was consistently undertaken throughout data analysis to ensure that the codes reflected the data and were not influenced by my preconceptions. The following memo presents how the concepts of bounded agency and autopiloting were initially considered as tentative avenues for exploring preterm father's experiences:

Analytical memo: bounded agency

Rather than the focus being on the individual's attributes informing their agentic action, bounded agency defines the situation within which the individual is constrained. Choices are made within the flow of situated agency and for preterm fathers this requires them to be in two distinct physical spaces: the NICU which includes their partner and baby; and life outside the NICU which includes their partner, work, and other children but does not include their baby. The novel situation of a premature birth has resulted in a spatial dislocation and unorientation. The temporal expectations of family formation have been disrupted by the premature birth. There is no time or space for fathers and therefore in negotiating a fathering presence they are trying to fit in with the mother-baby dyad. The mother-baby focus of the midwifery and NICU environments pulls the father into a vortex of championing the mother-baby dyad. They are perceived to be the important ones in this situation. Robert repeatedly stated – *it is not about me*. This requires them to stand aside and allow the professionals 'vicarious parenting'. However, they enact a watchful monitoring role that aligns them with the professionals and keeps them on their side. Marshalling care-getting is important and they recognise that they are beholden to the nurses. They just get on with it and are acting on autopilot. This explains how preterm fathers are acting but not really why. It feels like this is part of something more and I need to go back to the data to explore the concept of space and the NICU environment and also time. Giddens (1991:86) suggests 'all social interaction is situated interaction – situated in space and time'. *The oak fought the wind and was broken, the willow bent when it must and survived.' — Robert Jordan, The Fires of Heaven*

These concepts were helpful in developing a theoretical understanding of premature fatherhood that moved beyond focusing on what was happening to how preterm fathers manage the novel situation of a premature birth. Memos led to further data analysis by comparing incident with incident to extrapolate patterns in the data that inform the categories of the substantive theory. Table 4.8 presents the comparison of incidents from two participants related to how preterm fathers defer to his partner and healthcare professionals to ensure that his baby receives high quality care. This led to using the code *deferring to others* as providing analytical direction in understanding why preterm fathers promote the role of his partner and the healthcare professionals above his fathering role.

Table 4. 8 Comparing incident with incident

Excerpt from interview 1 with Harrison		Excerpt from interview 1 with Frank	
I am very glad that not only has my little boy got his mum he has also got all these amazing people that are looking after him. If no one was dealing with…this is it, if no one was dealing with {name of son} *I would do it myself but there are better people equipped i.e. those medically trained and his mum already around him I feel like there's absolutely no point in me trying to push them out of the way to reinvent the wheel*	Appreciating mothering role Rationalising the situation Realising the presence of healthcare professionals Acknowledging standing back as others better placed to care for his baby Rationalising the situation Recognising others can better meet his baby's medical needs Moving aside	*You can't do anything so you can sit and stare at the baby because it's such an alien place and because as parents you can't do anything you can't do anything at all meaningful so er doing cares and changing nappies is great for getting a connection it needs to be done but on the other hand it doesn't need to be done by us because there is this wonderful team of nurses who would be doing it anyway*	Being redundant Adopting an observing role Rationalising the situation Experiencing unfamiliar and novel situation Being role-less (useless) Participating in parenting activities Forming a connection Ensuring baby's needs are met Realising the presence of others Acknowledging vicarious guardianship of healthcare professionals

In vivo codes are specific terms used by participants that can illuminate meanings in the data and can inform theoretical sensitivity (Charmaz 2014). The concept of time as creating a situation of living on hold emerged during data analysis and preserving the participant's own words as codes condensed the meaning of how time is experienced by preterm fathers. Examples of in vivo codes include: *having*

time out; experiencing slow time; appreciating NICU as a half-way house; being in a holding pattern; the world stands still; being submerged. Through constant comparison these in vivo codes captured an understanding of how preterm fathers construct premature fatherhood and how this understanding influenced their subsequent actions. These codes therefore informed the analytical process of focused coding and through theoretical sensitivity enhanced the conceptual level of the emerging categories.

4.7.3. Focused coding

Focused coding involves sifting and sorting through initial codes and reviewing memos to extrapolate those codes which 'make the most analytic sense to categorise the data incisively and completely' (Charmaz 2014:138) and results in the explicit conceptualisation and abstraction of larger segments of data. For example, the initial codes of *monitor watching* and *keeping an eye* were conceptualised in the focused code of trenchant monitoring (table 4.9).

Table 4. 9 Example of focused coding

Data segment	Initial codes	Focused code
I walked in there and I just crumbled it was like I didn't know what to do I was looking at the machines… you've got heart rate you've got the saturation and you've got the respiratory…..I look at it as what I think is normal between the heart rate of 120 and 140 the saturation at above 95 I hate it going above 95 if it goes down to 90 I get anxious and the respiratory because I know about what the respiratory does I don't like it going above 100 or under 10 ….this beeping this alarming so you're scared	Monitor watching	Trenchant monitoring

You do you make sure that the whole thing is holding together working properly everyone is happy and doing what they need to be doing I suppose and it's all just ticking along and any problems that come along you try and sort them out as uneventfully as possible if you know what I mean just try and not make a big deal of it and just get on and try and sort it out whatever it is	Keeping an eye	

Memoing and keeping a methodological journal (see 3.2.3) facilitated data analysis and informed defining substantive codes and emerging categories (box 4.2).

Box 4. 2 Example of an analytical memo

Analytical memo: NICU as a space

Space of parenting activities: The NICU is the situated space for defining their identity as a preterm father. It promotes fulfilling the complete parental role on hold. HCPs are operating vicarious parenting. This results in moratorial fathering in which the father's role as being more back stage is sanctioned. The mothering role is brought to the fore more both by the HCPs, family and friends and to some extent by society. The important role that the mother will have in caring for the baby following discharge is understood by preterm fathers very early on. The father recognises that the mother is the best person to take on this role and then actively promotes this in a number of ways. The sense of inhabiting parallel worlds relates to two physical spaces (NICU and work/home/social) but also to the fact that preterm fathers experience time as moving on but they are standing still with regard to fully enacting their parental role in the formation of the family

Space of monitoring: The technological environment of the NICU, including the monitors and the need for large numbers of staff, symbolises the need for monitoring their sick baby who is in danger. The more preterm the baby is the greater the vulnerability and justification for the need for monitoring. The use of medical language further medicalises the situation and parents will subsume this medical terminology to be able to comprehend the unknown and uncertain situation they are suddenly in. The meaning making for preterm fathers in this situation is the acknowledgement that their family is in danger and they need to work with (rather than against) HCPs, who are experts in the

clinical management of preterm babies. The gendered aspect of parenting for preterm fathers relates to them appraising and rationalising the situation. Surveyancing incorporates the strategy of monitoring the mother and baby in NICU and following discharge home. It is a way of continually appraising the situation to manage the uncertainty of being a parent to a preterm baby. Garnering information is key and a strategy for keeping track of the level of his family's welfare.
Space of caring: Preterm fathers may gain solace from speaking to other fathers whilst others prefer to use their current friendship ties for support. The HCPs become agents in supporting preterm parent's transition to motherhood or fatherhood. They are experts in caring for preterm babies and can impart knowledge and information related to caring for a preterm baby. The HCPs therefore replace the role of families and friends in providing advice and support for the new parents. This support is appreciated as *a cosy blanket, a safety net* and then following discharge there is a sense of betrayal and having to take sole responsibility for the baby which had been shared. The effect of NICU means that life needs readjusting again once the baby is discharged home from living a life polarised by the preterm baby in hospital to shifting the central focus away from the premature experience and accommodating everyone's needs in the home environment.
Outside of NICU, preterm fathers are engaged in activities of their established life world with responsibilities and connections associated with multiple networks[32] Need to have a look at the boundary zone in systems theory (spaces of action at boundaries) and social geography literature

4.7.4. Defining the substantive theory

Theoretical sensitivity is the ability of the researcher to give meaning to data in abstract terms by way of insight and understanding of the fundamental processes of participant's concerns and actions. The process of developing theoretical sensitivity enables substantive codes to be defined as categories and their properties made explicit. Theoretical sampling is the process of saturating the categories with data and involves abductive reasoning (Charmaz 2014). Further data generation and analysis is guided by creative consideration of theoretical explanations that account for the patterns in the data. The process of abduction acknowledges how doubt can enhance theoretical purchase by expounding possible explanations for surprising findings. The temporal experiences of premature birth and the impact of the NICU environment were conceptualised through recourse to literature from other disciplines (table 4.10).

[32] 'Upon entering the NICU, parents' external life often comes to a jarring halt while they become an agent of critical influence in the life of their fragile infant' (D'Agata and McGrath 2016:248).

Table 4. 10 Summary of defining and refining categories

Autopiloting (living on hold)	Surveyancing (vigilant attending)	Auditioned theories
Survivorship: ➢ total trusting (relating to 'own and wise others'), ➢ appreciating visual manifestations of being cared for ➢ façading (it's not about me), impression management, emotional distance needed to adjust ➢ waiting for an outcome (loss and grief, facing mortality, trauma)	**Safeguarding/championing mother-infant dyad**: ➢ marshalling care-getting (hypervigilant and only intervening if needed e.g. breastfeeding angst) ➢ arbitrating or mediating (coalition, cautious in raising concerns as could get it wrong) ➢ shared caring	Social identity theory Stigma Ontological dissonance Life course theory Liminality: moratorium – being in abeyance (a state of being suspended or put aside temporarily; a legally authorized postponement of the fulfilment of an obligation; an agreed suspension of activity) Survivorship Transition theory – change as helical Gendered experience NICU as a socialization agent (context enables the enactment of father identity, social community) Uncertainty theory Communication theory Social geography theory
Standing aside: ➢ occupying a liminal space, ➢ displaced agency, ➢ bounded agency (moral obligation-orbiting/encircling and anchored by NICU) ➢ preserving motherhood ➢ forfeiting fatherhood (disrupted biography) ➢ mediated fathering by proxy through others ➢ enacting a transitional presence/merely situated/situated fathering	**Trenchant monitoring:** ➢ encountering and interpreting technology ➢ rationalising the situation (being ill prepared - missing out on antenatal education) ➢ appraising the situation (reconfiguring fatherhood) ➢ NICU as an alien, surreal and overwhelming environment ➢ being on tenterhooks ➢ vigilant attending ➢ enduring the ups and downs (emotional labour of NICU) ➢ experiencing the whole range of emotions (mirrors the baby's illness trajectory)	
Soldiering on: ➢ gendered role – instrumental	**Taking stock:** ➢ establishing a connection (fragility of baby)	

caring vs emotional caring, 'don't rush me', ➢ being time poor – negotiating a fathering presence	➢ sanctioning his presence ➢ NICU experienced as a cosy blanket ➢ appreciating other children ➢ befriending other families (communitas) ➢ stress-related growth	
COP: realising premature fatherhood, revisioning fatherhood, surviving moratoria, enduring a moratorium, being in abeyance, transcending uncertainty		

The category defined as autopiloting was eventually refined as *negotiating boundaries* and the temporal dimensions of the experience of premature birth (captured by the in vivo code of *living on hold*) found to be an important element of a higher concept that explained *surveyancing* and *negotiating boundaries*. Moratorial fathering was identified as the core category for understanding the social process of premature fatherhood. The category of *surveyancing* explains how fathers manage the uncertainties of the preterm situation and *negotiating boundaries* explains why their fathering role is in abeyance (table 4.11).

Table 4. 11 Initial and substantive codes and categories

Initial Codes (these represent a small sample of the larger number of initial codes)	**Substantive Codes**	**Categories**
Having no defined role Staying out of the way Observing traumatic birth events Being managed by staff Promoting mothering role Acknowledging shock of premature birth Orientating to the situation Assuring safekeeping of family Receiving information from staff Managing everyday life Being managed and feeling safe	Deferring to others Standing aside Trusting professionals Soldiering on Rationalising the NICU environment Living in parallel spaces Conflicting loyalties Being emotionally strong	**Negotiating boundaries** Preterm fathers are negotiating the physical, social and interpersonal spaces encountered as a consequence of premature birth Preterm fathers manage this negotiation by:

Needing to be in two places at once Acknowledging lack of social support Feeling isolated Defining role as supporter Defining the NICU environment as stressful, tense, alien Acknowledging vicarious guardianship of professionals		-deferring to others (both mother and health professionals) - total trusting - standing aside - façading - soldiering on
Adjusting to parenthood Questioning feelings of fatherhood Anticipating the loss of the baby Experiencing the loss of a baby Feeling disconnected from the baby during the pregnancy Feeling disconnected from the baby at and following birth Defining the birth process as terrifying	Delayed fathering Experiencing a surreal situation Living in fear Living on hold	**Core category: moratorial fathering** Their fathering role is in abeyance as a result of the need to negotiate boundaries and manage the uncertainties of prematurity
Worrying about partner during birth rather than the baby Recovering from shock of premature birth Affirming baby's condition Monitor watching Experiencing oscillating emotions Putting partner's needs before his own Defining mother as immediate care giver	Safeguarding mothering role Taking stock Vigilant attending Trenchant monitoring Living with uncertainty Promoting/preserving mothering	**Surveyancing** Preterm fathers respond to the uncertainties of the situation by: - safeguarding the mother-infant dyad and supporting the mothering role - trenchant monitoring - taking stock

Summary

This chapter identified the methods used to generate and analyse data from interviewing seven participants on ten occasions. Four participants were first-time fathers, one was a step-father, and two second time fathers. The seven participants were all mature men, all bar one in employment and in stable and long-term relationships. Immersion in the data and carefully adopting an open mind when

analysing the data generated codes and categories to explain the social process of premature fatherhood. A storyline memo (box 4.3) is offered here to present the amalgamated key concepts that emerged during the process of identifying the core category. This provides a succinct overview of the iterative process of data generation and analysis undertaken to generate a substantive theory of premature fatherhood. The findings are presented in the next chapter.

Box 4. 3 Storyline memo

Men begin to prepare for fatherhood during the pregnancy, demonstrating increasing emotional and behavioural involvement, beginning to envision themselves as fathers, but frequently experiencing feelings of disconnection with the baby until birth. At birth the couple become parents as part of the new family unit. The birth of a new baby is normally the focus of celebration and parental leave provides sanctioned time to establish parental roles and responsibilities. Learning to be a new parent is undertaken with the support of family and friends and in the private space of the home environment. Preterm labour abruptly ends the pregnancy and exacerbates men's feelings of disconnection from the baby experienced in pregnancy. Close proximity to the baby fosters parenting behaviours but during the pregnancy the baby occupies a space in the mother's uterus and in NICU the baby occupies a space in an incubator. Both contexts act as physical barriers to men forming a connection with their baby through the denial of close proximity. Men consider premature labour and birth as life threatening for both mother and baby and therefore 'step back' to enable healthcare professionals to keep his partner and baby safe. NICU is a highly technological environment and reinforces men's perceptions of their baby being in danger. The mother-focused approach to obstetric and midwifery practice is reflected in NICU. The emphasis on supporting the mother's recovery from the birth process and establishing breast milk production sanctions a mothering role but as a consequence the fathering role is ambiguous. Initially, men experience NICU as a surreal and alien environment associated with polarised and extreme emotions. By enacting coping strategies, they are able to become familiar with the nature of prematurity, the routine practices of neonatal care interventions and technology, the NICU staff and the shared experience with other preterm parents. There is little sanctioned space or time for fathering and men's role as a father is to a large extent in abeyance. Men experience NICU as a mediated space of situated fathering framed by: a diffusion of responsibilities for his baby's care between himself, his partner and healthcare professionals; balancing daily routines and domestic and employment responsibilities with visiting NICU; waiting for an uncertain outcome; and managing interpersonal relationships with many people (partner, family, friends, healthcare professionals, and work colleagues) in several places (hospital, work, home). The long-anticipated day of discharge home is over-shadowed by uncertainty in their ability to manage to care for their preterm baby without the clinical and social support of the NICU.

Chapter 5 Findings

5.1. Introduction

This chapter presents the patterns in the data identified in the social process (defined as 'unfolding temporal sequences that may have identifiable markers with clear beginnings and endings and benchmarks in between' Charmaz 2014:17) of becoming a father of a preterm baby. The key chronological events and defining moments of premature fatherhood can be identified as: the pregnancy (temporal expectations); the birth (a disruptive event); NICU (a situated space); and home (life starts again). It is recognised that each experience forms a continuous, overlapping and interconnected process.

The chapter therefore acknowledges the chronological events of pregnancy and birth, admission to NICU and discharge home. The headings capture the categories identified as abstractions of phenomena observed in the data and their relationship with each other provides the evidence for how a grounded theory was inductively generated. Verbatim participant quotes illustrate how the theory is grounded in the data and are presented in italics. The participants have pseudonyms taken from the letters of the word fatherhood i.e. Frank is participant 1, Arthur is participant 2, Tim is participant 3 and so on. The immediate number after the participants' pseudonym identifies the gestational age of the baby in weeks and the second number identifies the interview number. For example, Eric 28/1 identifies the quote from participant 5 whose baby was 28 weeks during interview 1. The interview number 2 was the discharge interview as the second interview on NICU could not be arranged for all participants.

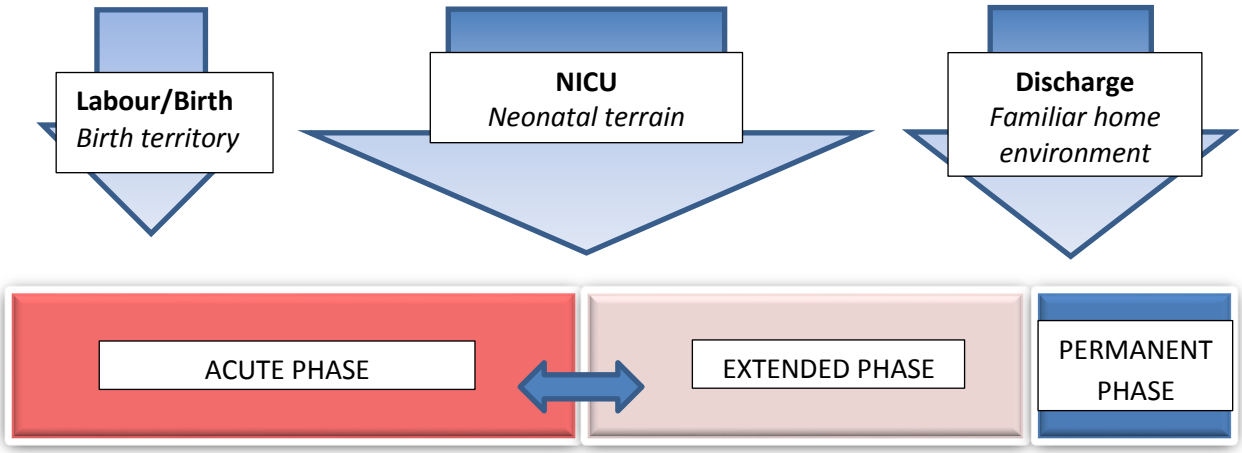
In order to enhance the evidence for the conceptual development of the grounded theory, pertinent theoretical perspectives have been referred to as footnotes. These footnotes support the development of the explanatory framework that forms the theory about how fathers experience the transition to parenthood when their baby is born preterm. In addition, reference to the literature in footnotes provides the evidence for defining the context within which preterm fathers experience parenthood. Contrasting the findings from the study with the literature relating to

term fatherhood has illuminated the distinguishing elements of the social condition of premature fatherhood.

5.2. Events and phases of premature fatherhood

Premature fatherhood comprises three significant events (labour/birth; NICU; and discharge home in their associated specific 'physical' spaces) and three phases: acute; extended; and permanent[33] (fig.5.1). These phases are not discrete but overlap and are not linear but can be cyclical with preterm fathers re-experiencing a previous phase. For example, the acute phase can be experienced again if the preterm baby's condition deteriorates during the NICU admission or following discharge home.

Figure 5. 1 Key events and phases of the preterm experience



Pregnancy is a time during which men begin to comprehend and adjust to impending parenthood and the expected trajectory for this is the full 40 gestational weeks. All the participants in the study were in a stable relationship with their partner and the pregnancy and birth of a baby an anticipated event in their biography. The early birth of their baby was unanticipated and precluded some from having the opportunity to complete all the practical activities that had been planned and resulted in less time to consider the psychological preparation of fatherhood. All the fathers stated that they did not yet '*feel*' like fathers during the pregnancy. The sense of disconnection

[33] It has been suggested that cancer survivorship begins at diagnosis and continues through three seasons: acute, extended and permanent (Mullan 1985). There is some resonance with the findings of the study and the cancer survivorship literature

from the baby is acknowledged during the pregnancy[34] and there appeared to be a strong sense of the anticipated birth of their baby being in some way *not real and not tangible*. Gathering information from friends, work colleagues and antenatal classes, researching and buying baby equipment, doing up a new house and the nursery, calculating whether he could support his partner and baby on his wage, and attending scans helped to support the process of beginning to perceive the baby as being more real, more *tangible:*

The focus has really been on having this house and so really haven't put in a lot of time of thinking about my partner being pregnant and it's been bubbling away in the background….(Tim 30/1)

I mean stupidly enough I started building an extension at home two months before she was born and I've got the back of the house ripped off (Robert 30/1)

It was almost as if we were playing because obviously my partner had got pregnant she was getting big we saw the midwives we saw the scans saw it all but until then {the birth} *it didn't really seem real* (Arthur 31/1)

C*os as a father yeah ok your wife's pregnant and you put your hand there and you feel the movement and she's getting bigger and there's obvious signs and all the rest of it but it's still very hard to connect with ….*(Frank 24(twins)/1)

In addition, the lack of a change in the relationship and their lifestyle during the pregnancy reinforced this notion of unreality:

I mean throughout my partner's pregnancy because it's our first one very little has changed… because my partner has been very mobile, she hasn't been unwell there's been none of that, so it's never really felt ….it's never really felt real…. (Arthur 31/1)

One first-time father demonstrated behavioural and emotional readiness to make the transition to fatherhood which appeared to be a reflection of biographical influences:

I've always wanted children so I was never really concerned. I'm quite confident that I'll be an alright parent like not being too cocky or anything but I should hope that I'd be ok you know just…. when I've looked after say my nephew or other people's children I've… I find it quite natural (Harry 34/1)

Men appreciated that fatherhood would involve a loss of certain aspects of their current lifestyle, such as having less time for himself and for recreational activities.

[34] Term fathers express wanting to be involved in the pregnancy and birth but their experiences of maternity services both antenatally and perinatally have often been that of exclusion. Their experience of pregnancy is framed in terms of: 'their lack of knowledge about the process; their feelings of isolation; their inability to engage in the reality of the pregnancy; and their sense of redundancy' (Draper 2003:67).

Ambiguous and polar feelings of impending fatherhood including fear, excitement, and self-doubt, were articulated:

I think I dealt with most of it by just pushing most of it out of my mind and sort of thinking well I'll just deal with it when he arrives ..yeah I think I guess alot of guys I've spoken to do feel like that …..yeah a mixture of fear, self-doubt .. excitement and a sense of impending loss all those things I guess they're all pretty sort of normal ……. (Tim 30/1)

I was certainly excited, but also I would say terrified at the same time I mean it's a big change going from you know being able to do whatever you want whenever you want to go out you know that sort of thing to having to then consider someone else other than yourself and your partner (Arthur 31/1)

In the context of parenthood, the availability of social support[35] (by individuals or groups) in terms of quantity and quality has been recognised as important in supporting an individuals' ability to parent. A new family unit may experience limited access to informal and semi-formal modes of social connectivity[36]. Several fathers highlighted how they were geographically isolated from grandparents and had little previous experience of babies:

…our family my mum and dad's in {geographically distant place name} *and her parents are in* {geographically distant place name} *so we haven't got family around* (Harry 34/1)

I don't really have any kids around me I've not really seen any babies before (Tim 30/1)

First-time fathers acknowledged the importance of having friends who were already parents in helping them to anticipate how they would manage their own transition to parenthood:

[35] Social support has been recognised as positively informing life course transitions and is integral to 'enhancing health and promoting well-being' and positively influences children's social and emotional development (Bennett et al 2017:12).

[36] This 'social connectivity' can include three types of associations: informal (based on parents' own social networks including friends, families, and neighbours), semi-formal (community groups and social events organized within a community by a volunteer organization), and formal (professional or needs based services' (Moran, Ghate, and van der Merwe 2004).

I've got quite a few friends around the same age and two have just had babies …my fiancée and her friend went out one night and so me and my friend were sort of left looking after the baby and that all seemed to go ok (Harry 34/1)

Well my friends have had thirty-seven children between them including my family so there's lots of stories about all of these things (Frank 24(twins)/1)

It has been acknowledged that new fathers need information that is specific to them in order to help them prepare for their new role[37]. In the situation of a very premature birth, the opportunity for attending antenatal classes may be lost to the parents. Frank's twins were born sixteen weeks early and this meant that he and his wife had not had the opportunity to attend antenatal classes. During the first interview he reflected that this was an expectation of becoming a parent that would not now be realised and this had denied his partner particularly of a potential source of making friends and creating an important social group[38]. This was expressed in terms of loss and he reflected that the preterm baby support groups would not fulfil the same function of preparation, education and support as antenatal classes would have done. In addition, he was continuing to view parenthood in terms of his wife's needs rather than himself:

We did expect to go on the NCT course… we did expect to meet some other mums and dads and maybe make a bit of a social group out of that which now we're not going to have…. so that's quite tough because there's a sort of loss there of something and… particularly for my wife because she doesn't have a lot of friends….I think she was really looking forward to a relatively easy way of meeting a new social circle and she doesn't have that anymore and that's really upsetting for her and by extension that's upsetting for me (Frank 24(twins)/1)

For those fathers experiencing a later premature birth, information provided at antenatal classes was found to be helpful to them in understanding the expectations of the process of labour and birth:

That {antenatal day} *did actually really help because….they did speak about C-section[39] and just the sheer amount of people in there…so then I was looking*

[37] Twenty men were interviewed on 2 occasions; before birth and following the birth of their baby. The findings suggested that the fathers identified a lack of support, lack of involvement in antenatal provision and that they welcomed more information antenatally regarding parenting, caring for the baby and relationships (Deave and Johnson 2008)

[38] An Australian study that recruited 35 women to receive group antenatal care that provided opportunities for the women to develop social support networks (Teate et al 2011)

[39] Caesarean section is a surgical procedure where an incision is made in the mother's abdomen and uterus to deliver the baby

around and thinking well…yeah…this is all normal and it's not cos there's something wrong (Harry 34/1)

So we were doing the NCT classes which was certainly making us more aware of the various aspects of the pregnancy and what it involved and what to do afterwards and everything else so were doing that and a bit of research (Arthur 31/1)

For some fathers there were no prior warnings of the likelihood of their baby delivering early:

Key events...there weren't that many during the pregnancy. I mean during all the checks there was nothing highlighted everything was going swimmingly so we just went through every stage went through every check and everything like that and there was nothing that stood out to me. My partner was fit well and healthy and everything was hunky dory really …completely unprepared we weren't expecting him to turn up quite as early…(Arthur 31/1)

..everything was going nicely that's good and then at 28 weeks… boom waters broke and that was it (Robert 30/1)

For others the likelihood of the pregnancy ending earlier than anticipated was very real:[40]

I expected us to carry on for a few more weeks. I didn't expect it to be term. We made a decision that we weren't going to talk about things like names and we weren't going to buy anything or get geared up until at least week 28, cos if they're born at week 28 they've got a very good chance of sort of making it. So in some ways we had put off a lot of that thinking about being a parent and stuff deliberately for… for quite a lot longer (Frank 24(twins)/1)

She {my wife} *kept thinking the baby was going to come. She was in and out of hospital and then on the 28th week of pregnancy she was staying here. She rung me she said I'm going into labour so I drove down she went up to labour ward was having really bad tightenings. So I got there and then it just all halted and she didn't give birth…we got 2 more weeks which was really good.. cos at 27 weeks I think we wouldn't ….he wouldn't be here now* (Eric 28/1)

The main concerns articulated during this father's interview were centred on the survival of his preterm baby with very little mention of the pregnancy or birth process, which is in contrast to the first-time father interviews. Unlike first-time fathers going through the labour and birth process for the first time, Eric had previous experience of both the birth process and becoming a father of a preterm baby. This pregnancy was unexpected and the risks of having another preterm baby were acutely

[40] There are known risk factors for premature birth such as multiple birth, pre-eclampsia, infection, substance use and misuse, low or high maternal age. However, premature birth is often unanticipated and unexpected with no risk factors or reasons identified for the pregnancy ending early (MBRRACE-UK 2017).

understood by the parents. Eric's narrative was dominated by the NICU and how this environment overwhelmingly affected his experience of becoming a father[41].

In the study, the pregnancy and previous experience of birth and labour influence how men then understood the context of their baby being born early. The social process of becoming a preterm father is managed by the participants in the study as enduring sustained uncertainties.

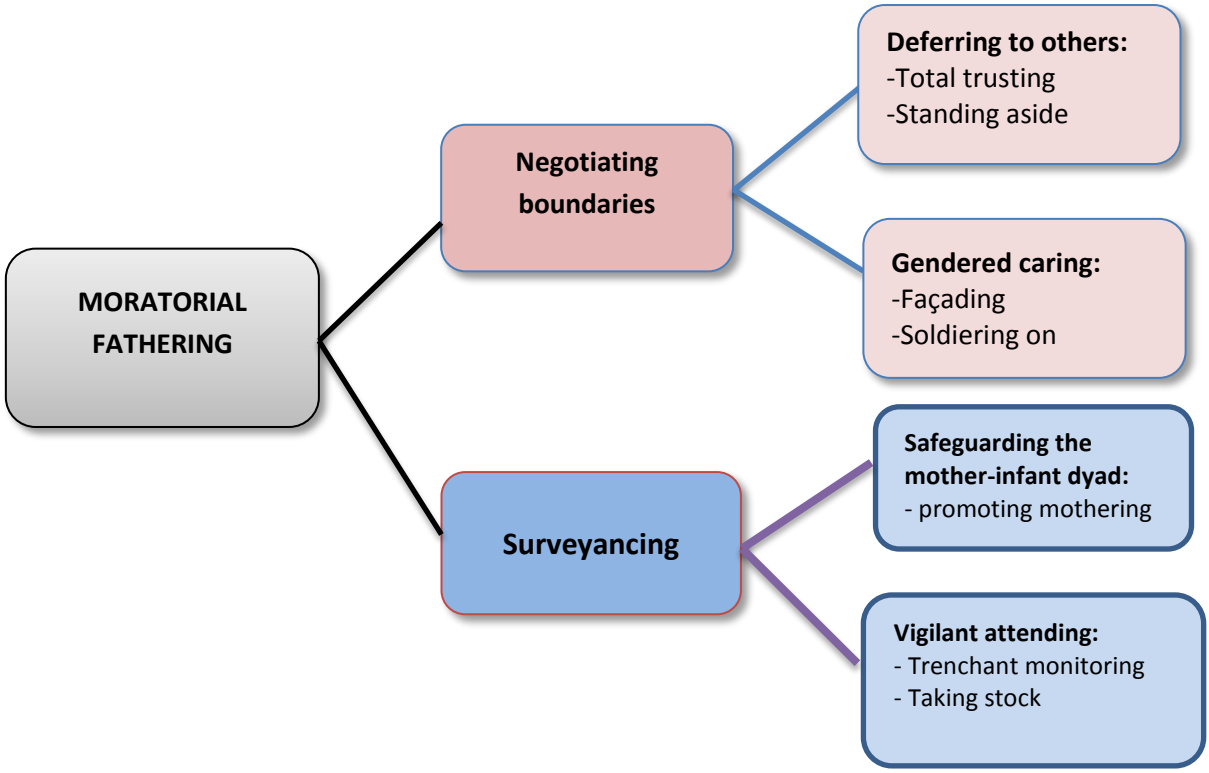
5.3. Premature fatherhood: enduring sustained uncertainties

Premature birth changes the anticipated trajectory of forming a family, with the disrupted transition to parenthood occurring in a public and unfamiliar environment. In response to this altered and novel situation, preterm fathers' appraisal of the situation means that they acknowledge the hospital as being the safest and best environment for his family to be in. In recognising that they cannot manage this unique situation, preterm fathers in the study initially experienced acute feelings of being redundant, supernumerary, and having no role other than that of acting as a support for their partner. Their main concern is to safeguard their partner and baby's wellbeing and return the family to a situation of safety. Men in the study enact coping strategies that enabled them to become familiar with the nature of prematurity, the routine practices of neonatal care interventions and technology, the NICU staff and the shared experience with other preterm parents. Men experienced premature fatherhood through the sociological process of **moratorial[42] fathering.** The categories of this social process include ***negotiating boundaries*** and ***surveyancing*** and their properties explicate how men in the study managed the uncertainties of premature fatherhood (fig 5.2).

[41] Carceral geographical research involving fathers has further explored the situated spaces of parenting in prison. The prison visiting room is seen as a 'spatially confined context in which men through their complex situated negotiations, tried to express their fathering practice, impose parental authority where appropriate, show affection, and give treats and gifts, whilst staying seated on the right chair, and conceding to prison staff where there was a conflict of authority (Moran et al 2017:18).

[42] A state of being suspended or put aside temporarily; a legally authorised postponement of the fulfilment of an obligation; an agreed suspension of activity

Figure 5. 2 Core category and major categories of moratorial fathering: enduring the sustained uncertainties of premature fatherhood



5.4. Negotiating boundaries

The nature of premature birth immediately 'medicalises' the situation and requires a heightened need for surveillance and intervention by both obstetric, midwifery and neonatal staff. The exact moment of birth is normally unknown unless an elective obstetric intervention is planned. Six of the seven participants had experienced threatened premature birth requiring obstetric evaluation in the hospital setting as either an outpatient or for short periods of time as an inpatient, before the birth of their preterm infant. Despite these 'false alarms', the participants all experienced shock at the suddenness of the premature birth:

It was a real ..it was a shock ..it's a big change especially as we were not expecting a preterm we had no complications at all so I think there was that mental I mean there was that physical drain as well the mental shock of it sort of wow we're now parents (Arthur 31/1)

..and just being I guess in shock just spent a long time just looking at him and I guess just trying to process everything I don't know what I was thinking or anything I was just sort of staring at him.....(Tim 30/1)

Arthur had become a father in a matter of hours:

…it was all very very rapid so before so Friday morning I had absolutely no idea … there was nothing. My partner had a check on Wednesday with the midwife measuring heart beat … everything was absolutely fine. There was no indication at all that this that this was going to happen… so a bit of a shock…. (Arthur 31/1)

All the participants in this study, except Eric and Harrison, were experiencing fatherhood for the first time. Eric had experienced premature fatherhood multiple times and empathised with those first-time parents experiencing premature birth and the possibility of losing their baby:

I spoke to a few people in there {the intensive care nursery} *who are first time parents and this is their life and if they lose that child their relationship is going to be tough until they either have another child or they split up, because what you go through in there and if you don't come out with a child that could break you so easily …because you've been in that position with that person and you either blame them or you think it's both of you that's not working… it's tough I think it's tougher for first time parents who don't bring their child out of that room that must be tough yeah that must be tough definitely……*(Eric 28/1)

Harrison, having experienced the birth of his first son at term, identified that he had less concerns for this pregnancy as he had been through the process before and acknowledged how positive an experience it had been for him.

The context of the NICU is 'hidden' both physically and geographically but also figuratively. Entry to the NICU is via security doors that are only opened following verification of the visitor's right of entry. Family members and friends can only visit accompanied by a parent. Even if family members visit, preterm fathers have reflected on how this can add to their stress and may result in the family not really demonstrating an empathetic understanding of what the parents are experiencing. Normative rituals of celebrating the birth of a baby and the formation of a new family are inappropriate and admission to a NICU disrupts the support that extended family members would normally be able to provide the newly formed family unit. The ways in which men in the study experienced premature fatherhood, highlight the importance of considering sources of boundary ambiguity (table 5.1).

Table 5. 1 Sources of boundary ambiguity

Social factors	Cognitive/emotional factors	Physical factors
Relationship with partner	Feelings of isolation (focus on mother and baby)	Managing expectations of employer
Parental alliance: differences in parental role expectations from his partner	Feelings of disconnection with the baby during pregnancy and following birth	Preterm baby occupying the NICU space fracturing the triadic proximity of mother, baby and father
Differences in the comprehension of the preterm situation from his partner	Lack of knowledge of prematurity	Parenting dimensions developing in the public space of the NICU rather than private space of own home
Attitudes and expectations of family and friends	Sense of redundancy, being supernumerary, 'a spare part'	Incubator acting as a physical boundary between father and baby
Societal and personal attitudes and expectations of fatherhood	Experiencing intense emotions across a spectrum	The hospital acting as a physical boundary between home and work
Interpersonal relationships with healthcare professionals	Uncertain normative expectations	

Adapted from 'sources of prenatal boundary ambiguity for teenage fathers' (Leite 2007:164)

Preterm fathers in the study suggested that the feelings of disconnection with their baby felt during the pregnancy continued at delivery, after birth and into the NICU admission. Premature birth results in not only feelings of disconnection but also of unreality and alters the anticipated opportunities for fathers to focus on forging new relationships with his baby:

Yeah I remember a distinct absence of feeling and that being …not concerning but surprised? Not sure it was that .. guilt… thinking you should be feeling something I remember because my partner was still lying on the table being patched up they went this is your son and I went yeah..and? I really don't care ..of course you felt you should...just that real sort of apathy just that there was no connection (Tim 30/1)

…this sense of disconnection is really really strong…..difficult to adjust because you can't quite get at your baby (Frank 24(twins)/1)

I don't know how I am supposed to feel as a Dad (Robert 30/1)

I don't know if I feel like a father as such yet ….you know because we haven't taken him home and because we haven't really cared for him as such ….I guess as a parent you sort of the child relies on you whereas he's not really relying on me I'm here for an hour or two and then I go (Harry 34/1).

First-time parents have to learn new skills and develop new knowledge required to care for their baby and this is challenging when faced with the premature birth of their baby. The attributes of parenting self-efficacy include cognitive, social and motor behaviours. The extent of parent's perception of their competence and effectiveness in demonstrating these is an important factor in the transition to parenthood (Bennett et al 2017). Preterm fathers perceive a lack of clear expectations in relation to having a defined role within this now extended 'family' of caregivers in NICU. The ambiguity in the boundaries between parents and neonatal staff presents a diffusion of responsibilities of parenting roles and behaviours between mother, father and healthcare professionals. In this context, preterm fathers consider the role of the mother to be of primary importance and therefore the emotional and behavioural attributes of fatherhood are in abeyance. Preterm fathers accept they are in crisis and faced with the unknown. However, rather than demonstrating passivity and being resigned to the situation, this is positively accepted and using the strategy of **total trusting**[43] enables preterm fathers to negotiate the boundary between his family and healthcare professionals.

5.4.1. Deferring to others: total trusting

During the labour and birth, preterm fathers acknowledged that there was little they could do in this situation other than support their partner and actively and consciously keep out of the way. This **total trusting** of the professionals to manage the situation and keep everyone safe commences during the labour and continues at birth and into the NICU admission:

Quite rightly the care is revolved around the lady I mean she is doing the work after all. My job was to look after my wife and go with the flow. From purely a selfish looking at the man point of view I would say the worst thing would be not quite knowing what your role is and you know you are in a hospital which means you are surrounded by professionals who know what they are doing so you know the best thing you can do is keep out of the way don't make a fuss (Frank 24(twins)/1)

[43] Total trusting is part of the surrendering mode in a grounded theory (living on hold) of palliative cancer patients and their relatives (Sandgren et al 2010)

There's very little that I can do other than try and stay out of the way of everyone else tried to minimise yeah minimise that impact (Arthur 31/1)

So I was just sort on a stool next to my partners head speaking to her just staying up that end just trying to stay out of the way (Harry 34/1)

It's just feeling so useless and not that you are in control of anything and there's nothing I can do. I'd stand there I was standing by my partner…she's just gone through a C section the baby's been taken upstairs which is the best place for her you know but my partner doesn't know what is going on I don't know what's going on I'm trying to make sure that my partners all ok ..(Robert 30/1)

The importance of deferring to the professionals renders the father's role as redundant and the father then experiences feelings of being supernumerary and having no defined role. Eric a father of five preterm babies suggests that fathers *are a bit like a spare part* (Eric 28/1). In addition, the family are in shock and have entered an 'alien' environment. Therefore, in response to this context the fathers rely on others to direct and advise them. Experiencing shock and feeling terrified, in accepting direction from the experts not only keeps their family safe but is also a problem-focused coping strategy for managing a stressful situation:

…..and because this is such a strange environment and you don't know your way around and you don't know what's right and wrong and you don't know what's going on and you don't know what to expect it's just so overwhelming to some extent you just go with the flow (Frank 24(twins)/1)

….and then you sort of just become this sheep cos they herd you around and they put you in scrubs and they put you in theatre and you're just terrified... (Tim 30/1)

In surrendering to the situation and releasing control, the fathers have to put total trust in the healthcare professionals. This **total trusting** requires the fathers to trust that the healthcare professionals know what is best for their partner and baby. Recognising that the staff are the experts they take a back seat and allow themselves to be guided by the staff:

…but mostly just trusting the professionals.. just let them steer you and yeah....that's it...I don't think there's much else you could do .....(Tim 30/1)

.....I would say ....just… I mean everyone knows what they're doing just let them do their job (Arthur 31/1)

I would say to them {potential preterm fathers} *it's terrifying but you are in the best possible place I'd say to them that you probably won't know what's going on alot of the time that's ok ….well in fact you can ask questions and everyone's unbelievably helpful and will always answer.. I'd say to them you have no choice but to put your trust in the Drs and the nurses and the team but you'll realise very very quickly instantaneously that ……even if you had a choice that would*

absolutely be the choice you would want to make because they are absolutely brilliant (Frank 24(twins)/1)

….cos the baby was being cared for 24 hours a day we didn't really need to worry about him… if there was going to be any issues then we'd have been informed (Arthur 31/1)

As parents you can't do anything you can't do anything at all meaningful. Doing cares and changing nappies is important and needs to be done but doesn't need to be done by us as there is a wonderful team of nurses who would be doing it anyway (Frank 24(twins)/1)

Total trusting requires fathers to acknowledge the central tenet of putting their lives in the hands of professionals. Being in the hands of others creates a feeling of being safe and facilities maintaining a manageable daily life:

After a couple of weeks on the unit you get very comfortable…. do you know what I mean…. you have huge confidence in the people around you and you have the bumps and scares and stuff but it's like having a new blanket wrapped round you very cosy….(Tim 30/2)

I guess if I'm honest I would say ....allow yourself ....give yourself a bit of slack because that's the hardest thing to do cos you will burn yourself out trying to be this ideal .... but talk to people talk to the nurses the Drs yeah.....there's nothing that you can do cos you can't say that everything is going to be alright you don't know if it is.....but yeah just give yourself a bit of slack and lean on the people (Tim 30/1)

…being shown how to do things just cos there's a midwife around all the time that you can ask ….where I'm sure if you were at home you might not know how to you'd have to ring your mum or YouTube or I don't know what you'd do.. they're ever so friendly..they don't mind running through anything they're patient and stuff so….. (Harry 34/1)

I think I must be honest in the actual process itself that's wanting {my wife} *to be safe to go from entirely safe to not safe relatively.. I know these days it is relatively very safe but you've moved into a different bracket so safe..not safe..and wanting to get back to safe and it's almost like the other stuff kind of …it's ..once you've dealt with that you can then start to.. for me focus and also enjoy the other bits..* (Harrison 24(twins)/1)

The important role of the nursing staff in facilitating **total trusting** for preterm fathers is appreciated:

I mean the staff up here well I don't know how I can praise them enough they are brilliant so caring and they are what you want when your baby is in that situation (Robert 30/1)

I think you just sort of get swept it has a momentum of its own so you just get carried along with it you know…you don't have to make decisions you don't have to do a lot of thinking you're just you know you get quite quickly into a routine ok you go in the morning then you go to work and then you come back in the evening and you are just directed by other people which is quite nice cos you've got this baby but you haven't really got to think yourself cos you're being told what to do …yeah so in that respect it was really nice and I can remember feeling safer I think and you feel in a bit of a bubble (Tim 30/2)

There is this… sort of that sense of you are a parent but you are ….actually you've got ten people on the ward that are going to look after your baby should anything go wrong …(Tim 30/2)

The extent of **total trusting** is influenced by the personality of the nurse caring for their baby and eased the situation rendering it more bearable. The attributes of the nursing staff relate to the integrity of their communication and interpersonal skills[44]. Eric was very articulate regarding the impact of nurses' personalities on the family (figure 5.3[45]). He stated that he could relax and leave the hospital happy if a preferred nurse was caring for his son:

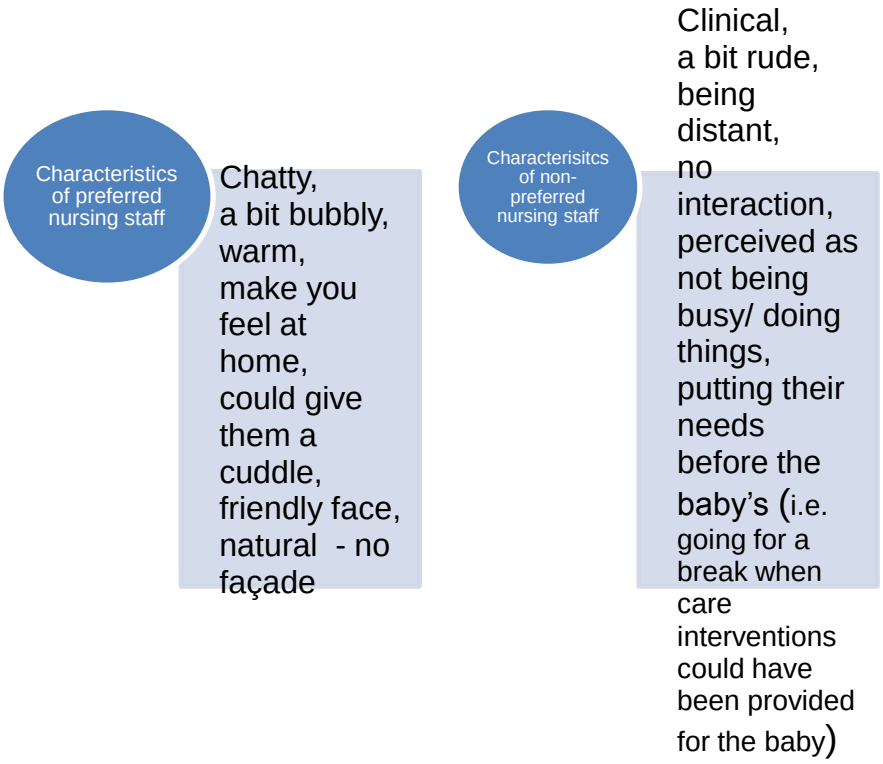
So there's certain people look after my son that I love looking after my son like I love …so when I know they're looking after him I feel more relaxed whereas if there's other people that are looking after him… I think…. I'm a little bit more anxious so a friendly face especially in intensive care and someone that you get on with is so much nicer (Eric 28/1)

It's just how you feel if ..cos for instance if I walk in and it's {name of nurse} *looking after my son I love* {name of nurse} *to bits …..because of how she comes across …as herself …whereas some of the nurses are clinical they're there to do their job …they put on a bit of a front and they crack on and they go home and that's it ….then you get someone like* {names of nurses} *those sort of people they're warm characters so they make you feel at home and then some of the older people like* {names of nurses} *who I love… those sort of people they make things easier they really do ….they're warm ….you could give that person a cuddle* (Eric 28/1)

[44] A qualitative study interviewing 8 fathers with a child diagnosed with cancer highlighted the importance of social support from a range of sources in enhancing resilience and coping. 'The professionalism and compassion of the healthcare team was a strong source of support for fathers' (Brody and Simmons 2007:160).

[45] The importance of the quality of the nurse/parent relationship in NICU has been consistently demonstrated (examples include Bry et al 2016, Thiele, Knierim and Mader 2016) and is discussed in more detail in the next chapter

Figure 5. 3 Characteristics of nursing staff



Frank also identified that there were certain members of the nursing staff that he would go to for advice and support. At the time his babies were in intensive care and being cared for by senior nurses:

There are several individuals as against everybody who stood out yes… in different ways…if you'd asked me, if I came up on to the ward and who I would go looking for, depending on what it is I wanted it would probably be one of those five nurses named….(Frank 24(twins)/1)

Preterm fathers in the study also appreciated the manifestations of their baby being cared for by nursing staff:

Another nurse because she makes my daughter look pretty which is a silly little thing but my God it's powerful when you suddenly see that she's all wrapped up nice and comfortably….. everything's in place all the lines are tucked in and out of sight and actually all of a sudden you look at your little baby girl and you go she's my little baby girl…(Frank 24(twins)/1)

The nurse said do you want me to take her and I said would you I just don't know what I'm doing I don't know what to do and she took her and started singing to her and I was like that's beautiful ..she's not yours …it really was lovely that she was that caring… and it was just yeah that really sort of got me that they were that caring and you can see it in them …every single one of them. I mean they are looking after your baby it's as though it's theirs…as bad as you feel leaving her you don't feel bad because you know that she's in the best place she could ever be so… (Robert 30/1)

The interaction with nursing staff is supported by chatting.[46] Social chatting forms part of the personality traits that preterm fathers identified helped them to feel secure in **total trusting** of the nurse to care for their baby when they are absent. The social chatting of nurses puts the fathers at ease and provides a feeling of being in safe hands. Chatting was seen as really important to normalise the situation and the staff being warm and friendly reassured the fathers that, in their absence, the care provided to their baby would be of a high standard:

So for instance again the people I have mentioned they like to talk and if they're there talking to you just saying yeah I'm just going to do this just to reassure you .. you can walk out of that room and know that your child is going to be cared for but if you've got someone else and they're like oh I've just got to go…and they wander off and they're doing this they don't interact with you whatsoever you leave feeling if they're like that now while I'm here are they going to be like that when I'm not here ……(Eric 28/1)

Something I think that I know has made the situation manageable and the situation much much better than it would have been otherwise ..yeah and that's just that more people a lot of the nurses seem to be very natural at that chat chat chat and before you know it you're talking about whatever I don't know then someone putting you completely at ease and what was a horrible situation suddenly you find yourself laughing or something and it yeah...that I think that makes it easier ..yeah definitely ..... (Tim 30/1)

The nursing staff to baby ratio in neonatal care has been standardised to ensure the provision of high quality care[47]. The availability of this consistent presence of expert nursing staff reassured the preterm fathers and reinforced **total trusting**:

I realised quite quickly that actually we were quite privileged I mean everyone is very good but we were particularly privileged because we had all senior nurses looking after our children which is great. I did think at the time that I hope we can graduate so we don't need the most senior nurses all the time which has happened but I actually feel a sense of loss I want them back again…. (Frank 24(twins)/1)

…it's …you do what they say …what's got to be done and you put your trust in them guys 100% that everything is going to be fine and you know .. they are so fantastic at what they do…. you know to come and realise that {name of baby} *had a nurse at the end of her bed 24 hours a day…. I was flabbergasted…. I mean 1:1 care to that extent is unbelievable you know… they don't know me… they don't know my baby but it's the same care for every baby and it doesn't matter what's*

[46] For mothers, chatting has been shown to be a strategy and process that provides positive interactions to enhance parental confidence connecting to and caring for their baby on NICU (Fenwick, Barclay and Scmied 2001).

[47] The nurse to patient ratio: 1:1 for intensive care; 1:2 for high dependency care; and 1:4 for special care (DH 2009).

wrong with them whether they're really ill whether they need a bit of support or whatever…(Robert 30/1)

I mean I was welling up with tears because of that not…. because of actually what was happening in a way but suddenly here …actually you're overwhelmed with support… it's almost too much… it's not ….but for me when I realised how much was being done that was the bit where I ….partly because it brings it home ….you wouldn't have twelve people in the room if it wasn't serious …. but then also all these people are going out of their way to do things for us not asking for anything….. I don't arrange it I don't have to call anyone I don't have to pay anything they're just doing it …..it is just amazing so yeah that's something…… yeah that's really touched me…(Frank 24(twins)/1)

It was the people the way they managed it managed me..it made me feel I guess safe or as safe as you could do (Tim 30/1)

However, **total trusting** creates a dichotomy of valuing the expert care given to his partner and baby, but paradoxically also means relinquishing rights to complain about the care given and the need for careful management of the relationship with staff:

It annoyed me a bit but I wouldn't go to anyone and say that because you're in a position where…….. they've got 4 aces and……. you've not really got a good hand….so because they're looking after your child you've got to …you have to appreciate what they're doing for you …it is tough to leave the hospital thinking I wanted to say something but I couldn't….(Eric 28/1)

Tim highlighted the importance of the interaction with the nurses and talked about putting the professionals on a pedestal. He highlighted a situation when a nurse mistook something he had said and how it had affected him:

One nurse was rude and aggressive to me once and that ...absolutely ruined..for 24 hours I felt..I went from being in a good space to a very very bad space .and taking that home with me and I …and that made me very aware of the power that ...I guess that the professionals have in the way they manage… cos again if they're positive with you you feel positive if they're not..... I just remember going home and wanting to cry and I just remember being that I couldn't shake it for 24 hours just feeling completely broken by one comment whilst somebody otherwise I wouldn't usually pay any attention to but it was just..partly because you're in this emotional state anyway secondly because these people you sort of put them on a bit of a pedestal incredibly indebted to them and when one of them tears you off a strip it was really ..it was really weird because I'm not a particularly fragile person emotionally and I'm normally not frightened of telling someone how I feel but I do remember thinking my partner and I both felt like a pair of scolded children we were both really affected by it.. really weird… (Tim 30/1)

In summary, **total trusting** in the staff is a logical and pragmatic response to acknowledging that their partner and baby need professional healthcare interventions to keep them safe. Preterm fathers in the study, in enduring the uncertainty of premature birth, need to establish a sense of stability in a disruptive and crisis situation. Once his partner is safely through the birth process, preterm fathers in the study then begin to focus on their baby in NICU. The perception by the participants of the ability of nursing staff on NICU to competently and expertly care for his baby reassures them that their baby is safe. In enacting **total trusting**, they relinquish many of the cognitive and physical behaviours of fatherhood. The decision-making process of child care and meeting the physical needs of the baby are then provided by neonatal staff. This ultimately presents a situation where there is a diffusion of responsibility for the care of the baby between the mother, father and healthcare professionals. As a consequence, preterm fathers **stand aside** to ensure that both his partner and preterm baby receive the best care possible.

5.4.2. Deferring to others: standing aside

The literature[48] on term fathers feeling like a substitute on a sport's bench watching the process of birth, having a vested interest in the outcome of the process but having no role or part to play in it, resonates with preterm fathers feeling they are *supernumerary, a spare part, on the periphery.* The substitution is that of the professionals taking over the care of the mother and infant which leads to the focus being entirely on the dyad:

I have to say the level of care is amazing, so you know which is also interesting because it means that the father is even more supernumerary (Frank 24(twins)/1)

The fear and uncertainty of pregnancy and childbirth is acknowledged for term fathers[49] but this is increased in the situation of premature birth. The birth is experienced as witnessing a terrifying situation in an intense environment with many professionals in attendance:

[48] A metasynthesis of 6 qualitative studies relating to fathers' experiences of the transition to fatherhood identifying 3 themes: emotional reactions to phases of transition; identifying their role as father; and redefining self and relationship with partner (Chin, Hall and Daiches 2011)

[49] A metasynthesis of 23 papers relating to fathers experiences of pregnancy, birth and maternity care identified several themes; 'risk and uncertainty, exclusion, fear and frustration, the ideal and the reality, issues of support and experiencing transition ' (Steen et al 2012:422)

As I say it was a terrifying experience, but I think that's just a case of giving birth you know that's just what it entails really. I mean once you get through the hardest bit… the hardest bit was definitely my partner giving birth (Arthur 31/1)

We had alot of people in the room which I am sure was much harder for my wife than it was for me ….so we had the 2 incubator machines we had 4 people from the neonatal team for each incubator we had 2 midwives we had a consultant in there at one stage and once in the room we had a second consultant ….so we had twelve hospital staff in quite a small room…. the neonatal team were literally climbing across the bins to get to their machines (Frank 24(twins)/1)

We got up to the hospital that evening then… I mean {name of partner} *was in real bad pain and then when we got to the hospital we find that* {name of daughter} *is in distress and they are worried about her and I thought oh God you know it's just everything was compounding on everything else…* (Robert 30/1)

The intense environment of the labour ward is enhanced by the number of professionals required to be present at a preterm delivery. This coupled with the appearance of their preterm baby affirm the seriousness of the situation and the need to **stand aside**. The father's agency is therefore framed by the need for healthcare professionals to be at the forefront of providing essential care and preterm fathers are then reliant on being directed by others.

The fathers therefore have the time and are in a physical position to witness the whole process from a different perspective to that of his partner. She is focused on what is happening physically to her body whilst he is in a physical position to additionally see what is happening to the baby. The result is that the father is able to see the birth and initial physical appearance of the baby which is significant, as it seems to compound the sense of disconnection encountered during the pregnancy. Frank experienced this during the birth of his twins:

.. *yeah I think if there was one thing that would help to prepare us more than anything particularly the man…because funnily enough she was in the situation where she was not likely to be able to see very much.. I'm of course keenly interested then got the shock of my life* (Frank 24(twins)/1)

The physical appearance of the baby was significant for two participants. Frank had extremely preterm twins and he was shocked at the appearance of his children:

I have to admit when they first came out I thought to be honest I didn't think they looked like human babies at all they reminded me of nothing more than these wildlife programmes where you see some you know baby chicks or birds being born and that that was a shock that was like woah and in fact so much so that it was quite difficult to connect with them you know are they really babies are they

human are they mine you know.. what's going on… that was really weird (Frank 24(twins)/1)

Harry talked about having a strange feeling seeing the look of his baby:

.. it's a strange feeling cos they look quite distressed and you know they've got the white ..I don't know what you call it but the white stuff over him and there's a bit of blood (Harry 34/1)

Fathers are not only in a position to witness the birth and initial physical appearance of the baby but are also witnesses to the medical interventions required following the delivery. Frank witnessed the intubation[50] of his very premature daughter and found this distressing:

…then unfortunately I got the glimpse of when the consultant was trying to intubate her and so her head was stretched out a bit and it's like he was trying to strangle a chicken you know...(Frank 24(twins)/1)

Harry felt that the nurses were a little rough with his baby but explained this in terms of the professionals knowing what they needed to do:

I did actually think the nurses they looked like they were actually quite rough with him yeah I know they know what they can and can't do what they need to do… (Harry 34/1)

The sense of disconnection with the baby experienced during pregnancy is not alleviated immediately following the birth. Even though there is now the physical presence of their baby, preterm fathers experience feelings of ambiguity and ambivalence. The nature of a premature birth necessitates the need for the baby to receive immediate clinical care and to be transferred to the NICU as soon as possible. This means that the parents are able to see their baby for a very brief period of time on labour ward before being transferred to the NICU. As a consequence of the on-going need for intensive clinical care interventions for the baby and mother, there may be a delay in the parents being able to see their baby on the NICU:

I can't say that I felt like a father at all at that point it was very surreal I had no more than 30 seconds seeing them.. no not even that… I'd say half a second between birth and then sort of seeing them popped in their incubators …and so

[50] A clinical procedure in which a laryngoscope is used to visualise the positioning of an airway (endotracheal tube) into the baby's airway (trachea) to provide respiratory support

that was it and then it's just sort of …then my wife and I were in the room which then seemed vastly empty and she's left there to recover (Frank 24(twins)/1)

{name of daughter} *was born she was put in an incubator the team were great I got to see her for literally a couple of minutes you know a quick glance and she's gone…..I knew I had a daughter but didn't feel like I had a daughter…I struggled to get a connection* (Robert 30/1)

Following the birth, the participants experienced feeling torn between staying with their partner and going with their baby to the NICU. This divided loyalty presented dilemmas for the fathers between wanting to visit the NICU to check on his baby's condition and also wanting to stay with his partner to support her:

..but yeah my partner had to be seen to and we wanted to sort of go up together but I was… I remember being really torn actually about where I should be because I wanted to go up and see him and make sure he was alright but I wanted to stay with my partner and make sure…I wasn't quite sure where I should be (Harry 34/1)

I said do you want me to ..she said yeah go and check on her make sure she's alright so I popped upstairs (Robert 30/1)

Tim visited his son on the NICU on his own against his wishes:

I didn't really want to leave my partner but at the same time she just wanted me to be with him (Tim 30/1).

Those fathers that chose to wait and visit the NICU with their partner experienced a delay in seeing their baby on NICU for several hours as a consequence of the condition of their partner or baby or the timing coinciding with shift changes and staff handover:

We got a very tiny glimpse of the babies just before they got whisked away and then that was sort of {time of delivery} *and then we were told that when the neonatal staff had finished doing their stuff and we would be able to go up and see them that would be some time after* {4 hours later} *as it happens by the time my wife was ..she just needed to.. recover a bit more before we actually went up so we didn't go up till about* {5 hours later} ..(Frank 24(twins)/1)

So yeah it was a bit of an awkward time really cos of the change over {of nursing shifts} *so my partner and I, my partner was a bit tired so we were taken to another room where my partner was able to lie down and just recover and we had a little bit of breakfast so I think we had to wait I think it was about 2 or 3 hours before we got to see him the baby and I think it was more to do with the fact that it had been change over* (Arthur 31/1)

So by the time we come up it was quite a long time after….but yeah my partner had to be seen to and we wanted to sort of go up together (Harry 34/1)

This delay in visiting their baby in the NICU reinforces feelings of disconnection and unreality. The spatial dislocation of not having the baby in close proximity compounds the feelings of unreality. In addition, due to the prematurity of their baby, the opportunity to have time with their baby at birth is curtailed:

I do remember the midwife lifted them up so my wife could see them and I could see them but they were very quickly whisked away ….the consultant and team sort of jumped on them and well… one incubator disappeared and I don't even remember it going out of the room and then the second one {twin} *was coming and the second team were there with their incubator and then they did their thing and then I remember all of a sudden that wasn't there either* (Frank 24(twins)/1)

They just wrapped him up and got him warm and I do have one regret that I didn't get to cut his cord though cos that was done quite quickly … (Harry 34/1)

The strategy of **standing aside** is a logical and pragmatic one and related to preterm fathers taking an overview of the whole situation and identifying what is the best role for them. They acknowledge that there is a need to secure the best care and outcome for their family. In achieving this, preterm fathers collaborate with healthcare professionals and their partner:

The main reason because if no one was dealing with {pause} *this is it, if no one was dealing with* {son's name} *I would do it myself but there are better people equipped i.e. those medically trained and his Mum already around him. I feel like there's absolutely no point in me trying to push them out of the way …it's almost like making sure you've got all the things that he needs…. managing the situation. I don't want to ascribe any corporate twaddle to it cos it's far more important than any of that* (Harrison 24(twins)/1)

In summary, the act of preterm fathers **standing aside** provides the opportunity for his partner and baby to receive the expert clinical care they require. Premature birth therefore incorporates a moral dimension in which the hospital environment, specifically the NICU, obligates the father to attenuate his behaviours of fatherhood to align with the medical needs of his partner and baby. The focus on the mother-baby dyad by healthcare professionals and family and friends brings to the fore the need to put his family's needs before his own. Preterm fathers in the study articulated their belief that the preterm experience is *not about me.* The conscious decision to prevent their partner seeing their emotional trauma and remaining emotionally strong and available, results in preterm fathers using the strategy of **façading.**

5.4.3. Gendered caring: façading

Façading[51] is a very deliberate action by preterm fathers to hide their feelings from their partner and others. They consciously put aside their own emotions in order to be emotionally available for their partner:

…. because my partner and baby both needed me when I had the space to be supportive because they were in hospital all the time, so I would do stuff to support them (Tim 30/2)

If you've created that baby you're in that situation that's not that baby's fault that's not your fault that's life in general you've got to deal with it… a lot of people don't though …again a lot of Dads are not in there …. it's like they say I'm too scared to go in there but what about that poor child that's in there or the mum that's got to go in there and do it all on her own… you see loads of mums in there doing it all on their own….it's just not fair (Eric interview 1)

That's how you deal with it…well that's how I deal with it …I can't speak for other guys but ….you keep yourself to yourself ….as long as you get home be strong for them…that's all that matters……you can be a jabbering idiot the rest of the day when you're not around them (Robert 30/1)

……because the care they give the mothers and babies is exemplary….I wouldn't want it to focus on the father I wouldn't want it to focus on me in any way shape or form and take away from them two… they have enough to deal with …….they haven't got time to be mucking around with me …you know…I'm alright…they've got enough to deal with mum and {baby's name} *..so…focus on them…spend your time looking after them …..I'll look after myself….*(Robert 30/1)

It's almost like the emotional shutters come down and allow you to continue to operate when things aren't as they should be (Harrison 24(twins)/1)

It is acknowledged that the notion of birth territory[52] is focused on the mother and baby and this continues into the NICU. Health professionals (obstetricians, midwives, and neonatal staff) family and friends act as a circuit of agents[53] around preterm fathers that promote and reinforce this focus:

Yeah and whenever I come up the first question is how's Mum…and then it's are you alright….so you know it's ..but then I look at it like that's how it should

[51] 'Façading is a powerful way of adjusting to a life put on hold (in palliative cancer care). Façading means keeping an emotional façade and staying emotionally strong, no matter what' (Sandgren et al 2010:88).

[52] Birth territory theory explains the relationships between the environment, issues of power and control and the experience of labour and birth. The environment is termed the terrain and can be explained on a continuum from surveillance room to sanctum. Power is identified as jurisdiction explained by integrative power and midwifery guardianship and disintegrative power and midwifery domination (Fahy and Parratt 2006)

[53] In a study of mental health patients, 'the circuit of agents (family, friends and professionals) conspired in a betrayal funnel to persuade the mentally unwell person to be admitted to a mental health institution for support and a rest' (Goffman 1961).

*be…Mum's the important one ….she's the one looking after my baby when I'm not here (*Robert 30/1)

When the uncertain and crisis situation of having a preterm baby on NICU becomes overwhelming, preterm fathers may attempt to seek support from healthcare professionals, friends or work colleagues. Sometimes the response they receive reinforces the need for **façading** and forecloses any further search for support. **Façading** therefore has negative consequences:

I've spoken to one of my mates at work but, it's not the done thing really. One of my closest pals at work I said to him you know I'm struggling a little bit and he's like you will do mate but you just deal with it and…you know a pat on the back from him and a man hug and that's it ..get on with it pal…that's it …(Robert 30/1)

So that was so I can see how I judged it wrong to unload my problems onto that person {close family member} *who has a history of bipolar in the family. However, I was not quite expecting that response so that almost kind of closed down another avenue kind of reaffirmed that you just need to suck it up and get on with it and don't go bothering other people with stuff* (Harrison 24(twins)/2)

As long as they're alright I deal with whatever I've got to deal with… however I deal with it…whether that be going to work and smashing the crap out of something at work…{laughs}…*or going to work and falling asleep in the car cos I'm that tired…or whatever……you do whatever* (Robert 30/1)

Preterm fathers acknowledge that the impact of living though the stressful situation of being in NICU would eventually be felt following discharge home:

There is this real sense of ….I think that's the biggest thing… you feel like while you are in crisis mode you are kicking all this stuff down the road… you're kicking all the stress cos you are coping…. you are in the eye of the storm…. .you're just dealing with it…(Tim 30/2)

The necessity {to meet with the bereavement counsellor} *has reduced but I suspect it would still be wise to just sort of chat through all this stuff try and actually get it out. Cos I do feel whenever I describe the* {preterm experience} *I can feel myself welling up as I describe it but I actually find that I feel quite positive cos I feel like there's a little bit just leaving the building not that it's some painful recurrent feeling its actually just it's talking about it, dealing with it and its entirely a positive* (Harrison 24(twins)/2)

The range and polarised emotions experienced by preterm fathers in the study was described by those fathers of more preterm babies:

You sit yourself on that rollercoaster and I mean one day you're going to be ….see this time what I've done cos I used to like be happy they used to tell me a bit of good news then I'd ring 12 hours later or whatever and they'd say sorry we've got some bad news…so it's literally up and down so you sit on the rollercoaster for the next 4 to 8 to 12 weeks, you are going to be up and down like anything (Eric 28/1)

You go from that to joy to that to ..it's …you're so up and down because you don't know what's going to happen …you're constantly thinking are we going to get a phone call that she's taken a turn for the worse (Robert 30/1)

This analogy of being at the mercy of a rollercoaster ride[54] alludes to uncertainty and that premature birth results in an indeterminate time experiencing extremes of emotions. A rollercoaster ride provides paradoxical emotions in quick succession of being terrified and excited and this mirrors aspects of the emotions experienced by fathers of premature babies:

This is totally a one-off thing that I've had to deal with …nothing has come close to the emotion that you feel, of varying spectrums from one end to the other, you go from elation to distraughtness you really are up and down the whole time …you cover the whole spectrum of emotion (Robert 30/1)

We sort of entered this whole you know this rigmarole (Frank 24(twins)/1)

I just think that it all depends on the frame of mind that you're in at the time… but I think that's quite a thing as well …how you feel on the day…some days the world can throw everything at you and you can stand up to it …..other days …like the other day {name of wife} *saw a few desats and bradys and it's just like…. I don't want anymore…. I totally empathised with where she was at…….. just leave me alone….. no more…* (Harrison 24(twins)/1)

You've gone from that joy of having a baby to worrying yourself to death that she's going to survive and literally at the flick of a switch you've gone from one to the other and everything changes again really that quickly (Robert 30/1)

The emotions experienced by preterm fathers in this study are aligned with the illness trajectory of the baby[55] and their partner's developing role as a mother. These emotions are inextricably linked to the fact that these fathers are waiting for an outcome. The consequence of living with uncertainty means that preterm fathers

[54] The experience of pregnancy and birth for term fathers is accompanied by feelings of tension, including risk and uncertainty, fear and frustration (Steen et al 2012) with the transition to fatherhood described as being on an emotional roller coaster (Asenhed et al 2013) and feeling like a hitch hiker in undertaking an unknown and uncertain journey (Draper 2003).

[55] Fear and anxiety are experienced by parents in response to changes in their baby's condition and has been likened to a game of snakes and ladders: *'you get up a ladder but then you just fall down a snake'* (Watson 2010:1466)

experience a range of emotions some of which, feeling disconnected for example, begin during the pregnancy and continue after birth into the NICU

Façading may lead to misunderstanding by mothers and potentially others when judging the father's reaction to the birth of his preterm baby:

There's been conversations {with his wife} *about I don't think you're taking this in I don't think you assimilating this properly. But I can't sit there and proactively grieve and proactively stare into an incubator for 12 hours instead of 2 it's just.. I'm just getting on with it* (Harrison 24(twins)/1)

He's self -ventilating and he has been for 5 days and they {name of consultants} *are all saying he's doing really well I'm still waiting for someone to come up to me and say he's going to die because I've got myself into a position where I'm expecting the worst cos two of my children have died so I have this time kept myself a little bit distant* (Eric 28/1)

As a Dad you want to be able to say he's doing really well people were texting me messaging me asking me how's he doing and I'm saying ….I talk like a doctor I say he's stable now small steps we'll see how he is tomorrow that's err…as a Dad you want to be like oh he's doing amazing I can't wait to bring him home but I'm not like that and I think my wife is trying to be little bit more positive and she thinks I'm being too negative but I'm just keeping myself ..because if something does happen then I'm not going to fall from such a great height ……..I don't want to be like that though I want to be jumping all around…saying how lucky I am to have him but I still feel a bit reserved (Eric 28/1)

The fathers of less preterm infants (more than 32 weeks) did not articulate their experience in the same way as those fathers of very preterm babies (less than 32 weeks gestation). The increased vulnerability and likely prolonged and unpredictable illness trajectory of very preterm babies lends credence to this finding. The information received from neonatal staff and how physically robust the baby looked reassured fathers of less preterm babies that there would likely be a positive outcome:

He's doing so well there's not really too much to discuss they just say you don't need to worry because he's doing great and you know you've got the nurses saying that you've got the doctors saying that so you get all the comfort from that really and the fact you can see he's ok (Arthur 31/1)

Just sort of seeing him you can't help but just smile and be happy ….just joy you know any worries I had about money or practical things didn't even enter my head really ……it's just sort of all emotion at the time it's quite nice really {smiles} …..*I didn't expect to feel like that* (Harry 34/1)

In summary, preterm fathers in the study displayed the strategy of **façading** in managing the uncertainty associated with premature birth. They acknowledged the central importance of mother and baby who need to receive healthcare interventions and although this strategy may be viewed as a masculine facet of fatherhood, this strategy has also been noted to be used by cancer survivor families.

5.4.4. Gendered caring: soldiering on

The nature of the preterm experience requires preterm fathers to acknowledge that the length of time of the NICU admission may be extensive and requires the ability to sustain endurance in the face of uncertainty:

It's probably health related stress ….hospitals all of that sort of thing… kind of ..I guess there's a process that you have to get through and just wanting it to be done (Harrison 24(twins)/1)

I've been coming up here every morning before work so I get up here at about 5.45 then I leave about 6.30-6.40 go to work get home get a bit of dinner either {partner's name} *will come back up with me or she'll stay at home with my stepson and take him to his clubs to try and keep things as normal as possible and then I'll come back up and that's how it is so I'm pretty dead on my feet at the moment but you just get on with it* (Robert 30/1)

The requirement to remain resilient and keep going is, in some ways, reflected in the situation being one of uncertainty, with the actual endpoint of the journey unknown. Preterm fathers (and healthcare professionals to some extent) do not know how long the NICU experience is going to last and they therefore manage each crisis as it transpires:

I wouldn't like to experience it again, being that you've been through it once I think it would make it a little bit more, would it make it worse? I don't know if it would make it worse if you know what to expect …whereas at the moment it's a bit of a journey ... (Robert 30/1)

I see in my mind's eye these dips, huge dips. The first one that springs to mind is all about whether he's going to die or not and one of the major ones was when he took a long time to come round after his hernia operation. Then his vital signs were all over the shop and he was unwell (Harrison 24(twins)/2)

It was difficult I had to sort of tell myself that it will all be alright and that you know she was my baby and you know it's all fine you had to convince yourself because you are making sure that everyone else is alright you then have to tell yourself that things are going to be alright and get on with it (Robert 30/1)

The fathers are experiencing two parallel spaces: one which contains his baby and his partner (NICU) and one which contains his partner, family and friends and the

workplace but not the baby (everyday life). The activities that make up everyday life are managed:

What really surprised me was you don't go into meltdown you go into ....that pragmatic space where you just start thinking about weird things like I need to do the washing and somebody's got to go home and cook this and unplug that and how the world doesn't end and stop turning and you still have to deal with all the mundane day to day stuff and there's space in your head for it and I remember ….there's always have been those sorts of events in life where you think those things wouldn't come into play but they do ....(Tim 30/1)

The two parallel spaces are occurring in tandem with the father entering and leaving the NICU from and back to everyday life as if through a 'revolving door'. The NICU space impacts hugely on everyday life but this cannot be reciprocated; everyday life cannot interfere with the NICU. This double life results in the father being 'merely situated'[56] in the NICU and renders him as being a transitional presence. Neonatal care continues whether the father is present or not and an attempt to negotiate a fathering presence is made without displacing his partner or the nurses who are both seen as having the ability to care for his baby. 'Vicarious parenting' by the neonatal staff is accepted by the father as integral to ensuring the safety and wellbeing of his baby:

When you come up here it's as though you're detached from everything else you walk through them doors and nothing else matters…. there is nothing else you are then just concentrating on what's going on with your baby and then I was finding when I walked out of the doors all I was thinking was what's going on with {name of partner} *what's going on with* {name of daughter}….(Robert 30/1)

The fathers acknowledge that they need to be supportive and accept they are in crisis and faced with the unknown:

You deal with it..nothing else you can do..knuckle down and get on with it and that's how I've looked at it, as long as I'm there for {partner's name}, {baby's name} *and* {stepson's name} *then that's all that matters, they need me and I make sure they're alright ….that's it… that's how it's got to be…*(Robert 30/1)

The biggest thing is that you pat yourself on the back…. well I did… when he was on the unit … there was a sense of …I pat myself on the back for being really supportive and not feeling stressed and not you know… being really really good at handling the whole situation for two and a half months …I did brilliantly (Tim 30/2)

[56] Being 'merely situated' in social interaction involves events taking place irrespective of whether the individual is present or not (Goffman 1983)

The whole thing was just surreal at the time …{pause}...*it's like the emotional shutters come down and allow you to continue to operate when things aren't as they should be…..* (Harrison 24(twins)/1)

There's still this element of no matter how prepared you are it's suddenly happened, and you have to get on with it (Frank 24(twins)/1)

As soon as that happened your life is sort of out of your hands really everything else takes over and you just get on with it do what you need to do..you know they are my family so you get on with it and look after them, as hard as it will be and it is hard but yeah you just man up I suppose …….that is the main thing.. no matter what you are feeling you stay strong for the mother and the baby and for anything that's going to come along……(Robert 30/1)

Managing NICU and everyday life[57] renders the preterm father 'time poor'. They are situated in two distinct spaces, one with the baby and one without, and are challenged by the need to fulfil their commitments in both. With a term baby the two weeks paternity leave provides space for both parents to have time together with their newborn baby and settle into their new status and fulfil the physical and psychological roles as parents in the privacy of their own home. Preterm fathers normally try and keep their paternity leave until the baby is discharged and therefore during the NICU admission all but one of the fathers in this study were working, supporting their partner, visiting the baby and managing the other activities that make up everyday life. The restrictions placed on their time require the preterm fathers to attempt to fit everything in:

It's just like having 100 balls in the air and you've just trying to juggle all of them… it really does get a bit like that… (Robert 30/1)

When I go back to work on Monday I can't pop in for a visit because I'll be half an hour in and out of the car park..if I'm 10 minutes later leaving the house for whatever reason I miss an hour with him {due to car park spaces filling up} *it sounds a really petty thing and completely unrelated but it's shocking yeah…*(Tim 30/1)

We need a PA or secretary… we had so many texts coming in …so many visits and then the midwife coming in and then coming up here for the parents time… the quiet time and ….it's just trying to fit it all in ….and then there's my partner's food cos that's also quite regimented….(Arthur 31/1)

[57] The assumptive world is 'created and defined by sociocultural and biographical realities consisting of the cognitive world (knowledge, beliefs, values, expectations) and the action world (routines, behaviours, events, relationships) and provides a sense of continuity and coherence that reduces the level of perceived uncertainty' (Cohen 1993:79)

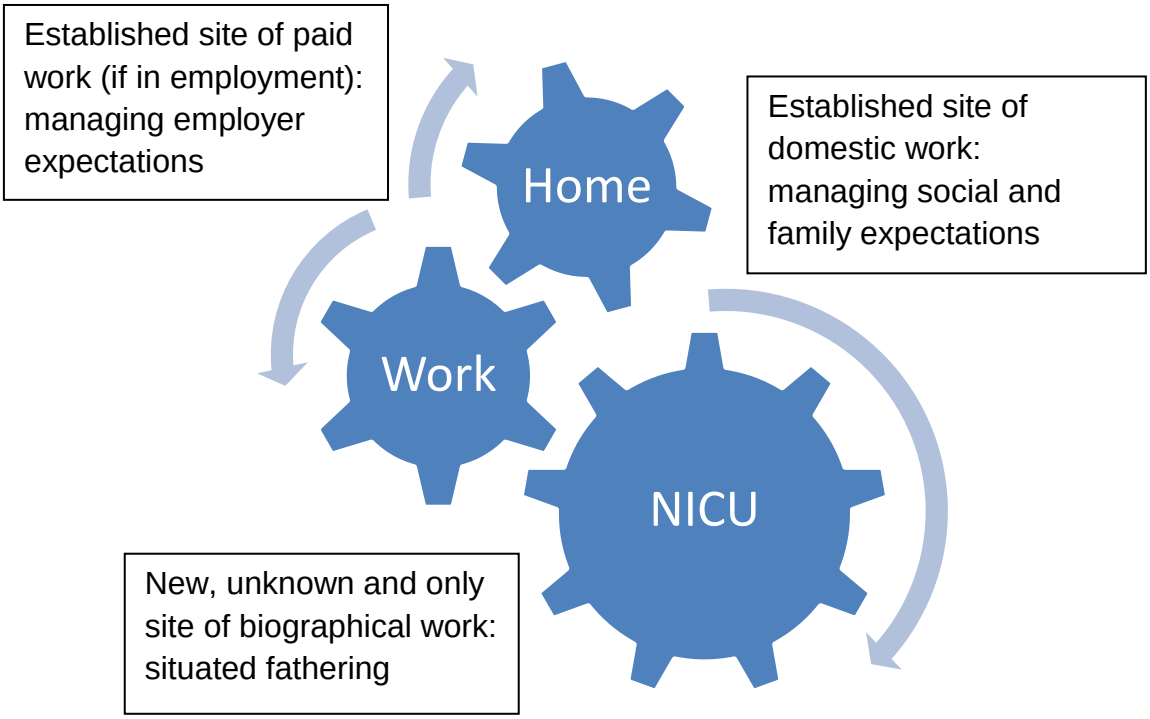
This balancing act results in preterm fathers neglecting their own needs:

It is a struggle because you're just putting your feelings aside you know…I found it hard…. I knew I had a daughter but I didn't see it that I had a daughter, when {name of partner} *came home we'd come back up and we'd be coming to see a baby in a box you know ….I've struggled to get a connection with* {name of baby} *because I was constantly making sure that* {name of partner} *was getting cuddles*….(Robert 30/1)

The worse part of this was {name of partner} *having the C-section so she was quite immobile and everything else…*(Robert 30/1)

Preterm fathers have to sustain a life and routine which additionally incorporates travelling to the hospital on a daily basis for weeks and months[58]. The physical space in which preterm fathers are encountering fatherhood is framed by the NICU setting. The social and symbolic processes related to this specialised and critical space will influence the practices of parenting[59]. The NICU is now added to home and work spaces which orbit the NICU and acts as the centralising and only site for preterm fathering (figure 5.4).

Figure 5. 4 Spaces of premature fatherhood



[58] The expected readiness for discharge of a preterm baby will be individual and relates to the gestation, weight, and problems of prematurity encountered. The readiness for discharge is normally close to the expected date of delivery but with the involvement of the neonatal outreach team this often occurs earlier.
[59] Parenting geographers have illuminated the effect of the numerous spaces and sites in which parenting takes place (Jupp and Gallagher 2013, Moran et al 2017).

This aspect of coping with the uncertainty associated with premature birth was particularly poignant during the NICU admission and relates to the properties of instrumental versus emotional caring[60]. Preterm fathers in the study often demonstrated a logical approach to managing the NICU admission:

Because it was a long time so yeah you are right I am not going to sit in a hospital I am going to go out with {name of other child} *or I am going to go to work ..the trouble is you sum all those things up and it means I wasn't at the hospital very much. From my point of view you* {partner} *deal with that bit I'll deal with this* {bit}.. *what* {wife's name} *is fundamentally saying is that a bit of emotional support rather than .. because the comparison she could justifiably make was that a lot of the other Dads are all sat there all day ….but I think we were all in a bad place and she felt very strongly we should be there for* {son's name} *and from where I was looking that was happening but then she was probably feeling that she has to be there all the time for 100 days which is probably true of all the mums I think from what I saw they were there every day…*(Harrison 24(twins)/1)

Negotiating a fathering presence is extremely challenging for preterm fathers due to being time poor, the sense of disconnection from the baby experienced during the pregnancy and continues following the birth and the NICU environment. The sudden and unexpected physical appearance of the preterm baby is experienced in terms of shock, both physical and mental. The first few days of admission to NICU are experienced as a time of beginning to come to terms with what has happened:

What is a wonderful thing is the mechanism called shock… stops you thinking stops you feeling that's a good thing ….we like shock and the point is not to be afraid of it erm because at that time I sort of recognised I needed it…. (Frank 24(twins)/1)

I think it was more just a case of trying to get ourselves sort of mentally into the right zone with it being a shock for everyone you know the baby included ...so .. busy few days.... (Arthur 31/1)

The sense of everything being a bit frantic … (Tim 30/1)

My heads a bit all over the place at the moment to be perfectly honest with you and what with working and tiredness and everything else it's yeah it is quite an undertaking I must admit it really is….(Robert 30/1)

[60] Studies of men caring for their spouses with a chronic illness have identified 'a take charge attitude that is characteristic of men's caregiving' (Barken 2014:712) and in attempting to control and provide effective care for their wife, use a task oriented, managerial approach (Calasantini 2010). Men in these studies used problem-focused coping strategies and evaluated their caregiving on tasks completed successfully rather than how well they had provided care or the effect of that care on their spouse.

Being in shock is compounded by the fact that the pregnancy is experienced as preparing for an event that does not seem *real or tangible* and this emotional disconnect continues into the NICU admission:

It's as though you're visiting someone else's baby…and it's …yeah..I did look at it yeah I am visiting a baby, but I'm visiting a baby in a box and while you're here she's yours and then you disappear….(Robert 30/1)

I don't know if I feel like a father as such yet ….you know because we haven't taken him home and because we haven't really cared for him as such ….I guess as a parent you sort of the child relies on you whereas he's not really relying on me I'm here for an hour or two and then I go ……..(Harry 34/1)

I'm a Dad but I don't know how I am supposed to feel as a dad…I don't know...(Robert 30/11)

Time and the NICU environment influence the development of preterm fathers' identities. The planned trajectory of pregnancy, birth and taking a healthy baby home has disappeared. In its place is a situation in which the preterm father has no script to follow and the outcome is unknown: .....

at the moment we're waiting for an outcome which is I dunno going home or organising a funeral, it's as cut and dried as that …… (Harrison 24(twins)/1)

you're in that room {intensive care} *and you either get out of there or you don't …there's not a manual book, you can't prepare anyone for that* (Eric 28/1)

A doctor said to me the other day how do you do this…….you're like superman ……but it either makes you or breaks you and I think if he didn't make it tomorrow if he died tomorrow I have cuddled him I've fed him I've changed him I've done everything I can do as a parent ….I know that I've done everything I can and I will do ……if he makes it if he pulls through, I will be the best parent I can ever be (Eric 28/1)

I mean {partner's name} *is absolutely brilliant she has been she has just taken to it and been absolutely brilliant but trying to support her as well you keep her going because she is worried obviously, and you try and shoulder the lot* (Robert 30/2)

In summary, **negotiating boundaries** involves the careful avoidance of displacing the staff and his partner, both of whom are perceived as being the experts and having the skills to meet all the needs of his baby. **Total trusting** of the staff and **standing aside** facilitates the provision of safe and effective care to his family. Preterm fathers in the study acknowledge the need to support and sustain his family and demonstrate aspects of hope, resilience and perseverance. Consequently, through a process of **surveyancing**, preterm fathers monitor the situation on the

NICU and following discharge home in order to record and evaluate the trajectory of his family away from danger (needing intensive care support) and uncertainty (being unsafe) and towards stability and recovery (being safe).

5.5. Surveyancing

The timing and asynchrony[61] of prematurity renders it problematic for preterm fathers. Unable to provide a consistent parental presence, preterm fathers therefore carefully monitor the situation through **surveyancing**. The strategy of **surveyancing** comprises examining all aspects of the situation (Table 5.2) and facilitates men's understanding of premature fatherhood by developing a cognitive map.

Table 5. 2 The characteristics of surveyancing related to premature fatherhood

Definition of surveyancing	Relevance to premature fatherhood
Look closely at or examine (someone or something)	Rationalising and appraising the situation Establishing a connection with the baby Being present on NICU Safeguarding the mother-baby dyad
Examine and record the area and features of an area of land so as to construct a map, plan, or description	Trenchant monitoring Hypervigilance Having constant access to a mobile phone Fathering in public Comprehending the preterm illness trajectory Marshalling care-getting Using medical language and monitor watching
Investigate the opinions or experience of a group of people by asking them questions	Seeking information from healthcare professionals Assimilating other families' experiences Taking stock

[61] Unexpected life course events for fathers such as delayed conception, unplanned pregnancy, separation and step-parenting 'can be experienced as problematic by challenging anticipated future trajectories' (Shirani and Henwood 2011a:49)

The properties of **surveyancing** include; **safeguarding the mother-baby dyad** and **vigilant attending** with this process commencing during labour/birth and continuing through the NICU admission and following discharge home.

5.5.1. Safeguarding the mother-baby dyad: promoting the mothering role

The deference to their partner by preterm fathers is evident during the birth and admission to NICU. It appears their actions are directed towards affirming motherhood, and their role is to make sure that the mother–baby relationship continues to be sustained[62]. The action of deferring to others is inherently focused on promoting mothering, supporting the continuation of the connection between mother and baby, particularly if the mother is breastfeeding and facilitating the clinical care of the baby by the healthcare professionals.

The importance of safeguarding and championing this dyad is of central concern to preterm fathers in the study:

In this whole thing I'm not important in this...not compared to them two..that's how I see it … you deal with it …you ask questions when you feel you need to ask questions because it's not about me…how I feel doesn't matter ….how them two feel is all that matters ..I'll look after myself…….(Robert 30/1)

When he is awake I think it's more beneficial for him to be with my partner ..sort of the closeness.. on her chest with trying to get him to breast feed and stuff (Harry 34/1)

We {fathers} *know what we are doing we are serving… the priority is the child. All the time that you can see it's for the benefit of the helpless being, who needs all the nurturing that they can get, it's just how it is, that's how things are meant to be* (Harrison 24(twins)/2)

Harry's baby was a less preterm baby and was six days old at the first interview. During the interview it came to light that Harry had not yet held his baby, even though the baby's clinical condition was stable enough. Due to work commitments, he was visiting for one or two hours a day which limited the time available for him to interact with his baby and when he did visit, his son was usually asleep. When his baby was awake, he felt that it was more important for his baby to be physically close to his partner to facilitate breastfeeding:

[62] A critical gender analysis of 21 fathers' experience of having a baby in NICU also identified the prioritisation of mothering exhibited by both fathers and healthcare professionals (Deeney et al 2012).

Cos he's sleeping a lot and then I don't catch him awake that much. I've changed him but I haven't really had a cuddle with him.. it sounds a bit strange doesn't it …I haven't even held my own son yet (Harry 34/1)

You just want to make sure that mum and baby are alright so you make sure that they get as much time together as they can because they are the important two that need to be together especially as the way {baby's name} *was with feeding and everything else…just trying to make sure that they get the time that they needed together to bond really at the start….*(Robert 30/1)

The recognition that the bond between his partner and baby[63] needed to be nurtured results in preterm fathers rationing his share of the limited opportunities available to interact with the baby:

You don't want to feel like you are being greedy so you limit your time, when I visited in the morning {6.30 am} *invariably* {baby's name} *was asleep so I would not want to wake her up so I would just be sitting there staring at her but felt that I had to come and see her because I would not see her all day. I'm still doing it now* {a year later} *you make sure that she gets her cuddles then she is happy* (Robert 30/2)

We almost would not want it to be family centred because at that point in time all that matters is the wellbeing of mum and the baby and we don't mind being taken for granted because it is for the benefit of the baby that we are all there and the best thing that we can do is to support the mother so that is not an issue in itself for me (Harrison 24(twins)/2)

The key stages in managing the process of premature fatherhood are two-fold: to ensure that his partner safely returns to her pre-pregnancy health status; and then to focus on the illness trajectory of the baby which remains uncertain. In terms of the care-getting adaptations and resources, the first of these relates to personal resources and adaptations. Individuals' response to life stressors, such as optimism[64], will vary depending on their disposition and attitude. Preterm fathers in the study appear to identify with the importance of acting resourcefully as part of their masculine role. They actively mobilise responsive care-getting by **standing aside** and promote the care-giving activities of their partner and the nurses. They maintain a constant watchful monitoring and hyper vigilance role, accepting all information given to them and asking questions if uncertain. They only intervene if

[63] The physical closeness (skin to skin/kangaroo care) of the mother and baby can facilitate the stabilisation of the baby's clinical condition and promote lactation and bonding (Ludington-Hoe 2013)

[64] Optimism has been recognised as ameliorating the effects of stress and provides a way to more effectively marshal care and support. Resourcefulness has been suggested as an important disposition in coping with health related stressors (Kahana et al 2009) and has a role in marshalling responsive informal and formal care-getting.

they encounter situations which they consider to be unresponsive or detrimental to their partner or baby:

Your role as a father is to sort of see the big picture and to see the continuity and to work out hang on a second this is different why is this why is that (Frank 24(twins)/1

There is no way that {name of wife} *is not going to be here for a very significant amount of time for as long as it takes and I would not… other than making sure it is sustainable and she is well.. I would not dream of telling her otherwise and in some ways I am very glad that not only has my little boy got his mum he has also got all these amazing people that are looking after him medically as well and that is part of the reason why I feel that at the moment I can go and do other things because he has got the best possible care* (Harrison 24(twins)/1)

The participants acknowledged the primacy of the mother-baby relationship and as a result occupy a state of being in abeyance with respect to their fathering role. They sacrifice their need to be a father in order to ensure that their partner takes up all the limited available opportunities to complete the transition to motherhood. They perceive the best people to care for their baby is their partner and the nursing staff. Their needs therefore have to take a back seat. In rationalising the situation, the action of **standing aside** affords the opportunity for marshalling 'care-getting'[65] for their partner and baby. Preterm fathers are proactive in ensuring their partner and baby are receiving the best care:

But my feelings don't matter and I'm not going to put my feelings on {my partner} *…I'll just keep shtum…I won't you know…unless it's something that I think needs saying I'll just go with it and not for the sake of an easy life or anything like that…but I know everything's good and all the while its good I'm happy…….that's all I can ask for..that's all I want for baby and mum to be alright and then everything's good* (Robert 30/1)

I think access is good because I think we would make sure we got it ..the time you have with them {the consultants} *is the time when you really you're building the plan for the future or trying to understand what is going to happen to you* (Harrison 24(twins)/1)

I will support everything you guys do and {partner's name} *does and as long as* {partner's name} *is in agreement I will back her 100% and I will back you guys but I just don't want to feel that she's being pressured in any way that's going to have an adverse effect* (Robert 30/1)

[65] 'The proposed model of proactive care-getting represents an innovative perspective by recognizing that frailty and the need for care-getting can coexist, while still retaining agency and initiative. Individuals with chronic and life threatening illness can still exert control over the care they get by proactively marshalling support in terms of mobilising proactive adaptations and resources' (Kahana et al 2009:185)

Preterm fathers predominantly marshal care-getting from healthcare professionals and this support is healthcare related and instrumental but also has a social and emotional dimension to it. Preterm fathers articulate that family and friends cannot really understand the nature and extent of the critical life event themselves and their partner are experiencing and therefore provide minimal social support. Even when family and friends have visited the baby in NICU, they demonstrate an inability to form an appropriate response to the situation:

Today she's ok and you know that's how I saw it when she was in intensive care ..yeah today she's ok ..but when people ask it's like she's doing alright they say oh great yeah that's brilliant ……..you don't understand…Mum or Dad….or Auntie or Uncle or friend or whoever it might be it's like you can't comprehend this situation (Robert 30/1)

One family having experienced premature birth multiple times actively excluded family and friends visiting the NICU. Their experience was deeply personal, and they did not feel it appropriate for family and friends to visit in what they considered to be voyeuristic:

We created that baby we will see that baby out of this hospital and people can enjoy that child however we didn't want to bring people up here to gloat on our sick child or bring their emotions into it too because this is us and if we leave they can enjoy that child with us but not in intensive care (Eric 28/1)

Some fathers had family where geographical distance precluded them from visiting. Others acknowledged the burden of managing visitors and one father resented how this contributed to his stress and was deemed unhelpful:

We'll come down and do all your washing we'll do all this and all that what they actually mean is they'll come down around lunchtime they'll spend a couple of hours with my son then they want lunch and then they want this and then they want to get away early and it becomes much more about them than about you, you don't actually get anything out of them that actually really annoyed me (Tim 30/1)

The experience of becoming premature parents is not normally shared by family or friends' experiences and therefore social support may be secured from parents on the NICU through informal discussions in the parent kitchen whilst making a cup of tea:

Speaking to the guys up here and chatting to other parents up here and speaking to other parents who are going through similar things just being able to chat to them and then sort of gee each other up yeah that's made a bit of a difference

chatting to other parents …knowing that you are not on your own and other people are going through this and it does happen (Robert 30/1)

The shared community of parents on NICU inevitably can be a source of stress in addition to being a source of support. One preterm father in the first interview experienced this as difficult:

If you could have allowed me not to befriend people up here or get to know people up here that would have helped cos it's been terrible … it's been a horrible week … very quickly it becomes a little community of people that know each other ..I think there has been two babies that we know of died and maybe if you could be wrapped in cotton wool and kept away from all that it might help (Harrison 24(twins)/1)

However, during the discharge interview, Harrison expressed a different view:

If that was my feeling at the time then that has changed quite a lot …it's funny now with the benefit of being one of the lucky ones..it doesn't matter which way you go round it that's the position I can talk from now… that sort of almost camaraderie is not bad I could see how good it was for {wife's name} *especially among the Mums …Dads are more like that sort of nod but it's quite clearly they're supporting the main act so yeah the only thing I can really think of is that thing of when something has just happened and maybe that's just a human response actually not wanting to see there's a car crash you drive away quickly you don't want it to weigh on you* ….(Harrison 24(twins)/2)

Preterm fathers are holding things at bay in the face of being in the 'eye of the storm'. They therefore need to stay strong and fulfil a supportive role for the mother but also the staff in enabling them to care for the baby. This results in a disenfranchisement and invalidation of his role as a father. Preterm fathers monitor the situation, remaining hyper vigilant, ready to intervene if needed. Several preterm fathers in the study highlighted how they were affected by the distress experienced by their partners when attempting to express breast milk for their baby. They also monitored the connection that their partner had with the baby:

I could see {name of partner} *was struggling and I was finding it quite hard to rationalise things with her so that she could..I don't know she just did not have that attachment with* {name of daughter} *at the beginning and I could see that it wasn't there because we'd go downstairs and I'd say shall we go back up and she'd say oh in a bit and I'm like …..ok I am going to have to try and keep an eye on this and I mean I hadn't slept you know I wasn't eating properly but you just get on with it and make sure {*name of partner} *was alright so my priority then was to…I knew that {*name of daughter} *was being looked after so I needed to look after* {name of partner} *and keep her going..* (Robert 30/1)

I think watching my partner get a lot of pressure on herself with regards to sort of the breastfeeding because she couldn't and then the midwives were saying maybe you produce more at 2 and 3 in the morning so she's setting the alarm getting up and doing that she was really tired I think and then with the pressure I think that's why she wasn't producing ….(Harry 34/1)

She was really sore and she'd be at home trying to express sitting there crying and I don't know what to do… I can't say anything I can't do anything to help and I said to her… she said the only thing I can do for {name of baby} *at the moment… it's all I've got to do… it's the only thing I've got to do and I can't do it..*(Robert 30/1)

In summary, preterm fathers focus on **safeguarding the mother-baby dyad**. They ensure that their partner's mothering role is prioritised and all their baby's physical and emotional needs are completely met. Preterm fathers are **negotiating boundaries** due to the diffusion of responsibilities between his father role, his partner's mother role and the role of healthcare professionals in the NICU. Preterm fathers in the study continue to safeguard his family by **trenchant monitoring** of the mother and baby during the NICU admission and following discharge home.

5.5.2. Vigilant attending: trenchant monitoring

The NICU is a technological environment with access restricted to parents and close family members and friends. Parents press the intercom bell and wait for entry to be granted following confirmation by staff of their right to enter. The NICU in the study has three nurseries which provide intensive care, high dependency care and special care. The intensive care and high dependency care nurseries are normally staffed by more senior staff and the special care nursery is staffed by junior nurses and nursery nurses. In practice, if there is time prior to the delivery, the neonatal team will meet the parents to talk through the implications of their baby being born early[66]. Fathers in the study recalled these conversations, which reinforced to them their comprehension of the seriousness of the situation:

The consultant neonatologist came down… we knew it was going to happen that day imminently so she {the consultant} *was bit more blunt about saying well you know 50% survival rate and of the ones that are born 25% of them have disabilities…that was quite a shock actually.. in fact that was the first time that anyone had really mentioned disabilities to us ..well as far as I can remember.....we were just taking it in at that time.....*(Frank 24(twins)/1)

[66] A focus group study involving NICU staff identifying a number of factors relevant to providing good antenatal consultation: 'supporting the building of a caring relation; sharing information in conversation; and, preparing for what is to come' (von Hauff, Taylor and van Manen 2016:103).

…one of the women from the neonatal team came down and spoke to us and she was brilliant she said look you know it's not ideal but we didn't lose any last year at this age you know he's in good hands he's probably… we can't promise anything but it's not as scary as you might think…(Tim 30/1)

…..if you have a baby at 28 weeks this is what to expect and I was like whoa… this is pretty full on this is not going to be easy to deal with..(Robert 30/1)

Potential premature parents will also be invited to visit the NICU to experience the environment before their baby is born. Those fathers who experienced this opportunity suggested that this was something that all prospective premature parents should do:

If you have the opportunity to have a look round the unit take it….. nice to do in terms of the idea that you're being prepared for what's coming… (Frank 24(twins)/1)

Looking round the unit is a must…that would be the one thing {for potential preterm parents to do} (Robert 30/1)

The NICU environment is perceived as unique and cannot be likened to any other situation previously experienced[67]:

It's still such an alien place and of course the other thing is you can't do anything so you just sit and stare at the baby (Frank 24(twins)/1)

It's like being in spaceship…there's noise there's …that was the one thing I couldn't comprehend…how noisy it was the first time I walked in here (Robert 30/1)

I came upstairs and it was... really surreal.... it was really like.... it's a really strange environment that nursery, especially late at night (Tim 30/1)

So although the stress {in my paid job} *comes from situations that I can't control, to some extent that's the environment that you're used to being in whereas this is a) much more important and b) you can't do anything at all and that's unbelievably stressful you wake up stressed and you're stressed all day long and you just get more stressed when you come up onto the ward and you go away and you're still stressed* (Frank 24(twins)/1)

[67] Experiencing being a parent of a sick newborn or small child was likened to being in an alien world with the sub-themes of 'a need to be there', 'what is going on', 'being vigilant', 'being a spectator to your own life', and 'oscillating between hope and hopelessness' (Hall 2005:178).

Preterm fathers rationalise the information they receive through encountering and interpreting technology[68] in order to plan for any future events that may require them to make a rational decision. This **trenchant monitoring** requires the preterm father to remain hypervigilant of his partner's and baby's physical and mental health with all the fathers having their mobile phone close to hand during the interviews. All bar two of the interviews were interrupted by a text or phone call. Preterm fathers suggested that the technological environment of the NICU rendered parents on 'tender hooks', anticipating deterioration in their baby's condition or a phone call at any time that would herald bad news and having to face the prospect of their baby dying. Preterm fathers in the study acknowledged the importance of collating information about the expected preterm illness trajectory:

{name of nurse} *was saying NEC[69] that was really noticeable how at first there was a conversation about it.. the main threats and then you realise it takes on it's own…. partly because how the staff respond to it. They don't want to shout it round the room and that was something very strong actually, the way that it took on its own persona and actually became like you know heart disease or cancers ….mortality* (Harrison 24(twins)/2)

Preterm fathers suggested that after a few weeks they began to feel comfortable in the environment and experience it as a *cosy blanket* and being able to come and go as they please. One father who was not employed during his babies' stay on NICU also experienced the subtle change in his role as being part of the team and that his opinion mattered. Preterm fathers also talked about the NICU environment in terms of technology. The monitors were a visual affirmation of their baby's condition and needed to be carefully watched to assure the safety of his baby. It is acknowledged that a father's role is to protect his children and in watching the monitors, preterm fathers were safeguarding the baby's welfare:

I don't know …by watching that monitor I was doing something ….I was making sure that she was alright..if anything happened I could make sure that someone knew about it, if the alarm went off. I don't know what I was going to do you know what I mean and they all look over and see and they all know before I even do…but I just felt like I had that little bit of control …I'm looking after her that sort of thing you know (Robert 30/1)

[68] The material-semiotics of fatherhood: exploring the role of caring technologies in the transition to fatherhood relates to how technology co-constructs and co-emerges with the transition to fatherhood (Bettany, Karrane and Hogg 2014)
[69] A life-threatening condition affecting the intestine and resulting in necrosis, potential bowel perforation and peritonitis

However, the monitors were a source of high anxiety and concern:

I was looking at the machines…one thing is which I think they should try and get rid of is the monitor ….so you've got heart rate you've got the saturation and you've got the respiratory…..I look at it and I get anxious if they're not normal …so I think if they could get rid of that machine and it be about the babies it would make the parents …..and the beeping and ….there should be a different way to solve that because a part of it is that it is just ….this beeping this alarming so you're scared….(Eric 28/1)

You just constantly know that that's your baby's vital signs and if anything is going wrong with them it's like….but yeah I felt myself monitor watching ….really bad…it gives me a bit of control I can see what's going on ..I'm not just looking at {name of baby} *…that monitor there I can see what's happening you know every time it bleeps I know that something's happening…* (Robert 30/1)

However, for one first-time father of a less preterm baby the monitors were considered a source of comfort. This may be a reflection of the baby requiring less intensive medical interventions:

I think that I'm quite pragmatic really so probably in my view generally I can sort of detach myself emotionally quite easily so I'm probably quite sort of analytical and so probably when I go into the ward and look at the numbers I can look at the numbers and think yeah ok I understand them and that you know I can draw comfort from that he'll be done when he's done and that will be that again I think because that is our outlook it's not been too stressful (Arthur 31/1)

Trenchant monitoring of the monitors and the baby continues throughout the admission and following discharge home[70]:

Yeah still do it now {monitor watching} *with her video monitor sit there constantly pressing it all night making sure she is alright any sound ..she's alright..sit there with my ear to the monitor yep she's breathing still the same I am terrible for it* (Robert 30/2)

It is a horrible place to be it really is.. I've been in there 5 times with 5 of my children. I know all the machines I know all …everything…all the graphs all of the computers. I know it all. But I still struggle being in there my heart pounds so the anxiety in there is horrible (Eric 28/1)

The need to remain connected with their partner and baby at all times in order to be prepared for receiving information was symbolised by all the fathers having their mobile phone close to hand during the interviews:

[70] A Danish phenomenological study involving 13 parents of a critically ill newborn or small child suggested that 'anything that touches on the child's wellbeing has salience for the parents and results in them being vigilant' (Hall 2005:183).

So he was doing so well so I said to the consultant is he alright has he definitely not got it and he said to put more or less to put us at ease he said he'll do another X-ray ….so we went home and he'd done the X-ray and we'd literally just about to get back home and my phone rung so I answered it and he said to me I'm so sorry it's exactly the same as {name of previous preterm son and daughter who had died} *my heart just sunk so we literally turned back ..drove back to the hospital just disbelief we just thought that we were going to see him deteriorate have to turn off his machine and that was it* (Eric 28/1)

Without being on the phone every minute of the day or you know it's you don't know what's happening and you're constantly thinking I hope the phone doesn't ring (Robert 30/1)

During the first interview, Harrison answered the phone call from his wife and updated her on their son's progress. During this phone call he used medical terminology and the conversation could be likened to a medical handover from one shift to the next. His son had gained weight that day, but he suggested that this was more likely to be fluid. The CRP[71] was down to 4 and he had had one desat and brady[72]. From her responses it seemed his wife appeared to understand this information.

In summary, the premature birth and technological environment of the NICU engenders the need for **trenchant monitoring** of the mother and baby's needs by preterm fathers in the study. In being time poor, preterm fathers need to constantly appraise the situation by **taking stock** of the progress of their partner and baby.

5.5.3. Vigilant attending: taking stock

Preterm fathers articulated real fear for their partner during the birth process and this focus on their partner can be attributed to a relationship that is already established, whereas the relationship with the baby is as yet undefined:

I just remember if I'm really honest not caring a monkeys about the baby…. with me it was just this idea all I cared about was my partner it's like… I don't really care.. just being really scared for my partner … you are concerned for the person who you think is ..is at most risk so..yeah..a bit weird (Tim 30/1)

……..very excited cos I knew it was happening ….but also I was try….I don't know if I was worrying about the baby as much I don't think I was thinking baby I was more thinking my partner and looking after her and making sure she was ok I was

[71] C-Reactive Protein is an inflammatory marker indicating infection

[72] Desaturations (low oxygen levels in the blood) and bradycardias (low heart rate) are common with preterm infants due to their immature central nervous system and poor respiratory drive

sort of worried about my partner she was having an epidural and major surgery (Harry 34/1)

I mean I would probably say don't worry it sort of the initial shock sort of thing because what will happen will happen hopefully everything will turn out ok .. the hardest bit was definitely my partner giving birth once you get through that phase hopefully everything will become a bit clearer and once that happens then hopefully you can start to relax about your partner because she will have been sorted by all the medical staff there and then you can then just concentrate on your baby (Arthur 31/1)

I think I must be honest in the actual process itself that's wanting {wife's name} *to be safe… to go from entirely safe to not safe relatively. I know these days it is relatively very safe but you've moved into a different bracket so safe..not safe..and wanting to get back to safe* (Harrison 24(twins)/1)

Frank suggested that developing a connection with the baby on NICU and adjusting to parenthood was difficult. Despite the challenges preterm fathers acknowledged the importance of ensuring that they found time to visit the NICU:

I find myself coming up here early in the morning, do a day's work and then come back here in the evening…. because I feel like you have to …that's the other thing…. I feel like it's expected that parents should come and see their child and if you don't then the nurses will think bad of you… not that they would but it's just that's what you think …oh God I'm not up there what must they be thinking my child is up there you know what must they think…. I haven't been up there yet and it's all them sort of things that run through your mind….. (Robert 30/1)

I've been able to stay here the past couple of nights and I think that's really settled my partner down and it's nice for me cos I can then come up and see the baby with my partner..it's not really a routine but it means that we are able to be a bit closer together rather than me having to drive off home and back. I've got next week off work so I can run my partner in and out but because she's had a C-section and she can't drive …so yeah I don't know it's not pressure but it's logistics of getting to the hospital and stuff and parking is not always cheap and all of those bits……a big concern I have really is I think tonight is my partner's last night and then tomorrow then she'll have to come home because I don't know how she'll be because at the moment she can express in the night and then come up and see him so that will be hard for her being at home and she will just want to be here all the time …(Arthur 31/1)

….just that feeling of being on a different floor feeling like you're so far apart so far away but again there's a reason for it he's in there being monitored he's in the best place……..(Harry 34/1)

The development of the connection with their preterm baby is facilitated by close proximity to and interaction with the baby and occurs over time. The more preterm and sicker the baby, the more likely that this sense of connection is delayed:

It wasn't really until one of the nurses said right you lift her and I'll take out the nappy and the bed and everything else and then I suddenly felt… ah I'm actually… you know this is my daughter…that was probably the first time and with my son… I don't think it was really until the actual moment when he died… when they put him in our arms and then when we were ready they disconnected him from the ventilator and they took out his tube… I don't think that until we had him in our arms that I really felt like actually this is my son, so that sense of disconnection is really quite powerful… it's quite a lot to overcome….(Frank 24(twins)/1)

When she was born she was the size of my hand and it was ….wow what am I going to do with that and even now I struggle with cuddling her cos… I just lose her you know… she's a lot bigger now than what she was when she was born but I still feel like I sort of lose her… worried I'm going to drop her you know she's just this tiny little bundle…(Robert 30/1)

I don't know there wasn't a defining moment there wasn't like a bang that's it that's happened…. it's just crept in I think over the last week or so.. I remember when he was really distressed and this was in the first day or so and he was crying and it broke my heart. I remember feeling acutely aware that there was that pull there was something there cos I didn't really feel anything when I just looked at him .....and he was just sort of laying there you know sleeping or whatever ..but when he starts interacting with you when he starts squeezing your finger or when you have him on your shoulder or your chest for the first time and you can feel his little hands and his little fingers that's what does it, it's the interaction I think you need that interaction (Tim 30/1)

I don't know if I feel like a father as such yet ….I'm here for an hour or two and then I go, so yeah I'm looking forward to getting him home and being able to hold him when I want (Harry 34/1)

Even now {a year later} *I have to pinch myself that I am a Dad that you know she is yours* (Robert 30/2)

Eric had experienced six pregnancies and five premature births and although he had felt very involved in all the pregnancies, he stated that the bond with the baby does not occur until after the birth. He made a poignant observation that it is not possible to really bond with the baby when they are in the incubator, but once his baby had looked at him and he had undertaken care activities for his baby, this facilitated the bond. Eric saw developing this connection with the baby as being different for the mother:

…….there is a massive difference between a woman and a man because obviously the woman has carried that child given birth to that child.. normally the dads bond after birth and when they're home and they're cuddling and they're changing the bum….when they're in intensive care and in the incubator they're not bonding…so the woman has gained that bond by carrying the baby and using the breast pumps and the man's just a bit like a spare part …I like doing things whereas some fathers probably they don't do that or they're too scared…. cos the

baby's fragile and small they're like …I was like that with my first but …..it got easier…… (Eric 28/1)

Frank experienced the first few weeks differently, because at the time of the first interview he was not working. He frequently visited his very premature twins on his own, as his wife initially found it too distressing. He described how it took a couple of weeks for him to feel at ease coming and going to the NICU the way he wanted to. He acknowledged that in comprehending the NICU experience he had a significant role by which he was helping his wife to reform her connection with the twins by sharing his experiences and then by encouraging her to do the same thing:

My wife finds it so distressing to come up to the ward and spend time there and probably because I am a curious and inquisitive person who wants to know everything about everything I spend quite a lot of time on the ward, when my wife has been resting, asking questions and then getting involved in things like cares and nappy changing and stuff (Frank 24(twins)/1)

By the time his daughter was well enough to be transferred to the high dependency nursery, his wife felt able to visit the NICU more frequently and Frank took more of a back seat. A nurse commented on her perception that Frank's behaviour as a father had changed since his daughter was no longer in intensive care following transfer to the high dependency nursery. She suggested to me that because his daughter was no longer sick, Frank appeared disinterested in care giving activities, leaving his wife to do this. A judgement seemed to have been made by the nurse that now his daughter was no longer very sick in intensive care, Frank was disinterested in the 'mundane' activities of caring for a baby. The reality for Frank was that during the time his daughter was in intensive care (and his preterm son had died) his wife had been unable to cope with being in the nursery and carrying out care-giving activities and therefore he had assumed this primary role. Once his wife was emotionally stronger, he had resumed his role in supporting the **mother-baby dyad**.

Eric highlighted that he needed his wife there as support and recounted a situation where he had driven to the hospital on his own to do his son's cares and on walking into the intensive care nursery realised that he could not do that without his wife so he drove all the way back home picked his wife up, drove back to the unit, (a round trip of eighty miles) completed his son's cares and went back home. He needed to

do this otherwise he would not rest or sleep that night. When asked why he felt he could not do this his response was:

Probably one of the main reasons is I know he needed his bum changed and his saturation and his heart rate when he's not changed is not that great and I didn't feel confident in saying to the nurse looking after him can you change his…I feel like…he needs this done because I felt like that was…not that it was my wife's job but that's what we normally do …we go in and I help her get all the stuff and she changes the bum and I clean it all up and so I dunno I just felt like I needed her there to do what she does as a mother (Eric 28/1).

It seems that this preterm father was consciously creating a family bond but needed to do this in partnership with his wife. Towards the end of the interview he started to talk about how fathers may be too scared to do this as the baby is fragile and small and that was how he felt with his first baby.

Although men experience the preterm experience as a stressful situation, a consequence of premature birth for some fathers in the study was experiencing stress-related growth[73]:

I think it's made me a better parent that my children have been in intensive care....I know that sounds surreal but because I've nearly lost my children I would do anything for them...how precious life is and until you've been up there and been told that your child is probably not going to survive then when you come out the other end of intensive care …and it is a horrible place to be it really is.. (Eric 28/1)

She is doing absolutely brilliant and I wouldn't change a thing if I was honest with you yes she was premature it was a pretty crap time but I wouldn't have had it any other way looking at her now you really wouldn't. It's something I mean I still don't know how we did it and in speaking to {name of preterm parents from NICU} *they are of the same opinion. Don't know how we got through it but you do and you manage to somehow. You just get on with it* (Robert 30/2)

I suppose .....this is a funny one I expected this abrupt transition from pregnancy to fatherhood bringing the baby home after 2 or 3 days getting on with the process of learning to be a dad. In a way what this has done is drawn it all out…….. (Frank 24(twins)/1)

If I'm honest it's probably done me a favour I think I would probably have started to become quite anxious leading up to his due date and I think because I'm slightly

[73] One study highlighted no difference in parenting self-efficacy between parents of preterm and parents of term infants (Spielman and Taubman-Ben-Ari 2009). In addition, this research identified that the stressful situation of premature birth is seen as a crisis situation and this then provides the opportunity for 'stress-related growth as people learn new things about themselves' (Spielman and Taubman-Ben-Ari 2009:207). Chronic illness, including cancer, disrupts biographies but this can also result in positive life changes as well as negative ones (Charmaz 1991).

scared and him just landing on us has probably meant that I am just dealing with it and actually I'm probably doing a better job of it (Tim 30/1)

Even though we have had a rough start and everything else we wouldn't change anything she would not be who she is if this had not happened (Robert 30/2)

Tim in the discharge interview described his role on NICU as a supporter role in which he felt he had achieved this role really well:

The biggest thing is that you pat yourself on the back well I did when he was on the unit. I pat myself on the back for being really supportive and not feeling stressed and being really really good at handling the whole situation for two and a half months….I did brilliantly ……problem is that you're sort of working in this sort of bubble that makes you think that it ends when you walk out the door and you go {sigh of relief}… *I did really well then, but the opposite is true because actually when you walk out the door that's when the real stress starts* (Tim 30/2)

After a couple of weeks on the unit you get very comfortable yeah you have huge confidence in the people around you and you have the bumps and scares and stuff but that it's like having a new blanket wrapped round you very cosy , this sense of feeling quite secure and that's probably more secure than you are ever going to feel again actually that is probably one of the things that you struggle with later is this sort of that sense of you are a parent but actually you've got ten people on the ward that are going to look after your baby should anything go wrong (Tim 30/2)

Preterm fathers experience unique challenges following discharge home. After a few weeks following the birth of the baby, preterm fathers in the study had assimilated the stress and shock and the NICU was perceived as providing them with time and space to adjust to being a preterm father. However, once the baby no longer required hospital care, the realisation that the responsibility now resided totally with them was overwhelming:

You've got that space to come home from it you've got that breathing room where it's not all dropped upon you. How can I explain it……you're not overwhelmed by it, because the day to day is being taken care of by other people {NICU staff}*. I think it's an easy way to come to terms with it* (Tim 30/2)

Up here {the NICU} *I knew she was fine that was the thing even if something happened I knew that she would be fine she would be looked after but then as soon as we got her home it was as though that safety net had gone, it had completely gone. You were on your own and that was a real worrying time. I really did struggle when she came home. This is real now, I have got this tiny little bundle at home* (Robert 30/2)

You don't have to make decisions you don't have to do a lot of thinking you're just you know you get quite quickly into a routine. Ok you go in the morning then you

go to work and then you come back in the evening and you are just directed by other people which is quite nice cos you've got this baby but you haven't really got to think yourself cos you're being told what to do. So in that respect it was really nice and I can remember feeling safer I think and you feel in a bit of a bubble its only when you get him home that first couple of weeks is really scary (Tim 30/2)

The effect of the emotional and physical activities needed to sustain the NICU admission was subsequently felt following discharge home. The constant journey to and from the hospital, balancing the needs of the family and work means that preterm fathers are emotionally and physically exhausted:

When we got her home the feeling of being completely drained hit you from doing the trips up and down to the hospital every day to doing none and having her at home. I am absolutely knackered I really am it really has taken more out of me than I thought it had. I went back to work, and I was dead on my feet, no sleep and everything else (Robert 30/2)

I guess you're not starting from zero I guess that's kind of the problem, it's accumulative. The thing is that we were knackered before we brought him home, but of course when you bring him home not only are you bringing him home, but you're back at work instead of he's just been born and I'm having 2 weeks off work. We used those up because you've used it whilst in hospital. Where I'm at now is probably quite a scary place probably quite a …..dangerous isn't the word but it's the most fragile place that I've been in. At the same time, it's been brilliant amazing and all that stuff but it's that feeling of being tired of having run two or three marathons and just like seeing more marathons in front of you. You feel like you kind of want some respite from it somewhere…. you won't get it. I think it's just that awareness that the stress gets increased when you leave rather than going away and I don't think you expect that. That's the biggest thing that's really hit me is that sense of when I get to exhale and you can't (Tim 30/2)

Preterm fathers identify a few sources of support and who they would turn to for information. Some fathers demonstrated a preference to contact their established friendship ties:

So the guy that I referenced as a more feminine character I had a good chat with him and on the night {his son took longer to recover from a minor operation} *he was the person I chose to phone when things were looking a bit dodgy and I did say I am really sorry mate I don't have anyone else really to call and I just need to project myself out of here for a while as this is just really starting to get heavy* (Harrison 24(twins)/2)

Some fathers anticipated that despite their partner finding social support and developing friendships with other preterm mothers from NICU, they did not feel that this was an option they would choose:

I just wish I had enough time to see my own mates more before trying to make friends with someone that I don't really know. He's a nice guy {preterm father from the NICU} *but I don't really know any of them and when you want a bit of downtime like this weekend if I've got five hours to myself I'll go to the rugby club watch the six nations and I get to trade extreme abuse with all those around me and thoroughly enjoy it* (Harrison 24(twins)/2)

I think they {preterm mothers from NICU} *have a plan to meet up at some point over the next couple of weeks, but men are really crap at that generally. Especially as she bonded with people and got to know them whilst she was on the unit, so I haven't really, so there's that sense of meeting up with strangers too but …and I guess as well …my partner said you should come and meet the guys and you should all talk, you should all share your experiences, but I can't see that happening spontaneously. I can't see a bunch of guys sitting in a room together and suddenly sharing. It's just not going to happen* (Tim 30/2)

One father did appreciate the mutual support he received from a father he met on NICU. Their babies were of a similar gestational age and weight and had been discharged home within days of each other:

I get texts from {name of preterm baby from NICU} D*ad. She has not done that yet or have you had any of this and I say yeah and he goes oh cool ok. It is that reassurance between us both and I do the same with him just that reassurance you are not alone, and another baby is doing the same thing knowing that they are both the same sort of size* (Robert 30/2)

Tim during the home interview suggested that the NICU experience had a momentum of its own. He talked about being wrapped in a cosy blanket and being in a safe bubble. This was due to the fact that there was time to adjust and the nurses were there if anything went wrong. Therefore, the responsibility was shared and total responsibility was not felt until he walked through his front door:

There was this sense that once you're out of the unit you can't come back for obvious reasons (Tim 30/2)

Eric talked about how life is on hold until you come out the other end and get home and you can enjoy life. This was anticipated by Tim but unfortunately his son required a number of hospital readmissions in the first few weeks of being home. He was therefore finding it difficult to enjoy life and felt that his stress levels had increased to higher levels during his son's readmissions back into hospital compared to being on NICU. He talked about his role changing from supporter role on the unit in which he felt he had done a good job to a provider role now which was

holding the baby and working mainly to support his partner and son to be an independent unit with their life.

In the context of family formation, premature birth is seen as a disruptive event and an unfamiliar and novel situation. The certainty of becoming a father of a term infant following an event free pregnancy and birth has suddenly and unexpectedly disappeared. Tim reflecting back on his experience following discharge, home identified a duality to his identity as a father of a preterm baby;*….. wow not only am I now a father but I'm also a father of something that's in danger* (Tim 30/2). The 'fateful moment' of premature birth results in the family experiencing an acute episode of shock. Temporal expectations have been altered and cause spatial displacement of the newly formed family. The temporal nature of premature birth is experienced as life being on hold:

It's just all happening in slow time so in some ways you could say oh that's not necessarily a bad thing…… plenty of time to learn about stuff from the best people in the business in terms of caring for my baby (Frank 24(twins)/1)

It sort of felt a bit like a holding pattern…a half-way house …there was space to get used to the idea of being a father…. (Tim 30/2)

I describe that whole period as feeling a bit like being underwater for five months (Harrison 24(twins)/2)

It's like you are in some sort of suspended animation here it is like everything is happening, but nothing is happening if you know what I mean (Robert 30/2)

For Eric an experienced father of five premature babies, this unexpected pregnancy so soon after losing two premature babies meant that the preparation at home for the baby had been deliberately delayed. The nursery was not ready and baby equipment had not been bought. Even after the birth of this baby and the baby being stable and self-ventilating in air, he was reluctant to verify the possibility of the baby coming home:

my wife said to me now…she said now can we start ordering things and I said no until he's…I said to her…maybe… when we get to the SCBU, then maybe. So I have found myself wanting to be a little bit reserved…. (Eric 28/1)

The expectations of becoming a father (Box 5.1.) can be seen to be influenced by a number of factors: first experience of fatherhood; previous experience of fatherhood;

previous experience of premature parenthood; anticipated pregnancy continuing to term; having time to practically, emotionally, socially and psychologically adjust to the reality of becoming a parent.

Box 5. 1 Participant's expectations of becoming a father

I didn't expect anything in particular at all .....well ok I expected to have two babies not one… we expected to have more time to think about names….. I expected my children to be baptised in a church with all my friends and family around not in an incubator at 4 am with some priest who I don't know…. I suppose .....this is a funny one I expected this abrupt transition from pregnancy to fatherhood bringing the baby home after 2 or 3 days getting on with the process of learning to be a Dad, in a way what this has done is drawn it all out ….we did expect to go on the NCT course we did expect to meet some other Mums and Dads and maybe make a bit of a social group out of that which now we're not going to have (Frank 24(twins)/1)
We were doing the NCT classes which was certainly making us more aware of the various aspects of the pregnancy and what it involved and what to do afterwards and everything else so were doing that but also because my partner is a teacher she would have broken up on Tuesday and then she had all of the summer holiday to go on the internet and buy everything basically so that was going to be the plan (Arthur 31/1)
You tend to sort of polarise everything in your imagination you think you're going to be either really really good or really really bad and you just want to make sure you push yourself one way or the other and actually you're going to be a bit more you're going to be good enough hopefully you'll be able to be in the middle (Tim 30/1)
Because we haven't taken him home and because we haven't really cared for him as such ….I guess as a parent you sort of the child relies on you whereas he's not really relying on me I'm here for an hour or two and then I go, so yeah I'm looking forward to getting him home and being able to hold him when I want (Harry 34/1)
There is a massive difference between a woman and a man because obviously the woman has carried that child given birth to that child normally the Dads bond after birth and when they're home and they're cuddling and they're changing the bum (Eric 28/1)
I suppose being that you just look at it that it's going to be its going to go term it's going to be ok baby is going to come home you have plenty of cuddles it's all going to be you know how it should be …how everyone portrays it to be you take the baby home and all the family come round lovely jubbly it's all going well and you just naturally bond because the baby's there and you can do whatever (Robert 30/1)
Yeah just being less scared of it…knowing that I had got to the point where …the product of this first birth you know is this little chap that I love so much you can't even imagine ..now I've seen you know how it works, that took away all trepidation for the second time round …cos I know that it's the best thing that can happen to you. I didn't know that before…I'd been told it could be (Harrison 24(twins/1)

In a similar way to cancer survivorship, premature fatherhood is a life-changing experience that has positive and negative aspects and involves uncertainty. In contrast to cancer patients, preterm fathers are not personally experiencing health related problems in the same way. However, premature birth can be seen as a critical life event that poses healthcare related challenges. Social losses include the disrupted biography of fatherhood rendered by the admission of their preterm baby to hospital. The diffusion of roles and responsibilities between parents, family and healthcare professionals contributes to boundary ambiguity. Men in the study used **surveyancing** to comprehend and manage the novel, unfamiliar and stressful situation of premature fatherhood:

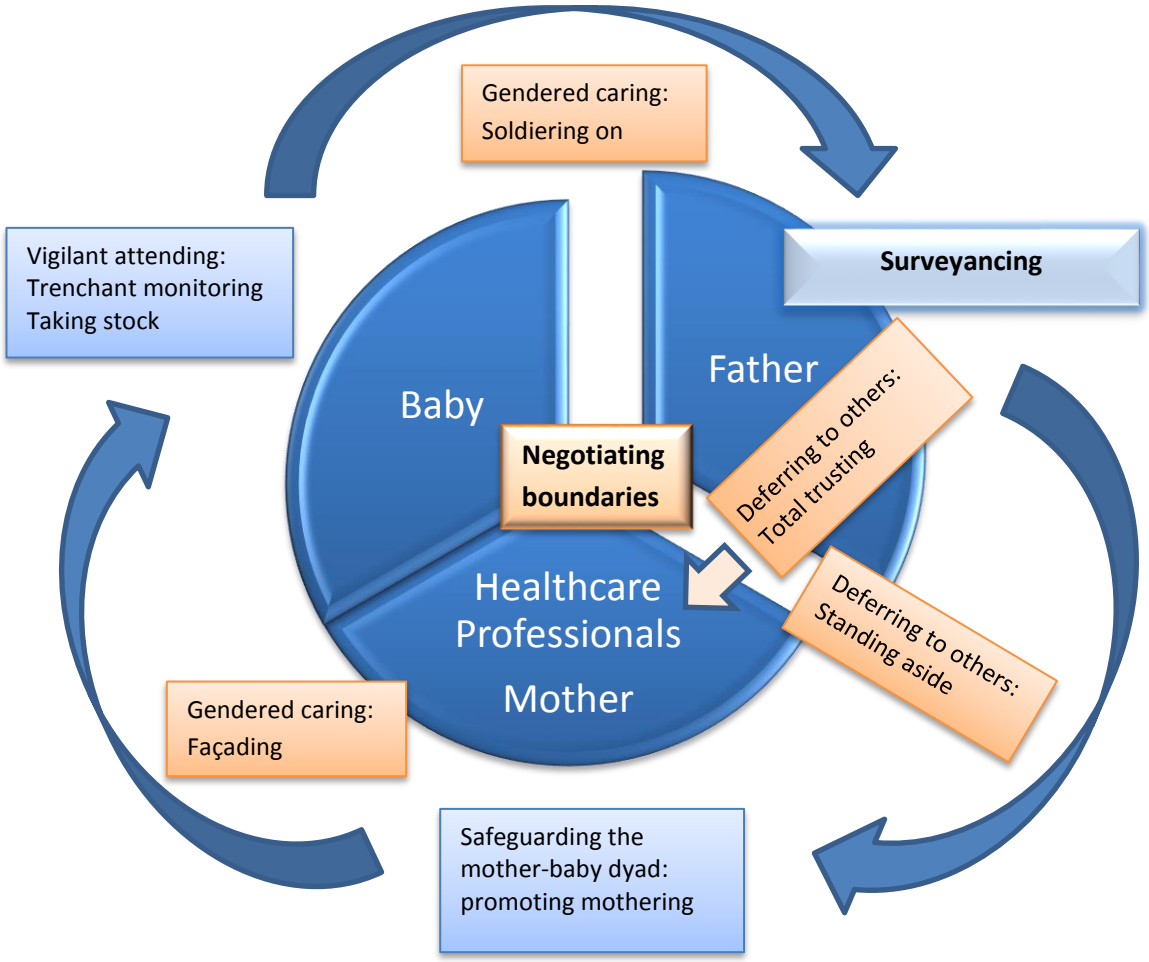
It's like nothing else I have experienced in my life (Robert 30/1)

It's has got worse for me over the five years because with my first child {name of child} I was nervous but now I'm even more…{nervous} maybe because I had two deaths last year…(Eric 28/1)

Summary

This chapter presented the patterns in the data related to the social process of becoming a preterm father and provides evidence for the conceptual development of the substantive grounded theory of moratorial fathering. Men in the study experienced NICU as a mediated space of situated fathering framed by: a diffusion of responsibilities for his baby's care between himself, his partner and healthcare professionals; balancing daily routines and domestic and employment responsibilities with visiting NICU; waiting for an uncertain outcome; and managing interpersonal relationships with many people (partner, family, friends, healthcare professionals, and work colleagues) in several places (hospital, work, home). The long-anticipated day of discharge home is over-shadowed by uncertainty in their ability to manage to care for their preterm baby without the clinical and social support of the NICU. **Moratorial fathering** conceptualises and explains why and how men cope with the uncertainties of the novel, unfamiliar and stressful experience of premature fatherhood (figure 5.5).

Figure 5. 5 Theory of moratorial fathering



Chapter 6 Discussion chapter

6.1. Introduction

The previous chapter presented an explanatory framework for understanding the social process of becoming a preterm father and explains how men endure the sustained uncertainties of premature fatherhood. The concepts of **negotiating boundaries** and **surveyancing** are abstractions from the patterns in the data identified through constant comparative analysis. Chapter 2 presented the literature on parenthood and preterm father's experiences to provide the context and inform the methodological decisions taken during the study. This chapter discusses the theory located in extant formal theories and situates **moratorial fathering** with literature that was theoretically sampled during the generation of the emergent substantive theory. Reference will be made to the relevant sections in the previous chapter to illustrate how the substantive theory of premature fatherhood emerged from, and is grounded in, the data. The admission of the baby to NICU changes the space in which men experience fatherhood and the theory of **moratorial fathering** provides new insights into the process of transitioning to premature fatherhood. Gaining clarity of the meaning of the situation, preterm fathers are negotiating physical and interpersonal boundaries and enduring sustained uncertainties.

6.2. The substantive theory

The participants in the study were mature men in a stable long-term relationship with their partner and the pregnancy was anticipated and welcomed. They identified how they experienced strong feelings of disconnection during the pregnancy and this continued after the premature birth. Experiencing a sense of redundancy during the birth and admission to NICU compounds this sense of disconnection. Preterm fathers in the study expressed feelings of isolation and experienced a range of intense emotions in response to having a preterm baby. Premature fatherhood presents both a situation and a role where there is a lack of normative expectations. The roles, rules and boundaries of premature fatherhood are understood in the context of the uncertain, medicalised and technological space of the NICU.

Premature birth is experienced by men in the study as a life threatening event, potentially for both his partner and baby and their emotions, actions and interactions

align with the illness trajectory of the baby. Their actions are influenced by the moral dimension of being a father; a duty of care to protect and care for his family which, in this instance, he cannot accomplish alone. Therefore, his agency is relational and framed by the NICU environment which, with its associated technology and expert professional staff, reinforces the notion of a situation characterised by vulnerability and uncertainty. In addition, preterm father's ability to be able to form a connection with their baby and fulfil all parenting dimensions are constrained by: the physical appearance and clinical condition of the preterm baby; uncertainty of the outcome of the NICU admission; barriers such as medical technology, incubator; time restrictions from managing employer, family and friends' expectations; and the restricted, confined and very public space of the NICU environment.

Preterm fathers in the study initially experienced the acute and unexpected early birth of their baby in terms of high stress and anxiety. The degree of these feelings appears to be influenced by the gestational age of the baby (stress and anxiety will be significantly heightened if the baby is very preterm) and by the individual's abilities to manage stress. However, the stress and anxiety experienced by preterm fathers is attenuated to a certain degree, as they begin to comprehend the situation and utilise problem-focused and emotion-focused coping strategies. The acute phase of high stress and anxiety can however be experienced again following deterioration in the baby's clinical condition on NICU or following discharge. NICU presents contradictions in being both a source of extreme distress and stress and a source of comfort and support. However, preterm fathers in the study were also appraising the preterm situation as opportunity, which has connotations with traumatic/stress-related growth[74]. In this way preterm fathers acknowledged that NICU provides an opportunity to begin to comprehend their transition to a peculiar form of fatherhood.

6.3. Moratorial fathering in the context of Uncertainty in Illness Theories

In order to explain how men 'understand and co-construct the many uncertainties' (Babrow, Kasch and Ford 1998:2) of the preterm experience, it is helpful to present the various definitions of the term. Uncertainty can be seen to be: 'an inherent

[74] Positive changes in an individual that can occur following a traumatic or stressful event and which has been researched particularly in the field of sports science (Salim, Wadey and Diss 2016).

attribute of a situation' (Tannert, Elvers and Jandrig 2007:892); 'existing when details of situations are ambiguous, complex, unpredictable or probabilistic, when information is unavailable [unknown] and/or inconsistent [imperfect] and when an individual feels insecure in their own state of knowledge or the state of knowledge in general' (Brashers 2001:477); and viewed as a cognitive state in which an 'individual cannot adequately structure or categorise an [illness] event because of insufficient cues' (Mishel 2014:53). All three of these definitions are relevant in explicating the process of the transition to premature fatherhood. Tannert, Elvers and Jandrig's (2007) definition provides a holistic perspective and is particularly relevant in understanding preterm fathers' response to the 'novel', unfamiliar situation of premature birth. Mishel's (2014) definition is helpful in acknowledging preterm fathers' first engagement with the experience of premature birth during the labour, birth and admission to NICU. The definition proposed by Brasher (2001) supports an understanding of the complex, unpredictable and probabilistic nature of the NICU admission and discharge home and how preterm fathers comprehend their lack of knowledge of premature birth which contributes to their appraisal of the situation as being uncertain.

A concept analysis of uncertainty in illness (McCormick 2002:129) reviewed the factors that have been associated with, and characterise uncertainty; 'ambiguity (more than one meaning); inconsistency (incompatibility or discordance); vagueness (lack of detail, imprecision, not definitive or clear); unpredictability (an inability to make statements about future events); lack of information (associated with uncertain situations); and unfamiliarity (difficult to perceive and categorise a situation or event)'. These characteristics can be seen to be ascribed to the situation rather than to uncertainty per se. 'Uncertainty is a person's perception of these situational attributes' (McCormick 2002:129) with the conceptual attributes of uncertainty identified as: probability (likelihood that something will happen); temporality (relates to conditions of time such as length, pace and frequency); and perception (interpretation or impression of something based on an understanding of it). Probabilities are based on outcomes or what is likely to happen, but this is unknown and therefore leads to meaning being the dominant force of uncertainty (Penrod 2007).

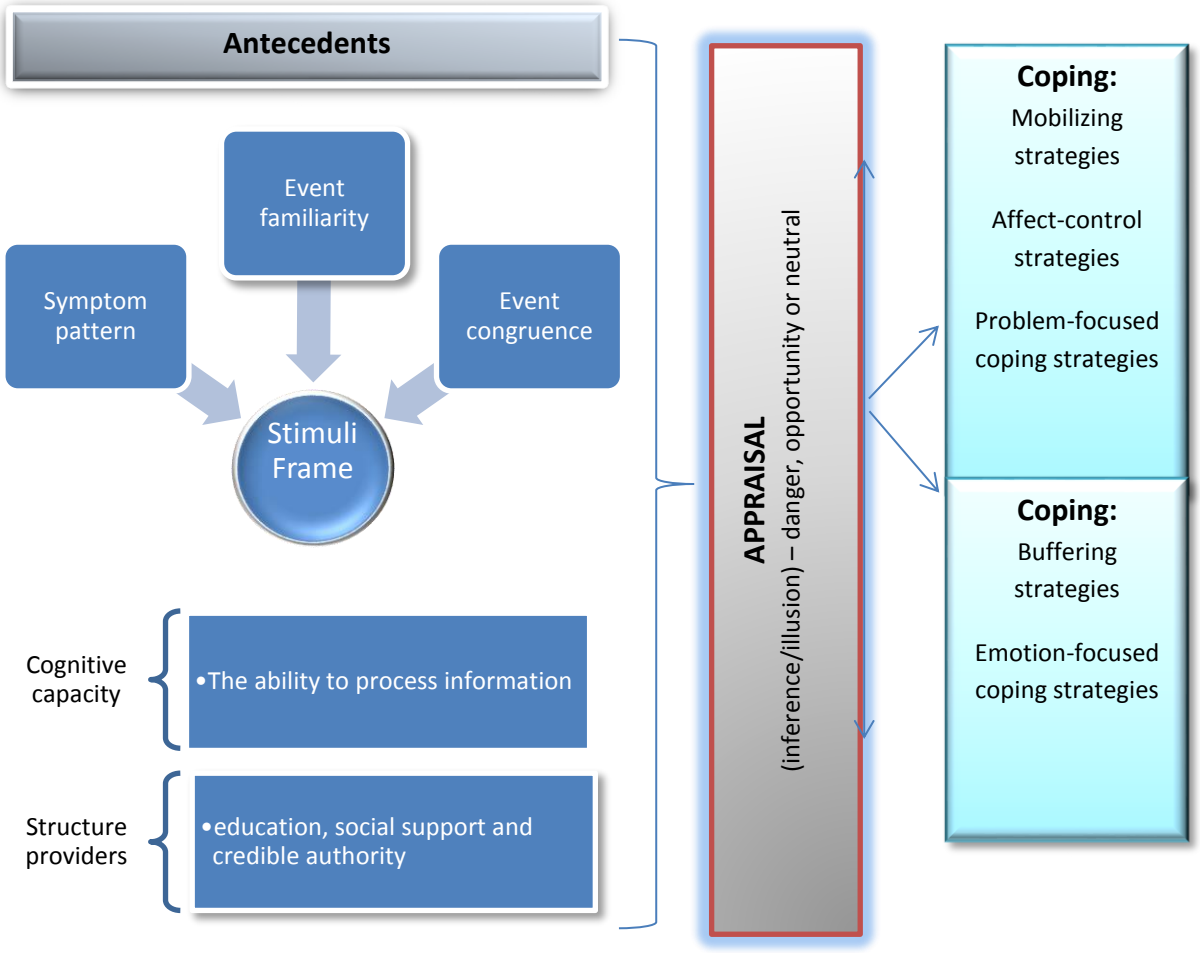
Premature parenthood is situated mainly in the context of the NICU and unfamiliarity with this situation renders prematurity as being perceived as an uncertain situation. The situational attributes of the NICU reflect the conceptual attributes of uncertainty outlined by McCormick (2002). Generally, the baby's illness trajectory, in terms of the probable events likely to be encountered, is not completely known. The length of time that the baby will require neonatal care in hospital is couched in tentative rather than concrete terms by healthcare professionals and the perception of preterm fathers regarding their understanding of the situation is framed as a danger and a threat to completing the life course transition of family formation and associated father identity.

6.3.1. Uncertainty in illness theories

Uncertainty in illness theory (UIT) was developed to conceptualise the role of uncertainty in the acute phases or downward trajectory phase of an illness (Mishel 1988) and revised as the reconceptualised uncertainty in illness theory (RUIT) to incorporate chronic illness or recurrent illness (Mishel 1990). Both theories explicate the process of how uncertainty in illness develops or is resolved and identifies four underlying factors: complexity; unpredictability; lack of information; and ambiguity. The outcome of the UIT is that the individual will return to the previous state of being, prior to experiencing the illness. The outcome of the RUIT differs because the individual is living with enduring uncertainty which requires them to incorporate uncertainty as an inherent aspect of a new way of being. It has been argued that both theories are relevant to the family or parent of an ill individual, in addition to the individual experiencing the illness (Mishel 2014). The emergent substantive theory of the study conceptualises the complex and unpredictable nature of premature fatherhood and the strategies used to manage its inherent sources of uncertainty.

Both the UIT and the RUIT have the same three themes: 'antecedants; appraisal; and coping (figure 6.1), with the main concepts being uncertainty and cognitive schema' (Mishel 2014:53). The RUIT has two further concepts; self-organization; and probabilistic thinking. Each of the three themes are conceptualised to provide a middle-range theory which, since its inception, has been further expanded through research exploring a range of contexts such as HIV, prostate cancer and paediatric intensive care (Mishel 2014).

Figure 6. 1 Uncertainity in illness theory (Mishel 2014:57)



The *antecedent* theme incorporates three concepts: the stimuli frame (symptom pattern, event familiarity and event congruence); cognitive capacity (information-processing ability of the individual); and structure providers (assist in the interpretation of the stimuli frame by providing meaning and explanation). *Appraisal* incorporates the individual's value of the situation as either danger or opportunity using inference or illusion. In making sense of an uncertain situation, an individual will appraise the situation as danger or opportunity which enables them to mobilise strategies for managing it (Mishel 2014). *Coping* highlights the problem-focused and emotion-focused strategies used by individuals to manage the uncertainty.

Loss of control and uncertainty are mutually inclusive and affect each other. The more a person feels a loss of control the more uncertain they feel, and the degree of uncertainty will, by extension, influence the feeling of uncertainty (McCormick 2002). The degree of uncertainty is predicated on the probability of an event

occurring: it is lowest if it is known that the event will definitely occur or not and highest if the likelihood of an event occurring or not is equally probable. In appraising any situation as uncertain, an individual will experience an emotional response, influenced by whether the situation or event is perceived in a negative, positive or neutral way. If viewed negatively as a danger (or threat), emotional distress, stress, anxiety and depression will be apparent. If a situation is viewed positively then uncertainty can be seen to be an opportunity (or challenge) (Mishel 1980). If the uncertain situation is appraised as an opportunity, the situation is reconsidered in this context and results in a revised perception (Mishel 2014). Uncertainty is seen as a neutral cognitive state until the individual is able to derive meaning from the event. The cognitive capacity of the individual to classify and cognitively structure meaning to the situation is therefore an antecedent of uncertainty. Once meaning has been assigned, an emotional response can occur replete with concomitant actions and behaviours.

This overview situates the substantive theory of moratorial fathering with uncertainty in illness theories, but it is the concept of event familiarity that has particular relevance to premature fatherhood. Mishel (2014) does suggest that the sociological response to event familiarity warrants further investigation, as this aspect of uncertainty in illness theory has received less attention in empirical investigations. Those available have focused on: parental uncertainty when their child is receiving critical care in a hospital setting (Turner, Tomlinson and Harbaugh 1990); maternal uncertainty in caring for their ill child (Horner 1997); parental and child uncertainty in childhood illness (Stewart and Mishel 2000); uncertainty in advanced illness (Nanton et al 2016); and family resilience in the adult Intensive Care Unit (Wong et al 2017).

A possible explanation for less attention being given to the concept of event familiarity is that the origins of uncertainty in illness theories were influenced by psychology (Budner 1962, Shalit 1977) and the cognitive response to uncertainty seen in relation to this as one type of stressful event (Lazarus 1974, Norton 1975, Moos and Tsu 1977 cited in Mishel 2014). The uncertainty in illness scale (Mishel 1981) enabled uncertainty to be measured and could be used to predict the psychological response of a patient and their family to illness. This scale has been used as an outcome indicator of the quality of neonatal healthcare services (Al-

Yateem et al 2017) and parental uncertainty in NICU (Bolivar and Montalvo 2016). It has also been used to explore the uncertainty and coping strategies of preterm Taiwanese parents and identified that parents using emotion-focused strategies achieved a lower uncertainty score than those using problem-focused strategies (Lu, Yen and Lee 2013). In this study fathers (and parents with higher education) most frequently used problem-focused strategies, a finding mirrored in other studies (Matud 2004, Barken 2014) and which may suggest fathers experience higher uncertainty than mothers. In the situation of premature birth, there are a number of sources of uncertainty that act as a stressor, and it is these that are of concern to preterm fathers, rather than the premature birth itself[75]. Uncertainty therefore can be seen to be an overriding characteristic that affects how men interpret and adjust to the novel, unfamiliar and stressful situation of premature fatherhood.

A related framework for understanding uncertainty inherent in health and illness is Uncertainty Management Theory (Brashers 2001). This theory identifies the sources and appraisals of health-related uncertainty and provides a framework for understanding the communication processes and information management strategies used to cope with uncertainty. One such management strategy is information seeking, which has been explored in a number of contexts (Brashers, Goldsmith and Hsieh 2002) and has also been used to explore parental uncertainty following discharge home from a NICU (White, Gilstrap and Hull 2017). Searching for information was found to be an important coping strategy for preterm fathers in the study and is discussed in section 6.9.

The substantive theory of moratorial fathering therefore contributes to current literature on uncertainty in illness theories, particularly the sociological response to event familiarity. It explicates how the NICU acts as a situated space where men experience premature fatherhood. The NICU context with its attendant roles, rules, boundaries and responsibilities (Mishel 2014) encapsulate the event of premature birth which is experienced as unfamiliar and appraised as danger. Preterm fathers are facing two potential outcomes in relation to their preterm baby: survival (with or without disability); or death. The NICU as a situated space for preterm fathering also

[75] It has been suggested the NICU context rather than the preterm baby alone is the source of the stress and distress experienced by preterm parents (see section 2.6.2.1).

predicates the need for men to engage in negotiating boundaries and the theory of boundary ambiguity (Boss 2016) illuminates how the interpersonal boundaries between the baby, mother and healthcare professionals are ambiguous and lead to a diffusion of responsibilities in meeting the needs of his family. Preterm fathers invoke a way of reducing and tolerating ambiguity by combining optimistic and realistic thinking, with the notion of dialectical thinking (Boss 2016) suggested as addressing the paradox of optimism and realism and results in fathers engaging in role flexibility, in addition to living with paradox (Boss and Couden 2002).

6.3.2. Moratorial fathering in the context of event familiarity

Event familiarity describes whether the situation is 'habitual, repetitive or contains recognised cues' (Mishel 2014:56). Premature birth is a situation that is neither habitual nor repetitive and does not contain easily recognisable cues, but which may become recognisable over time. The spaces of NICU, both its physical and time dimensions, symbolise the differences in the usual spaces and practices of being a parent. In acknowledging the claim of geographers 'that parenting is fundamentally spatial' (Jupp and Gallagher 2013:157), the various sites and practices of being a parent have been explored and include: cars; parks; parent groups and forums (both physical and online); and cafes.

In a similar way to understanding addiction treatment systems, the NICU can be seen to be a 'space of abeyance, care and survival' (DeVerteuil and Wilton 2009:463). Parenting changes across time and space and Marsiglio, Roy and Fox (2005) in their seminal text on 'situated fathering', identified the importance of physical space as being a contextual influence on shaping a father's identity, particularly when the father is not living with their children. For preterm fathers, the situated space of prematurity is predominantly focused on the NICU with its many unknowns in terms of responsibilities, roles, routines, treatments and equipment, all of which are associated with uncertainty (Mishel 2014, White, Gilstrap and Hull 2017) and provides a useful contextualisation of the intersection between health and social geography.

The domain of a hospital setting immediately presents a situation that is encountered as one framed by the 'sick' patient needing care from expert healthcare professionals. The philosophy of midwifery expounds the importance of pregnancy

and child birth as being a natural state rather than a medical condition (NHS England 2017), but the clinical surveillance of women by healthcare professionals during this process may promote a sense that care is being provided to 'a patient'. This patient-focused medical model increases term father's perceptions of being redundant, secondary to the mother and marginalised (Draper 2003, Leite 2007). The situation of premature birth, by its nature, increases the degree of medical intervention and heightens the concern by preterm fathers for the welfare of both their partner and baby and is compounded by the sustained clinical surveillance of their preterm baby by healthcare professionals.

Preterm fathers experience the NICU environment as novel and unfamiliar, with the additional attendant lack of knowledge of how to be a parent to a preterm baby. Appraisal of the preterm situation can only be inferred from contextual cues, as preterm fathers generally have no prior experience on which to base their understanding of the situation. They therefore rely on neonatal staff and other preterm parents (termed structure providers by Mishel 2014) to help them interpret the preterm experience. The emergent substantive theory of moratorial fathering emphasises how sources of uncertainty emanate from unfamiliarity with the preterm situation, particularly the NICU environment. Preterm fathers in the study appraised the situation as one of danger and this elicited the sociological response by which they developed relational strategies to manage these uncertainties.

The sensitising concepts of uncertainty in illness theories and boundary ambiguity theory explicate the theory of premature fatherhood in enduring sustained uncertainty. The healthcare setting of the NICU influences preterm father's perceptions and understanding of their role and in developing meaning of the situation (section 5.4.1). The appropriate and effective responses of preterm fathers in managing the uncertainty associated with premature birth can be understood by exploring the ways in which uncertainties are connected (Brashers 2001). The normative expectations of forming a new family in terms of reorganising roles, rules and rituals are in abeyance until the parents are 'able to perceptually reconstruct the meaning of the ambiguity' (Boss and Couden 2002:1352) associated with premature birth. The family adjusts to this new situation in ways that reflect the uncertainty of whether the formation of a family will in fact transpire.

The NICU therefore is seen to be a socially specific context in which premature fatherhood is situated and which influences the experience of parenthood. This contrasts with the way in which the cognitive, emotional and behavioural skills of parenting are normally developed in the private domain of the home environment. The NICU is the source of medical, personal and social uncertainties (table 6.1) and inhibits and constrains preterm fathers in their ability to demonstrate the behaviours anticipated and expected of a new parent.

Table 6. 1 Sources of uncertainty for preterm fathers

Sources of medical uncertainty	Sources of social uncertainty	Sources of personal uncertainty
Uncertain medical outcome of NICU Unknown preterm illness trajectory Uncertain medical outcome of baby Uncertain medical outcome of partner	Disruption to family formation Suspension of usual celebratory activities associated with the birth of a new baby Suspension of developing parenting competencies Ambiguous father status	Uncertainty as to father role Managing competing responsibilities Being time poor Fulfilling maternal and healthcare professionals' expectations of the father role

Preterm fathers comprehend the NICU as a space in which they experience a delay in completing the transition to fatherhood and have time to adjust to the change in their circumstances. The physical spaces of NICU, which include the special care, high dependency care and intensive care nurseries, convey the seriousness of the baby's clinical condition not only through the names and definitions of care but the degree of technology and number and seniority of nursing staff supporting the baby. The numbers of staff required to move the preterm baby from being medically in danger (the intensive care and high dependency nurseries) to being more medically stable and in recovery (the special care nursery and home) is overwhelming (section 5.5.2:138). The technology imparts a symbolic representation (Barbard and Sandelowski 2001) of the severity of illness in addition to the label of the unit as *intensive care*; the monitors measure the baby's vital signs and act as a barometer for anticipating changes in the baby's condition, as well as the degree of danger

(Pohlman 2009, Provenzi and Santoro 2015, White, Gilstrap and Hull 2017). This is exacerbated by the noise of the alarms and flashing lights which alert healthcare professionals to a change in the baby's clinical condition but is a source of stress for fathers.

In the absence of a predetermined 'cognitive map' (Stewart and Mishel 2000:307), preterm fathers in the study navigated the preterm experience by **negotiating boundaries** (5.4:107) and **surveyancing** (5.5:132) in order to gather information about the NICU situation. They learned the rules and routines; came to understand the equipment, language and medical and nursing interventions needed by their preterm infant; and appraised the clinical competence and caring abilities of the nursing staff in meeting the physical and emotional needs of their baby. The technological environment of the NICU, including the monitors and the need for large numbers of staff, symbolises the need for monitoring a baby who is critically ill. The use of medical language further medicalises the situation and parents will subsume this medical terminology to be able to comprehend the unknown and uncertain situation they are suddenly in. The meaning making for preterm fathers in this situation is the acknowledgement that their family is in danger and they trust the neonatal staff, who are experts in the clinical management of premature babies (section 5.4.1:110).

Preterm babies may present with anticipated medical conditions, but the presence and severity of symptoms are individual, variable and dependent on genotype, in addition to the gestational age (NICE 2017). This temporal dimension of prematurity creates uncertainty in terms of the unknown length of the baby's illness trajectory and the uncertain outcome and influences how preterm fathers manage this situation. It is suggested that there are masculine and feminine nuanced ways of experiencing time. Feminine perspectives of time are suggested as being relational and shorter term whereas 'a linear sense of temporality based on achievement and progress has been suggested to be a masculine orientation to time' (Shirani and Henwood 2011a) and is described as 'embodying high levels of instrumental rationality' (Odih 1999:35). Preterm fathers are experiencing a situation in which both achievement and progress is uncertain and, in the study, a gendered approach to managing this uncertain situation was displayed through deferring to the neonatal

staff (section 5.4.1:110 and 5.4.2:117) and expressed through vigilant attending (section 5.5.2:138 and 5.5.3:142).

The uncertainty regarding the illness trajectory and clinical outcome of the baby results in medical staff providing information to parents couched in such terms to encompass and reflect this uncertainty (Watson 2010). Preterm fathers therefore also focus on the monitors as an additional way in which to supplement the information provided by healthcare professionals and measure the degree of their baby's clinical progress and the responses of the neonatal staff (section 5.5.2:138). The unpredictable nature of the symptoms of prematurity in terms of onset, duration, intensity and recurrence creates uncertainty about the outcome of premature birth. For very preterm babies, this uncertainty continues after discharge home (section 5.5.3:142), as the long-term repercussions of prematurity are unpredictable, and only become evident with time (NICE 2017).

6.4. Moratorial fathering in the context of identity theory

Participants in the study acknowledged that family formation was expected to be incorporated into the continuity of their life course, an aspect highlighted in life course theory (Roy 2014). Premature birth, as an unexpected event, dislocates the fatherhood trajectory and challenges ontological security (Giddens 1991). Individuals faced with a disruption to their family life formation, experience a lack of control over timing and utilise temporal strategies to manage this (Shirani and Henwood 2011b). In a longitudinal study of men's transition to fatherhood, unanticipated events such as 'delayed conception, unplanned pregnancy, separation and step-parenting were experienced as: imposing a pause; propelling men forward; and regressing to a previous life course' (Shirani and Henwood 2011a:62). These events produce a temporal disruption that predicates a more short-term focus and a taking one day at a time approach to coping with the unexpected event.

The linkages between fatherhood and masculinity explicate the way in which men enact the paternal role and support an understanding of the influences on the nature of paternal identity. Father involvement research has moved towards understanding the relational nature of the interaction between fathers and their child(ren). Rather than viewing father involvement as the unidirectional behaviour of the father towards

his child(ren), the influence of the child(ren) on that interaction has been recognised as having a moderating effect on father identity (Lamb 2010). This has implications for situations in which the child is unable to reciprocate the behaviours inherent in an interactional process and which will then by extension affect the father's sense of parental identity. In this way the identity of premature fatherhood can be seen to be influenced by the lack of opportunities for close proximity and interaction with their baby (section 5.5.1:133). This precludes preterm fathers from being able to commence the identity work inherent in developing the nature of their fathering role. Prematurity delays their ability to form a connection with their baby and establish their sense of self as a father. There exists a disparity between their expectations of term fatherhood and the realisation of and coming to terms with the actual premature fatherhood self.

The exponents of identity theory suggest that the commitment to the father role is a result of: the salience of the father role to the man's sense of self; the evaluation of his effectiveness as a father endorsed by significant others; and the extent to which the father role provides personal satisfaction (Stryker 1968). In this theory the self is seen as comprised of multiple identities which are hierarchically ordered with the most prominent (salient) at the top. An alternative presentation is one of concentric rings, with the innermost ring defining the central (prominent) identity of an individual (McCall and Simmons 1978). Rather than the existence of one salient identity, a further conceptualisation of identity provides value in appraising preterm father identity. This conceptualisation of identity introduces the concept of role balance (Marks and McDermid 1996) and suggests that individuals will enact a number of salient identities rather than one, depending on the circumstances.

In balancing multiple selves and roles, self-concept is continuously being subject to restoration, adjustment or reconstruction. A commitment to a role has been suggested as stemming from: personal (want to); moral (ought to); or structural (have to) components (Marks and Macdermid 1996). The consequences of the variance in these components are likely to affect the total role system and possibly the degree of role ease and role strain. From a cognitive social psychology perspective, identities enable the individual to define and appraise a situation in order to gauge its nuances and display its attendant behaviours (Markus and Wurf 1987, Scott 2015). From this perspective, the salience of the identity will exert an

influence on which of the multiple identities of self will be uppermost and therefore which behaviours are expressed by the individual as congruent with the role underlying the identity.

The multiplicity and multidimensionality of self-concept or identity acknowledges that the self-structure is 'dynamic and active, incorporating roles and social status, personal characteristics, feelings and images' (Markus and Wurf 1987:300) that encompass a fluctuating range of accessible self-knowledge. Self-representations vary in accordance with the actual self or a 'would like to be, could be, ought to be, or afraid of being' self. Self-conceptions[76] are defined as core (central) (or salient identities) or peripheral conceptions (Markus and Wurf 1987). Core conceptions are considered to be dense enough to exert a powerful effect on information processing and behaviour. However, it is acknowledged that peripheral conceptions may also affect behaviour. Self-presentations hold potential for the concept of possible selves: those selves that the individual idealises, and which directs behaviour towards achieving this hoped for self. Behaviour is also directed towards avoiding a self that the individual is afraid of becoming and is subsequently seen to be consistently mediated and regulated by the self-concept (Markus and Wurf 1987).

Prenatally men consider the shape of their father role in terms of 'possible selves' (Markus and Nurius 1986), a term that relates to a role that is anticipated and requires the individual to evaluate how they will fulfil this future role. This evaluation is based on: 'ideals (what they would like to become); realities (what they could become); and fears (what they want to avoid becoming)' (Adamsons 2013:247). This notion of possible selves is mirrored in the idea of 'imagined future possibilities' identified in youth research (Evans 2002:262) and provides the context in which men are beginning to realise their father identity during the pregnancy. However, it is acknowledged that men take longer to assimilate the notion of pregnancy and likely transition to fatherhood (May 1982) and this is particularly pertinent when the pregnancy ends prematurely (section 5.2:101).

A difference between the actual, ideal and ought self will induce different forms of emotional response. For example, if there is a perceived shortfall between the actual

[76] 'Self-representations that can be the subject of conscious reflection are usually termed self-conceptions' (Markus and Wurf 1987: 302)

and ideal self then depression may exist, whereas anxiety may be experienced if there is incongruity between actual and ought selves (Markus and Wurf 1987). Preterm fathers have only just begun to imagine their possible father self during the pregnancy which has unexpectedly ended early. Following the premature birth, fathers are beginning to comprehend a transition to a novel way of fathering which does not match their provisional identity standard. The type of identity standard will 'direct the type of emotional response in the successful verification of self-standards' (Stryker and Burke 2000:293). It is purported that individuals with integrated identities experience healthier mental wellbeing. The temporality of self-representations has also been acknowledged; how the self-representation is related to the past, present or future images of the self. Positive and particularly negative self-conceptions are also thought to inform the process for self-concept change. An individual's self-assessment of their ability to achieve life tasks will direct an individual's inclination to find out information about the self which potentially may be threatening (Markus and Wurf 1987).

The concept of liminality was considered as a sensitising concept during the process of developing theoretical sensitivity (section 4.6.4:95). Drawing on the anthropological work of Van Gennep (1960) and Turner (1969), the transition to term fatherhood during pregnancy and birth (Draper 2003), the experiences of women undergoing induction of labour (Jay, Thomas and Brooks 2018) and parental experiences of very preterm infants (Watson 2010) have been considered as a transition or threshold. Van Gennep (1960:vii) analysed human beings' life crises and identified that there are ceremonies within traditional societies that have associated activities which are common across societies, a pattern he termed 'rites of passage'. These rites of passage occur regardless of the event and have three distinct phases: separation, transition or limen and incorporation. Ambiguity and uncertainty are properties attributed to being in a liminal space between two identifiable states. However, rather than transitioning to an expected and known state, fathers of preterm infants are experiencing a transition to an unidentifiable moratorium state framed by novel identity standards and influenced by social interaction with significant others.

6.4.1. Identity and behaviour

The link between identity and behaviour is embedded in shared meanings i.e. the meaning of the identity matches the meaning of the behaviour. The identity standard is the meanings which define the role identity in a situation and these are compared to the individual's perceptions of meanings in a given situation. The behaviour or actions of the individual is a product of the individual evaluating the differences between the two (Stryker and Burke 2000). Agentic behaviour and actions seek to alter the situation to align perceived self-relevant meanings with the identity standard i.e. self-verification. Emotions form part of this relationship between self-meanings and identity standard. Negative emotions are experienced when there is a gap between self-meanings and identity standard and therefore discordance in self-verification. The findings in the study suggest the identity standards of premature fatherhood are novel and men therefore need to create standards from their own and others' expectations of what they ought to do in this unexpected and unfamiliar situation. The expectations of his partner and healthcare professionals can therefore be seen to influence preterm father's actions following the premature birth of their baby (section 5.4.1:110 and 5.5.1:133).

The literature focusing on the negative emotional states experienced by parents of preterm infants accounts for this aspect of identity formation (Provenzi and Santoro 2015). Behaviour is considered to be a result of how the perceived meanings (signs and symbols) gained from the environment relate to the individual's identity standard. Behaviour demonstrated in this way suggests that perceived meanings in the environment will be considered against an internal identity standard. It has been further proposed that part of this process includes the potential provision for being able to control resources in the environment (5.4.4:126) to align with meanings attributed to the identity standard (Burke 1997).

Identity theory focuses on role identities presenting a duality of internal and external dimensions. The 'role is external and linked to social positions within the social structure and identity is internal consisting of internalised meanings and expectations associated with a role' (Stryker and Burke 2000:289). Self-verification is situated and contextual and is confirmed or denied through interactions with others. If the process of identity verification fails, then the salience of the identity will probably reduce. Multiple roles and multiple identities may cause identity

competition or conflict as the links between commitment, identity salience, identity standard and self-relevant perceptions are conflated (Stryker and Burke 2000). For preterm fathers in the study the NICU acts as a social unit with attendant relationships and interactions. This is a situated context in which the father role is uncertain, neither consistently confirmed nor affirmed (section 5.5.1:133). The commitment to the father role remains high but the actualisation of the role is inhibited (5.4.3:122).

From the symbolic interactionist's perspective self-knowledge is gained through the process of social interaction mediated by the immediate social environment (Scott 2015). Core aspects of self remain stable when exposed to differing social contexts but other self-conceptions may be more malleable and influenced by the social context. This change in self-concept can be temporary or permanent. The importance of social contexts in influencing how men father is particularly relevant to the preterm situation as this determines how preterm fathers behave in the context specific social interactions implicit in premature birth, NICU and discharge home. Meeting an identified goal involves a cognitive process that uses not only the individual's range of procedural knowledge or strategies but also an individual's metacognitive knowledge. Thus, an individual will appraise a situation or goal and use strategies that are likely to be helpful in the situation or in achieving the goal i.e. using the right strategies at the right time, operating as **taking stock** in the study (5.5.3:142).

Procedural knowledge encompasses production rules or scripts which are understood and direct behaviour in social situations previously encountered by the individual (Scott 2015). For preterm fathers, the procedural knowledge relating to the preterm situation is unknown; there is no previously understood 'preterm script'. Therefore, preterm fathers respond to the novel situation by using metacognitive knowledge to inform the strategies they use to manage the uncertainties in the process of becoming a preterm father.

The self-concept, if considered to be dynamic and a product of a range of self-representations accessible at any given time, is therefore a product of the activation of self-representations determined by the given social circumstances and the individual's self-motives. From this perspective it can be seen that an individual's

behaviour (actions and reactions) is related to and directed by the self-concept currently at play. The self-concept draws on a suite of structures currently active which include 'self-schemas, possible selves, prototypes, ego tasks, standards, strategies or productions' (Markus and Wurf 1987:314). These structures influence the actions taken by the individual and the evaluation of those actions. Part of this appraisal will involve gauging feedback from significant others and those sharing the novel situation. A subset of possible selves is that of desired selves which can be viewed as the cognitive structures by which information in the social setting is processed and through which behaviour is mediated (Schlenker and Weigold 1992).

Preterm fathers acknowledge that prematurity is life threatening and their ideal or desired father self-concept is therefore no longer considered appropriate. Consequently, they experience a delay in being able to display or enact relevant behaviours concomitant with their possible or ideal father role but remain committed to it. In order to manage the psychological tension between fulfilling their ideal father role and the reality of their actual father role constrained by the neonatal environment, preterm fathers in the study executed other strategies to achieve a sense of self-definition as a father (Wicklund and Gollwitzer 1981). These include **total trusting** (5.4.1:110), **façading** (5.4.3:122), **safeguarding the mother-infant dyad** (5.5.1:133) and **trenchant monitoring** (5.5.2:138). The multiple identities conception of self acknowledges the way in which multiple identities interact and how they can 'reinforce, conflict with, or are independent of one another' (Stryker and Burke 2000: 291).

Becoming a father is seen as a life task (Cantor and Kihlstrom 1986 Markus and Wurf 1987) and in terms of motivation, the approach used to complete this task will depend on self-knowledge and how it is framed by the individual. A situated identity is a joint construction of the person, the audience and the situation (Schlenker and Weigold 1982). Preterm fathers in the study perceived that they needed to demonstrate to healthcare professionals that they were a dedicated father in order to provide reassurance that their infant would receive the best care. Feedback from others in a given situation and the nature of the relationship in a social interaction will influence the way an individual reacts cognitively, affectively and behaviourally.

Preterm fathers in the study experienced life as ‘being on hold’. Loss of certainty and security in the anticipated temporal trajectory renders the future unpredictable and long-term plans are no longer deemed to be relevant. The concepts of grief and bereavement have been used to explain how people cope with the loss of certainty which can lead to disorientation of purpose (Shirani and Henwood 2011a). For preterm fathers the temporal dimension of the preterm event results in a state of being in abeyance. Although this provides time and space to come to terms with fatherhood it results in an ambiguous identity. The concept of transitional identity illuminates the experiences of preterm fathers in the study and is a concept evident in a variety of literature such as, organisational identity change (Clark et al 2010), therapeutic communities of substance misuse recovery (Best et al 2014), bisexuality (Guittar 2013) and professional role transition literature (Woodside, Ziegler and Paulus 2009). The term ‘boundary dwellers’ has been coined to explain how school counselling students make sense of being on the periphery of communities of practice (Woodside, Ziegler and Paulus 2009:23). Preterm fathers in the study negotiated the ambiguous boundaries of premature fatherhood (section 5.4:107) and attempted to make sense of their novel emerging identity (5.5.3:142).

In pedagogical approaches to learning and teaching, the concept of knowledge in the making within a transitional space is germane to understanding an emerging teacher identity (Phillips 2010). The uncertainties inherent in teacher identity are viewed within a context of appreciating the process of becoming a teacher with a focus on a ‘practice of relationality’ (Phillips 2010:642). The transitional space of becoming a teacher resonates with the NICU acting as a transitional space in becoming a preterm father and both contexts are replete with uncertainties. The NICU provides time and space for fathers to begin to comprehend a father identity through their interaction with their partner, baby and healthcare professionals. However, in the study, preterm fathers, during the NICU admission, considered that they had not yet completed the transition to fatherhood and anticipated that this would occur once the baby was discharged home and they had total parental responsibility.

The relevance of symbolic interactionism in understanding preterm father’s actions and emotions has been demonstrated throughout the study and is particularly pertinent to illuminating identity and behaviour. Symbolic interactionism

acknowledges the premise of a ‘smooth ebb and flow of interaction’ for individuals and how in a given situation, ‘the behavioural capacity for self’ is the basis for role-taking and the active process of continually adjusting conduct to align with others’ identities (Turner and Stets 2009:100). The different roles that human beings hold have been differentiated into ‘general’ and ‘situated’ roles. Situated roles are by definition specific to a context (Goffman 1983) and in achieving interactional order within a specific context, individuals will negotiate and adapt their behaviour to coordinate joint action. Networking in the workplace relies on ‘different stakeholders establishing social connections by acting in a socially competent way allowing the circulation and diffusion of shared and convergent knowledge’ (Scaratti, Ivaldi and Frassy 2017:4). In a similar way preterm fathers are learning their situated role within the context of NICU and negotiating and adapting their behaviour within a team comprising healthcare professionals and his partner. These social connections provide for a shared understanding of the preterm situation and ensures that his family’s needs are met.

This collaboration with non-family members is challenging, with the expectations and display of social roles of each team member defined by the healthcare context and the medical needs of the preterm baby. These medical needs require specific medical interventions that during labour and following birth assign the patient role to mother and baby. In this context the role of the father is ambiguous but perceived to be a supporter for his partner. Following admission to NICU, the father role aligns with the healthcare professional role in safeguarding his family and explicates the importance of his social interaction with significant others (5.4.1:110).

6.5. Social interaction with significant others

The common theme in life course studies is ‘development and changes in the meanings of life experiences through time’ (Holsten and Gubrium. 2007:339). Premature fatherhood resonates with the conceptualization of a reforming identity which involves ‘a degree of ambiguity, is fluid rather than static and dynamic rather than stable’ (Meleis et al 2000:24). The social self is ‘conceived as an entity that constantly scans and tests the interactional environment for direction. Individuals actively seek others’ feedback in relation to their own action. Through the give and take of social interaction, the individual learns to present the appropriate attitudes,

values and emotions, with the perceived evaluations of others providing the 'basis for formulating assessments of one's own behaviour and serve to organise courses of action' (Meleis et al 2000:24).

Social comparison theory suggests that individuals gain information about their behaviour by comparing it with others (Gentina, Huarng and Sakashita 2018). Fathers will construct what it means to be a father through social interaction with significant others. Behaviours relevant to specific roles and the feedback given to the individual on behaviours will be particularly important if provided by an individual acknowledged as having a counteridentity (Adamsons 2010). An individual will therefore have two identity standards for each status they hold: one identity standard is that of personal expectations for themselves in that identity; and the other is the expectations of the other holding the counteridentity. There has been some consistency in the literature suggesting that, rather than fathers' identity standards predicting his father behaviour, his perception of mothers' identity standards hold a greater degree of influence (Adamsons and Pasley 2016).

Social identity theory illuminates how preterm fathers perceive the centrality of their father role, how salient this role is in being enacted in the context of the NICU experience, and his commitment to it. The literature on father involvement both prenatally and postnatally is varied and includes retrospective and prospective small and large scale studies and differences in how father involvement is conceptualised and therefore measured (Adamsons 2013). The importance of considering the content of the father status has highlighted the disparate roles of a father identity, which include being an emotional support for the mother of his baby. Rather than directly caring for his baby he enacts his father role through caring *about* the baby (Lee et al 2009, Habib 2012). Average qualitative gender differences in parenting have been found to be smaller than the differences within gender (Adamsons 2013). There is however recognition that father's role making work may be mediated by their partner's parenting actions and behaviours. It can be seen therefore that fathers co-construct their father identity to align with their partner's mothering identity (Lee et al 2009, Habib 2012).

For preterm fathers the 'episodic enactments of their fathering identity' (Turner and Stets 2009:127) during the preterm experience provide interruptions in the

confirmation of their father identity and may result in negative emotions such as distress, anxiety and stress. This inability to sustain organised activity in 'fully rehearsing behaviours associated with the identity meanings' (Turner and Stets 2009:127) was a finding in the study with the participants expressing feelings of '*living on hold', 'being in a bubble', 'being submerged'*. With its roots in coping with stress (Lazarus 1974), uncertainty in illness theories acknowledge how individuals manage and reduce negative feelings (Mishel 2014). Coupled with affirming their partner's identity and experiencing the challenges of interruptions in confirming their own father identity (Burke 1991), preterm fathers in the study were additionally experiencing the uncertainty of whether their baby would live. This adds an additional moral duty of putting the interests of his partner and baby above all else and results in reduced opportunities to display fathering behaviours. A sense of well-being is linked to others confirming self-conception. However, due to the emphasis on the mother and baby's well-being during the episode of obstetric and neonatal care, preterm fathers in the study aligned their behaviour accordingly to match the situational role expectations. This choice leads to cooperation with others (section 5.4.1:110) that serve to protect his family and sustain a viable self in an uncertain, novel and stressful situation. During the preterm experience, fathers in the study became cognisant of the role expectations of their partner and invoked emotion- and problem-focused strategies to affirm the mother's identity as much as possible (Turner and Stets 2009). Through **surveyancing** (section 5.5:132) preterm fathers in the study also sustained 'a viable self in a situation' (Turner and Stets 2009:106) and in affirming their partner's self-conception, preterm fathers own self-conception remained in abeyance.

Gender differences in parenting a child with a health problem have suggested that men tend to hide their emotions, use cognitive problem solving to inform action-oriented responses to the situation and may evade, deny or escape the situation through recreational activities (Palkovitz and Palm 2009). A couple experiencing parenting for the first time will individually learn roles specific to themselves in order to limit criticism from and tension with their partner (Cook et al 2005) and the quality of supportive relationships in moderating the commitment to the father identity and resultant behaviours has been acknowledged (Henley and Pasley 2005). The bidirectional process of forming a parental identity consists of role taking behaviour

that is aligned with the perception of the identity standard of their partner (Pasley, Petren and Fish 2014). Through mutual negotiations, parents influence each other's identities to varying degrees with gatekeeping activities that are framed by social, personal, cultural and power dynamics. Power in this context has traditionally been attributed to resources, education and occupational status (Adamsons 2010), but this concept has resonance for preterm fathers in the study. The power in the NICU environment is related to access and ability to meet the caregiving needs of the preterm infant, both aspects of which are provided by neonatal staff and and/or the mother.

The biological and psychological connection that mothers have with their children has been presented as the basis on which the centrality of the mothering role has been defined (Dermott 2008). For preterm fathers in the study, the centrality and commitment of his partner's mothering role and the role of the neonatal staff were acknowledged as imperative in meeting the needs of his preterm baby (section 5.5.1:133). Preterm fathers evaluated their father identity standard and adjusted their fathering behaviour to align with these more powerful individuals. The NICU acted as a 'perceptual filter' (Jackson and Warin 2000:379) through which preterm fathers perceived the situation as novel and which then provided the context for negotiating a fathering role. Within this context, the moderating factors influencing father identity and behaviour included: the gestational age of the infant, the illness trajectory, relationship with staff, technology, relationships with other parents, employer support, and having other children. The influence of significant others' reflected appraisals of father identity and fathering behaviours, when compared to his father self-identity, highlight the importance of evaluating the context, including relationships, when considering father identity (Maurer, Pleck and Rane 2001, Fox et al 2015).

A review of the literature suggests that the majority of research on fathering has focused solely on the relationship with mothers rather than extending this to incorporate other relationships (Pasley, Petren and Fish 2014). Research focusing on supportive and unsupportive relationships in influencing commitment to an identity, acknowledges how the context will affect the enactment of that identity (Adamsons and Pasley 2016). For preterm fathers' relationships with staff and their partner in the healthcare context influence their efforts to confirm their fathering

identity and feedback from these significant and important others present a source of ambiguity and uncertainty (section 5.4.2:117). Additionally, it is recognised that the baby's behaviour influences father-infant interactions. The different cues and signals displayed by preterm infants may lead to fathers experiencing difficulty in understanding this behaviour and feeling less competent in responding to his baby's needs. This has been suggested as a reason for preterm fathers experiencing higher stress than fathers of term babies at six and twelve months (Ravn et al 2012). The lack of quality time and opportunity for preterm fathers to spend with their baby during the NICU admission inhibits their knowledge of preterm infant behaviour and enhances their promotion of the mothering role and may explain why preterm fathers in the study were acutely aware of their total parental responsibility for their baby following discharge home (section 5.5.3:142).

6.6. Negotiating boundaries in the context of agency theory

The concept of agency, specifically relational agency[77], is important in explicating the concept of **negotiating boundaries** (section 5.4:107) in the substantive theory of **moratorial fathering**. Fathers act in ways that are in response to the uncertain situation of suddenly being a parent of a preterm baby. In depicting agency as actions that produce a particular effect or result, sociologists have traditionally defined agency as a consequence of the individual acting reflexively as an agent in response to the social world, either through its structures, ('rules and resources' in social reproduction) (Giddens 1984) or the properties of relations (Archer 2008). In contrast, relational agency can be viewed as socially situated agency and uses the term interactant rather than agent to define how 'agency emerges from the emotional relatedness to others as social relations unfold across time and space' (Burkitt 2016:332).

The actions of preterm fathers in the study can be understood in terms of social interactions embedded in the life course transition to parenthood (Roy 2014) and the interdependencies[78] with their baby, partner and the neonatal staff resulting from the admission to NICU (section 5.4.1:110). The associated meanings and values

[77] In relational agency theory, agents are defined as interactants who are:' interdependent, vulnerable, intermittently reflexive, possessors of capacities that can only be practised in joint actions, and capable of sensitive responses to others and to the situations of interaction' (Burkitt 2016:322)
[78] Physical, meaningful, emotional, practical, economic, political and social

attributed to premature fatherhood are embedded in the 'nature of the interdependence with others' both at an interpersonal and impersonal level (Burkitt 2016:331). For preterm fathers in the study, the context of the NICU environment provided the boundaries for different forms of interactions. The interplay of the physical and social space of NICU and its associated symbolic imperatives can be seen to influence preterm fathers' identities and the requirements of contingent social interactions. By drawing attention to the NICU in terms of space and time, the behaviours of preterm fathers in the study in terms of their motivations, choices and goals were illuminated.

The creation of short versus long-term goals will result in whether existential, identity, pragmatic or life course agency will be displayed (Hitler and Elder 2007). In eliciting short-term goals preterm fathers are enacting pragmatic solutions in response to the uncertainties of prematurity. The situated social interactions of prematurity have a temporal dimension which requires preterm fathers to alter their time horizon to align with this new event. The temporal and corporeal boundaries of NICU framed the way in which preterm fathers in the study managed and expressed their emerging fathering identity. The concept of 'bounded agency' has been used in young adult transitions research to explain how a number of boundaries and barriers can exist which influence the 'expression of agency' and takes account of the interplay of the individual and the social situation i.e. 'socially situated agency' (Evans 2002:262). The NICU can be seen to act as a locus for the transition to parenthood and, as such, the pattern of meaning of prematurity for men is understood through communication and interaction with the NICU environment and neonatal staff, as well as his partner and baby.

6.6.1. Boundary ambiguity

In addition to negotiating the boundaries of the NICU and family, preterm fathers in the study had to additionally negotiate the boundaries between NICU, family and work (if employed). Men, finding it difficult to manage work and family demands, may withdraw into safe and familiar roles (Genesoni and Tallandini 2009) and it has been suggested that being at work is a coping strategy enacted by men to manage the stress of having a preterm baby (Pohlman 2005, Arockiasamy, Holsti and Albersheim 2008). However, in the study preterm fathers experienced meeting employment responsibilities as limiting the opportunities for them to engage in

behaviours associated with the parental role (section 5.4.2:117). It also limited the opportunities for engaging in relationships with neonatal staff, which due to organisational constraints are dynamic and fluid (Fegran, Fagermoen and Helseth 2008). A NICU can employ up to one hundred staff (DH 2009, NHS Improvement 2017) and, coupled with the daily shift changes, means that preterm fathers in the study were interacting with a large number of different staff during the course of the NICU admission. The differences in previous studies' findings regarding work as a coping strategy compared to the findings in the study may be related to the changes in paternal role expectations over time.

Family stress theory takes account of the sociological and psychological response to a stressful situation and provides for greater clarity in understanding the social process that shapes preterm fathers' response to uncertainty. Within family stress theory, the constructs of ambiguous loss and boundary ambiguity build on the contextual model of family stress (CMFS) (Boss 2016). Ambiguous loss is defined as a specific loss whose nature is inherently ambiguous ensuing from a lack of concrete and objective information relating to the family member's status and whereabouts (lost at sea for example). Ambiguous loss is seen as the 'stressor event or situation and boundary ambiguity is the perception of that stressor' (Boss 2016:278). Although this theory relates to missing family members, it is also relevant for the preterm situation to the extent that the baby's status as a member of the family is uncertain. Additionally, following a premature birth, the boundary defining the family is extended to incorporate the neonatal staff and contributes to boundary ambiguity. Changes in family boundaries can be seen to be inherent in many family life cycle transitions (Carter and McGoldrick 1989) and a deviation from the normative may result in ambiguity.

The CMFS highlight the two contexts which mediate family stress: internal context (identifies what aspects of the situation can be controlled by the family); and external context (those factors that the family have little or no control over) (Boss 2016). Although in the CMFS these two contexts are identified as mediating the stress response (Berge and Holm 2007), in explaining the social process of premature fatherhood, these can be seen to contribute to the dimensions of **moratorial fathering**. The premise of ambiguous loss builds on the notion that human beings will find meaning in their experience and make sense of the situation. Although the

work of Boss (2016) has been influenced by her discipline of psychology, the constructs of ambiguous loss and boundary ambiguity holds resonance with the social process of situated fathering of premature fatherhood.

Boundary ambiguity can occur as a result of ambiguous loss and explains the family's response to this stressor situation (Boss and Carnes 2012). It has been suggested that this has two dimensions and produces incongruence around family membership and roles (Boss 2016). Membership ambiguity (who is part of the family) and role ambiguity (who is doing what within the family), has been considered in relation to families caring for a chronically ill child (Berge and Holm 2007) and boundary ambiguity was found to be relevant in understanding the psychological and sociological environment for families in a Paediatric Intensive Care setting (Tomlinson and Harbaugh 2004).

In the context of premature fatherhood, membership ambiguity contributed to understanding the difficulties preterm fathers in the study experienced in forming a connection with their baby (5.4.4:126). Their preterm baby is physically absent from the family home but physically present in the NICU and paradoxically persistently psychologically present when inhabiting the spaces of home, NICU and work (if employed). This paradox of presence and absence is also recognised in situations of ambiguous loss. Preterm fathers in the study acknowledged that there is nothing that can change the situation they find themselves in, but their perception of premature birth can be adjusted to enable the provision of meaning 'based on congruence between reality and perception' (Boss 1977:142). In other words what is expected compared to what is actually experienced. If events are perceived to be 'stable and reliable' an individual can make sense and understand the situation (Neville 2003:208). This mirrors the extended phase of premature fatherhood in the study during which men began to make sense and understand the NICU situation though **taking stock** (section 5.5.3:142).

There also exists a boundary defined by the space between the family and the NICU. This space, although geographically distinct, is ambiguous in terms of defining where the boundary of the family now resides (Carroll, Olson and Buckmiller 2007). This boundary has had to be extended virtually to incorporate a team of healthcare professionals that need to provide the medical care to ensure the welfare of the baby

and results in a diffusion of parental responsibilities. The clear line that demarcates the normal internal, private status of a family has been blurred and extends beyond this normal boundary to occupy a space that requires an assimilation of additional significant members involved with the family and subsequent renegotiation of roles.

In the study, preterm fathers encountered complex and uncertain relational situations during the labour, birth, NICU admission and following discharge home. The agency of preterm fathers was framed by uncertainty and emerged from their emotional response to the various social relations within the preterm situation. The emotional dimension of relations and interdependencies is particularly pertinent in understanding preterm fathers' actions during their transition to parenthood. The concepts of **total trusting** (section 5.4.1:110) and **façading** (section 5.4.3:122) illustrate how preterm fathers in the study worked to adjust their actions to meet the needs of his baby and partner, rather than his own. Preterm fathers acknowledged that they have limited capacity for action in fulfilling the roles and responsibilities normally associated with fatherhood. The premise of the obstetric, midwifery and NICU environment, based on caring for the mother and baby, is conveyed by the presence of technological equipment and the clinical interventions of neonatal staff.

In this way, the NICU acts as a space of abeyance, providing time to process the transition to an unexpected and novel form of fatherhood. The NICU is the situated space for defining their identity as a preterm father, inhibiting the complete fulfilment of a parental role. This results in **moratorial fathering** in which the father's role as being more back stage is sanctioned. The mothering role is brought to the fore by neonatal staff, family and friends and the important role the mother has in being able to care for the baby following discharge is acknowledged by preterm fathers very early on. The imperative for one parent to have the confidence and competence to care for a preterm baby is the priority. The fathers in the study considered the mother to be the best person to take on this role and then actively promoted this in a number of ways.

The relevance of considering the concept of family in the study, further illuminated the concept of **negotiating boundaries**. It has been suggested that 'contemporary families are defined more by *doing* family things than by *being* a family' (Finch 2007:66) and acknowledges that rather than being a rigid constitution, family is

understood in terms of fluid social actions and activities which have been framed as 'family practices' (Morgan 2011). Family practices include social interaction in relationships that result in actions that present a *display* of family (Finch 2007) and has been explored in the family practice of seeing the baby during prenatal ultrasound scanning (Roberts, Griffiths and Verran 2017). Doing family is a process of conveying meaning to others that the individual's actions are confirming their participation in family relationships which are effective, and this is recognised by others (family, friends, colleagues, employers and public agencies). This endorsement by others that the individual's actions are perceived as 'doing family' reflects the theoretical perspective of symbolic interactionism (section 3.3) with its focus on meaning making within social interactions in different social contexts. The relevance of the concept of family practices for the study lies in the acknowledgment that NICU limited the opportunities for fathers to engage in anticipated family social interactions and to demonstrate actions that present a display of family. This display of family requires affirmation by others and is premised on relationships being defined 'not only by their existence but also by their quality' (Finch 2007:79).

Preterm fathers in the study therefore maximised the opportunities to fit in visits to the neonatal unit around his work and family commitments, at huge emotional and physical cost to him (5.4.4:126). This enabled him to present a fathering presence and signalled to his partner and the neonatal staff the nature of his fathering identity and provided opportunities to enact that identity. Through reflected appraisals, preterm fathers defined how they see themselves in the preterm situation and enacted a role that is accepted and endorsed by others (Burke 1997).

6.7. Enacting a fathering role

From a symbolic interactionist perspective, the social self is processual with individuals framing their understanding of the self through interaction with others. This suggests the existence of multiple social roles (Scott 2015) that are enacted in different situations and amalgamated form a sense of identity. Social identity, framed within the symbolic interactionist perspective, is considered germane to understanding the process of social interaction in the emerging and developing identity of premature fatherhood and behaviours associated with fathering (Habib 2012).

Cultural and societal messages that promulgate hegemonic masculinities and fatherhood may induce fathers feeling that the criticality of the father identity is subsumed by the mothers. The 'navigating the path to fatherhood' theme highlights how a focus on 'fathers as parents rather than fathers as men' (Schmitz 2016:17) is helpful in exploring how men increase their confidence in developing the knowledge, skills and competence to be an effective parent. This theme is also reflected in the recognition that men following the birth of their baby continue to appraise how accomplished they feel they are in meeting the goals and expectations they consider relevant to the father role and negotiate the shifts between the ideal, real and feared selves (Adamsons 2013).

It has been suggested that 'transitional phases require a person to cope'; a way of assuring a consistent sense of self when faced with an unfamiliar situation and is proposed as an 'appropriate way of conceptualising the operation of the sense of self since it incorporates both cognitive and affective dimensions' (Jackson and Waren 2000:378). Further evidencing of the significance of the cognitive and affective dimensions of self is professed in the problem-focused and emotion-focused coping strategies presented in uncertainty in illness theories (Mishel 2014). Preterm fathers in the study enacted problem-focused coping strategies (**total trusting, standing aside, trenchant monitoring** and **taking stock**) and emotion-focused coping strategies (**promoting mothering, façading** and **soldiering on**) in order to cope with the uncertainties of their role as a father in the context of the NICU.

With respect to the goal and ways of parenting, the parenting literature has often focused on mothering and fathering as conceptually different. Fagan et al (2014:390) have challenged this approach, suggesting that there is a lack of evidence to support the view 'that the dimensions (cognitive, social, motor/physical behaviours, beliefs, skills, attributes and emotions) of father's and mother's parenting behaviours are conceptually unique'. Fagan et al (2014) acknowledge that gender influences the expression of the dimensions of parenting but argue that these dimensions should be considered conceptually identical for both mothers and fathers.

The process by which men take on the social role of being a father is reflected in the theoretical perspective of identity theory (Fox and Bruce 2001) and has been applied in the study of father involvement with their children (Habib 2012, Redshaw and Martin 2013). These findings present methodological limitations in terms of consistent definitions of concepts and the homogeneity of participants (Pasley, Petren and Fish 2014). However, limitations aside, increasing numbers of empirical studies have identified: how fathers begin the transition to fatherhood during the pregnancy; there is recognition of the multi-dimensional nature of fatherhood; and the challenges faced by men in balancing the provider and caregiver role (Habib and Lancaster 2006, Miller 2011, Carlson, Kendall and Edleson 2016). These studies have also framed fatherhood as evolutionary, influenced by social locations and social structures and by extension therefore seen as developmental.

Dimensions of paternal involvement have been ascribed differing definitions; however, the three core dimensions of engagement, accessibility and responsibility have traditionally been most germane to understanding how positive paternal involvement influences healthy child development (Pleck 2010). Paternal responsibility for children has been defined as the ways in which fathers ensure that their children's' needs are met and refers to process and indirect care (Lamb 2010). Process responsibility involves fathers monitoring the extent to which the needs of his child, in terms of positive engagement activities, warmth and responsiveness, control (particularly monitoring and decision-making) and indirect care (material and social) are being met, but not directly by himself. Indirect care includes 'activities undertaken for the child rather than with the child' which can be material or social (Lamb 2010:65). Process responsibility is suggested as a component of paternal involvement (Doucet 2009) and refers to the father's role as one of monitoring emotional, community/social and moral responsibilities: 'seeing the need' (Doucet 2006 cited in Lamb 2010:66) and managing the child's needs. Process responsibility in the context of premature fatherhood elucidates the dimensions of **surveyancing** (section 5.5:133) by which preterm fathers in the study monitored the extent to which the needs of his baby were being met. However, process responsibility is enacted within the constraints of the NICU context and the competing responsibilities of employer and family expectations.

6.7.1. Parenting alliance

In terms of family formation, the transition to parenthood can be seen to begin with the decision to plan to extend the hitherto couple to incorporate another individual. Parenting alliance (or coparenting) is considered to be an integral part of adjusting to becoming a parent (Luz et al 2017) with motherhood and fatherhood co-developing and the child-parent relationship being influenced by this alliance. There have been a number of proponents of the elements of parenting alliance and these have been synthesised to present a conceptual model of four components: 'parental harmony (the level of agreement, mutual respect, emotional support and unity in the goal and ways of parenting), boundary preservation (the degree to which parents will form a cohesive unit (affirming or discrediting the other parent) in parenting their children within the family), reciprocal caregiving (how parenting tasks are divided between the parents and the extent of accommodation and relief for each other's tasks), and parental connection (the development of the bond derived from learning to be parents together and recognising their achievements)' (Hock and Mooradian 2013:324). Becoming a parent therefore involves a process of working together to care for a new baby (Schoppe-Sullivan and Mangelsdorf 2013) by fulfilling the dimensions of parenting. Differences in the parenting dimensions of preterm and term fathers exist, with the opportunities for preterm fathers to fulfil all the parenting dimensions curtailed, minimised or obstructed following admission to NICU (Table 6.2).

Table 6. 2 Differences in parenting dimensions of term and preterm fathers

Parenting dimension	Term baby	Preterm baby
Cognitive behaviour	Co-parenting engenders joint decision-making. Family members and friends may also be consulted for advice	Decisions regarding caring for the baby are predominantly made by HCPs and the mother with the father monitoring and only intervening if needed. As the mother has more opportunities to learn about how to care for a preterm baby the centrality of the mother in decision-making continues following discharge home.

Parenting dimension	Term baby	Preterm baby
Social behaviour	There are social behaviours that celebrate, promote and support the couple's new roles as parents and being a family: 'wetting the baby's head', sending out arrival of baby cards, being seen out with their baby in the pram, inviting family and friends to the family home to meet the new baby. Meeting up socially with a new social circle of antenatal parents and sharing experiences.	Celebratory behaviours are not considered to be appropriate as the baby is in danger and may not survive. Therefore, their social role is ambiguous. Fathers are unable to 'wet the baby's head', the baby is absent from the family home, family and friends may be excluded or their presence limited during the NICU admission and in the early weeks of being at home. The new social circle is now one of a community of shared experience.
Motor/physical behaviour	Fathers gain increasing confidence in providing instrumental and emotional care through cuddles, feeding, changing nappies, bathing and sharing the child care responsibilities	There are limited opportunities for preterm fathers to engage in direct care giving activities due to: being time poor; sustaining the mother-infant relationship; promoting breast feeding; the clinical condition of the baby; and rationing his contact in deference to the mothering role
Motivations and goals	Motivations and goals are predicated on the immediacy of the baby's needs and are facilitated by the baby being in close proximity.	Motivations and goals are predicated on the NICU environment sanctioning the enactment of these. The baby is distanced by physical geography and barriers such as the incubator and the baby's clinical condition
Beliefs	Individual experiences of being parented influence their belief about what the role of a father entails. There may be a belief that the role of the father is to be a co-parent	Being a preterm father is unknown and is experienced in the context of a life-threatening and uncertain situation

Parenting dimension	Term baby	Preterm baby
Skills	Parenting skills are taught in antenatal classes and then developed in the privacy of their own home. Family and friends and the Health Visitor (HV) can offer advice	The skills needed to care for a preterm baby are mainly focused on the clinical interventions needed to treat the baby and promote recovery during the NICU admission. The skills set for caring for preterm babies are taught on the NICU mostly to the mother due to the father's intermittent presence. These skills remain appropriate for the first few weeks at home and then as the baby's needs change the parents seek further information as they acknowledge the need for a different skill set as the baby transitions to the next developmental stage. Preterm parents may experience a lack of knowledge from their GP and HV concerning the needs of preterm babies
Attributes	Confidence in becoming a parent. Experienced with child care activities. Ability to meet their child's physical needs and nurture their intellectual, emotional and social development	The qualities needed to be a preterm parent are unknown. Parenthood is experienced as an anxious and stressful event. HCPs are meeting their baby's physical needs and therefore there is little opportunity for preterm fathers to display their parenting attributes
Emotions	Normal emotions tend to be ones of relief, joy, satisfaction and beginning to feel close to the baby.	The spectrum of emotions experienced is vast and include feeling disconnected from the baby. Fathers oscillating between polar emotions experience this as a roller coaster. The emotions are aligned with the illness

		trajectory of the baby and their partner's physical and emotional state in relation to them becoming a mother

Based on Fagan et al's (2014) dimensions of parenthood

Coparenting has been suggested as a useful concept to explore contemporary parenthood and incorporates other individuals who have conjoint responsibility for the child (Van Egeren and Hawkins 2004). The role of gender, in terms of the degree of paternal engagement in caregiving, and the concept of 'maternal gatekeeping' have indicated how parenting patterns are co-created through input from both parents rather than just one. In acknowledging the dynamic nature inherent in the process of family formation, interactions and meanings attributed to actions of family members need to be considered. The importance of supportive coparenting has been demonstrated in reducing parental stress in first-time parents (Durtschi, Soloski and Kimmes 2017) with the temperament of the baby also receiving attention in the ways in which this may influence the development of a positive parental alliance (McHale et al 2004).

6.7.2. The influence of gender

Empirical studies have explored the level of parental investment in term compared to preterm infants with some studies identifying parental difficulties in bonding with their preterm baby (White, Gilstrap and Hull 2017) and others highlighting enhanced investment in their preterm baby's care (Hoffenkamp et al 2012). More recently there has been a change in the ontological approach to studies exploring the gender differences of parental responsibility for child care. This approach suggests that embodiment needs to be considered as a dimension to parental care giving[79]: From this perspective, the NICU context draws into sharp relief the gender differences embodied in fathering. Encountering the pregnant body during pregnancy, labour and birth (Draper 2003) during which the mother's 'body is transformed' (Doucet 2013:296) continues into the NICU, where both the mother and baby are considered to be the legitimate receivers of care interventions. The imperative of supporting the

[79] 'Gender differences in mothering and fathering are embodied, relational, and fluid identities and practices that shift and change over time and within complex webs of social and institutional relationships: embodied gender differences can appear suddenly in particular contexts while being irrelevant, mute and inconsequential in other contexts' (Doucet 2013:291).

mothering role is sanctioned by the process of premature birth, including the actions of healthcare professionals, and results in endeavours at every opportunity to promote close bodily proximity of the mother to the baby, as soon as the baby's clinical condition allows (section 5.5.1:133). This precludes the preterm father from extensive opportunities for close bodily proximity to their baby and reinforces feelings of disconnection. In essence, the NICU context continues to present 'moments and social spaces where men's bodies matter in ways that exclude them from care' (Doucet 2013:299).

Parenting relationship has been identified as important for parents in attenuating the effects of stress experienced in having a child with intellectual disability (Kersh et al 2006) but there does appear to be a gender difference. Fathers profess the need to seek the support of their partner whereas mothers are more likely to secure support from sources outside the relationship (Grant and Whittell 2000). Research exploring the impact of autism on parents suggests that employment outside the home is a mediating factor for fathers (Macdonald and Hastings 2010). Fathers are then less directly affected by their child's problems and more indirectly affected by their partner's wellbeing. Defining the situation of having a child with a developmental disability in a negative light also predicts the likelihood of parental stress (Macdonald and Hastings 2010). In the situation of premature birth, the degree of negativity associated with the situation determines preterm father's interpretation of the meaning of their father identity. Fathers in the study acknowledged the positive effect of having children prior to experiencing premature birth and perceived this as relieving some of the stress of the preterm situation (section 5.4.4:126).

The physical pain and emotional and psychological adjustments attributed to childbirth has led society to develop rituals and practices that promote the mothering role e.g. baby shower, gifts for the mother as well as the baby, extended maternity leave (Draper 2003). Pragmatic decisions based on survival are made related to the roles of significant others, such as obstetric, midwifery and neonatal staff. The sense of inhabiting two parallel spaces (NICU and work/home/social) contributes to preterm fathers in the study experiencing time as moving on but they are standing still with regard to fully enacting their parental role in the formation of the family

A qualitative Australian study exploring the complex ways in which fathers experience grief when their baby is stillborn, highlighted how 'fathering and grief are situated within a highly gendered and relational dynamic' (Bonnette and Broom 2011:248). Within the context of pregnancy loss, it has been highlighted how men take on a supportive role for their partner rather than an expressive role in terms of their own feelings. The gendered discourse of masculinities and the relational dynamic of the parental alliance, illuminate the ways in which fathers, experiencing a loss of their term baby through stillbirth manage and express the fathering identity (Bonnette and Brrom 2011).

A developmental life stage for men in becoming a father is to contribute to the next generation and to take on parental responsibility (Bradford and Hawkins 2006). Premature fatherhood results in the father experiencing unanticipated dimensions to his transition in becoming a father. These dimensions include: tolerating extremes of emotions; evaluating an intense health related environment; adjusting to revised family relationships and boundaries; keeping things together; stress-related growth; and negotiating parental alliance. It has been suggested that mothers tend to focus on the immediate care needs of the child (in the private domain) but in contrast fathers tend to use problem-focused coping strategies to manage the wider needs of the family (in the public domain) (Stoneman and Gavidia-Payne 2006). Considering the family as a system, father identity is shaped by the different relationships that are considered integral to the family and in the context of premature birth additionally includes relationships with healthcare professionals.

6.7.3. Preterm fathering in the context of moral practice

Within the medicalised context of obstetric and midwifery services, role expectations of men may be conflicting: non-hegemonic masculinities expected in being an 'emotionally engaged father and conversely hegemonic masculinities in being a supportive partner and advocate' (Draper and Ives 2013:727). This may present tensions for term fathers and has been framed by the notion of moral residue[80] (Ives 2014). This concept is relevant in the context of preterm, as well as, term fatherhood. In **deferring to others** (section 5.4.1:110 and section 5.4.2:117) and **safeguarding**

[80]' When a dilemmatic situation is encountered the decision-maker, despite feeling they have acted correctly, experiences some feeling of guilt or remorse because in acting correctly overall they have failed to act correctly in some other respect '(Ives 2014:1015)

the mother-infant dyad (section 5.5.1:133), preterm fathers in the study promoted the mothering role at the expense of their fathering role. Preterm fathers were also coping with the mental labour (Offer 2014) of negotiating roles and responsibilities of being a preterm father, a partner and an employee (section 5.4.4:126). Managing the activities related to NICU, family life, and work commitments resulted in these fathers having to negotiate boundaries in terms of both space and time. The chronicity of prematurity has been described as both physically and psychologically exhausting, the symptoms of which can be ascribed to exhaustion rather than attributed to psychological pathology (Boss and Couden 2002).

Preterm fathers in the study enacted the perceived male imperative of remaining strong for his family which additionally can be seen to have a moral dimension to it. This moral dimension has been considered in the context of family members providing personal care to individuals with advanced cancer (Chattoo and Ahmad 2008) and has resulted in the development of the concept of 'caring as moral practice' (Broom and Cavanagh 2010:875). In the study, preterm fathers enacted the behaviours associated with the resilience required to survive a novel and uncertain situation. The moral practice of preterm fathering incorporated **façading** (section 5.4.3:122) which is both gendered and relational in terms of parental alliance but was also influenced by the social interactions with neonatal staff in NICU. **Façading** relates both to the problem-focused coping strategy of **deferring to others** (section 5.4.1:110 and section 5.4.2:117) but is also an emotion-focused strategy inherent in **safeguarding the mother-infant dyad** (section 5.5.1:133).

By virtue of its nature, premature birth defines how men negotiate fathering and what it means to them within this context. The literature related to term fathers acknowledge the continued close connection between his partner and the baby is of main concern to men and leads them to consider their partners to have the right to 'determine the narrative of the pregnancy and to take on a more subservient role of deference and support' (Ives 2014:1015). This is acknowledged as pertinent to preterm fathers in the study, as premature birth complicates fatherhood transition and rendered the men in a position of deference and support to not only his partner but to healthcare professionals (section 5.4:107). In this way, preterm fathers accepted that both his partner and the neonatal staff have the right to determine the narrative of the NICU admission and necessitate the development of relationships

with healthcare practitioners, in addition to the previously established members of the family network.

In palliative care, façading is exhibited to people outside the family but is also a strategy used within the family as a protection or shield (Sandgren 2010). The consequence of façading is that the illness is diminished and can lead to a perception of the individual being emotionally cold and distant. For preterm fathers in the study this strategy was imperative in protecting his partner from being emotionally overwhelmed by his feelings as well as her own. His perception was that she should not be required to have the emotional capacity to manage his feelings in addition to her own physical and emotional trauma of experiencing a premature birth. However, a consequence of this was that his partner may consider him emotionally distant when enacting this façade and may lead to misunderstandings between parents. In addition, neonatal staff may also foster perceptions of men appearing to be emotionally distant and by extension in some way experiencing reduced feelings and emotions.

Parental alliance in premature parenthood is distorted with the baby being cared for by both healthcare professionals and the mother. Preterm fathers in the study and elsewhere (Provenzi and Santoro 2015) emphasised the need for the focus to be on the mothering role but this ultimately results in reforming a father identity. **Moratorial fathering** presents a developmental and dynamic process in transitioning to premature fatherhood. For preterm fathers, the existence and quality of the relationships with his baby, partner, family, friends and colleagues are altered by premature birth and affected the process of meaning making of fatherhood.

The importance of parental alliance in the context of premature birth relates to how fathers endorse the mother-baby attachment and explains how parental alliance is affected by the preterm baby's admission to the NICU. If a father's identity and subsequent level of involvement with their child is symbiotic with the mother's appraisal of their nurturing role, it is likely that the admission to NICU will significantly alter this. In order to begin to develop their father identity they require the endorsement of their partner and this goes some way in explaining why preterm fathers in the study were so focused on the mothering role. In the NICU setting the father was extremely limited in the extent to which he could demonstrate his

nurturing role. The important interactions between mother, infant and father influenced the man's developing sense of father identity. Preterm fathers endeavoured to be involved with their preterm baby as much as possible, within the constraints of time, place and other competing statuses and roles. Once the preterm baby was discharged home the expected behaviours attributed to the father role could begin.

6.8. Deferring to others: a problem-focused coping strategy

Preterm fathers in the study were able to appraise and rationalise the situation of premature birth as 'danger' by comprehending and anticipating the likely events inherent in the illness trajectory through **deferring to others** (section 5.4.2:117). Preterm fathers very quickly acknowledged and appreciated the obstetric, midwifery and neonatal care processes which safely and efficiently controlled and managed both his partner's journey through the delivery process and the baby's illness trajectory. **Deferring to others** was not a passive act chosen because it was an easier option but formed a problem-focused coping strategy of marshalling effective care-getting for his family.

Deferring to others was also a strategy for enabling meaning- and sense-making of the preterm situation. The neonatal staff assisted preterm fathers in the interpretation of the preterm situation. The meaning attributed to the situation was one of danger for both their partner and baby, which contributed to preterm fathers exhibiting the problem-focused coping strategy of **total trusting** (section 5.4.1:110). For very preterm fathers this had much more significance than if the baby was moderately preterm. The longer the baby was perceived to be in danger the longer the need to endure sustained uncertainty, with elements of uncertainty continuing following discharge home.

The data in the study suggest that the shock of the early birth of their baby means that initially the participants felt unsure about how to act or what decisions to make and therefore relied on the healthcare professionals to guide them through this unfamiliar experience. The uncertainty of premature birth resulted in a suspension in the new family being able to reorganize roles, rules and rituals. Once the preterm baby had been discharged home, this process became reanimated but in a way that was framed by the context of the NICU experience. The new family needed to adjust

to having sole responsibility for a baby that had been in danger and, in regard to a very preterm baby, would continue to require medical surveillance and intervention for an indeterminate length of time (White, Gilstrap and Hull 2017). Following discharge home, the fathers in the study were unsure of the timeline for the discontinuation of defining their baby as preterm.

The cancer survivorship literature contributes to illuminating the processes through which premature fatherhood is enacted. The term survivor has historically been associated with wars or natural disasters but began to be used to describe patients surviving myocardial infarction in the 1960s, followed by cancer survivorship in the 1980s (Doyle 2008). The term 'survivor' refers to a patient 'who remains alive and continues to function during and after a serious hardship or life-threatening disease. In cancer, survivorship focuses on the health and life of a person with cancer from the time of diagnosis and then post treatment until the end of life. It covers the physical, psychosocial, and economic issues of cancer, beyond the diagnosis and treatment phases. Survivorship includes issues related to the ability to secure health care and follow-up treatment, late effects of treatment, second cancers, and quality of life. Family members, friends, and caregivers are also considered part of the survivorship experience' (National Cancer Institute 2015).

One concept analysis of cancer survivorship defines its attributes as 'a dynamic, emerging concept pertinent to all cancer care and may be defined as a process beginning at diagnosis and involving uncertainty. It is a life-changing experience, with a duality of positive and negative aspects unique to the individual experience but with universality' (Doyle 2008:502). It has been suggested that survivorship begins at diagnosis and continues through three seasons: acute, extended and permanent (Mullan 1985) and people with a history of cancer live in the ambiguous liminal space between the well and the sick (Little et al 2000). In light of this literature, the transition to premature fatherhood was acknowledged as being a process that mirrored the 'three seasons': the acute phase of labour, birth and initial admission to NICU; the extended phase of being on NICU; and the permanent phase following discharge home.

In a similar way to cancer survivorship, premature fatherhood is a life-changing experience that has positive and negative aspects and involves sustained

uncertainty. The research exploring premature fatherhood has not, to date, alluded to cancer survivorship literature. Reviewing this literature explicated particularly by a grounded theory 'living on hold' (Sandgren et al 2010), enhanced the conceptualisation of the properties of the category **negotiating boundaries**: **total trusting** and **façading**. The theory of 'living on hold' explains how patients and relatives manage the palliative cancer care experience at home (Sandgren et al 2010). The palliative care stage of the cancer journey is profound and involves being in a waiting mode replete with uncertainty and a fractured normality and resonates with preterm father's experience. Preterm fathers in the study were waiting for an outcome which was framed by uncertainty and a change in how the expected transition to becoming a family was envisioned. In the situation of palliative care, the extent and degree to which patients with a serious illness engage in care getting activities in order to cope with their 'illness journey' has been presented as a model (Sandgren et al 2010). This care-getting model defines three modes of living on hold and the strategies aligned to each of them: Fighting mode (renormalizing, rebelling, blaming, foreseeing, scrutinizing, fighting evaluating); Adjusting mode (moment-living, disease diminishing, façading, adjusted evaluating); and Surrendering mode (total trusting, releasing control, surrendered evaluating).

In palliative care, total trusting is achieved when the patient and family have accepted, rather than resigned themselves to living on hold and they rely on others to manage the illness journey for them (Sandgren et al 2010). Patients and family members release control of trying to maintain normality and surrender to the unknown and uncertain situation. Totally trusting the professionals to act in their best interests and submitting control to healthcare professionals engenders feelings of safety and security. However, the paradox is that the patient and family may consider that they have relinquished the right to be involved in care decisions and acknowledge a reluctance to complain about the care given (Sandgren et al 2010). Preterm fathers in the study experienced similar challenges in being unable to express concerns about the medical and nursing care provided to their preterm baby. Although reference to the cancer survivorship literature is helpful in explicating total trusting, the concept of trust in healthcare relationships presents a deeper understanding of how the strategy of **total trusting** was enacted by preterm fathers in the study in negotiating the boundaries of premature birth.

6.8.1. The concept of trust in healthcare relationships

The relevance of healthcare professionals' personality and professionalism (Gilson 2006, Hall 2006) and the central component of trust which is relational and based on context-sensitive interpersonal interactions (Calnan and Rowe 2006) have been acknowledged in the adult patient literature. Extensive research with parents of chronically ill children (Robinson 1996) and families with an adult member with cancer (Thorne and Robinson 1989) provide an explanatory framework for explicating how trust evolves in three stages (safekeeping, disenchantment and guarded alliance) during healthcare relationships in chronic illness (Robinson 2016). Trust was particularly significant in the context of the preterm situation in the study due to the nature of preterm illness: chronicity; uncertainty related to outcomes; and the reliance on healthcare providers for an extended period of time. The interactional patterns in healthcare relationships are relational and consequently influenced by the behaviours of the patient/family and healthcare providers.

Guarded alliance conceptualises the interaction of trust in healthcare relationships and is pertinent to the strategy of **total trusting** (section 5.4.1:110) exhibited by preterm fathers in the study. During the acute phase of the preterm illness trajectory (preterm labour, birth and initial admission to NICU), fathers entered the first stage of the healthcare relationship, described as safekeeping, in which trust is termed as naïve (Robinson 2016). Naïve trust is seen as imperative to easing the uncertainty associated with a lack of knowledge about the situation. This notion of safekeeping has resonance for the study, in that preterm fathers acknowledged the NICU as a safe space. Although it can be argued that naïve trust can invoke passivity, preterm fathers moved from naïve trust to informed trust within a few days of admission to the NICU. This evolution of trust is reflected in the provision of intense medical care and is built on the nurses' relational stance (Robinson 2016).

In the study, the temporal dimensions of the evolution of trust meant that preterm fathers moved from stage one of the evolutionary development of trust in a timely way and, in the situation of very premature birth, moved onto stage three very quickly. In the situation of a late preterm baby, preterm fathers remained in the safekeeping phase during the shorter stay on NICU. In the study, the disenchantment associated with stage two was rarely and transiently experienced

and stemmed from perceptions by the fathers that the physical and emotional needs of his family were not being effectively met.[81]

Stage three is conceptualised as both an alliance which is 'conditional and guarded' and in chronic illness involves the establishment of relationships with selected healthcare providers (Robinson 2016:7). In the preterm situation, the opportunity for parents to select who will provide healthcare to their preterm baby is restricted by the organisational structures and processes of the NICU environment (DH 2009, NHS Improvement 2017). However, through communication with healthcare staff, the development of interpersonal healthcare relationships and observation of nurses' care giving approach, preterm fathers in the study were reassured of the integrity and competence of healthcare providers to effectively care for his family.

The relational stance of healthcare providers in fostering trust and competence include 'the curious listener, the compassionate stranger, the non-judgemental collaborator and the mirror for family strengths' (Robinson 2016:9). Preterm fathers in the study acknowledged the significance of all four attributes in contributing to their evaluation of neonatal staff that they trust. The degree of compassion and effective listening styles of favoured nurses had particular resonance for them (figure 5.3:114).

In the study there appeared to be a contextual factor of gender that influenced the type of relationship predominantly favoured by preterm fathers. The four relationship types of hero worship, resignation, consumerism and team playing attributed to guarded alliance, relates to the degree of trust (from low to high) in a family's own competence and that of the healthcare provider (Thorne and Robinson 1989). Preterm fathers in the study favoured the hero worship relationship, in which there is a high level of trust in the competence of, not only healthcare providers, but also his partner and lower levels of trust in his own need to demonstrate competence in managing illness problems. Preterm fathers were therefore placing their trust in two 'heroes': neonatal staff and their partner, which provided for a degree of security. As a result of competing time pressures associated with work commitments particularly, preterm fathers ensured the continuity of effective care to their baby

[81] An example of this in the study was the lack of communication experienced by the parents perinatally, between the obstetric and midwifery staff and the NICU staff

during NICU and following discharge home by **deferring to others** and **safeguarding the mother-infant dyad**

However, this reliance on the hero worship relationship resulted in preterm fathers in the study encountering a significant increase in uncertainty once their baby was discharged home (Rowe and Jones 2010, White, Gilstrap and Hull 2017). The importance of continuing a guarded alliance can be seen in preterm fathers appreciating the support of community-based neonatal staff. However, following the transfer of care from neonatal focused community staff to community Health Visiting staff, preterm fathers experienced uncertainty in the ability of community staff to competently provide the specific information and support they needed. Discharge home was then experienced as an unsafe and uncertain situation.

The importance of conceptualising discharge from NICU to home as a continuation of the preterm experience, as opposed to being considered as achieving a discrete organisational marker (White, Gilstrap and Hull 2017:114), is reinforced from the findings of the study. The medical, social and personal sources of uncertainty in the preterm situation continued following discharge. Preterm fathers in the study acknowledged temporal uncertainty in terms of defining when their baby was no longer considered as a preterm baby and lamented the lack of a trusting relationship fostered between parents and competent healthcare professionals following discharge. The relevance of the team playing relationship, aligned to reciprocal trust, for parents with chronic illness has been explicated (Giambra et al 2014, Robinson 2016) but has only recently been explored in the preterm literature (White, Gilstrap and Hull 2017). However, the substantive theory of **moratorial fathering** challenges one aspect of the relevance of the theory of trust in healthcare relationships, which is the framing of the continuum of competence from low to high. **Safeguarding the mother-infant dyad** seemed to preclude preterm fathers from developing their paternal competence and altered the dynamic of the healthcare relationship. Consequently, paternal behaviours remained in abeyance during the NICU admission, but then needed to be enacted following discharge home.

The stress and uncertainty that is associated with crossing care boundaries is recognised but has historically been viewed in the context of major events such as discharge (Haggerty 2012). In the context of premature fatherhood there are

multiple care boundaries that fathers have to negotiate such as the premature birth, the NICU admission, the addition of or reduction in medical interventions and clinical support, moving to a different nursery once a change in the baby's clinical dependency triggers less surveillance, and discharge home. These multiple care boundaries require preterm fathers to accommodate the uncertainties experienced during each transition, in addition to negotiating the related dynamic interpersonal relationships with his partner, baby and healthcare staff.

6.9. Moratorial fathering in the context of communication theory

The importance of effective communication and information sharing by healthcare professionals has been demonstrated to enhance patient's understanding of the antecedents of uncertainty (Mishel 2014) and to foster patient and families' trust and confidence in the healthcare professionals' abilities to provide skilled and safe care (Santacroce 2000). Preterm fathers perceive healthcare professionals as credible information providers (Bry et al 2016, Thiele, Knierim and Mader 2016) and support a reduction in uncertainty by demonstrating clinical expertise in caring for their sick preterm infant. This was demonstrated by preterm fathers in the study enacting **total trusting** (section 5.4.1:110) and explains the imperative of the nurse-parent interaction in reducing uncertainty. This reduction in uncertainty is sustained for the duration of the NICU experience, unless there is an unexpected change in the baby's clinical condition. Faced with this new event, preterm fathers experienced an increase in uncertainty again with the need to reappraise the situation (section 5.5.3:142). These sources of uncertainty were perceived by preterm fathers as the 'ups and downs' of the NICU experience and described as a rollercoaster by Eric in the study and in other studies of first-time term fathers (Asenhed et al 2014) and NICU parents (Stacey, Osborn and Salkovskis 2015).

Credible authority, social support and education (defined as structure providers by Mishel 2014) can be used by individuals as resources to enable them to interpret and understand the situation and cope with uncertainty. Social support provided by friends, family and those living through similar experiences has been recognised as positively informing life course transitions and is integral to 'enhancing health and promoting well-being' and supporting the individuals' ability to parent (Bennett 2017:12). For fathers in the study, the inability of family and friends to provide them with social support was due to unfamiliarity with the premature experience.

However, the social support provided by healthcare professionals was then deemed to be crucial (Koliouli and Gaudron 2018). Particularly relevant for preterm fathers, was also the shared meaning of preterm related events and the baby's developmental progress compared with other families of preterm infants.

The components of uncertainty theory have been extended through research in a variety of contexts (Mishel 2014), with the understanding of the use of coping strategies to manage the uncertainty further advanced through the contribution of communication and uncertainty management theory (Brashers, Goldsmith and Hsieh 2002). It is acknowledged that uncertainty can be 'multi-layered, interconnected and temporal' (Brashers 2001:481) and therefore the responses of an individual to concurrent multiple sources of uncertainty, and how appropriate and effective they are, will depend on the context and situation (Babrow, Kasch and Ford 1998). The importance of communication in the appraisal of uncertainty is seen to be central and provides the means by which the uncertainty is understood and then managed.

Inherent to appraisal is the need for information. Preterm fathers in the study appraised and reappraised the sources of uncertainty during the preterm experience and used the main strategy of **surveyancing** to manage these (section 5.5:132). This explains why preterm fathers continued with **vigilant attending** following discharge home and also explicates the range of emotions experienced by them during this time. The emotional response to the labour, birth and initial NICU admission (the acute phase of the preterm experience) was appraised as danger and therefore experienced as fear, stress and anxiety (Chiara et al 2016). Fathers then continued to seek information about their baby's clinical condition, a problem-focused coping strategy that has been recognised in another study as associated with the preterm father role during the extended period of the NICU admission (Matricardi et al 2012).

Preterm fathers in the study continued to enact the coping strategy of **trenchant monitoring** (section 5.5.2:138) during the NICU admission and following discharge home. This strategy served to provide a way for preterm fathers to manage the sustained medical uncertainty in this context. Although the nature of the information causes fear and anxiety, it also provided an instrumental and rational way of coping

with sustained uncertainty. Information-seeking behaviour, such as using the internet, is seen by parents as actively engaging in care giving (Rouck and Leys 2012). Although the internet, as a health information and communication channel, was not highlighted in the study, preterm fathers enacted **trenchant monitoring** as a means by which they secured information in order to contribute to the care of their baby.

The preterm context is inherently uncertain and preterm fathers in the study responded to this by acknowledging the chronicity of the situation and the need for endurance (section 5.4.4:126). Seeking and avoiding information has been presented as a way in which uncertainty is increased, decreased or maintained (Brashers 2001). For preterm fathers, information seeking was seen as a way to comprehend the multiple sources of uncertainty in the preterm situation and to readily have the knowledge needed to be involved in any decision-making concerning the care needs of their baby. The main source of uncertainty alludes to the clinical/medical uncertainties of his partner and baby and through the reappraisal of the situation secured though **vigilant attending** (section 5.5.2:138 and section 5.5.3:142) preterm fathers were able to make corresponding behavioural responses.

Structure providers influence the appraisal process by acting as sources of information (Mishel 2014) and neonatal staff act as a conduit of information, directly or indirectly providing information, evaluating or buffering information. The availability of and the ability to secure and evaluate information is contingent on the cognitive capacity and the associated expectations of the social role of the individual. Communication between the neonatal staff and parents is crucial in enabling parents to understand the preterm illness trajectory and the position of their baby on this path. In this context, illness relates to the family's experience of the sickness as opposed to the medical definition of the disease or condition (Robinson 2016). In relation to the preterm situation: the disease course describes the biomedical condition of the mother or preterm baby; the healthcare trajectory identifies the healthcare interventions needed to manage the disease course; and the sickness trajectory relates to the emotional state of the parents (De Rouck and Leys 2011:63). The concept of information behaviour (information sources and information use which can be passive or active) of preterm parents is suggested to

be mediated by the illness trajectory (De Rouck and Leys 2011). In the study, the information behaviour of preterm fathers was enacted through the problem focused strategies of **surveyancing** and **total trusting**.

The complementary nature of communication of parents with nurses and doctors highlights how medical staff inform parents about the medical condition and treatment, whereas nurses provide more emotional support in enabling the fulfilment of their role as parents (Wigert, Dellenmark and Bry 2013). The physical presence of nurses by the cot side provides parents with more opportunities for communication and information seeking from this specific professional group and acknowledges the importance of the parent-nurse relationship (Mok and Leung 2010, Reis et al 2010). This finding from other studies was articulated by preterm fathers in the study and was particularly pertinent to fathers due to work commitments, limiting the available time for them to have a presence on the NICU. Fathers relied on the communication with nurses as a source of emotional support as well as providing health related information. The importance of informational, management and relational continuity in hospital and following discharge home has been acknowledged (Zanello et al 2015). However, the NICU organisational constraints of staff numbers and shift changes result in a lack of staff continuity which impedes communication and information sharing (McGrath 2001). Fathers in the study affirmed the importance of this parent-nurse relationship and not knowing from day to day which nurse would be caring for his baby acts as a continual source of uncertainty in the NICU. In addition, fathers particularly emphasised the role of nurses' personalities in facilitating the reduction of uncertainty for that shift. Fathers were reassured when a nurse they have confidence in to provide effective and emotional care to their baby, was allocated to care for their baby for that day or night.

For preterm fathers, **trenchant monitoring** (section 5.5.2:138) was a way of attributing meaning to medical and care-related events through the preterm illness trajectory and following discharge home. Preterm fathers sought alternative service providers to counteract these continued uncertainties. The support from family members was appreciated but was conditional on their personal experiences of term babies and preterm fathers therefore experienced incongruence with family and friend's experience of fatherhood. Formal programmes of peer to peer support by

‘veteran’ NICU parents has been presented as a well evaluated form of support for preterm parents (Levick, Quinn and Vennerma 2014, Hall et al 2015) but this service was unavailable on the research site for the study. However, in the study, informal peer support was noted to be important for fathers in being able to share the preterm illness journey with others experiencing the same situation; an aspect of communication that has been addressed in very few research studies in the preterm father literature (Sisson et al 2015). However, in the study the support provided by other preterm families following discharge home appeared to be more salient for mothers than for fathers.

The gendered aspect of parenting for preterm fathers relates to them appraising and rationalising the situation. **Vigilant attending** (section 5.5.2:138 and section 5.5.3:142) incorporated the strategy of monitoring the mother and baby in NICU and following discharge home. It was a way of continually appraising the situation to manage the uncertainty of being a parent to a preterm baby. Gathering information was a key strategy for keeping track on the progress of the family’s welfare and reducing the uncertainty associated with the preterm illness trajectory. Preterm fathers engaged in probabilistic thinking in which certainty was no longer a part of family formation, but replaced with the sustained uncertainty of premature fatherhood.

NICU can be seen to be a space of caring for the family but also as a community of shared suffering and support involving parents and neonatal staff. Some preterm fathers in the study gained solace from speaking to other fathers on the NICU, whilst others preferred to use their personal friendship ties for support. The neonatal staff became agents in supporting preterm parent’s transition and as experts they were perceived as having credible authority and could impart knowledge and information related to caring for a preterm baby. To some extent the neonatal staff were therefore considered as displacing the role of families and friends in providing advice and support for the new parents. This support was appreciated as a ‘cosy blanket’, a ‘safety net’ and then following discharge there was a sense of betrayal and having to take sole responsibility for the baby which had, up to that point, been shared with healthcare professionals. Following discharge home, the effects of the NICU admission meant that life needs readjusting again from living a life polarised by the

preterm baby in hospital to shifting the central focus away from the premature experience and accommodating the family's needs in the home environment.

Summary

This chapter presented the emergent substantive theory informed by three main theoretical contributions: situated fathering; boundary ambiguity; and uncertainty in illness. **Moratorial fathering** is the core category for understanding the social process of transition to premature fatherhood. The major category of **negotiating boundaries** explains why preterm fathers' role is in abeyance and the major category of **surveyancing** explains how fathers manage the uncertainties of the preterm situation. The theory is presented as a diagram in figure 5.5 (see page 153) and demonstrates the interrelationships of the categories. The theory of **moratorial fathering** offers a conceptualisation of space as a factor in preterm fathering and relates to how men experience becoming a preterm father in the social, physical and abstract space of NICU. Premature birth disrupts the expected timing for making the transition to becoming a father and results in an ambiguous identity and diffusion of responsibilities with healthcare staff in caring for his preterm baby. The theory focuses on the sociological response to event familiarity and identifies the temporal, aetiologic, situational and biographical sources of uncertainty inherent in the preterm situation.

It has been acknowledged that parenting is spatial (Jupp and Gallagher 2013) and that physical space is an important contextual influence on shaping a father's identity (Marsiglio, Roy and Fox 2005). The admission of their preterm baby to a NICU altered both the usual spaces and practices of being a parent and restricted and limited the extent to which preterm fathers in the study were able to fulfil the expected dimensions of parenting. The NICU therefore acts as a socially specific context in which premature fatherhood is situated. This contrasts with the way in which the cognitive, emotional and behavioural skills of parenting are normally developed in the private domain of the home environment. The physical spaces of NICU convey the seriousness of the baby's clinical condition through the degree of technology and number and seniority of nursing staff supporting the baby. The technology symbolically represents (Barbard and Sandelowski 2001) the severity of the illness, measuring the baby's vital signs and acts as a barometer for changes in the baby's clinical condition, as well as the degree of danger (Pohlman 2009,

Provenzi and Santaro 2015, White, Gilstrap and Hull 2017). The clinical vulnerability of the preterm baby additionally inhibits preterm fathers' opportunities for close proximity with their baby.

The pregnancy foregrounds men's understanding of and preparation for fatherhood which is cut short by a premature birth and disrupts the process. Prematurity delays the ability of the father to form a connection with their preterm baby and establish their sense of self as a father. Following a premature birth, fathers in the study were beginning to comprehend a transition to a novel way of fathering which did not match their provisional identity standard. The NICU acts as a situated context in which the father role is uncertain, neither consistently confirmed nor affirmed. The temporal dimension of prematurity results in a state of being in abeyance and, although this provides time and space to come to terms with fatherhood, it results in an ambiguous identity. Fathers who participated in the study therefore appraised the situation and used strategies to align their behaviour to match the situational role expectations. The strategies of **standing aside**, **gendered caring** and **safeguarding the mother-infant dyad** affirmed the mother's identity while sustaining a viable self in an uncertain, novel and stressful situation.

Transition theory had the potential to provide strong analytical purchase during the process of developing theoretical sensitivity in the study. The essential properties of transition experiences have been identified as 'awareness, engagement, change and difference, time span and critical points and events' (Meleis et al 2000:5). Evaluating the nature (types, patterns and properties), conditions (facilitators and inhibitors) and patterns of response (process and outcome indicators) to multiple and complex transitions, such as premature fatherhood, enabled substantive codes to be defined as categories (section 4.6.4).

Drawing on the anthropological work of Van Gennep (1960) and Turner (1969) the transition to term fatherhood during pregnancy and birth has been considered as a transition or liminal stage (Draper 2003). Van Gennep (1960:vii) analysed human beings' life crises and identified that there are ceremonies within traditional societies that have associated activities which are common across societies, a pattern he termed 'rites of passage'. These rites of passage occur regardless of the event and have three distinct phases: separation, transition or limen and incorporation. The

framework of ritual transition theory had relevance in highlighting activities associated with pregnancy and child birth for fathers and illuminated the differences in the activities of preterm fathers in the study. Ambiguity and uncertainty are properties attributed to being in a liminal space between two identifiable states: a former identity and future identity.

However, preterm fathers in the study experienced a transition to an unidentifiable moratorium state framed by novel identity standards rather than a transformational change from one identity to another. Premature fatherhood presents both a situation and a role where there is a lack of normative expectations. The roles, rules and boundaries of premature fatherhood are understood in the context of the uncertain, medicalised and technological space of the NICU. Men therefore need to create identity standards from their own and others' expectations of what they ought to do in this unexpected and unfamiliar situation. The expectations of his partner and healthcare professionals influence men's actions following the premature birth of their baby. Feedback from others and the nature of the relationships in the social interactions on NICU influenced the way preterm fathers in the study reacted cognitively, affectively and behaviourally. They negotiated the ambiguous boundaries of premature fatherhood and attempted to make sense of their novel emerging identity.

The context of the NICU environment therefore provides the boundaries for different forms of interactions. The NICU acts as a locus for the transition to parenthood and, as such, the pattern of meaning of prematurity for men is understood through communication and interaction with the NICU environment and neonatal staff, as well as his partner and baby. Boundary ambiguity (Boss and Carnes 2012) results from the diffusion of parenting responsibilities between healthcare professionals and preterm parents and the paradox of physical and psychological presence and absence of the preterm baby in the family. The sense of inhabiting two spaces (NICU and work/home/social) contributes to preterm fathers experiencing time as moving on. However, they are standing still with regard to fully enacting their parental role in the early formation of their family, which is occurring in a challenging situation. The NICU limits the opportunities for preterm fathers to engage in anticipated family social interactions and to demonstrate actions that present a display of family (Finch 2007). The uncertainty of premature birth results in a suspension in the new family

being able to reorganise roles, rules and rituals and in response preterm fathers in the study enacted the strategies of **gendered caring** and **safeguarding the mother-infant dyad**. Managing the activities related to NICU, family life and work commitments results in preterm fathers having to negotiate boundaries in terms of both space and time. In securing the provision of quality care for his baby, preterm fathers in the study deferred to and placed their trust in two 'heroes': neonatal staff and their partner. However, the reliance on the hero worship relationship (Robinson 2016) resulted in preterm fathers in the study encountering a significant increase in uncertainty once their baby was discharged home.

The substantive theory from the study emphasises how sources of uncertainty emanate from unfamiliarity with the preterm situation, particularly the NICU environment. Preterm fathers experienced this environment as novel and unfamiliar and therefore appraisal of the situation could only be inferred from contextual cues. The fathers in the study relied on structure providers (Mishel 2014) such as other preterm fathers offering social support and those with credible authority, particularly nurses, to make sense of the uncertain situation. Premature birth, by its nature, increases the degree of medical intervention and clinical surveillance of both mother and baby. Preterm fathers in the study experienced heightened concern for their partner and baby, appraising the situation as one of danger. They therefore **deferred to others** and enacted the strategy of **vigilant attending** to secure and monitor safe, effective care for their partner and preterm baby. The contextual perspective of situated fathering in NICU provides a way of understanding how preterm fathers transition through the uncertainties of prematurity.

Uncertainty in illness theories have been shown to be relevant for both patients and their families experiencing a significant illness (Mishel 2014). **Moratorial fathering** acknowledges the three dimensions of uncertainty: 'its multi-layered nature; the ways in which uncertainties are interconnected; and the temporal dimensions of uncertainty' (Brashers 2001:481) and recognises that preterm fathers are enduring sustained uncertainty through a life course transition. The substantive theory articulates the problem-focused coping strategies (**total trusting**, **standing aside**, **trenchant monitoring** and **taking stock**) and emotion-focused coping strategies (**promoting mothering**, **façading** and **soldiering on**) used by men in the study

during the process of accommodating the uncertain preterm situation in the biography of their transition to premature fatherhood.

The NICU is the source of medical, personal and social uncertainties and inhibits and constrains preterm fathers in their ability to demonstrate the behaviours anticipated and expected of a new parent. The importance of communication in the appraisal of uncertainty is central and provides the means by which uncertainty is understood and managed. Preterm fathers in the study appraised and reappraised the sources of uncertainty during the preterm experience and used the main strategy of **surveyancing** to manage these. Neonatal staff act as a conduit of information, directly or indirectly providing information, evaluating or buffering information. They support preterm parent's transition and to some extent displace the role of families and friends in providing advice and support for the new parents. In enduring sustained uncertainty, continuous appraisal of the preterm situation rendered the fathers in the study as experiencing a life on hold. Preterm fathers in the study were waiting for an outcome framed by uncertainty and a change in how the expected transition to becoming a family was envisioned.

Moratorial fathering offers a new way of conceptualising premature fatherhood and acknowledges that neonatal care provision needs to accommodate the specific needs of fathers. The NICU acts as a novel and uncertain space of parenting with preterm fathers experiencing sustained disconnection and lack of close proximity with their baby, a delay in enacting parenting dimensions, role ambiguity and sharing the family boundary with healthcare professionals which presents a diffusion of responsibilities. The theory focuses on the sociological response to event familiarity. It identifies the sources of uncertainty inherent in the preterm situation and the problem-focused and emotion-focused coping strategies enacted by preterm fathers in the study.

Uncertainty in illness theories have been used in studies on family experiences of children's illness and paediatric and adult intensive care (see page 159) but is absent from the neonatal intensive care literature. A review of the literature identified a master's degree dissertation that used uncertainty in illness theory as the theoretical framework for understanding fathering in neonatal intensive care (Golberg 1999). The findings from this study reflect the context of neonatal care at

the time and proposed that preterm fathers experience an uncertain present and uncertain future. No further publications could be found from this study. The next chapter presents the limitations of the substantive theory of the study and outlines the implications for clinical practice, education and research.

Chapter 7: Limitations and implications for practice

7.1. Introduction

The study was undertaken by a researcher new to grounded theory, who is a neonatal nurse and mother of preterm twins. Recruitment of participants relied on busy neonatal staff approaching fathers during the emotional and distressing time of admission to the NICU. Over one hundred letters of introduction and participant information sheets were distributed, but over the course of the study only seven men indicated their interest, and subsequently gave consent to be included in the study. The methodological limitations of the study in terms of participant numbers, biographical profile, gestational age, location of the study to one geographically specific NICU and the exclusion of the views of neonatal staff will be discussed.

7.2. Limitations: lack of neonatal nurses' views

The focus of the study was to explore how fathers transition to parenthood when their baby is born preterm. The important role of the neonatal nurse is acknowledged, but due to the paucity of literature on premature fatherhood, the study focused solely on the experience of men becoming a father of a preterm infant. The important role of the neonatal nurse in preterm father's experience of the NICU, however, was also demonstrated.

Managing uncertainty is not only relevant to preterm parents but has also been considered in relation to neonatal nurses. The preterm experience, particularly the NICU, provides a context which is bound by sustained uncertainty for everyone involved. For neonatal staff the clinical uncertainty of the preterm infant's illness is experienced on a daily basis. The main cause of uncertainty in clinical practice for nurses is suggested as being the unclear domain of practice. Nurses use the strategies of 'losing sensitivity' and 'avoiding trouble' to mitigate against uncertain situations and reduce the psychological responses to uncertainty such as agitation, fear, frustration and anger (Vaismoradi, Salsali and Ahmadi 2011:995). In recognising and responding to uncertainty, nurses display four process actions: 'assessing; reflecting; questioning; and being unable to predict' (Cranley et al 2012:152). Nurses manage uncertainty either autonomously, collaboratively or by seeking evidence, which leads to three consequences: resolving uncertainty;

experiencing a lingering doubt; or embracing uncertainty as a learning opportunity. The level of clinical experience of the nurse influences how uncertainty is managed and is reflected in the confidence of the nurse in using the four actions to resolve uncertainty. Interestingly, embracing uncertainty as a learning opportunity provides a feedback loop to the four actions (Cranley et al 2012) and further supports the evidence that suggests managing uncertainty is a dynamic process (Cohen 1993).

Neonatal nurses hold a high level of event familiarity and cope with sustained uncertainty by 'balancing hope with reality' (Green et al 2015). Hope promoting strategies offered by neonatal nurses to parents in this study were tempered by their clinical knowledge and experience of the likely progress and outcomes of preterm infants of different gestational ages. Neonatal nurses therefore support parents of extremely preterm infants to manage one day at a time rather than focusing on the future survival and outcome of the baby, which is inherently uncertain. The importance of developing a trusting nurse-parent relationship to support parental, realistic hope is highlighted (Green et al 2015). The NICU context influences the closeness of nurse-parent relationships with the interaction contributing positively or negatively to parental coping strategies (Fegran, Fagermoen and Helseth 2008). Parents in assessing the competence of the neonatal nurse give greater salience to the demonstration of caring behaviours, in addition to appraising their knowledge and skills (Cescutti and Galvin 2003). The nurse's role in achieving a successful partnership with parents includes: informing parents; making parents feel welcome; making involvement a process; influencing the future of the family through partnerships; empowering parents; and moving from caring to coaching (Thiele, Knierim and Mader 2016).

Neonatal nurses' behaviours that meet parental needs[82] include: emotional support; parent empowerment; a welcoming environment with supportive unit policies; and parent education with an opportunity to practise new skills through guided participation (Cleveland 2008). The importance of the nurse-patient relationship to the patient experience has been highlighted and is negotiated and dependent on time, the degree to which the patient engages in the relationship and the degree of

[82] Accurate information and inclusion in the infant's care; watching-over and protecting the infant; contact with the infant; being positively perceived by the nursing staff; individualised care; and a therapeutic relationship with the nursing staff

commitment of the nurse to the patient (Morse 1991). The various types of patient-nurse relationships have been suggested, such as a clinical relationship, a therapeutic relationship, a connected relationship and an over-involved relationship. The term 'commitment is offered as a more appropriate term than caring' when exploring the role of the nurse in the patient-nurse relationship (Morse 1991:467). A model of negotiated partnership presents the role of the neonatal nurse as 'teacher, guardian and facilitator' (Misty et al 2010:679). Through the nursing actions of 'perceptive engagement, cautious guidance and subtle presence' an effective and collaborative relationship is established, which is central to the experience of preterm parents in the NICU context (Misty et al 2010:678). The fathers in the study highlighted the reassurance provided to them in having an experienced, competent and caring nurse allocated to their baby and how **total trusting** helped them cope with uncertainty.

Nurse-parent relationships are influenced by the premise of working in partnership with parents to care for the neonate (Fegran and Helseth 2009) and require neonatal nurses to balance personal and professional approaches to these interactions. From the study, it is acknowledged that preterm fathers appreciated the personal dimensions of the nurse-parent relationship, in addition to the professional approach. Although neonatal nurses recognise the importance of developing a close, trusting relationship with parents, this is considered a challenging aspect of the healthcare professional's role which can lead to compassion fatigue and burnout in both nurses (Sorenson et al 2016) and neonatologists (Weintraub et al 2016). The emotional labour of neonatal nursing (Cricco-Lizza 2014) and the presence of moral distress (de Boer et al 2015) has also been highlighted. Therefore, neonatal nurses carefully manage the balance between interacting in a personal and professional way, between closeness and detachment (Fegran and Helseth 2009). Fathers' perceptions of the support provided by neonatal nurses have been found to be high for the four aspects of functional social support: instrumental, emotional, appraisal; and informational. However, emotional support scored the lowest in the four domains (O'Brien and Warren 2014).

7.2.1. Limitations: methodological constraints

There are methodological limitations to the study, which include the chief investigator being new to grounded theory, the biographical profile and small

number of participants, the range of gestational ages of the infants and the location of the study to one geographically specific NICU.

The experience of preterm fathers was located in one particular NICU. The culture of this NICU may not be reflective of all NICU's nationally or internationally and this will have influenced the context in which the participants experienced premature fatherhood (Wilson, McCormack and Ives 2005, Spence and Lau 2006, Mahl et al 2015). The small sample size, biographies of the participants and the gestational age of their infants limits the transferability of these findings. The participants were white, heterosexual, in established relationships (either married or engaged), of a similar age (30-45) and were supporting the family financially during the admission to NICU and following discharge home. Further research involving ethnically diverse, young, unemployed, single, gay or transgender fathers would further explore the theoretical reach of **moratorial fathering**. The study had ethical approval to include participants from sixteen years of age, but it is acknowledged that a more tailored approach would be needed to recruit this age group.

The infant's gestational ages ranged from 24 to 34 weeks and the degree of sustained uncertainty experienced by the participants was reflected in the gestational age of their infant. Fathers of more preterm infants were managing high levels of sustained uncertainty. In comparison, fathers of less preterm infants experienced a lower degree of uncertainty and a reduced length of time on the NICU. Separate research studies involving a greater number of fathers with preterm infants 23 to 30 weeks and those with infants 30 weeks to 35 weeks would enhance an understanding of the extent to which **moratorial fathering** is relevant for less preterm fathers.

The transferability of the findings to countries outside of the UK would need to be considered in light of the context of UK neonatal services and the context of the local NICU. However, the findings from research conducted in other countries resonate with elements of the grounded theory of **moratorial fathering**. For example, a Brazilian qualitative study interviewing eight preterm fathers following discharge (Marski et al 2016:203-206) identified three themes: fatherhood boundaries (negotiating a father presence and understanding the NICU context); high responsibility for the child (accountability and monitoring the quality and effectiveness of healthcare); and social network and support (honest and clear

information and seeking social support from family and friends). These findings may be re-evaluated by considering uncertainty in illness theories to further illuminate the experiences of preterm fathers during the NICU admission and following discharge home in non-UK countries.

7.3. Implications for neonatal practice

Many forms of uncertainty are experienced by preterm fathers during the labour, birth, NICU admission and discharge home of their preterm infant. Articulating the nature of these uncertainties serves to inform healthcare professionals' understanding of how men experience the transition to premature fatherhood. It is suggested that 'uncertainty is multi-layered, interconnected and temporal' (Brashers 2001:481) and will result in varied responses by individuals in different contexts and situations. The multidimensionality of experiencing uncertainty is not only biographically individual but may also be 'socially shared' (Cohen 1993:79). The appraisal of a situation informs the emotional responses to it (Mishel 2014) and subsequent demonstration of uncertainty management strategies. The sources and consequences of uncertainty and the strategies used to manage these for men experiencing the transition to premature fatherhood are varied and are framed by the gestational age of the baby and subsequent length of time on the NICU (Table 7.1).

Table 7. 1 Sources of uncertainty, consequences and management strategies (adapted from Cohen 1993)

Sources of uncertainty	Consequence	Management strategies
Temporal	Being time poor Life is on hold	Organising NICU visits around work and family commitments Acknowledging that time is discontinuous and influenced by the pattern of symptoms of their infant and subsequent medical interventions Enduring sustained uncertainty
Aetiologic, treatment and prognosis of preterm infant	Waiting for an outcome	Anticipating changes to baby's clinical condition Having close proximity to the phone Securing information Comprehending the pattern of symptoms in prematurity Vigilant attending

Sources of uncertainty	Consequence	Management strategies
Situational	Entering an alien world NICU as a safety net/cosy blanket Being discharged home	Encountering and understanding technology Coming to terms with the appearance of their preterm baby Trusting healthcare professionals Establishing a new routine to incorporate the sudden and unexpected early birth of their baby Establishing a new routine and a new family life following discharge home
Biographical	Suspended fathering Shared community Disrupted biography	Safeguarding the mothering role Developing a connection with their baby Sharing the experience with other preterm families Acknowledging that family and friends may not understand the preterm experience Coping with changed and changing circumstances

Parents of children diagnosed with a chronic, life-threatening illness experience a disruption to and a change in their sociocultural reality (the cognitive world of knowledge, beliefs, values, expectations) and the biographical reality (the action world of routines, behaviours, events, relationships) (Cohen 1993). In order to manage the sustained 'temporal, aetiologic, treatment, prognostic, situational, biographical and social uncertainties, parents manage time, social interaction, information, awareness, the illness, and the environment' (Cohen 1993:83). Similarly, preterm fathers in the study utilised strategies to manage sustained multiple uncertainties and the findings contribute to the literature on the study of uncertainty as a dynamic process, rather than being linear and as a response to a single or short-term stimuli.

The human response to experiencing uncertainty is normally one of 'discomfort as their usual way of being is disrupted' (Penrod 2007:661). In managing fluctuating uncertainty, continuous appraisal of the situation renders the individual as being in 'a present-oriented state of being' (Penrod 2007:661) and as 'living one day at a time' (Charmaz 1991, Kahana et al 2009). Cognitive, emotional and behavioural strategies to manage the uncertainty and discomfort (Penrod 2001) interact over time to alter the individual's sense of 'confidence (reflecting issues of meaning)

and/or control (reflecting issues of outcome) and results in a present-focused temporality' (Penrod 2007:664).

The importance of optimising the time that the father has with his preterm infant may result in the need for care interventions to be arranged when the father can visit such as early mornings. This may also include offering the father time for skin to skin when the father is present even if care interventions are not scheduled to occur. This would need to be considered on an individual basis and would be dependent on the clinical condition of the baby.

There are a number of uncertainty management strategies used by men to manage the sustained uncertainty of premature parenthood. One uncertainty management strategy is that of communication and information provision. Preterm fathers in the study enacted **vigilant attending** in response to managing uncertainty and to secure a high degree of information related to their partner and preterm infant's welfare. Information management in the preterm situation is relational and collaborative and involves negotiation and coordination (Brashers, Goldsmith and Hsieh 2002) between preterm fathers, his partner and baby, and healthcare professionals. Information may be obtained from healthcare professionals, supportive others (family members, other preterm parents, friends) and mediated sources. Fathers value being provided with high quality information, particularly during the initial admission period to NICU, which is comprehensible, individual to them and conveyed by caring and knowledgeable staff (Modé et al 2014).

In contemporary society, the importance of researching the relationship between consumers and technology, particularly focusing on identity and gender, has been highlighted. This has led some researchers to explore how technology co-constructs and co-emerges with the transition to fatherhood (Bettany, Kerrance and Hogg 2014). The importance of information and communication (ICT) technology in supporting parents of preterm infants has been acknowledged. The information behaviour of preterm parents includes that of mediated sources such as those available online. Uncertainty motivates on-line health information behaviour (De Rouck and Leys 2012) and this has been shown to have a gendered aspect to it (Kim, Garfield and Lee 2015). There is growing interest in the role that the Internet plays in providing healthcare related information and from the findings in the study,

preterm fathers would value an additional source of information as a means of managing the uncertainty of the preterm situation following discharge home. Hospital online resources such as frequently asked questions (FAQs) and advice from experienced preterm father's websites may provide helpful information that is specifically focused on the information needs of preterm fathers following discharge home.[83]

The nature of premature birth as sudden and unexpected is perceived to be a traumatic event and as such exposes preterm fathers to psychological distress. Parents of seriously ill children use information management, both intensive and evasive forms, as a strategy to manage uncertainty (Santacroce 2003). The intensive form, during which information is maximised, has resonance with the hypervigilance symptom of posttraumatic stress disorder (PTSD). The evasive form is similar to the avoidance symptom of PTSD. This has led to an acknowledgement of the theoretical link between parental uncertainty and PTSD (Santacroce 2003) and NICU-induced PTSD (Clottey and Dillard 2013). It has been suggested that mothers of preterm infants experience a greater degree of stress than fathers. However, a meta-analysis has indicated that the stress level between mothers and fathers are similar, with fathers experiencing greater stress in some situations (Schappin et al 2013). The study explicates the sources of uncertainty that may cause stress in preterm fathers and why the effects of this emotional response should be considered by healthcare professionals.

The integral importance of structure providers supporting preterm fathers in their understanding of the stimuli frame of preterm experience is demonstrated in the study. The neonatal nurse acts as a source of information and provides therapeutic support for preterm parents (Neville 2003) and for preterm fathers in the study this enhanced their emotion-focused and problem-focused strategies used to manage sustained uncertainty. Preterm fathers valued information that explicates the symptom pattern of prematurity. Although neonatal nurses are very aware of the need to avoid providing 'false' hope, providing information that serves to reinforce the uncertain clinical progress of the baby, increases the uncertainty for preterm fathers. Neonatal nurses should therefore provide information to preterm fathers that

[83] Many of the available websites currently focus on mothers e.g. MumsNet

reflect the expected clinical presentation of preterm babies based on previous knowledge and experience. This would enable preterm fathers to recognise anticipated or commonly experienced patterns of symptoms in their preterm infant.

The availability of social support for parents is challenged by premature birth (White, Gilstrap and Hull 2017). Preterm fathers in the study identified that social support from healthcare providers and their partner was relatively accessible. However, the support provided by friends and family were notably restricted by a lack of insight into, and understanding of, the preterm experience. The social support provided by families concurrently experiencing a premature birth was highlighted in the study. This was perceived as having both negative and positive facets along a continuum, from sharing the emotional distress of another family's baby deteriorating clinically to sharing the reassurance provided by another family's baby achieving the same developmental milestones in line with their own baby's progress. Neonatal staff in appreciating the social support provided by other preterm families can be aware of the impact this may have if there is deterioration in the clinical condition of that baby. Neonatal nurses also need to evaluate if there are other sources of social support that may be helpful for preterm fathers. For example, offering to explain symptom pattern of prematurity and contextualising event familiarity of the NICU for family members and friends.

It has been suggested that the most important factor influencing preterm parental investment is access to caregiving resources (Burke 1997). Resources include: material (e.g. money); temporal (amount of time available); social (e.g. partner, family support); level of skill (e.g. parenting or child care experiences); and attentional or emotional engagement (may be dependent on parental mental and physical wellbeing). Neonatal nurses have a moral and ethical responsibility (NMC 2015) to support preterm fathers during the stressful and uncertain situation of premature birth (Fegran, Helseth and Slettebø 2006), appreciating the importance of men's access to caregiving resources. The importance of comprehending men's transition to premature fatherhood is also highlighted. It has been suggested that nonrecognition or misrecognition of an identity can be harmful and lead to an individual inhabiting a 'distorted or reduced mode of being' (Bonnette and Broom 2011:262). It is therefore incumbent on neonatal staff to understand **moratorial fathering**, to ensure that both parents are supported through this stressful and

uncertain transition and that there is equal provision of an exceptional high quality standard of neonatal care. Enhancing event familiarity and acknowledging boundary ambiguity may facilitate reductions in uncertainty.

Preterm fathers' individual appraisal and response to uncertainty explains the variance in their transition to premature fatherhood and needs to be acknowledged by neonatal staff. Neonatal staff are key in understanding the nature of uncertainty as a dynamic and temporal process. The baby's characteristics, fathers' coping styles and social support available will contribute to how each individual father will manage the sustained uncertainty of prematurity. In recognising the individuality of managing uncertainty, strategies for supporting preterm fathers are tentatively presented (Box 7.1). These are not considered to be exhaustive or relevant for all fathers. Their effectiveness may also vary. However, neonatal staff may wish to consider using them as part of their 'toolkit' for providing individual care for fathers that is based on assessing individual need over the NICU admission and following discharge home.

Box 7. 1 Strategies for supporting preterm fathers to manage sustained uncertainty

- Facilitate a pre-birth visit to NICU if possible
- Explain the anticipated symptom pattern of prematurity
- Provide on-going, information that is adjusted according to changes in the situation and that acknowledges the individual needs of the father
- Acknowledge sources of uncertainties (temporal, aetiologic, situational, biographical)
- Acknowledge triggers of uncertainty (change in baby's clinical condition, change in clinical dependency, discharge home)
- Explore and sustain the father's individual and unique approach to coping with uncertainty
- Suggest strategies that fathers may find useful in managing sustained uncertainty
- Be mindful of the importance of maintaining trust in the nurse-parent relationship
- Be aware of father's ongoing social, medical or health needs that may affect their ability to manage the sustained uncertainties of the preterm experience
- Signpost fathers to available support services/resources
- Prepare fathers for the continued uncertainty experienced following discharge home

Conclusion

During the three phases of premature fatherhood (pregnancy, admission to NICU and following discharge home) fathers endeavour to assign meaning to events using a number of strategies to address the uncertainty associated with the preterm experience. How preterm fathers manage multiple sources of uncertainty and their responses to it are captured by the concept of **moratorial fathering**. The theory of **moratorial fathering** provides a new conceptual understanding of the sociological process by which men manage the sustained uncertainties of premature fatherhood. Careful empirical research has contributed to an expanding body of knowledge that will inform healthcare practitioner's practice in meeting the needs of preterm fathers. This theory adds to the current understanding of premature fatherhood in a number of ways: by contextualising the event familiarity of the preterm situation; by outlining the gendered approaches to uncertainty management; and through highlighting the uncertainty-based nature of the transition to premature fatherhood. Appraisal of uncertainty during the preterm experience is not a linear process but requires preterm fathers to persistently reappraise uncertainties during the course of the NICU admission and following discharge home.

In recognising that families of preterm infants are enduring uncertainty through a life course transition, there is an increased need for neonatal staff to be skilled in supporting the interaction and relationship of the practitioner and parent in the space that bounds the context of situated fathering: the NICU. In appreciating the concept of negotiating boundaries, neonatal staff can identify how the diffusion of responsibilities in NICU can impact on the family and how uncertainty operates at the level of interaction between the neonatal nurse particularly, and the parents. Identifying the factors that influence the uncertainty of premature birth is imperative in contributing to an understanding of its impact on fathers and illuminates the importance of providing specific support for fathers following discharge home. This understanding may enable neonatal staff to acknowledge and appreciate the role of uncertainty in explaining the social process of becoming a preterm father. The conceptualisation of premature fatherhood provides neonatal staff with the knowledge to reassure fathers that their feelings and behaviours are in response to the uncertainty related to the unfamiliar, novel and stressful situation.

Preterm fathers continuously appraise and reappraise a range of sources of uncertainty during the NICU admission and following discharge home. It is recognised that the interaction of nurses and parents within this sustained uncertainty is complex and contingent on personal attributes. Their role is integral in enabling preterm fathers to become familiar with the event of premature birth and to understand the illness trajectory of their baby. Promoting preterm father's individual emotion-focused and problem-focused strategies will support men to manage the transition to premature fatherhood in ways that minimise the situational uncertainties of prematurity. **Moratorial fathering** explains how men manage the unexpected transition to premature fatherhood and acknowledges how neonatal staff, particularly neonatal nurses, are integral to supporting preterm fathers experiencing the sustained uncertainty of prematurity.

The world stands still ….your life has just stood still until that baby recovers and you come out of this hospital ….(Eric 28/1)

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Appendix i Literature searches

Non-committal literature search	
Rationale	The initial literature search was non-committal and was undertaken to support the research proposal and identify there was a gap in the literature. This search continued during the study in order to remain cognisant of relevant literature in preparation for transfer from MPhil to PhD and when completing the final thesis
Key search terms	Father, fatherhood, fathering, Dad, paternal, men, premature fatherhood, preterm infant, premature infant, neonate, neonatal intensive care, NICU
Databases	CINAHL Plus, British Nursing Index, Health Research Premium Collection, JSTOR, Maternity and Infant Care, OneSearch, PsycINFO, Royal College of Nursing (RCNi), ScienceDirect, Web of Science (WOS), Wiley Online,Google Scholar, ProQuest, Ovid, Scopus
Developing theoretical sensitivity	
Rationale	This literature search was continually undertaken during data analysis to define and refine concepts and categories of the developing theory. Extant literature was used as conceptual levers to facilitate abstraction of the data and to confirm that the developing theory contributed to understanding the transition to premature fatherhood
Key search terms	Father, fatherhood, fathering, Dad, paternal, men, premature fatherhood, preterm infant, premature infant, neonate, neonatal intensive care, NICU, uncertainty, uncertainty in illness theory, communication theory, information sharing, survivorship, boundary ambiguity, healthcare professionals, identity theory, liminality, transition theory
Databases	CINAHL Plus, British Nursing Index, Health Research Premium Collection, JSTOR, Maternity and Infant Care, PsycINFO, Royal College of Nursing (RCNi), ScienceDirect, Web of Science (WOS), Wiley Online, ProQuest, Ovid, Scopus
Situating the substantive theory with extant literature	
Rationale	This focused literature search of extant theory aimed to ensure that the substantive theory did not exist in the published literature and supported the writing up of chapters 6 and 7
Key search terms	Father, fatherhood, fathering, Dad, paternal, men, premature fatherhood, preterm infant, premature infant, neonate, neonatal intensive care, NICU, uncertainty, uncertainty in illness theory, communication theory, information sharing, boundary ambiguity, identity theory
Databases	CINAHL Plus, Health Research Premium Collection, JSTOR, PsycINFO, Royal College of Nursing (RCNi), ScienceDirect, Web of Science (WOS), Wiley Online, ProQuest, Ovid, Scopus
Search strategies	
Boolean operators (AND, OR, NOT) were used to combine terms Truncation was used for father*, neo*, “pre* infant” to ensure that all terms were included Terms were combined in various ways in each database to secure relevant literature Time limits were not used to ensure that all available literature was sourced Search results were saved and updated The facility for viewing similar articles was used, including the “find similar results using SmartText” in EBSCO*host* searches Interlibrary loans were requested when required	

Appendix ii Recruitment Process

Midwifery and NICU staff identified potential participants

Staff provided a letter of invitation to the father and contacted the researcher by mobile phone. As the staff were identifying potential participants the researcher was outside the initial recruitment process which reduced the risk of any coercion

Researcher approached family

A verbal explanation of the study was provided and an opportunity given for the family to ask questions and find out further information about the

Study

Interested fathers given the PIS

Father's interest and acceptance of further information were not seen as consent to participate in the study. The researcher confirmed that accepting this information did not mean implied consent to take part in the study. The researcher's contact details were made available to the father should he have wanted further information

Father returned consent form to researcher

Consent form stored in a locked filing cabinet on University of Brighton premises.

Researcher contacted participant for interview 1

The researcher arranged a convenient date and time for the first interview after 72 hours and within the first 14 days of the infant being on NICU. This was held in a quiet room on NICU and took place during the day, in the evenings and at weekends when the father visited his infant. Willingness to be part of the study was re-affirmed prior to the interview commencing

Researcher contacted the participant for interview 2

The researcher arranged a convenient date and time for the second interview prior to the infant's discharge. From feedback from the parent's forum this was not too close to the actual discharge date as this is both an anxious and exciting time. This was held in a quiet room on NICU when the father visited his infant. Willingness to be part of the study was re-affirmed prior to the interview commencing

Researcher contacted participant for interview 3

The researcher arranged a convenient date and time for the third interview following the infant's discharge home. The arrangement for this interview depended on the participant's preference: face-to-face in a quiet room on NICU or at the University of Brighton; a telephone interview; or by Skype. Willingness to be part of the study was re-affirmed prior to the interview commencing

Appendix iii Letter of Invitation

University of Brighton
School of Health Sciences
College of Life, Health and Physical Sciences

Study title: Transition to parenthood: Becoming a father of a preterm infant on a Neonatal Intensive Care Unit (NICU)

Dear parent,

I am a PhD student at the University of Brighton and I would like to invite you to take part in a research study. This research study is being undertaken as part of a doctoral research degree and I am interested in how fathers experience becoming a parent when their infant is preterm and admitted to a Neonatal Unit. You have been invited to take part in this study because you are a father of a preterm baby born less than 35 weeks gestational age admitted to the Neonatal Intensive Care Unit (NICU).

The staff caring for your infant have given you this letter of introduction and have suggested that I contact you. I will be present on the NICU and will come and introduce myself to you and your partner. If convenient I can then give you further written and verbal information about the study. This information will be about the nature of the study, its purpose, why you have been chosen to take part, what the study involves and what I will ask you to do.

In brief, the study will involve interviewing you about your experience of becoming a father of a preterm infant. There will be 3 interviews: one during the first 2 weeks following your baby's birth; one before your baby is discharged home; and one after your baby has been discharged home. It is entirely up to you whether or not you decide to participate in all or parts of the study and your decision will not affect the care you and your baby receive. If you do decide to take part in the study, then I will

ask you to sign a consent form and the interviews will be arranged at a convenient date and time for you.

I appreciate that this is a particularly critical time for you and your family and this may make it difficult for you to consider participating in all or parts of this study. However, if you are able to help, your contribution will be extremely valuable in identifying how health care professionals can support fathers when their preterm baby is on NICU and following discharge home.

Thank you for your time and co-operation. I look forward to meeting you

Yours sincerely

Susanne Simmons

Telephone number: 01273 644036

Email: S.J.Simmons@brighton.ac.uk

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Participant Information Sheet (10.05.14 version 3)

Study title: Transition to parenthood: Becoming a father of a preterm infant on a Neonatal Intensive Care Unit (NICU)

Why am I being asked to take part in this research study?
You are being invited to take part in this research study because you are a father of a preterm baby admitted to the Neonatal Intensive Care Unit (NICU). Before you make a decision whether to participate in all or parts of the study, I would like you to understand why the research is being done and what it will involve for you.

This information sheet tells you the purpose of this study, how the research will be carried out and what this will mean for you if you take part in the research. The Information sheet has been reviewed by a father's forum advisory group. Please ask me if there is anything that is not clear.

I will go through the information sheet with you and your partner and answer any questions you have. I would suggest that this should take about 15 minutes of your time. You will be able to keep a copy of this. If you wish, please talk to others about the study.

What is the purpose of the study?
This research is being undertaken as part of a doctoral research degree. It is recognised that parents experience distress when their baby is born prematurely and this study aims to help health care professionals understand fathers' experiences and how they might be able to support fathers when their baby is born early. I am a PhD student and I am also a Senior Lecturer in Neonatal and Child Health at the University of Brighton. I will be carrying out the research for this study with support from two research supervisors.

Why have I been invited?
You are being invited to take part in this research study because you are a father of a preterm baby born less than 35 weeks gestational age admitted to NICU. During this study I am planning on interviewing between 12 and 15 fathers during their baby's stay on NICU and following discharge home.

Do I have to take part?
It is up to you to decide to participate in all or parts of the study. Taking part or not taking part in the study will not affect the health care received by your baby and family during your baby's stay in hospital or following discharge home. I will describe the study and go through the information sheet with you (and your partner at your request) and give you the sheet and consent form to take home. Accepting this information does not mean that you are agreeing to take part in the study.

After no less than 24 hours I will meet with you to see if you require any further information. If you agree to take part in the study at this point then I will ask you to sign a consent form. You are free to withdraw from the research study at any time without giving a reason. The information that you have provided up until this point will still be included in the study but will not be identifiable as your information. Opting out of the study will not affect your legal rights.

What will this mean for me if I take part?
I will invite you to take part in 3 interviews with me at a time that is convenient to you. The first interview will be arranged after the third day following the birth of your baby and during the first two weeks of your baby's admission to the NICU. The second interview will be arranged before your baby is discharged home. The third interview will be arranged once your baby has been discharged home. Before each interview, I will ask you to give signed consent to continue being part of the study.

The interviews will be carried out in a quiet private room on the NICU and arranged at a time of day that suits you. The interviews will be audio-taped and then transcribed by myself. Each interview may last between one and one and a half hours. All information you provide will be anonymised and confidential. It will be stored securely and access to this information will be restricted to me and my two research supervisors.

What are the possible disadvantages of taking part in the study?
During the interviews I will be exploring with you your experience of becoming a father of a preterm baby. Talking about this experience may cause you to have feelings and emotions that may be distressing for you. If this should happen I will stop the interview and only continue if you want to. As a neonatal nurse I can support you if you become distressed during the interview. The medical and nursing staff caring for your baby will also be available to provide support for you. The unit also has a counselling service and a referral can be made for you if you feel this may help.

What are the potential benefits of taking part?
I cannot say how participating in this research study will benefit you. However, your experiences are important in helping health care professionals understand how they may support fathers when their baby is born early.

What if there is a problem?
If you have any worries about any part of this research study then please contact me on dedicated mobile number. If you wish to discuss your worries with another person then please contact Professor Julie Scholes at the University of Brighton on 01273 641085. You can also contact the hospital's Patient Advice and Liaison Service (PALS) between 10 am and 4pm on 01273 696955 ext 4029 or 4588 or email pals@bsuh.nhs.uk.

Will my taking part in this study be kept confidential?
As far as possible all information about you will be handled in confidence. All information you provide during the interviews will be anonymised and confidential, stored securely and access to this information will be restricted to me and my two

research supervisors. Once the doctoral research degree study is complete, all paper records will be destroyed. As a University of Brighton research study all electronic records of transcripts and data analysis need to be securely stored for 10 years following completion of the study

Information will only be shared with others if during the interview it is clear that there may be risk to either yourself or your baby. For example, if during the interview you tell me something that may be poor clinical practice, then as a professional nurse I would need to share this information with a senior member of staff. If during the interview I think that a referral to another professional is needed, then I will discuss this with you. In both cases, I will explain to you why and with whom I need to share the relevant information from the interview.

What will happen if I do not wish to carry on with the study?
You are free to withdraw from the research study at any time without giving a reason. This will not affect your legal rights or affect the health care your baby and family receive during your baby's stay in hospital or following discharge home. The information you provided when you were participating in the study will still be included.

What will happen to the results of the research study?
The information provided by you during the study will be included as part of the thesis for the doctoral research degree. Information will also be included in research articles for publication and for conference presentations. The information you have provided will be anonymised and you or your family will not be identified in any work.

Who is organising and funding the research?
This is a self-funded study being undertaken by me as a doctoral research student studying at and also employed by the University of Brighton. The study is covered by the University of Brighton's indemnity cover, sufficient for low-risk research studies. As the study is being carried out on NHS property and involves NHS service users, agreement from the NHS Research Ethics Committee and the Brighton and Sussex University NHS Hospitals Trust's Research and Development Department has been gained to carry out the study.

Who has reviewed the study?
All research in the NHS and University is looked at by an independent group of people, called a Research Ethics Committee. The purpose of this committee is to protect your interests. This study has been reviewed by the Faculty Research Ethics and Governance Committee (FREGC) at the University of Brighton and the NHS Research Ethics Committee.

Further information and contact details
If you require any further information at any time please contact me:

Susanne Simmons
School of Health Sciences, University of Brighton, Westlain House, Village Way, Falmer, East Sussex,
Telephone number dedicated mobile number

Appendix v Consent form Version no 2 10.05.14

University of Brighton

Centre Number: .....
Study Number:
Patient Identification Number for this trial:

CONSENT FORM

Title of Project: **Transition to parenthood: Becoming a father of a preterm infant on a Neonatal Intensive Care Unit**

Name of Researcher: **Susanne Simmons** **Please initial all boxes**

1. I confirm that I have read and understand the information sheet dated **10.05.14** version **[2]** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ..... ☐
   .....
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my baby's care or legal rights being affected. ☐
3. I understand that if I do withdraw from the study, the anonymised information I have provided in the interviews will still be included in the study ☐
4. I understand that if a significant disclosure of possible clinical malpractice or poor practice is made during the interviews the chief investigator will follow the NHS trust policy for raising concerns ☐
5. I understand that if risk to either myself, my baby or others is identified in the interviews, then this will be discussed with me and the relevant information shared with an appropriate authority in a professional and sensitive manner ☐
6. I agree to the use of audio-taping and the use of verbatim quotation and understand that all information from the interviews will be anonymised. ☐
7. I agree to take part in the above study..... ☐

   .....

   .....

Name of participant, date and signature.....
Name of person taking consent, date and signature:.....

Appendix vi Interview agenda

Version no. 1 31.03.14

Interview agenda

The interview agenda for the series of three interviews is outlined below. However, the questions asked will be directed by the participant's *main concerns* as they become apparent during the interview. Exploratory and validating questions will be used by the chief investigator throughout the interviews to provide the contextual backdrop for the transition to fatherhood such as: how the experience of pregnancy and delivery affects the transition to fatherhood; the factors that support the transition to fatherhood; and the barriers that may hinder this transition. The chief investigator will ask the participant's permission to take notes during the interview in addition to using audio recording.

Interview 1

Before the interview begins, some biographical information from the participant will be obtained i.e. age, marital status, employment, first time father, ages of other children, previous experiences of premature birth. The participant will be reassured that this information will be kept confidential and all information anonymised during data analysis.

Initial open ended questions[1]

1. *Could you describe any key events during the pregnancy that have a particular meaning for you*? How would you describe your experience of anticipated fatherhood *leading up to the* birth of your baby?
2. *Tell me how you would describe the person you* were before your baby was born. What were your thoughts and feelings about becoming a father?
3. Could you tell me about what happened when your baby was born?
4. How would you describe your first experience of visiting the NICU

Intermediate questions[1]

5. How would you describe seeing your baby for the first time?
6. What do you remember most about the first few days of your baby's life?
7. What (if anything) would you say has been the most helpful to you during this time? How was this helpful?
8. What (if anything) would you say was not helpful to you during this time? How was it not helpful?
9. *Who has been the most helpful to you during this time*?
10. *Tell me how you would describe the person you are now* since the birth of your baby. How (if at all) have your thoughts and feelings about becoming a father changed since your baby was born?
11. What would you say has been the most difficult experience for you since the birth of your baby?

Ending questions[1]

12. *As you look back on the* last few days *are there any other events that stand out* for you? *Could you describe these*? How did they affect you?
13. *After having these experiences what would you say to someone* who is expecting to have a preterm baby?
14. Would you like to tell me anything else about your experience of becoming a father of a preterm baby?
15. Would you like to ask me anything before we end the interview?

Interview 2

Initial open ended questions[1]

1. Could you tell me what has happened since the first interview?
2. How would you describe your thoughts and feelings now of being a father of a preterm baby?
3. How would you describe your experiences of NICU?

Intermediate questions[1]

5. How would you describe your experiences of visiting your baby on NICU?
6. What do you remember most about the time that your baby has spent on the NICU?
7. What (if anything) would you say has been the most helpful to you during this time? How was this helpful?
8. What (if anything) would you say was not helpful to you during this time? How was it not helpful?
9. *Who has been the most helpful to you during this time?*
10. What would you say has been the most difficult experience for you since the birth of your baby?
11. How would you describe the preparation for the discharge home of your baby? When did this start? Who is involved?

Ending questions[1]

12. *As you look back on the time* your baby has been in NICU*, are there any events that stand out* for you? *Could you describe these*? How did they affect you?
13. *After having these experiences what would you say to someone who is* expecting to have a preterm baby?
14. Would you describe how you feel about the discharge home of your baby?
15. Would you like to tell me anything else about your experience of becoming a father of a preterm baby?
16. Would you like to ask me anything before we end the interview?

Interview 3

Initial open ended questions[1]

1. Could you tell me what has happened since the discharge home of your baby?
2. How would you describe your thoughts and feelings now of being a father of a preterm baby?
3. How would you describe your experience of leaving the NICU when your baby was discharged home?

Intermediate questions[1]

4. What do you remember most about the first few days after the discharge home of your baby?
5. What (if anything) would you say has been the most helpful to you during this time? How was this helpful?
6. What (if anything) would you say was not helpful to you during this time? How was it not helpful?
7. *Who has been the most helpful to you during this time*?
8. *Tell me how you would describe the person you are now* since the discharge home of your baby. How (if at all) have your thoughts and feelings about becoming a father changed since your baby has been discharged home?
9. What would you say has been the most difficult experience for you since the birth of your baby?

Ending questions[1]

10. *As you look back on the time since* your baby was discharged home *are there any events that stand out* for you? *Could you describe these*? How did they affect you?
11. *After having these experiences what would you say to someone who is* expecting to have a preterm baby?
12. Would you like to tell me anything else about your experience of becoming a father of a preterm baby?
13. Would you like to ask me anything before we end the interview?

1 Adapted from Charmaz 2011:30-31

Appendix vii Distress protocol

This protocol has been adapted from a protocol devised by Dr Chris Cocking, School of Health Sciences, University of Brighton with his kind permission.

	Signs to look out for	Action to take
Mild distress	Tearfulness Voice becomes choked with emotion/ difficulty speaking Participant becomes agitated/ restless	The chief investigator will acknowledge the participants' distress, and reassure them that their experiences are natural reactions to their situation The participant will be given time to pause and compose themselves The chief investigator will ask the participant if they are happy to continue The chief investigator will remind he participant that they can stop the interview at any time Once the interview has ended, the chief investigator (with the participant's permission) will alert the nursing and medical staff caring for the family that the participant became distressed during the interview
Severe distress	Uncontrolled crying Inability to talk coherently Panic attack- e.g. hyperventilation, shaking	The chief investigator will stop the interview Relaxation techniques will be suggested to regulate breathing/ reduce agitation The chief investigator will acknowledge the participants' distress, and reassure them that their experiences are natural reactions to their situation The chief investigator will gently enquire whether

		the participant would like to have the support of his partner and/or nursing and medical staff caring for his infant. The chief investigator will discuss with the participant the availability of referral to the neonatal unit counsellor The chief investigator will ensure that the participant's distress is visibly reduced before she leaves the neonatal unit The chief investigator (with the participant's permission) will alert the nursing and medical staff caring for the family that the participant became distressed during the interview
Extreme distress	Severe agitation and possible verbal or physical aggression	All interviews will be conducted following a risk assessment of the safety of the environment for both the participant and the chief investigator Participant disclosure during an interview of intended harm to either himself or another person will require the chief investigator to use her professional judgement in assessing her capacity to manage the disclosure at the time. If the situation is considered by the chief investigator to be beyond her level of competence then she will inform the participant that she has a duty to refer to another professional body e.g. hospital security, police,

		social worker, mental health team The chief investigator will ensure that the participant's distress is visibly reduced before she leaves the neonatal unit and alert the nursing and medical staff that the participant became extremely distressed during the interview and inform them of the actions taken

Appendix viii Lone worker policy

Lone Worker Policy

(adapted from School of Health Sciences Community Lone Working policy)

Where lone working takes place, the following minimum precautions must be observed where relevant:
The lone worker must have a means of documenting home visits; the destination recorded and estimated time to be spent.
A procedure must be in place whereby nominated persons monitor the whereabouts of the lone worker visiting home premises
A system must be put in place to ensure that the lone worker has adequate communications between themselves and the nominated person and that the system is used, audited and tested
Lone workers must receive adequate training including security awareness and conflict resolution training.
Risk assessment checklist

Activity	Yes	No
Will the participant's partner be at home?		Rearrange the interview for a day when the participant's partner is also at home
Does the lone worker have a mobile phone?		
Does a designated person know where the lone worker is going and for how long?		
Is the lone worker able to contact the nominated person prior to entering the participant's home?		
During the interview were any concerns raised by the participant or chief investigator?		
Has the record for undertaking the interview at the participant's home been completed?		

Record of undertaking an interview with the participant in their own home	
Name of participant	
Address	
Date	
Duration of interview	
Any concerns raised by the participant or chief investigator? Record any actions taken	

Appendix ix Rec favourable opinion

NHS
Health Research Authority

27 November 2014

Mrs Susanne Simmons
Senior Lecturer
University of Brighton
School of Nursing, University of Brighton, Westlain House
Village Way, Falmer
East Sussex BN1 9PH

Dear Mrs Simmons

Study title:	**Transition to parenthood:becoming a father of a preterm infant following admission to a Neonatal Intensive Care Unit(NICU)and following discharge home**
REC reference:	**14/EE/0170**
Protocol	**N/A**
IRAS project ID:	**123953**

Thank you for your letter of 27 November 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 09 May 2014

The documents received were as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Interview Agenda]	2	10 May 2014
Other [GCP Certificate - Susanne Simmons]		03 June 2014
Other [Poster for Nursing Staff]		
Other [Application Approval - University Governance Cttee]		09 June 2014
Other [Peer Review - Faculty of Health and Social Science]		10 March 2014
Participant consent form	2	10 May 2014
Participant information sheet (PIS)	3	10 May 2014
Research protocol or project proposal	2	10 May 2014
Response to Request for Further Information [Response Letter]		10 July 2014

Approved documents
The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering letter on headed paper		08 April 2014

Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		31 March 2014
Interview schedules or topic guides for participants [Interview Agenda]	2	10 May 2014
Letter from sponsor		08 April 2014
CV of supervisors		
References	undated	
Lone Worker policy	1 (appendix 6)	31 March 2014
Interview adgenda	1 (appendix 5)	31 March 2014
Distress Protocol	(appendix 4)	31 March 2014
Invitation letter	1 (appendix 1)	31 March 2014
Advert for parents	1	31 March 2014
GCP Certificate - Susanne Simmons		03 June 2014
Poster for Nursing Staff		
Application Approval - University Governance Cttee		09 June 2014
Peer Review - Faculty of Health and Social Science		10 March 2014
Participant consent form	2	10 May 2014
Participant information sheet (PIS)	3	10 May 2014
REC Application Form	12395/59264 1/1/729	08 April 2014
Research protocol or project proposal	2	10 May 2014
Response to Request for Further Information [Response Letter]		10 July 2014
Summary CV for Chief Investigator (CI)		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/EE/0170 Please quote this number on all correspondence

Yours sincerely

REC Manager