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Factors Influencing Men's Experiences of a Termination of Pregnancy

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ABSTRACT

The termination of pregnancy (TOP) is one of the most commonly performed gynaecological procedures in England. Despite the prevalence of the TOP procedure, limited research to date has investigated male partner's experiences of a TOP. The aim of the present study was to investigate the mood and affect experienced by men accompanying their female partner to a TOP. Additionally, factors influencing male partner's experiences of a TOP were also investigated; namely hegemonic masculinity and social roles. A combined qualitative and quantitative approach was used to address the research questions.

Participants were 63 men accompanying their female partner to a TOP on a gynaecology day ward. Men completed questionnaire packages including self-report measures of their mood, affect and masculinity. Participants were invited to write responses to open-ended questions regarding the reasons for adopting specific roles, and experiences of the NHS environments.

The most commonly reported feelings experienced by male partners were tired determined and strong. Participants did not experience significant levels of depression; levels of anxiety experienced were somewhat higher. Results suggest that men do not experience a TOP as an entirely negative procedure. Participant's experiences highlighted the confusion as to a clear role to be adopted. Men who adopted the role of 'Bystander' were more

anxious. Being emotionally in control was considered a positive masculine characteristic when accompanying a female to a TOP.

Clinical and theoretical implications are discussed, in terms of understanding the experiences of men, improving service delivery and contributing to the existing body of TOP research.

CONTENTS

CHAPTER ONE: INTRODUCTION

Overview

The focus of this study explores male partners' experiences of a TOP. This is considered important for a number of reasons. Firstly it is recognised that how a man copes during a TOP can impact upon the female's coping. Secondly, men's attendance at clinic appointments provides an opportunity for engagement, in order for health professionals to deliver much needed contraceptive advice. Thirdly, the experiences of this group of men have received limited research to date. Despite the recent deterioration of the sexual health of the nation, and the predominance of TOPs currently being performed in England and Wales (RCOG, 2001), we are aware anecdotally of the current low male attendance figures at clinic and hospital TOP appointments. It is therefore considered important to understand the experiences of these men, in order to provide the necessary information and services that they require. Additionally, the experiences of the men who do attend is likely to affect future male attendance rates at such appointments. An improved understanding of the experiences of those who do attend will inform attempts to improve male attendance rates at TOPs.

This chapter will consider the importance of researching TOP both on the individuals involved and also on the wider society. Psychological models are described to provide a hypothesis for understanding the different responses

to a TOP. Social role theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000) will be covered in detail. In the absence of specific TOP research, information will be drawn from related pregnancy and childbirth literature. Links will be made with this related literature which highlights the need for further studies to investigate male partners in relation to TOP. Additionally information regarding men who fail to accompany their partner through this process will add further depth to this up and coming area of research.

1. Sexual Health Climate in the U.K. today

The increased rate of terminations is just one of the sexual health problems identified by the government as requiring immediate action (DoH, 2002). Increased rates of emergency contraceptive use, unintended pregnancies, sexually transmitted infections, and the two- fold increase in the number of visits to genito-urinary medicine (GUM) departments ignited the concern of the U.K. government. The government recognised that poor sexual health can have a number of serious consequences. The government acknowledges that unintended pregnancies and STIs can have a long lasting impact on people's lives. They identify a link between sexual ill health and reduced quality of life, including poverty and social exclusion (DoH, 2002).

The government launched a National Strategy of Investment and reform, to deliver a 10 year investment of £47.5 million. By addressing the poor sexual health of the nation (Department of Health, 2002), the strategy aimed to reduce the health inequalities in existence by changing the sex attitudes held by society.

When presented with a statistical summary of the nation's sexual health, the government's rationale for targeting the sexual health of England and Wales becomes clear. It is estimated that as many as 30,000 individuals have HIV, with approximately 1/3 of these cases currently remaining undiagnosed. Additionally, a 40% rise in HIV cases occurred between 1999 and 2003 (CDR, 2000). Between one third and half of teenagers do not use contraception at their first intercourse (Wellings, Field, Johnson, & Wadsworth, 1994). Finally, statistics demonstrate that teenage birth rates in England are the highest in Western Europe, abortion rates are also high, with almost 174,000 abortions occurring in England and Wales in 1999 (DoH, 2002).

2. Incidence of Abortion Today

The termination of pregnancy (TOP) or abortion procedure (as it is often referred to) is one of the most commonly performed gynaecological procedures in England and Wales (RCOG, 2001). Legal abortion rates tend

to vary from one country to the next as a result of the variation in non-restrictive laws operating in many of these countries (Henshaw, Singh & Haas, 1999).

Such varied laws have resulted in an absence of statistics representing worldwide abortion rates. Henshaw et al. (1999) provide the most recent research focussing on the incidence of abortion rates. Based on information provided by government statistics and abortion providers, Henshaw et al. (1999) reported trends in legal induced abortion in 54 countries for the period of 1975 to 1996. In 1999 Henshaw found recent trends in legal abortion rates to be decreasing, although variations between countries existed. Limited information from developing countries, increased access to contraceptive services and increased governmental support for family planning were postulated as contributing factors for the fall in abortion rates (Henshaw et al. 1999).

The most recent abortion statistics for England and Wales suggest that the total number of abortions carried out in 2005 was 186,400, a rise of 0.4% since 2004 (DoH, 2005), the NHS funded 84% of these abortions. It is estimated that at least one-third of British women will have had an abortion by the time they are 45 years old (RCOG, 2001), with the most common age group accessing abortion services being women aged 20-24. Almost 90% of abortions were carried out at less than 13 weeks gestation. The two types of

legally induced abortion available today are Surgical Terminations of pregnancy (STOPs) and Medical Terminations of Pregnancy (MTOPs). MTOPs represented 24% of the total number of abortions carried out in 2005, compared with 19% in 2004 (DoH, 2005).

2.1. Surgical Termination of Pregnancy

Surgical termination of pregnancy is one of the most commonly practiced gynaecological surgical procedures in the United Kingdom (Flett & Templeton, 2002). Until the late 1980s and 1990s, the only methods of abortion available in the United Kingdom were surgical (Pipes, 1998). The main method of early surgical termination of pregnancy is vacuum aspiration. This method is considered to be a safe and simple way of terminating a pregnancy, with minimal cervical dilation (Hatcher et al. 1998). Vacuum aspiration can be accomplished via one of two methods; manual vacuum aspiration involves using a handheld syringe, compared to electric vacuum aspiration which requires the use of an electric pump (Paul, Stubblefield, & Grimes, 1999).

Surgical terminations of pregnancy during the second trimester are typically performed using the dilation and evacuation (D&E) method. D&E requires dilation of the cervix, followed by the evacuation of the uterus. A vacuum

cannula is used to evacuate the foetus and the placenta. D&E methods are preferred in many cases, as they involve little bleeding (Hatcher et al. 1998).

2.2. Medical Termination of Pregnancy

In 1982 a drug manufacturer named Roussel-Uclaf developed a drug to be used as a medical abortifacient (Hadley, 1996). The subsequent licensing of the drug RU 486 (Mifepristone) in France in 1988 was regarded as launching a new era in fertility control (Grimes, 1997). Britain, Sweden and China have all approved this drug for use since its licensing in 1988. Roussel-Uclaf identified that within any one country, the political climate must be accepting of abortion before his company would introduce mifepristone into a population (Beckman & Harvey, 1998). Therefore, the introduction of mifepristone to the United States was delayed until 1992 as a result of the degree of political controversy surrounding the concept of abortion in the United States.

Mifepristone and Misoprostol are used to abort pregnancies up to seven to nine weeks gestation. Success rates include 92% for terminations at ≤49 days gestation (Pirruccello & Winikoff, 2000). Abortions carried out within the first 12 weeks of gestation are regarded as extremely safe (Pipes, 1998). The anti-progestorone steroid Mifepristone is administered at the first visit at a dose of 600mg. During the second visit (48 hours later), Misoprostol

tablets are given orally, or in the form of vaginal pessaries. The expulsion of the foetus can occur within a few hours, or in some cases up to two weeks after taking the misoprostol. A physical examination occurs two weeks later to ensure the abortion is complete, and that additional complications do not exist.

2.3. Termination Literature: The Inclusion of Men

As the number of abortions carried out in England and Wales today increases, so does its accompanying body of research. A review of the current termination of pregnancy literature reveals that the majority of studies focus on the experiences of the women involved, leaving the men involved somewhat neglected (Conklin & O'Connor, 1995). In 1992 Major, Testa and Mueller recognised that little if any attention was being paid to the male partners of women obtaining abortions. Neustatter and Newson (1986) recognised this gap within the literature and identified the actual experiences of male partners during the abortion procedure as an area requiring further research.

Critics have argued however that researching males takes a necessary focus away from the women's own experiences; additionally it is felt that focusing on men may add support to the argument for removing the elements of choice and privacy that a woman is entitled to during the

procedure (Simon, 1997). Burgess (1997) stated that in the past, researching male partner's experiences of a TOP was considered a 'breach of patient confidentiality' (p108).

However, men not only contribute towards the creation of the pregnancy to be terminated (Boyle, 1997), but the limited research into the male partner's perspective that exists suggests that male partners provide positive support to their partners (Major et al., 1992 cited in Boyle, 1997). Gordon (1978) pointed out that a pregnancy is the result of the intimate involvement of a male and a female; therefore one would predict that an abortion will have psychological implications for both the female and the male.

Shostak et al. (1984) found that many men respond silently to their partner's abortion, conversely, some men needed to express their thoughts and feelings in response to the TOP. Many of the latter men were acutely affected by the procedure, resulting in daydreaming about the process and having thoughts of the foetus (Shostak et al. 1984). Furthermore, Beckman & Harvey (1998) found that some men responded indifferently to a TOP, relieved that they were free from many of the responsibilities that fatherhood carries with it.

2.4. Coping with a TOP: Women and Men

Major, Cozarrelli, Testa and Mueller (1992) presented questionnaires to 73 couples at an abortion clinic. Major et al. hoped to compare men and women's expectations for coping with an abortion and their attributions for the unwanted pregnancy. Also of interest was the relationship between men's coping expectations and their partner's psychological adjustment following an abortion. Major et al (1992) found both men and women's coping expectations to be very similar, in that both groups expected to cope moderately well. Interestingly, women's and their partner's coping expectations were both found to be significant predictors of the female's adjustment post-abortion. Women with lower pre-abortion coping expectancies were found to be more depressed following the abortion than the women who had higher coping expectancies. Additionally, the women whose male partners had lower coping expectancies were also found to be more depressed post-abortion than the women whose partner's expected to cope better. The extent to which a male's coping expectations affected his partner's adjustment post-abortion depended on the females own coping expectancies. The lower the female's coping expectancies, the greater the influence the male's expectancies had on her ability to adjust.

Major et al (1992) postulated three hypotheses which attempted to explain how the level of stress experienced by female's attending an abortion may be exacerbated when accompanied by their male partner. The first suggested that worrying about the adjustment of their male partner may

create an added stressor for the already stressed female. The second hypothesis suggested that the men who doubt their own ability to cope, may be less able to engage in supporting their partner. Additionally, it was suggested that men who doubt their own ability to cope may be perceived by their partner as ambivalent and/or less supportive about the abortion.

Major et al. (1992) found men more likely to blame the unwanted pregnancy on features of their own character, such as not being responsible. Self character blame is associated with a greater risk of developing depression (Janoff-Bulman, 1979; Major, Mueller & Hildebrandt, 1985; Mueller & Major, 1989), with this in mind, Major et al. (1992) speculated whether the accompanying men are actually at a higher risk for depression than the women themselves.

2.5. The Decision to Terminate

Two key studies have recognised that men can influence their partner's decision to terminate (Bracken, Hachamovitch, & Grossman, 1974; Miller 1992). Furthermore, post-abortion reactions can be heavily influenced by the manner and environment in which these decisions are made (Bracken, et al., 1974; Miller 1992). In 1972, Osofsky and Osofsky studied short term reactions following an abortion. Their results indicated that women who find

making the decision to abort more difficult experience more guilt following the abortion.

The importance of the pre-abortion decision making process highlighted by Osofsky and Osofsky (1972), prompted Bracken et al. (1974) to study more broadly the relationship between the decision to abort and subsequent psychological sequelae. It was found that women who made 'high quality' (p155) decisions, that is the women who rehearsed the responses to the reactions of her partner, friends and family, with her own post-abortion reaction were more able to cope, and thus experienced fewer negative psychological sequelae when these reactions became real. The interpersonal milieu, (which includes the male partner) in which the decision was made was recognised as an important factor in determining the females post-abortion reaction. For the older participants, when the partner was perceived as being more supportive, the female's post-abortion reaction was less negative, this contrasted with the younger group, whose post-abortion reaction depended on the perceived support of their parents. It was therefore concluded that the support provided by significant others must be accounted for to allow a comprehensive understanding of female's post abortion reactions (Bracken et al., 1974).

Miller (1992) presented findings from a 1970's research project on the psychological antecedents and consequences of induced abortion. The

project was valued for enlisting a non-clinical probability sample, and for the diversity of the psychological variables that were prospectively measured. These findings indicated the significant influence male partners had on the female's decision to abort; this influence however was not regarded as entirely positive. Miller (1992) postulated that involving men increases the complexity of the decision making process, which in turn may result in 'ineffective decision making' (p 73).

Miller's (1992) results further uncovered that the less independent minded women were less likely to choose an abortion. It was therefore suggested that joint decisions including both the female and her male partner, whilst on the surface appear sensible, run the risk of compromising the decision making process of women, in particular the decision making process of women who struggle with issues of independence. This study illustrates the significant impact men can have on the decision to terminate, as well as on their partner's reactions and coping strategies.

3. Men and Miscarriage

A miscarriage is very different to a TOP, in that it does not involve the elements of choice that a TOP offers. However, both a miscarriage and a TOP involve the end of a pregnancy, which is likely to result in some men experiencing similar reactions/feelings. Duncan (1995) recognised that

similar to the termination literature, father's feelings are rarely given much consideration within the miscarriage literature. Duncan recognised that men's reactions to an unplanned pregnancy can often be a desire to 'get rid of it' (p30), as a result of being in an uncommitted relationship or for financial reasons. Duncan made the distinction between these reactions, and the reactions of men experiencing a miscarriage. Duncan (1995) stated that the grief of a man following a miscarriage is underestimated. Murphy (1992) suggests that a man may feel that his manliness is affected by a miscarriage as the baby serves as 'proof' of a man's success at lovemaking and providing his partner with viable sperm.

In her paper 'Fathers have feelings, too,' Duncan (1995) attributed the commonly held assumption that men are not affected by miscarriage to the media and society. Duncan commented upon the notion reinforced by the media that 'big boys don't cry' (p30), commenting that men are not expected to express their feelings, and are therefore not expected to feel attachment to their unborn child (1995). Men are often expected to be more rational in response to their partner's miscarriage, and tell her that it is for the best (Duncan 1995). Duncan (1995) recognised that these attitudes and expectations surrounding men were likely to change as a result of the shift in family dynamics. As men become more involved in home life, men's domain will no longer be work and the outside world. Instead, men are already

becoming more involved in the childbirth process and the care of their children (Duncan, 1995).

4. The History of Men and Reproductive Health

For many centuries in many cultures, the birth process has been perceived as 'women's business' (Draper, 1997, p133). Nolan (1994) surveyed 30 fathers attending antenatal classes. Similarly, in her study, Nolan recognised the female-oriented nature of childbirth, describing men's experiences of pregnancy and birth as 'a voyage into another world- a woman's world generally unfamiliar even for today's 'new man" (p25). Zoja (1997) regards pregnancy as a public example of a woman's power. 'It was not until the natural child birth movement of the 1950's that expectant fathers began their entry into the labour and birthing units' (Chapman, 1991, p21).

Draper (1997) noted that over the last 20 years there has been a considerable increase in the number of fathers attending their child's birth. Enkin et al (1995) recognise this 'recent phenomenon' of father's attendance at childbirth as 'virtually universal compared to the occasional involvement of fathers 20 years ago' (p194). In 1984, Kliman and Kohl reported that 80% of fathers attended their child's birth. Palkovitz (1987) studied first-time fathers' motives for birth attendance. In doing so, he experienced difficulty finding a sample of fathers who were not planning to attend their child's birth. Of

Palkovitz' sample, 35% held the belief that it was necessary for fathers to attend their child's birth.

The increasing involvement of fathers in childbirth has been regarded by many as a good idea (Hearn, 1984), alongside which, men are increasingly regarded as important in the process of pregnancy and parenting, views that are stressed in the recent adoption of terms such as 'expectant fathers' and 'pregnant couples' (p13). These views have existed for over 20 years. In 1986 Lamb recognised the expectation for fathers to be more actively involved in aspects of child care than at any time in the past. Lamb (1986) went on to discuss the shift in expectations, from a father being solely involved in economic support and discipline of children, to the adoption of the role as a direct carer of children of all ages. Despite the increasing involvement of men in areas of reproductive health, as a socio-cultural phenomenon, fatherhood is far less studied than motherhood (Barclay & Lupton, 1999).

4.1. The Experience of Fatherhood

Previously, the body of literature focussing on the experience of fatherhood has tended to view the paternal experience in a negative light. Berman and Pederson (1987) represented fatherhood as pathological, similarly, fatherhood has been regarded as a disruptive process involving

intrapersonal struggle (Cowan & Cowan, 1987). Additionally, Shapiro (1987) recognised the 'double bind' (p37) that many expectant father's experience. When writing from his own personal experience of fatherhood, Shapiro identified that although men are encouraged to participate fully in their partner's pregnancy and birth, in many ways they are made to understand that they are outsiders. These men are inadvertently told that their presence is required, but their feelings are not, especially if these feelings are negative, such as the nervousness they are experiencing about the impending birth. Furthermore, Shapiro (1987) believed this 'double bind' to restrict the intimacy that exists between couples, at a time when communication between the expectant parents is needed more than ever.

Draper (1997) reviewed the key literature on father's attendance at childbirth. Draper concluded that changing cultural attitudes have encouraged fathers' attendance at childbirth and contributed to an increasing body of associated research. Despite the recognition that men are not treated equally, and that more needs to be achieved in terms of understanding the experiences and needs of men, it is not unusual for men to be viewed in a negative light if they do not attend (Palkovitz, 1987). Draper (1997) recognised that the social construction of what is expected of a father still needs to be explored, both in terms of its cultural and historical context.

Oakley's (1981) study 'Becoming a mother' recognised that few opportunities exist for men to discuss how they felt about the pregnancy, labour and their impending fatherhood. Previously, Shannon-Babitz (1979) had acknowledged that little was done in terms of research to discover the psychological needs of these men. Nolan (1994) found that unlike women, men carry powerful cultural and media messages about mothers dying while giving birth. Nolan (1994) stated that these messages are reinforced by masculine guilt, and deserve the respect and attention of professionals working closely with these men.

4.2. Fathers and Childbirth

Existing research into the effects of pregnancy and birth on men is relatively recent, with many criticisms of this body of research existing (Lewis, 1983; Duncan, 1995). Lewis (1983) accuses the literature of placing too much emphasis on maladaptation. Duncan (1995) criticises the literature for failing to explore men's normative feelings and for being simply an extension of the research that focuses on mothers. More recently, Draper (1997) acknowledged that a greater awareness of men's experiences during childbirth is required to effectively provide for men's independent needs during both pregnancy and birth.

However, although these studies provide useful information, they tend to view the male partner as occupying a supportive role, rather than being a direct participant in the process (Barclay & Lupton, 1999). Shapiro (1987) recognised that seeing men as supporters rather than direct participants, serves to reinforce their sense of exclusion.

5. Social Roles

The roles adopted by men in areas of reproductive health will be discussed in order to shed light on the sparse literature focussing on men's roles and TOP. The term 'role' 'typically refers to the behaviour expected of individuals who occupy particular social categories' (Zurcher, 1983, p11). Social roles can be defined as the shared expectations that exist within a group about how particular people are supposed to behave (Aronson, Wilson & Akert, 2002). Similarly, a role adopted by a certain individual can be regarded as being driven by social norms. Social norms can be understood as the rules and standards that guide one's behaviour (Cialdini & Trost, 1999). The motivation to adopt different roles comes from the fact that individuals are active within their social environment (Dewey, 1922). Additionally, it is thought that satisfying primary (hunger, sex) or secondary (approval) needs, motivates us to enact roles (Masden, 1968; Atkinson & Birch, 1978).

As individuals we consistently try to combine what we want to do ourselves, with what is expected of us within a particular setting (Zurcher, 1983). Roles are enacted consciously and purposefully, interactions with others are regarded as guiding and shaping the development of roles within specific settings (Stryker, 1981). Many researchers have found that individuals perform well when group members follow a set of clearly defined roles (Barley & Bechky, 1994; Bastien & Hostager, 1988). If a role is vaguely defined, individuals try to find a way of establishing a workable role, which is usually guided by an individual's self-concept and through their interactions with others (Zurcher, 1983).

5.1. Gender Roles

The most consistent finding across cultures is that gender is often used to assign roles (Harway & Moss, 1983). Eagly (1987) offers a theory of sex differences in terms of the role expectations placed upon men and women. It is suggested that society divides labour between the sexes on the basis of gender. This division leads to differences in gender-role-expectations regarding the characteristics and behaviours of men and women. These expectations are responsible for the differences in men's and women's social behaviour.

Two types of social norms exist that are believed to ensure traditional gender roles are adhered to; these are descriptive norms and injunctive norms (Zurcher, 1983). Deviation from descriptive and injunctive norms may result in the negative attitudes of others. (Cialdini, Kallgren & Reno, 1991). Descriptive norms provide information about how similar people behave in specific situations. Therefore, observing same-sex others provides information regarding the appropriate way to behave. Behaviours that stray away from these descriptive norms may threaten social interactions (Cialdini et al., 1991). Injunctive norms are the second type of norms that aim to maintain gender role adherence. Injunctive norms comprise of expectations about how people are supposed to behave, they provide rules as to the behaviours that may result in the disapproval of others (Cialdini et al., 1991). Disapproval is likely to result from the violation of gender norms, for example, men failing to provide for their family.

Men are therefore expected to fulfil the masculine gender role that reflects powerful qualities, and women are expected to fulfil the feminine gender role that reflects communal/social qualities (Wood & Eagly, 2002). Such differences in gender-role-expectations are often interpreted as masculinity and femininity. Terman and Miles (1936) (cited in Edley & Wetherell, 1995) encouraged the interpretation of gender differences to be based around roles and feminine and masculine ideals, and it was from the idea of distinct

male and female sex roles that the concepts of masculinity and femininity emerged (Connell, 1995).

As social role theory states, gender role orientations have stronger links with the social roles occupied, and not to the sex of the individual (Eagly, Wood & Diekman, 2000). Therefore, perceptions of gender role orientations of men and women are influenced to a greater degree by the roles that they fulfil (Eagly et al., 2000).

5.2. Foetal Screening: Men's roles

Many similarities exist in terms of gender differences during the process of foetal screening, and that of the termination of pregnancy procedure. The women are usually the primary recipients of information about the actual procedure, with the male partner less likely to attend the consultation than the process itself. Men are also less likely than women to have a chance to discuss either process directly with a healthcare professional (Locock & Alexander, 2006). Role confusion was reported by men during the process of foetal screening (Locock & Alexander, 2006). Locock & Alexander (2006) reported a number of roles which the men filled during the screening process and afterwards. These roles could be assigned intentionally or unintentionally by others, in many cases the differing roles were found to come into conflict with one another. The roles included parent, bystander,

protector/supporter, gatherer of facts and decider/enforcer. It was therefore concluded that men are placed in a complex and uncertain position during the process of foetal screening (Locock & Alexander, 2006).

For those men feeling like a bystander, they experienced a loss of control as well as a loss of the ability to protect and support their partner, two aspects of hegemonic masculine identity (Locock & Alexander, 2006). Support is regularly mentioned within the childbirth literature, with regards to the roles adopted by expectant fathers.

5.3. Pregnancy and Childbirth: Men's Roles

Moran-Ellis (1989) recognised that within today's culture, women rarely give birth alone. In this sense, Moran-Ellis (1989) regarded childbirth as a social event, and not solely a biological procedure. Kunst-Wilson and Cronenwett (1981) commented upon the transformation of the father's role during childbirth. This role was described as evolving from 'one of an unnecessary source of infection to an essential source of affection for both the mother and the newborn' (p202), the father was previously considered to be a negative factor that was not welcome with regards to taking care of their child. Despite the longstanding recognition that the father has an important role to play during childbirth, these men experience a great deal of conflict between the woman's need for support and the man's need for his own emotional space

(Nolan, 1994). Men also worry about their partner's need for both physical and emotional support (Nolan, 1994).

These men have to cope with their own confused feelings about what is appropriate behaviour; the rapid changing roles of fathers in society today, and the contradictory messages from the expectations of those around them. May (1982) studied the phases of involvement for a father during pregnancy, and discovered that fathers often received the message from health care providers that they were second rate if they were unwilling to coach or get intimately involved with their female partner.

Moran-Ellis (1989) interviewed couples expecting their first child. The labour-role expectations of men in this study included making decisions, acquiring information, and offering practical support such as providing a back massage for their partner. Similarly, Shannon- Babitz (1979) found men to feel most useful if they were able to provide physical support to their female partner. An additional expectation that men announced in Shannon-Babitz' research was that of a gate keeping role. The men felt as though they should be helping the female maintain control during labour, in many cases the men stated that although they felt they should be able to adopt this role, many were confused as to how to do this.

More recently, in 1991, Chapman studied men's experiences during labour. Three roles came out of this research; Coach, Team mate and Witness. Coaches were physically involved in the labour, whilst helping the female maintain control. Team mates were there to help, responding to the requests of their female partner. Finally, the role of Witness saw men observing the labour whilst providing emotional and moral support; Chapman (1991) identified that this role was most commonly adopted by the men. Additionally, Nolan (1994) discovered that some men perceive themselves as helpless during their partner's labour, as they are unable to take her pain away. Nolan recognised that feeling out of control was an unfamiliar and uncomfortable experience for men who are socialised into roles of authority that carry with them a certain degree of control. This explanation fits well with another of Nolan's (1994) findings that men tend to seek an active role in order to have more control rather than just doing nothing. In relation to these findings, Nolan (1994) recognised that professionals need to empower these men so that they feel more comfortable adopting an unfamiliar passive role.

Nolan (1994) recognised the need for men to be treated as equal partners during the birth process, as they experience the trauma and emotional strain experienced by the female. The numerous potential roles that men may fill during pregnancy and childbirth, and the confusion that many men experience when deciding on the most appropriate role is somewhat

mirrored by the uncertainty of the medical staff working with these men. Similarly, Donovan (1995) discovered that the feelings of exclusion experienced by such men can be reinforced or alternatively reduced by the actions of the professional staff.

5.4. Men's Roles: Staff perceptions

Much research has recognised that it is not unusual for the professionals working in areas of reproductive health to have unclear role expectations for men (Moran-Ellis, 1989), in many cases the men are not included as an equal partner (Henderson & Brouse, 1991). Professionals often see the father's role as solely to support the woman (Jordan, 1990), but men still find it difficult to be accepted as the main carer (Jordan, 1990). In many cases the language and terminology adopted by the professional serves to exclude the father (Nolan, 1994). In Nolan's sample, 2 of the 30 men surveyed perceived the health professionals as influential in augmenting their sense of powerlessness. Brown (1982) found that the medical staff treated the expectant fathers in a way that emphasised a lack of a clear set role for them, due to the absence of a physical reason for their presence at birth. Additionally, Shannon-Babitz (1979) found that often staff are unaware of the influence that their use of both verbal and non-verbal communication has on these men. Shannon-Babitz (1979) stated that if staff fail to acknowledge the fathers' needs, the fathers may feel excluded from a life event which they

had planned to share with their partner. She went on to recommend that staff should acknowledge the father's physical and psychological needs in order to express their recognition that he is an important person involved in his child's birth (Shannon-Babitz, 1979).

Additionally, if the staff have unclear role-expectations for these men (Moran-Ellis, 1989), it is not surprising that the men themselves are uncertain as to their responsibilities and roles in the labour room. It has been suggested that the social expectations that our society holds about men are structured by the masculine ideologies held in 'the broader culture' (Pleck, 1995).

6. TOP: Men's Roles

The increasing involvement of men during childbirth and throughout the parenting process adds weight to the argument not only for men to be involved in the process of abortion, but for research to acknowledge this trend, and explore the male partner's involvement further. Studies that did just this and went on to explore the actual experiences of the male partners during the TOP procedure (Neustatter, 1986; Shostack, Mclouth & Seng, 1984, cited in Boyle, 1997) identified a number of common themes; role uncertainty, shock at the absence of a constructive role for themselves, and the intense feelings men confront about the abortion. Similarly, Briggs,

Glover and Guthrie (2005) identified 'My Role' (confusion as to the role that should be adopted) as one of the main themes that male partners reported experiencing during a medical TOP procedure.

Boyle (1997) recognised that role uncertainty often leaves the partner feeling excluded or marginalised from the process, whilst at the same time feeling responsible for their partner being pregnant. The importance of understanding men's roles in the abortion process is highlighted by research that suggests male partners' coping expectations affect women's adjustment to the abortion process (Major et al., 1992).

6.1. TOP: Men's Emotional Reactions

In 1990 Shifman recognised men's standing in relation to the concept of abortion as having remained unchanged during the previous two decades. Many men respond to an abortion silently, as they believe that discussing their own pain and confusion would heighten their partners' concerns (Shostak et al., 1984).

Since this time, researchers have recognised the need for research studies to consider men's emotional reactions in response to an abortion (Major et al., 1992; Shostak et al., 1984).

Little information is available to date that describes the emotional states of these men including the presence of Anxiety and Depression. Furthermore, a literature search conducted via internet search engines, associated journals, cited references and secondary sources revealed that little is known about the specific emotions experienced by men during a TOP. Two dominant dimensions of emotional experience are regarded by many as accounting for the majority of variance in self-rated affect (Watson, Clark & Tellegen, 1988). These two factors are labelled Positive Affect (PA) and Negative Affect (NA). Positive Affect indicates the degree to which an individual feels enthusiastic and alert, conversely, Negative Affect denotes the degree to which an individual experiences a number of unpleasant mood states including anger, disgust, and fear (Watson et al., 1988). Clearly there is a need for further research to study the emotional states of men accompanying their partner through a TOP.

7. Masculinity: Men and TOP

Marsiglio and Diekow (1998) also recognised that men's responses to their partner's pregnancy are likely to be shaped by both interpersonal and personal factors, such as masculinity. It is therefore possible that the degree to which a man conforms to masculine ideals may influence his response to his partner's pregnancy and furthermore his abortion response.

7.1. Development of Masculinity

Masculinity has been shaped over recent years by the influence of feminist thinking on psychology (Seidler, 1989, 1991; Frosh, 1994). Many researchers believe that the influence of feminist thinking has resulted in a fragile view of masculinity, with unclear parenting and work role expectations. Further, it is felt that the influence of feminist thinking has left men with the uncertainty of what it actually means to be 'a man' (Frosh, 1997, p70). Masculine ideology is regarded as idealising rationality (Frosh, 1997). Many definitions consider masculinity as opposing the body and its associated emotions. In psychoanalytic terms, contesting the body is seen as a refutation of the power of the mother, on whom these mother's sons were once dependent. Subsequently, attempts to distance the self from his mother are viewed as attempts at withholding an ever-fragile masculine identity, to free the self from a dependent feminine nature (Frosh, 1997).

Seidler (1994) attributes the unstable view of masculinity to the challenging of rationality by feminist thinking in existence today. Rationality has traditionally been associated with the concept of masculinity. Rationality can be defined as 'the attempt to make meaning out of experience' (Frosh, 1997, p71). Attempting to challenge rationality is considered as opening the self up to confusions surrounding feelings and uncertainties that one would typically associate with femininity (Frosh, 1997). Frosh (1997) believes that the notion

of rationality should not be abandoned, but that it should open itself up to emotions, creativity and love; facets usually related with the irrational.

It is in accordance with these traditional views of masculinity and the extent to which they operate in society that boys are taught from an early age to avoid exhibiting behaviours that could be associated with femininity (Pleck & Thompson, 1987). Simon, (1997) recognised that childbearing and pregnancy are two capacities that are most associated with femininity and female gender identity. Interestingly, Humphrey (1977) found that men were most likely to associate fatherhood with masculinity.

7.2. Masculinity: Childbirth and Parenting

For a man to be present at the birth of their child, they risk being opened to a very emotionally provoking experience that in many ways could be viewed as breaking the 'first commandment of masculinity', (Hearn, 1984, p15). In his book 'Fatherhood Reclaimed', Adrienne Burgess (1997) postulated that deep within our psyches notions of femininity and male homosexuality are closely intertwined, resulting in men fearing being labelled not 'man enough' if they are to be seen engaging in the care of small children (p110).

Burgess (1997) recognised that men often conceal their desire to have children, and recognised that it is often more difficult for a man to admit that he wants a baby, than it is to declare the manly wish to have a son. Burgess

(1998) proposed that men often rely on their partner to express the unmanly wish to have a baby, as being intimate with young children is not part of western culture's masculinity scenario. Burgess stated further that what society expects of men socially are powerful inhibitors of men's participation in fathering. At the same time, Gilmore (1990) points out that fatherhood is not entirely outside of masculinity's remit, as provision and protection are fundamental characteristics of many definitions of masculinity.

7.3. Masculinity and Emotionality

Fejes (1992) stated that real men are repeatedly shown to be found in a world of objects, rather than in a world of family and relationships. In this sense, men are perceived as operating from a rational mind, rather than in response to their emotions, as men are often expected to be in control of their emotions as well as the situation they are in (Fejes, 1992). Previous research has suggested that men use aggression and hostility in order to replace avoided feelings such as fear and shame (Long, 1987; Dutton, 1998). It was suggested that men attempt to avoid such feelings due to masculine gender norms prohibiting emotionality (Jakupcak, Tull, & Roemer, 2005). However, it is proposed that masculine norms drive men's fear of emotions which in turn results in expressions of anger and hostility, rather than displays of aggressive behaviour being a direct attempt to conform to masculine norms (Long, 1987).

7.4. Hegemonic Masculinity

Connell (1995) defined the concept of hegemonic masculinity based on the notion of hegemony developed by Gramsci (1971). Gramsci used the term hegemony in an attempt to understand class relations, specifically how a dominant class manages to justify its rule in societies typified by class inequality. Based on Gramsci's (1971) work, Connell (1995) described hegemonic masculinity as 'the configuration of gender practice which embodies the currently accepted answer to the problem of legitimacy of patriarchy, which guarantees the dominant position of men and the subordination of women' (p77).

One area of gender research has considered the attitudes towards and the adoption of behaviours relating towards one's own health. One striking gender difference is the increased prevalence of risk-behaviours among men, compared to the safer, health-promoting behaviours of women (Courtenay, 2000). The distinct health attitudes of males and females prompted Courtenay (2000) to consider the constructions of health attitudes of men in terms of masculinity and health within a relational construct.

Many researchers have recognised the high agreement within society regarding the characteristics typically associated with masculinity and femininity; characteristics that have been adopted from culture (Williams & Best, 1990; Golombok & Fivush, 1994). It has further been recognised that

men and women are encouraged to conform to these dominant forms of femininity and masculinity and subsequently do (Eagly, 1987; Bohan, 1993). Geis (1993) and Crawford (1995) state that this behaviour operates in society as a self-fulfilling prophecy.

Increased societal pressure is placed upon men to endorse health-related beliefs in support of gendered societal prescriptions of what it means to be a man; including independence, self-reliance, strength and toughness (Williams & Best, 1990; Martin, 1995). Although such behaviours carry with them a number of health risks, it is felt that the risks are compensated for by the increased social acceptance achieved through demonstrating such power (Courtenay, 2000). Men play a role in constructing and reconstructing dominant norms of masculinity, as power demonstrated by men is crucial to constructionism (Courtenay, 1999). Furthermore, the practice of health behaviour is one that men use to demonstrate hegemonic ideals that establish them as men.

Hegemonic masculinity is regarded as the idealised type of masculinity operating at a certain time or situation (Connell, 1995). Hegemonic masculinity has been established as a representation of power and authority that overrules femininity as well as alternative forms of masculinity. It is felt that men's social relationships with women are shaped by hegemonic ideals (Courtenay, 2000).

Kaufman (1994) states that in order for men to demonstrate such power, they are required to acknowledge or admit to being in pain. Courtenay (2000) adds that further health-related beliefs and behaviours supportive of hegemony include the denial of weakness/vulnerability, appearing strong and robust, dismissing any need for help, having a ceaseless interest in sex, displaying aggressive behaviour, appearing to be physically dominant and emotional and physical control. Pyke (1996) regards these beliefs and behaviours as channels for maintaining gender inequalities, by reinforcing that men are more powerful and less vulnerable than women. Rejecting all that is feminine is considered crucial for demonstrating hegemonic masculinity (Courtenay, 2000).

O'Brien, Hunt & Hart (2005) presented the discussions and experiences of help seeking among a sample of men who had suffered from a range of illnesses. The discussions illustrated that not all men conform to the hegemonic ideal, instead, some men showed a greater willingness to consult medical professionals in response to health concerns. The willingness of men to consult medical professionals may depend on the clinical setting in which the consultation takes place.

7.5. Possible Relationships between Masculinity and TOP

Due to the lack of research linking masculinity and male partner's experiences of a TOP, related literature is drawn from areas of reproductive health. General psychology models are not reviewed at this stage, for example the transactional stress-coping model (Lazarus & Folkman, 1984), as it was of concern that such a generic model may have failed to recognize the unique nature of a TOP. It was therefore felt that it would be more appropriate to consider men's experiences of a TOP in relation to other reproductive health events/procedures in which the male and female tend to occupy distinct positions. Throughout the majority of reproductive health events, such as childbirth, foetal screening and miscarriage, the focus is placed primarily placed on the female, with the male partner typically attempting to find something to do. The reproductive health literature will inform predictions as to the possible relationships between masculinity and TOP. Firstly, we will consider the literature that suggests the more masculine men will experience a TOP more negatively.

For some men, if a TOP is against their wishes, it may be an extremely emotionally provoking experience. Hearn (1994) commented that being present at the birth of a child opens men up to emotionally provoking experiences, that he postulated break the 'first commandment of masculinity' (p15). In this sense for those men whose emotions are aroused by a TOP, they may experience a threat to their masculine identity.

As discussed previously, Nolan (1994) discovered that some men perceive themselves as helpless during their partner's labour, as they are unable to take her pain away. Occupying power and authority that overrules femininity is considered representative of Hegemonic masculinity as well as alternative forms of masculinity (Courtenay, 2000). Nolan recognised that the unfamiliar feeling of being out of control was an unfamiliar and uncomfortable experience for men who are socialised into masculine roles of authority. One might therefore assume that a TOP will provide a similar helpless and uncontrollable experience for men as that of childbirth. In this sense, one would expect more masculine men to experience a TOP more negatively.

Murphy (1992) suggested that men may feel that their manliness is compromised by a miscarriage, as a miscarriage may represent an inability to provide viable sperm. The above argument would similarly predict that the more masculine men, concerned with being 'manly' would be less negatively affected by a TOP, as their initial job of providing viable sperm was successful. One might argue further that if a healthy pregnancy is terminated, the male partner might experience this as a rejection of his sperm, and therefore a denial of his masculinity. Similarly, Humphrey (1977) found that men are most likely to associate fatherhood with masculinity. This therefore might result in the more masculine men reporting more negative affect and more distress during a TOP due to a rejection of their sperm and being prevented from becoming a father.

Conversely, aspects of the reproductive health literature suggest that the more masculine men have a more positive experience of a TOP. Pregnancy can be interpreted as proof of a woman's power (Zoja, 1997) which may threaten the power a man strives to embrace in order to confirm his masculinity. One would therefore predict that the more masculine men would experience a TOP more positively, as the possibility of a pregnancy and subsequently their female partner gaining a degree of power is removed.

Burgess (1998) stated that men fear that they will be considered unmanly if they engage in the care of small children, or express their desire to have a child, due to the feminine nature of intimacy between young children and men in Western culture, and the links between homosexuality and femininity within our psyches. A TOP once again eradicates the impending 'unmanly' fatherhood experience, and may result in a more positive perception of a TOP, and subsequently a more positive TOP experience.

The number of hypotheses above illustrate that the relationship between men's experiences of a TOP and masculinity is unclear.

8. Medical Environments

Due to the increasing profile of TOP within the media and among the government's targets, the TOP service within which the present study took

place is extremely keen to continually appraise their service with the aim of constantly improving. Specifically, it is of interest to the staff, how the environment and service provision is experienced and rated by male partners, in order to understand how best to engage these men in the future. Additionally, in relation to the theory adopted to guide the present study, social roles are thought to be influenced by a particular setting (Zurcher, 1983). Similarly, hegemonic masculinity is regarded as operating at a certain time or within a certain situation (Connell, 1995). The medical environment was therefore deemed an important factor when considering men's experiences of a TOP.

Within clinical settings, the environment is considered to be the first impression of the healthcare facility that a patient receives (Arneill & Devlin, 2002). The way in which a service is delivered is viewed as influential in one's perception of the level of care received, rather than the actual procedure or treatment provided (Arneill & Devlin, 2002). Patient's perceptions of the level of care received are often related to the interaction between themselves and the environment. A patient's perceived quality of care is therefore not only dependent on the positive interactions between themselves and staff, such as empathy, warmth and friendliness, but is also dependent on the clinical environment (Rempusheski, Chamberlin, Picard, Ruzanski & Collier, 1988; Wilde, Starrin, Larsson & Larsson, 1993).

Wilson-Barnett (1979) recognised that being a patient in a hospital or a doctor's office can be a stressful experience. In support of these findings, Volicer and Volicer (1978) identified a positive correlation between stress during hospitalisation and changes in HR and blood pressure. The unfamiliar environment of a clinical setting is one factor thought to precipitate such stress. Other factors include; loss of independence and sense of control, and being separated from one's friends and family (Carpman & Grant, 1993). Factors associated with the clinic environment that have been found to add to this stress include; overcrowding, noise, lack of privacy, ineffectual communication and the use of strange equipment (Winkel, 1986).

It has been suggested that if an environment communicates that the staff care about its appearance and function, and have designed it with the patient in mind, a patient is more likely to arrive with a positive image of the health care process. Banks (2001) suggests that men are put off by environments that on the surface appear to be female oriented. For example, surgeries that employ female receptionists and nurses, coupled with an enormity of children and women's health information in the waiting rooms.

Anecdotally it has been reported that a large number of male partners fail to attend TOP consultation clinics and TOP hospital appointments with the female patient.

9. Summary

In conclusion, research into men's experiences of a TOP is limited. Little is known about men's emotional reactions and the roles they adopt during this process. The current study has drawn upon the reproductive health literature to hypothesise possible relationships between masculinity and men's experiences of a TOP. The number of hypotheses explored illustrates the lack of clarity when attempting to understand men's experiences of a TOP. The exploratory design of the present study is therefore supported by the ambiguity of the related literature.

10. Rationale for Current Study

The increasing involvement of men in issues of reproductive health and parenthood is not only considered to be socially desirable, but is beginning to prove to be an area worthy of further research (Draper, 1997). The TOP procedure has received limited research interest in terms of the men involved (Conklin & O'Connor, 1995) despite existing research suggesting that the male partners often provide positive support to the female (Major et al., 1992).

Furthermore, given that the government has launched a strategy aimed at changing the sex attitudes held by society (Department of Health, 2002), it would seem imperative to carry out research in an area recognised as

requiring change, especially as at present, the experiences of these men is an under-researched area (Conkllin & O'Connor, 1995). An exploration into men's experiences and feelings during a TOP may shed some light on the possible needs of men whose female partner is undergoing a TOP. An exploration may also expand upon the current literature, which views men as adopting a supportive role.

The current study aims to provide a more in-depth understanding of men's own experiences, their feelings, any active roles adopted, and the impact that masculinity can have on their experience. Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000) are employed as a guiding framework to explore the experiences, masculinity, and roles adopted by men accompanying a female through a TOP. The study aims to explore mood, feelings, masculinity, roles adopted and medical environment ratings by carrying out a quantitative piece of exploratory research based analysis of one group of participants (men who are present at a TOP hospital appointment with their female partner).

A detailed awareness of these men's experiences could then be used to inform medical professionals in this area of how best to approach and engage these individuals. An increased ability to engage these men will hopefully offer increased opportunities to provide sexual health and contraceptive advice to a larger sample of men. It is anticipated that the

provision of such information and advice will hopefully work towards reducing the number of future unwanted pregnancies. Additionally, a greater understanding of men's experiences of a TOP will provide medical staff with the necessary information to respond more effectively and sensitively to the needs of these men. Effective and sensitive responses will hopefully reduce the distress and negative affect experienced by these men.

11. Research Questions

In relation to the existing research findings relating to men's involvement in a TOP, the following research questions are put forward:

Primary Research Questions

1. What are male partners' feelings during the termination of pregnancy procedure?
2. What are male partner's levels of distress during the termination of pregnancy procedure?
3. What roles do the men perceive that they play during the termination of pregnancy procedure?
4. What do male partners perceive as the reasons for adopting these role(s)?
5. Is there a relationship between the role(s) adopted, and the level of distress experienced?

6. Is there a relationship between overall masculinity scores and levels of distress and affect experienced during the TOP.
7. To what extent do the roles adopted and masculinity scores predict mood and affect?

Secondary Research Questions

8. How do men feel the service could improve from presentation to end of episode?
9. What are male partners' experiences of the clinic environment?
10. Why do some men fail to attend the termination of pregnancy procedure with their partner?

The last research question cannot be addressed directly, as access to the male partners that fail to attend will not be possible, it will therefore be answered by seeking the views of the male partners who do attend.

CHAPTER TWO: METHODOLOGY

Overview

This study was a quantitative piece of exploratory research investigating the experiences of men accompanying their female partner through a TOP procedure on a gynaecology day ward. Specific aims included investigating the levels of distress experienced by these men, uncovering the roles adopted by them during this process, exploring their masculinity, and discovering if any relationships existed between these three concepts.

1. Design

An exploratory study, using quantitative and some descriptive data was conducted. A cross-sectional questionnaire design relied on the collection of data from male participants. Data were collected from men whilst they accompanied their female partners through a TOP procedure. Questionnaire packages given at a single time point provided quantitative data and were analysed using descriptive statistical tests. Open-ended questions on the questionnaire provided the more in-depth data, these were analysed using Content Analysis (Barker, Pistrang & Elliot, 2003).

2. Setting

The present study took place on a gynaecology outpatient day ward within an NHS Hospital. During the 12 month period prior to data collection (August 05 – end of July 06), 1179 Terminations of Pregnancy (TOPs) took place on the ward. Of the 1179, 1044 were Surgical (STOPs) and the remaining 135 patients had Medical Terminations (MTOPs).

2.1. The Termination of Pregnancy Procedure

Females attending the Hospital for a Termination of Pregnancy Procedure are told to arrive at the Gynaecology Day Ward at 8am on the morning of their appointment. Patients and their family members/friends arrive at the waiting room, and wait to be approached by a member of the nursing staff. The female patients are then shown to the ward by the nurses on duty. Surgical Termination (STOP) patients are shown to the main 11 bed ward, Medical Termination (MTOP) patients are shown to a 4 bed ward. Each ward has its own separate waiting room. All accompanying friends and family members (including partners) are told that they can wait in the waiting rooms; individuals accompanying a STOP patient are not allowed onto the ward at any time due to space limitations. For patients under the age of 16, one family member/friend is allowed onto the ward. Patients undergoing a STOP may return to their families/friends in the waiting room for a short period of time in between seeing the Consultant, and waiting to have their

procedure. After this point, male partners do not get to see their female partner until the females are ready to leave the ward at 2pm to go home. Therefore, male partners accompanying a female to a STOP procedure spend the entire length of their partner's stay in the waiting room. When it is time for the patients to have their procedure, they are taken to theatre and returned to the day ward following the Termination, which takes approximately 10 minutes. STOP patients are normally on the ward for 6 hours, this usually involves arriving at 8am and leaving the ward to go home at 2pm the same day.

Patients undergoing an MTOP procedure are allowed to be accompanied on the ward by their partners. For the present study, the male partners of MTOP patients were only approached if the female was attending for the second visit, 48 hours after taking the initial Mifepristone tablet. Male partners were only approached on the second visit, as this appointment is relatively lengthier in time than the first visit. Additionally, it is at the second stage when the 'product' is passed, this stage was therefore deemed the most significant appointment in terms of regarding the termination as complete. At the second visit, there is a period of approximately 2 hours when the patient is allowed off the ward with their partner, however, they are told they must return at a specific time. The entire second visit requires the female patient to remain within the department for 6 hours.

The MTOP procedure is such that male partners are involved slightly more than during the STOP procedure. Females arrive at 8am, the male partners typically wait in the waiting room until their partner is allowed up from bed rest, and this is at approximately 9am. At this stage many couples leave the ward to go for a walk, but they are told to remain within the building and to return to the ward by 11am.

3. Participants

3.1. Recruitment

Recruitment took place in one Gynaecology day ward. Male partners accompanying women to a TOP procedure in the region under study between the months of August 2006 and March 2007 were approached as they arrived at the ward at approximately 8am and asked to take part in this study. Participants were approached on days when the researcher was available; therefore not every accompanying male partner was approached to take part. Participants were therefore recruited via a voluntary, self-selecting sampling method.

Men were approached whilst they were in the waiting room, after their partner had been admitted onto the ward. The men were asked if they would take part in a research project by completing a questionnaire. If the men agreed, the researcher provided them with the necessary documents (see

Procedure, Methodology section 5). In drawing from this population the inclusion criteria were as follows;

- Men who were accompanying their female partner through a TOP procedure.
- Over 18 years of age

The exclusion criteria for this study were as follows;

- Participants with evident mental health problems
- Participants displaying evidence of alcohol or substance misuse
- Participants whose first language was not English
- Individuals choosing not to participate
- Males under the age of 18 years
- Males partners accompanying females under the age of 18 years
- Males accompanying women having a TOP because of foetal abnormality.

The primary investigator and the staff on the gynaecology ward made the necessary judgements to ensure the above exclusion criteria were adhered to. If participants appeared to be under the influence of alcohol or other substances, they were not approached to complete the questionnaires. Specific questions with regards to an individual's mental health were not asked, however if an individual appeared to be extremely distressed, they

were not approached to participate. Participants were asked to provide their age at the start of the questionnaire. Women having a Top because of foetal abnormalities were screened out by the nurses working on the ward.

3.2. Response Rate

Data were collected for the present study on a gynaecology day ward, during the period between August 2006 and March 2007. Participants were approached on days when the researcher was available; therefore not every accompanying male partner was approached to take part. During the data collection period 116 MTOPs and 573 STOPs were carried out. The researcher was present for 40% of the MTOPs (N=46) and for 45% of the STOPs (N=256) carried out during the data collection period.

Table I: Response Rate & Attendance data

	Frequency (%)				
Type of TOP	Females accompanied by Male Partner	Male Partners consenting to participate	Females attending alone	Females accompanied by someone other than their partner	Refusers
MTOP	19 (41.3)	19 (100)	6 (13)	21 (45.7)	0 (0)
STOP	56 (21.9)	44 (78.6)	96 (37.5)	104 (40.6)	12 (21.4)

Table I displays the frequency of female TOP patients accompanied by a male to the gynaecology ward. Additionally, frequency data for the male partners consenting to participate and those refusing to participate are also

represented in table I. Among the 12 males who refused to participate in the present study, 6 were unable to stay due to work and/or family commitments (e.g. taking their children to school), 4 of the males were aged under 18 and therefore fell under the exclusion criteria, 1 male was a non-English speaker, finally, 1 male refused to participate but did not provide a reason.

4. Measures

4.1 Study Questionnaire (APPENDIX VI)

A questionnaire was designed specifically for the present study to investigate the demographic details of each participant, and to explore the roles adopted by these men during the TOP.

4.1.1 Section 1. Demographics

All participants were asked to report their age, occupation, qualifications, relationship status, and their relation to the female patient, whether they have any children and whether they have attended a TOP procedure before. Participants were also asked to outline their partner's referral pathway.

4.1.2 Section 2. Roles

Participants were asked to rate the extent to which they felt they had adopted 5 different roles on a Likert scale ranging from 1 (not at all) to 5 (very much so). Participants were then asked to explain why they thought they had adopted each role to the extent they had rated on the scale. The 5

roles included in the questionnaire were taken from a recent study which considered men's roles during the process of foetal screening and diagnosis (Locock & Alexander, 2005). To avoid limiting the range of possible roles that men in the present study may have identified themselves as adopting, an additional question was added for men to list any extra roles they felt that they had adopted and the associated reasons.

4.2 Masculinity Measure (APPENDIX VII)

Refer to CHAPTER TWO A: Development of the Masculinity Measure

4.3 Hospital Anxiety and Depression Scale (HADS)- Zigmond & Snaith 1983

The HADS was used in the present study to identify the presence of any anxiety and depression symptoms among the participants. The HADS is a well known and widely used measure within health care settings.

The HADS is a 14 item self report measure of anxiety and depression designed for measuring distress in medical outpatient populations, developed by Zigmond and Snaith (1983). The subscales of anxiety and depression are each made up of seven items, each item is rated on a 4-point scale from 0-3. Total scores of between 8 and 10 identify mild cases, 11-15

moderate cases and 16 or above severe cases of anxiety or depression separately (Snaith & Zigmond, 1994).

Herrmann (1997) recognised more than 200 publications reporting original experiences with this instrument in over 30,000 individuals. Herrmann (1997) found the scale to be well accepted by both patients and non-patients. Herrmann's (1997) review of over 200 published studies obtained results showing satisfactory or good item-total correlations within the two subscales. Retest reliability uncovered a high correlation, r>.80, after up to two weeks (Salkovskis, Stoer, Atha & Warwick, 1990).

Snaith & Zigmond (1994) reported concurrent and construct validity of the HADs in studies of physically ill populations. More recently, Whitmarsh et al. (2003) utilised the HADs in their study, they found the internal consistency for anxiety and depression to be .89 and .75 respectively.

4.4. The Positive and Negative Affect Schedule (PANAS-X) (Watson & Clark, 1994) (APPENDIX VIII).

The Positive and Negative Affect Schedule (expanded version) (PANAS-X) (Watson & Clark, 1994) was used in the present study to ascertain more detailed measures of the emotional states of the participants. The original version of the PANAS (Watson, Clark, & Tellegen, 1988) is generally used to assess the two broad dominant dimensions of emotional experience; these

general factors are typically labelled Positive Affect (PA) and Negative Affect (NA). The original PANAS has been shown to possess good psychometric properties when sampled across a general adult population. Additionally, the scale has proved to be both reliable and valid (Crawford & Henry, 2004).

The expanded version of the PANAS (PANAS-X) provides for mood measurement at two different levels by assessing 11 specific emotional states in addition to the original two high order scales. The specific emotional states include Fear, Sadness, Guilt, Hostility, Shyness, Fatigue, Surprise, Joviality, Self-Assurance, Attentiveness, and Serenity. It was therefore felt that the expanded version of the PANAS would provide a greater insight into the range of emotions experienced by the participants during a procedure as potentially distressing as a TOP. The expanded version of the scale comprises of 60 items. The items all of which describe different feelings and emotions are set up on 5-point likert scales. The scale ranges from 'very slightly or not at all' to 'extremely'.

Watson and Clark (1994) provide extensive data demonstrating that trait scores on the PANAS-X are stable over time, show significant convergent and discriminant validity, and strongly relate to measures of personality and emotionality.

Due to the emotionally charged circumstances under which data was collected for the present study, the researcher realised the importance of keeping all measures as brief as possible for the theoretical requirements of the present study. Therefore, only those items relevant to the present piece of research were selected. This meant eliminating 19 of the original 60 items, resulting in a 41 item scale. In order to reduce the length of the questionnaire further, items were eliminated if they were regarded as synonyms of other items in the two general PA and NA scales. Consideration was also given to the participants who would be distressed during data collection; it was felt that it would be insensitive to include too many descriptions of positive emotions in the scale. Therefore many positive emotions such as cheerful and delighted were eliminated. For data analysis, individual item results were used, as were PA and NA total scores.

4.5 Clinic Environment Questionnaire (APPENDIX IX)

In order to understand fully the experiences of men accompanying a female to a TOP procedure, it was considered as important to understand how these men experienced the different NHS clinic environments at their different appointments, and if they felt the service could be improved in any way. Therefore, participants were given the opportunity to rate and comment upon their experiences at the consultation clinic, and on the hospital ward. For this purpose, the researcher developed a questionnaire for participants

to rate and comment upon their experiences of these different environments. The questionnaire was made up of open-ended questions and 5-point likert rating scales.

The first section of the questionnaire required participants to rate the consultation clinic environment on two 5-point likert rating scales. Participants were then asked to comment upon what they considered to be the best and worst aspects of the clinic. Finally participants were asked to give their suggestions for how the clinic could be improved.

The second section of the questionnaire was identical to the format of the first section, instead of answering about the consultation clinic, participants were asked to answer the questions about the hospital ward environment.

The third section of this questionnaire asked participants to comment upon the Information for Partner's leaflet. This included yes/no tick boxes relating to whether their partner gave them the leaflet, and whether they had read the leaflet. If participants had read the leaflet, they were asked to comment upon what they found useful about the leaflet, as well as what was not useful to them. Participants were asked to comment upon how they felt the leaflet could be improved. For the fourth section, participants were asked to rate on a 1 to 5 Likert rating scale how difficult it was deciding whether or not to attend the procedure with their partner. Participants were also asked to comment upon the factors that contributed to them making this decision.

Finally, participants were asked why they thought some men fail to attend the TOP process with their partner. As this research question could not be addressed directly, due to the impossibility of accessing the male partners that fail to attend, the male partners who did attend, were considered to have the next best insight into their reasoning. It was therefore hoped that this data would indicate methods that could be used to improve the inclusion of men during future TOP procedures.

5. Procedure

Ethical approval was sought and gained from the local research ethics committee (appendix II). This then led to the relevant NHS Trust being approached. Full ethical Trust and R&D approval was gained and an honorary contract was awarded (appendix II).

Upon attending the ward, all participants accompanying their female partner to a TOP procedure were approached and asked if they would consider taking part. Potential participants were then supplied with an information sheet outlining the purpose of the study. The information sheet clearly outlined that the study was only open to participants over the age of 18.

After allowing participants sufficient time to read through the information sheet, the researcher approached the potential participants to obtain verbal

consent, and written consent by signing the consent form. Potential participants were given the chance to ask the researcher any questions they may have had. Those who did not choose to take part were not asked to give a reason for this, however, a record was kept of the number of men choosing not to take part.

Participants were asked to complete the questionnaire package whilst waiting for their partner, in either the main waiting room for STOP patients, or in the waiting room for MTOP patients. The questionnaire package took participants between 20 and 45 minutes to complete.

6. Ethical Considerations

For the purpose of the present study, men were approached directly; permission was not sought beforehand from their female partner/the NHS patient. Typically, research studies that involve the partners/ family members of NHS patients require consent from the NHS patient first, as the data collected often includes personal information about the NHS patient. This issue was discussed by the ethics committee who decided the female did not need to consent to participation first. For the purpose of the present study the ethics committee did not identify any items on the questionnaires requiring personal information about the NHS patient; it was therefore felt that consent should be sought solely from the male partner.

Verbal and written consent was obtained by all participants before they completed the study questionnaire, additionally; participants were reminded that they could withdraw from the study at any time. All questionnaires were anonymised and stored in a locked cabinet.

Throughout the entire study, the researcher acknowledged the potential distress that may arise from the termination of pregnancy procedure, and therefore was sensitive to each participant and their individual needs. When participants were identified as distressed, either from their scores on the proposed measures, or from their presentation, the researcher was able to access the Pregnancy Advisory Service (PAS) specialist counsellors if the individual wanted further help and consented. A counselling service for the male partners is not routinely available, and is usually available for the female patients only. For the purpose of the present study it was negotiated that for the male partner's requiring such help, referrals could be made to this specialist counselling service.

A contact number was provided on the consent form, giving the participants the option to access the study conclusions

7. Data Analysis

7.1. Analysis of Quantitative Data

All the quantitative questionnaire data were analysed using SPSS software (version 14.0). The demographic details of all participants were collated. These data were explored using descriptive statistical techniques. Histograms were plotted for each mood and affect measure. Histograms were also plotted for the adoption of roles frequency data, and the environment ratings. Pearson Correlations were used to consider the relationships between roles, and any relationships between masculinity scores, mood and affect. The non-parametric statistical Spearman Correlations were employed to analyse any relationships between roles, mood and affect. A Spearman Correlation was employed due to the failure of the data to be normally distributed.

7.2. Analysis of Qualitative Data

Qualitative data obtained from the open-ended questions contained within the questionnaire packages were analysed using a content analysis procedure, this allows the data to be transferred to categories (Barker et al. 2003). The responses to the open-ended questions were grouped into common responses and then given a suitable label which in this study is termed the 'theme'. A secondary source also grouped the responses into categories in order to allow the primary investigator to ensure that the

categories chosen were as suitable as possible. The concordance level between the two categorisations was high. Both sources agreed on 96.2% of the themes. The remaining themes were then jointly considered until an alternative theme or eradication of the theme was decided upon. During data analysis it was determined that participant responses to the questions focusing on the Information for Partners leaflet were somewhat arbitrary and could not therefore be separated into themes. In this instance, the few responses were analysed individually.

CHAPTER TWO A: DEVELOPMENT OF THE MASCULINITY MEASURE

The study required that the participants be given the opportunity to indicate the degree to which they regard themselves as operating on a number of characteristics associated with the concept of masculinity. For this purpose, existing measures of masculinity were considered. These included, the Bem Sex-Role inventory (Bem, 1974), the Auburn Differential Masculinity Inventory (Burk, Burkhart & Silkorski, 2004), and the Conformity to Masculine Norms Inventory (Mahalik et al. 2003).

The Bem Sex-Role Inventory was deemed inappropriate for the purpose of the present study, as many gender-role perceptions have changed since its development 33 years ago (Holt & Ellis, 1998), therefore many of the items on this Inventory did not appear to fall in line with more up to date research on masculine characteristics. The Auburn Inventory (Burk et al. 2004) consists of 60 items, this was considered to be too long for the purpose and sample included in the present study. Additionally, many of the item statements appeared somewhat extreme and egotistical (hypermasculine), and this was not the focus of the present study. Finally, the Conformity to Masculine Norms Inventory (Mahalik et al. 2003) was sampled on a limited population of American Caucasian young adult students. The validity of this inventory was therefore not deemed transferable to the sample of men

included in the present study; the present study was likely to include a sample of primarily British men varying in culture and level of education.

The researcher therefore created a questionnaire specifically to fulfill this requirement. This was achieved by reviewing the previous and more recent literature describing frequently reported masculine characteristics (O'Brien et al, Hunt & Hart, 2005; Jefferson, 2002, & Good, Wallace & Borst, 1994; Courtenay, 2000) to create a 21 item rating scale. For each masculine characteristic, 2 rating scale items were created, for one of the characteristics 3 items were created. Participants were asked to rate the extent to which they considered themselves to possess a number of masculine characteristics by responding to five-item Likert scales (1 and 5 representing opposite extremes of each characteristic).

This measure was piloted on 12 males and 10 females. The internal consistency of the items produced an alpha of .730. The individuals who took part in the pilot data collection were asked to provide comments and suggestions in order to improve the structure and content of the questionnaire. Comments on the piloted questionnaire were also sought from a researcher experienced in studying masculinity. Following the pilot, and the experienced researcher's suggestions, a number of alterations were made to the layout of the measure, to make it clearer and simpler to

complete. Following the modifications, this measure was given to all participants included in the present study at a single time point.

Given the good alpha value obtained from the pilot questionnaire data, a Coefficient alpha was not re-calculated at this stage. The total scores obtained on the Masculinity Measure were entered into Pearson Correlations along with the mood and affect scores obtained on the HADS and the PANAS. Pearson Correlations were utilised to identify existing relationships between overall masculinity scores and the mood and affect scores; in order to confirm research hypothesis 6; 'There will be a relationship between overall masculinity scores and the levels of mood and affect experienced during the TOP' The analyses obtained results that were not significant and that did not follow a clear pattern.

At this point, the reliability of the measure was reconsidered. Coefficient alpha was calculated on the average of all possible split-half reliabilities from the Masculinity Measure. It was found that Alpha was 0.622. It is generally accepted that a coefficient alpha of 0.8 to 1.0 is satisfactory for the purpose of psychologically based research (Howitt & Cramer, 2000). As the coefficient value did not fall into the accepted range, further analyses were considered. Interestingly, the coefficient value obtained for the present study differed from the coefficient value of .730 obtained by the pilot study.

A Factor Analysis was employed to determine whether any underlying factors could be identified within the Masculinity Measure that represented separate facets of Masculinity, as opposed to the single masculinity factor originally presupposed by the present study. It was hypothesised that a Factor Analysis would identify two or more separate supervariables.

Principle-components analysis was performed on the 21 items of the Masculinity Measure from a sample of 63 men. Three factors were initially extracted. Item 'Asking for help' did not load onto any of the three factors; this item was therefore removed from the analyses. Four of the nine factors loading onto the third factor loaded onto one of the other two factors to a greater extent. These were; 'Ignoring own wants and needs', 'Lashing out physically when provoked', 'Mental toughness', and 'How often thinks about sex'. As a result of the small number of items loading onto factor 3, factor 3 was extracted, and factors one and two were analysed further.

Despite loading onto either factor one or factor two, items 'Pain tolerance', 'Admitting when in emotional pain' and 'Enjoying life without sex' also loaded onto factor three to a greater extent. It was therefore felt that these items should not be included in factor one or factor two. Once these items were extracted the internal consistencies were calculated for the remaining two factors. Factor one yielded a Coefficient Alpha of 0.796, with all variables loading onto factor one at 3.85 and above. Initially, factor two yielded a

Coefficient Alpha of 0.694. It was noted that removing the item 'Physical Power' would cause the Coefficient Alpha value to increase to 0.716. This item was considered and it was decided that its interpretation could differ greatly from one individual to the next. This item was therefore removed. The remaining items on factor 2 loaded at 0.395 and above. Table 2 displays the three original factors extracted. The items that do not appear in bold are the items that were removed. Figures in bold represent the loading of their item on the respective factor.

Table II: Original Component Matrix for the Masculinity Measure.

	Component		
	1	2	3
Cannot ignore my own wants/needs		**0.484**	0.331
My needs are my number one priority			0.408
Asking for help			
Pain tolerance	0.387		0.443
Admitting when in physical pain			
Admitting when in emotional pain	0.303		0.539
Level of vulnerability	**0.582**	0.346	
Feeling inadequate	**0.486**	0.335	
Level of emotionality	**0.564**		
Lashout physically when provoked	-0.41	**0.466**	0.318
Mental Toughness	**0.562**	0.393	0.317
Reliance on others for help	**0.537**	0.309	
How often thinks about sex		**0.622**	-0.384
Enjoying life without sex		0.318	-0.473
Behaving aggressively	-0.487	**0.689**	
Voice and speech in stressful situations	-0.555	**0.398**	
Physical power		0.52	
Dependence on others	**0.606**	0.417	
Need to be in control	**0.459**	0.381	
How often cries	**0.408**		
How copes under pressure	**0.781**		

Factor one and factor two (and their associated items) created two separate masculinity factors. Factor one comprised of items high in emotional control. Factor one was therefore labeled 'Masculinity: Emotional'. Factor two comprised of items low in physical and emotional control; factor two was therefore labeled 'Masculinity: Uncontrolled'. 'Masculinity: Emotional' and 'Masculinity: Uncontrolled' therefore replaced the original Masculinity Measure and were entered into a number of Pearson Correlations in response to research question 6; 'Is there a relationship between overall masculinity scores and levels of distress and affect experienced during the TOP?'.

CHAPTER THREE: RESULTS

Overview

This chapter will describe the results of the statistical analysis utilised for this study. Firstly, the sample is described via the presentation of demographic data characteristics. Each research question is then considered in turn. The concepts considered include mood, affect, roles, masculinity and an evaluation of the TOP service. A Content Analysis method was utilised to analyse the responses to all open-ended questions.

1. Description of the sample

A summary of the demographic data derived from the sample is presented in Table 1 and Table 2 overleaf, the data is discussed in more depth below. Table 1 represents the participant characteristics and demographics. Table 2 represents data relating more specifically to the TOP.

Participants Characteristics

Age

The men participating in this study were aged between 18 and 50 years and had a mean age of 26 years (std dev, 25.87).

Education/qualifications and socio-economic class/status

In terms of educational attainment the majority of the sample had achieved at least O-level/G.C.S.E level. Almost 20% of the sample (N=11) did not have any qualifications. Information regarding the participants' employment was categorised according to a modified version of the classes utilised by the Socio-economic classification from the Office for National Statistics (2001). The classes were modified for the purpose of the present study to simplify the process of assigning occupations to employment classes. Also, it was felt that the classes used by the Office for National Statistics (2001) were too specific for the present study, beyond the requirements for the current data analysis.

Living Arrangements and Relationship Status

All participants reported being the partner of the female patient they were accompanying. All participants reported that they were the father of the pregnancy to be terminated, 50.8% (N=32) of the participants reported living with their female partner, 49.2% (N=31) of the participants reported living separately from their partner. The results showed that the majority of the participants (85.8%, N=54) had been in a relationship with their female partner for 5 years or less; 35% (N=22) of the male participants had been in a relationship with their partner for less than one year.

Any Children

The majority of the participants did not have any children of their own at the time of the study 55.6% (N=35/63). For those participants reporting having additional children, it was most common for the men to have one child at the time of the study 23.8%.

2. TOP Information

Previous attendance at a TOP and Type of TOP

Only 7.9% (N=5) of the sample reported having previously attended a TOP. The majority of the participants were accompanying a female having a STOP (69.8%, N=44).

Number of weeks pregnant

Reports of the number of weeks pregnant ranged from 4 to 13. The majority of the men were accompanying a female between 8 and 10 weeks pregnant (57.1%, N=36).

Referral pathway and presence at the Clinic Consultation

The majority of the male participants reported that a G.P. had referred their partner for a TOP (74.6%, N=47). The rest of the sample reported that their partner had been referred by a Family Planning Clinic, a Sexual Health Clinic or a Hospital. Finally, 57.1% (N=36) of the sample reported being present at the TOP clinic consultation.

Table III. Frequencies and percentages data of socio-economic status, level of qualification/education, living arrangements, length of relationship and any children.

PARTICIPANT CHARACTERISTICS					Frequency (%)
Age	**Mean (years)**	**Range**	**SD**	**N**	
	26	18-50	25.87	63	
Highest Qualification					
No qualifications					11 (17.5)
O-level/G.C.S.E's					19 (30.2)
A-Levels					14 (22.2)
Diploma					8 (12.7)
Degree/professional qualification					9 (14.3)
Postgraduate degree					2 (3.2)
Total					63 (100)
Socio-economic Status					
Student					7 (11.1)
Skilled Trade					14 (22.2)
Unskilled Trade					11 (17.5)
Clerical					1 (1.6)
Managerial					5 (7.9)
Professional					13 (20.6)
House Husband					1 (1.6)
Unemployed					3 (4.8)
Sales					3 (4.8)
Other					5 (7.9)
Total					63 (100)
Living Arrangements					
Live Together					32 (50.8)
Live Separately					31 (49.2)
Total					63 (100)
Length of relationship					
Less than 1 year					22 (35)
1-5 years					32 (50.8)
6-10 years					5 (8)
11-15 years					3 (4.8)
16+ years					0
Total					62 (98.6)*
Number of Children					
None					35 (55.6)
One					15 (23.8)
Two					8 (12.7)
Three					3 (4.8)
Four					2 (3.2)
Total					28 (100)

* Missing data for one participant

Table IV. Frequencies and percentages data of information of previous attendance at a TOP, type of TOP, number of weeks pregnant, referral pathway and presence at the clinic consultation.

TOP DATA	Frequency (%)
Type of TOP	
MTOP	19 (30.2)
STOP	44 (69.8)
Total	63 (100)
Number of weeks pregnant	
0-5	2 (3.2)
6-11	51 (87.9)
12+	5 (7.9)
Total	58 (92.1)*
Who referred the female?	
G.P.	47 (74.6)
Family Planning Clinic	6 (9.5)
Sexual Health Clinic	5 (7.9)
Hospital	5 (7.9)
Total	63 (100)
Present at the clinic consultation	
Yes	36 (57.1)
No	27 (42.9)
Total	63 (100)
Attended a previous TOP	
Yes	5 (7.9)
No	58 (92.1)
Total	63 (100)

* Missing data for 5 participants

3. Male partners' feelings

Participants rated themselves on a 5 point scale, where 'Not at all' = 1, and 'Extremely' = 5. The results are displayed in Table V overleaf in order of Quite a bit/Extremely ratings with most frequent at the top.

Table V: The results of the frequency of emotions experienced by the research sample during a TOP procedure.

Feelings	Frequency (%) Quite a bit/ Extremely	Frequency (%) Moderately	Frequency (%) Very slightly or not at all/ A little
Negative Affect			
Guilty	20 (31.8)	11 (17.5)	32 (50.8)
Upset	16 (25.4)	16 (25.4)	34 (53.9)
Nervous	14 (22.2)	13 (20.6)	35 (55.5)
Irritable	14 (22.2)	14 (22.2)	35 (55.5)
Afraid	11 (17.5)	14 (22.2)	39 (61.9)
Distressed	10 (15.9)	6 (9.5)	39 (61.9)
Scared	9 (14.3)	13 (20.6)	38 (60.4)
Ashamed	9 (14.3)	14 (22.2)	48 (76.2)
Hostile	3 (4.8)	4 (6.3)	56 (88.9)
Jittery	3 (4.8)	9 (14.3)	51 (80.9)
Positive Affect			
Determined	30 (47.6)	12 (19)	21 (33.3)
Strong	30 (47.6)	20 (31.7)	9 (14.3)
Interested	27 (42.9)	24 (38.1)	16 (25.4)
Active	26 (41.2)	19 (30.2)	17 (27)
Attentive	25 (39.7)	20 (31.7)	19 (30.2)
Alert	24 (38.1)	26 (41.3)	13 (20.7)
Enthusiastic	13 (20.7)	7 (11.1)	32 (50.8)
Proud	10 (15.9)	18 (28.6)	49 (77.7)
Inspired	9 (14.2)	4 (6.3)	47 (74.6)
Excited	3 (4.8)	8 (12.7)	52 (82.5)
Remaining Items			
Tired	33 (52.4)	11 (17.5)	19 (30.2)
Calm	25 (39.7)	21 (33.3)	17 (27)
Sad	22 (34.9)	19 (30.2)	28 (44.4)
Confident	20 (31.8)	10 (15.9)	22 (34.9)
Down heartened	20 (31.8)	13 (20.6)	30 (47.6)
Fearless	18 (28.6)	16 (25.4)	26 (41.2)
Relaxed	17 (27)	21 (33.3)	30 (47.6)
Happy	16 (25.4)	13 (20.6)	28 (44.4)
Angry at self	15 (23.8)	16 (25.4)	38 (60.4)
Blameworthy	14 (22.2)	19 (30.2)	33 (52.4)
Alone	9 (14.3)	4 (6.3)	50 (79.4)
Angry	9 (14.3)	11 (17.5)	43 (68.2)
Dissatisfied with self	9 (14.3)	13 (20.6)	41 (65)
Frightened	8 (12.7)	16 (25.4)	39 (61.9)
Lonely	7 (11.1)	9 (14.3)	47 (84.1)
Disgusted with self	7 (11.1)	6 (9.5)	50 (79.4)
Blue	6 (9.6)	16 (25.4)	41 (65)
Disgusted	4 (6.4)	6 (9.5)	53 (84.1)
Scornful	4 (6.4)	13 (20.6)	46 (73)
Shaky	4 (6.4)	8 (12.7)	51 (81)
Loathing	2 (3.2)	8 (12.7)	53 (84.2)

Feeling 'Guilty' was the most commonly felt negative affect item; 20 (31%) participants rated the extent to which they felt 'Guilty' as 'Quite a bit/Extremely'. Feeling 'Determined' was the most commonly felt positive affect item. (N=30). 47.6%. From the remaining 21 items, feeling 'Tired' was the most commonly felt item; 33 (52.4%) participants rated themselves as feeling tired 'Quite a bit/Extremely'.

It is interesting to note that among the remaining items, a large number of the participants rated themselves as feeling Calm (N=25, 39.7%), additionally, over one quarter of the participants rated themselves as feeling happy (N=16, 25.4%).

Figure I: Negative affect scores obtained by the research sample.

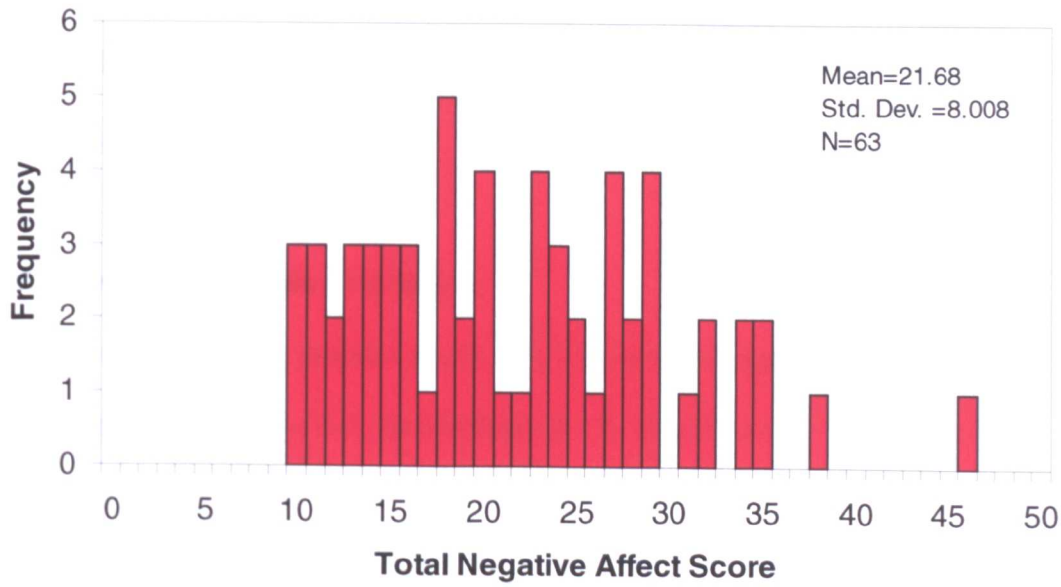


Figure I above shows that the majority of participants had negative affect scores between 10 and 30. Possible scores range from 10 to 50.

Figure II: Positive affect scores obtained by the research sample.

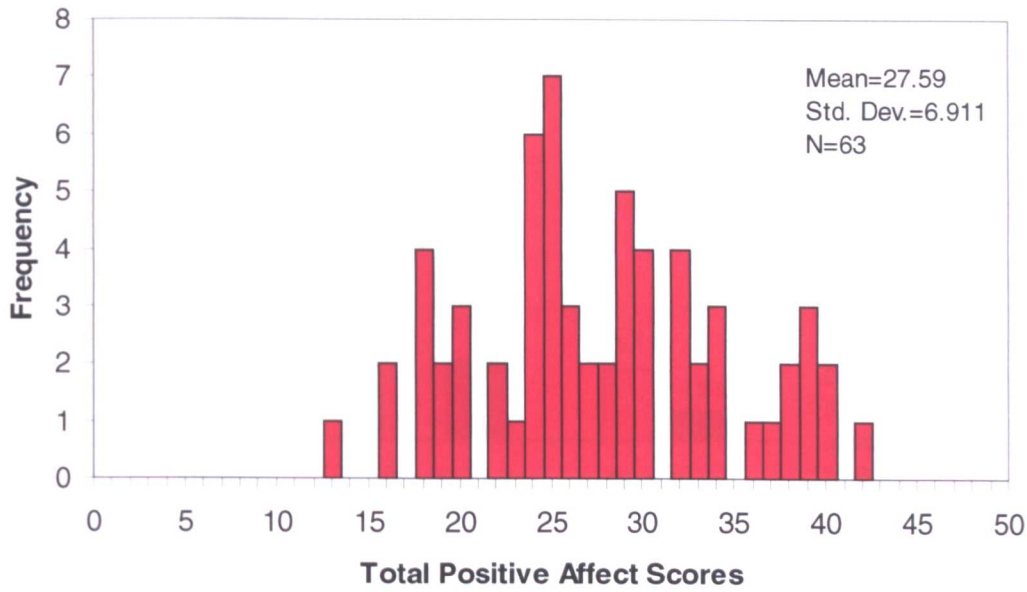


Figure II shows that the majority of the sample obtained positive affect scores of 21 to 34 out of a possible 50. No participants obtained positive affect scores of 12 and below.

4. Male partner's levels of distress

For the purpose of the present study, the following categorisations of scores are employed; Normal= 0-7, Borderline= 8-11, Significant= >11 (Zigmond & Snaith, 1983).

Figure III: Anxiety and depression scores from the HADs obtained from the research sample.

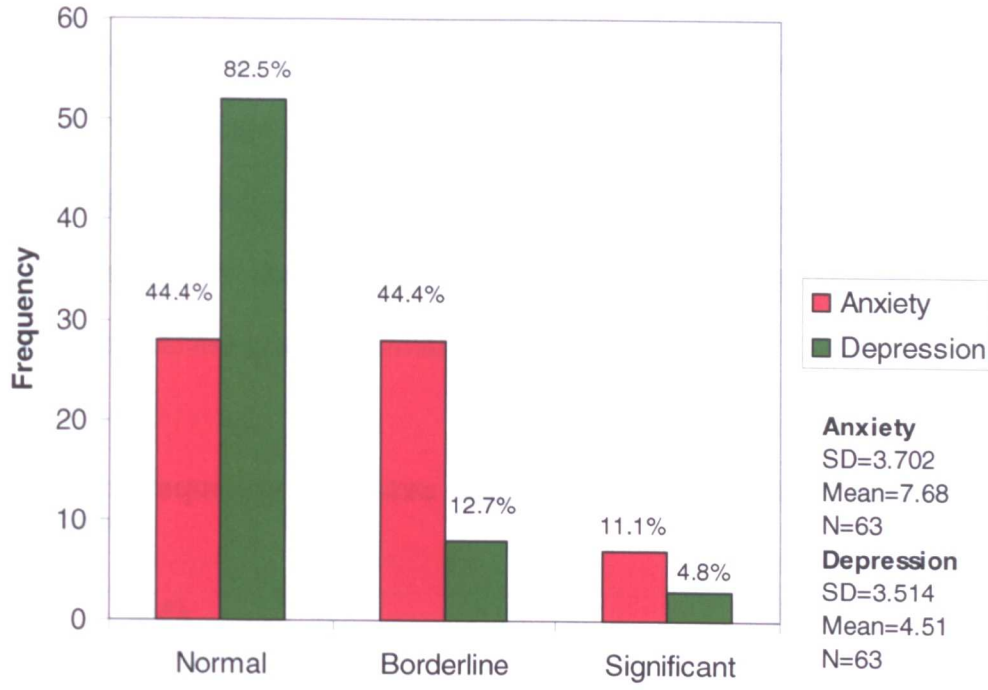
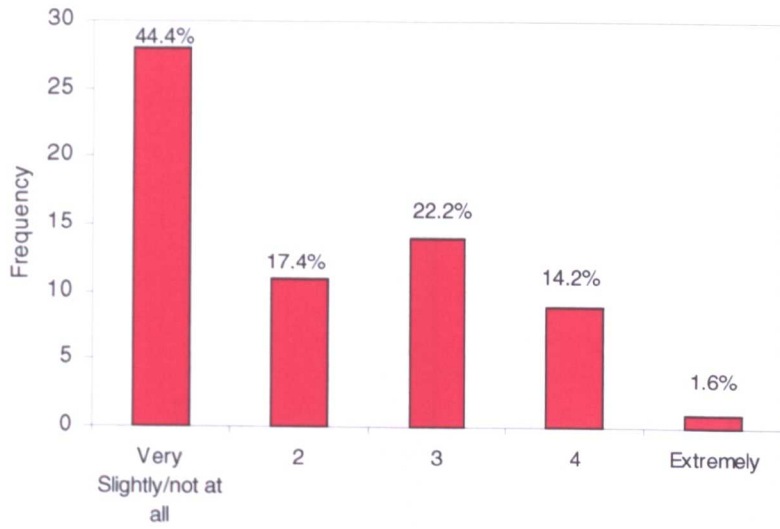


Figure III shows that the majority of participants obtained results within the 'Normal' range on the depression scale (N=52, 82.5%), N=8 (12.7%) obtained results within the 'Borderline' range on the depression scale, N=3 (4.8%) of the sample obtained scores within the 'Significant' depression range, The results obtained on the anxiety scale were a lot more evenly distributed between the three scoring categories of 'Normal', 'Borderline' and 'Significant'. The same number of participants obtained results within the 'Normal' and the 'Borderline' categories for anxiety. More participants obtained anxiety scores than depression scores within the 'Significant' category, with 11.1% scoring in this range. Within his study, Herrman (1997) presented the frequency of different patient group scoring within the different classifications for anxiety and depression. The results obtained in the

present study are comparable with certain types of patient groups. Within the present study, N=11 (17.5%) of participants obtained depression scores >8, this frequency data is comparable with the frequency of cardiological patients (17%) obtaining depression scores within this range (Herrman, 1997). The frequency of 'Significant' anxiety scores (11.1%) obtained by the present sample is comparable with the anxiety scores obtained by an oncology outpatient group (Hermann, 1997).

Figure IV: Frequency of scores obtained on the PANAS-X for the item 'distressed'.

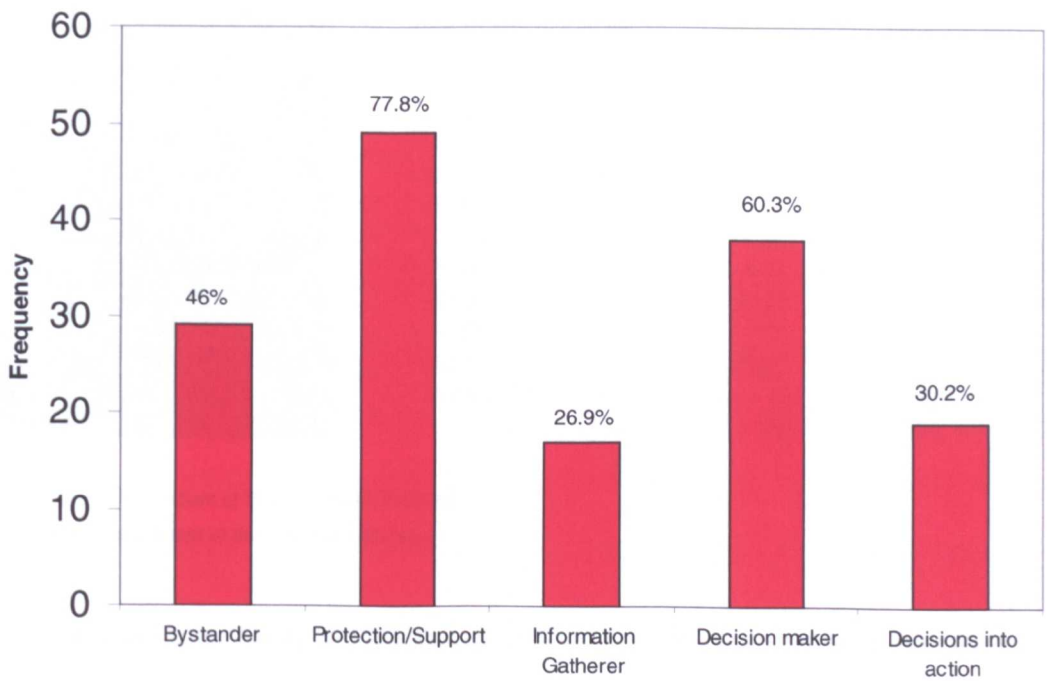


As can be seen from Figure IV, the majority of participants rated themselves as feeling 'Very slightly/not at all' Distressed. Only 1 participant (1.6%) rated himself as 'Extremely' Distressed.

5. Roles Adopted

All of the participants rated the extent to which they felt they had adopted each of the 5 role options included in the roles questionnaire; Bystander, Protection/support, Information Gatherer, Decision maker, Putting decisions into action. Participants were asked to rate themselves on a Likert scale ranging from 1 to 5; where 'Not at all'=1, and 'Very much so'=5. All graphs represent adoption of the roles to a significant extent, therefore displaying only ratings of a 4 and a 5.

Figure V: Frequency of participants rating themselves as adopting a role.



* Includes only the participants who rated themselves as a 4 or 5 for the extent to which they felt they had adopted a role.

Figure V displays the frequency of participants who rated the extent to which they adopted a role as a 4 or a 5 (Very much so) on the Likert scale provided. The most frequently adopted role was that of protector/support; 77.8% (N= 49/63) of the participants rated themselves strongly as adopting the role of protector. The least adopted role was that of 'Information Gatherer', only 27% (N= 17/63) of the men rated themselves as playing a major role in gathering information about the TOP.

Table VI: Correlation Matrix: Adoption of roles

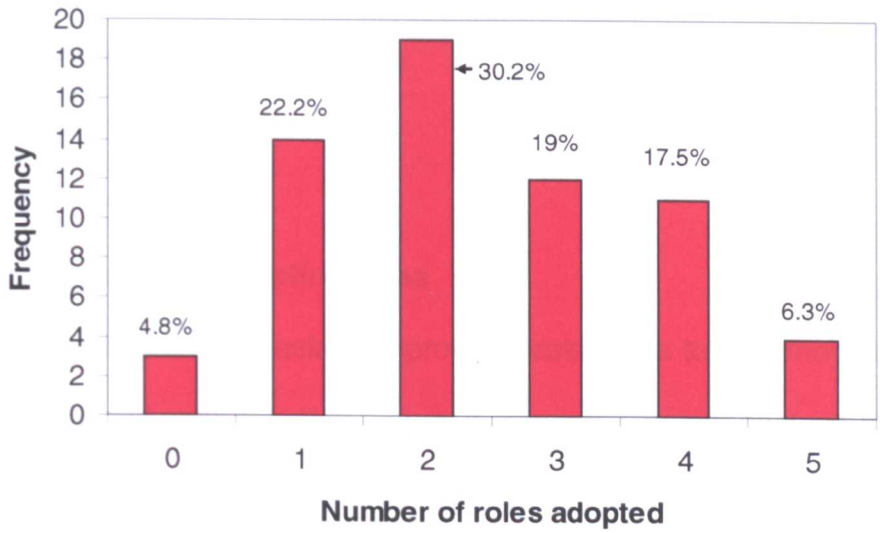
		Bystander Role	Protector Role	Information Gatherer Role	Decision Maker Role	Putting decisions into action Role
Bystander Role	Pearson Correlation	1	0.022	-0.117	0.032	-0.038
	Sig. (2-tailed)		0.863	0.361	0.803	0.765
	N	63	63	63	63	63
Protector Role	Pearson Correlation	0.022	1	.396**	0.071	.320*
	Sig. (2-tailed)	0.863		0.001	0.579	0.01
	N	63	63	63	63	63
Information Gatherer Role	Pearson Correlation	-0.117	.396**	1	0.01	.452**
	Sig. (2-tailed)	0.361	0.001		0.939	0
	N	63	63	63	63	63
Decision Maker Role	Pearson Correlation	0.032	0.071	0.01	1	.390**
	Sig. (2-tailed)	0.803	0.579	0.939		0.002
	N	63	63	63	63	63
Putting Decisions into Action Role	Pearson Correlation	-0.038	.320*	.452**	.390**	1
	Sig. (2-tailed)	0.765	0.01	0	0.002	
	N	63	63	63	63	63

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

As can be seen in Table VI; Information Gatherer Role appears to be related to Protector Role ($r= 0.396$, $p<0.001$) and Putting Decisions into Action Role ($r= 0.452$, $p<0.001$). Decision Maker Role appears to be related to the role Putting Decisions into Action ($r= 0.390$, $p<0.001$).

Figure VI: Frequency of roles adopted by the research sample



As can be seen from Figure VI the majority of participants reported adopting two roles. A large proportion of men reported adopting one role only. Three participants reported that they did not adopt any roles. Four participants reported adopting the maximum 5 roles.

5.1. Additional roles

6.3% of the participants (N= 4/63) commented on additional roles other than the five roles listed, that they felt they had adopted during the TOP process.

Table VII: Additional roles identified by participants

Participant Number	Additional Role Adopted
6	'Carer'
24	'More responsible'
40	'A voice for my partner when needs be'
49	'I feel as though she blames me for putting her through this'

Interestingly, among these few responses, only the response from participant 6 describes a clear role. The other 3 comments fail to identify an additional role that was adopted.

5.2. Reasons for adopting roles

Every participant was asked to provide reasons as to why they thought they had assumed each role that they had adopted. Content analysis was used to analyse the reasons the participants gave for adopting certain roles. The following tables display the themes that emerged from the content analysis for the reasons given by individuals who rated the extent to which they adopted each role as either 4 or 5 (extremely).

The explanations given by five of the participants who rated themselves as either a 4 or a 5 for adopting the role of 'bystander' were excluded from the themes above. These participants failed to give an explanation for adopting the role of 'bystander'. Three participants gave explanations that contradicted their ratings, the other two participants described either their decision making process leading up to the TOP, or the decision itself.

Table VIII: Themes for the reasons given for adopting the role of Bystander

Role of Bystander	
Themes	**Frequency**
Feeling Excluded	9
Feeling Useless/restricted	4
Feeling excluded but accepting of this	2
Against TOP	1
It is the female's choice	1
Total	**17**

- 48.9% (N=22/45) rated the extent to which they had adopted the role of Bystander as either 4 or 5.
- 77.7% (N=17/22) of the responses given by those who rated themselves as a 4 or a 5 are included in the above themes. As explained above, 5 participants failed to explain why they felt they had adopted the Bystander role.

The following responses were given by participants who described feeling excluded:

P19: *'I haven't been asked for my thoughts and feelings on anything, not really involved in any of the consultation'.*

P34: *'Nobody talked to me about what happens apart from my partner'.*

Below are two examples of the responses given by the men who felt useless and restricted in their ability to offer useful support:

P33: *'You feel useless as there is nothing you can do apart from support them with emotional guidance/support'.*

P36: *'Understandably my partner has been physically ill and there has been little relief for her. Other than offering comfort and home care I have been frustrated at not being able to ease her more'.*

Only one participant stated at this point that he did not agree with TOPs:

P49: *'I don't agree with the termination of an unborn child'.*

Table IX: Themes for the reasons given for adopting the role of Protector/Supporter

Role of Protector/Supporter	
Themes	**Frequency**
Being there throughout	10
Responding to the female's emotional needs	6
The only one there for her	5
The closeness of the couple's relationship	3
Blaming self	2
The female has control	1
Big decision	1
Total	**28**

- 75% (N=33/44) rated the extent to which they had adopted the role of Protector/Supporter as either a 4 or a 5.
- 81.8% (N=27/33) of the responses given by themselves as either a 4 or a 5 were included in the above themes.

The majority of the participants described their reason for adopting the role of Protector/Supporter being due to the fact that they had been with their partner throughout the whole process:

P3: *'I have been there as much as possible without missing work commitments'.*

P18: *'Because I am there for her and understanding of the situation and her decisions'.*

Two participants described adopting the role of Protector/Supporter due to self-blame:

P26: *'My fault my partner is in this situation'.*

P62: *'Want to help as this is my fault as well'.*

The explanations given by five of the participants who rated themselves as either a 4 or a 5 for adopting the role of 'protector/supporter' were excluded from the themes above. Three of these participants reiterated that they had tried to support their partner. The other two participants commented on the fact that they and their partners had jointly discussed the TOP.

Table X: Themes for the reasons given for adopting the role of Information Gatherer.

Role of Information Gatherer	
Themes	**Frequency**
Felt it was important for the female to be fully informed	2
To help the female	1
Doing everything together	1
In order to be aware of all the options	1
Always there for her	1
In order to be aware of the risks	1
Total	**7**

- 48% (N=12/47) rated the extent to which they had adopted the role of Information Gatherer as either a 4 or a 5.
- 58.3% (N=7/12) of the responses given by the participants as either a 4 or a 5 were included in the above themes.

The reasons given for adopting the role of Information Gatherer were varied, with only one or two participants giving similar reasons. Two participants commented on the importance of the female being fully informed of the TOP process:

P35: *'I didn't want my partner to make the final decision without considering all the information'.*

P57: *'It is important to be informed of the process'.*

One participant commented that they adopted the role of Information Gatherer because they are always there for their partner:

P5: *'I'm always there for her and go to all of the appointments'.*

Another participant explained that he thought it was important for him to gather information in order to be aware of possible risks:

P15: *'Increase of risks to my partner's health and to know how to cope afterwards'.*

The explanations given by five of the participants who rated themselves as either a 4 or a 5 for adopting the role of 'Information gatherer' were excluded from the themes above. Three of these five participants gave examples of their role as information gatherer, rather than giving reasons for adopting this role. One participant explained why he had not been able to gather information, the final participant did not answer the question, instead he explained that he and his partner jointly discussed matters relating to the TOP, once again not answering the question.

Table XI: Themes for the reasons given for adopting the role of Decision Maker.

Role of Decision Maker	
Themes	**Frequency**
It was a Joint decision	*27*
Female's choice	*2*
Knowing what was the right thing to do	*1*
Total	**30**

- 62.5% (N=30/48) rated the extent to which they had adopted the role of Information Gatherer as a 4 or a 5.
- 100% (N=30/30) of the responses given by the participants as either a 4 or a 5 were included in the above themes.

The majority of participants who rated themselves as adopting the role of Decision Maker explained that they were joint in their decision making:

P36: *'We both decided absolutely to terminate the pregnancy, but I was 100% involved in the decision'.*

P52: *'Discussed, both decided together'.*

P58: *'My partner and I discussed everything through together'.*

Two participants commented that it was the female's choice:

P6: *'I got asked by my partner what I feel about it all but at the end of the day it's their decision, like it or not and you've got to respect that'.*

P61: *'Although all decisions were joint, the conclusive choice of process remained my partner's'.*

Only one participant commented that he had made the decision alone. This participant also began to briefly explain his reasons for deciding on a TOP:

P12: *'I had to make the decision and convince my girlfriend because it was not the right time at all, due to various circumstances. She was also confused about the future and what she wanted'.*

Table XII: Themes for the reasons given for adopting the role of Putting Decisions into Action.

Role of Putting Decisions into Action	
Themes	**Frequency**
There for her throughout	3
It was a joint decision	3
To be aware of all options	2
Did not think much action was needed	1
Being close	1
Agreed with the decision	1
Total	**11**

- 26.2% (N=11/42) rated the extent to which they had adopted the role of Putting decisions into action as either a 4 or a 5.
- 100% (N=11/11) of the responses given by the participants as either a 4 or a 5 were included in the above themes.

Three participants described being there for their partner throughout as a reason for adopting a role that involved them putting decisions into action:

P35: *'I've attended all consultations with the GP and clinic to make sure my partner didn't forget to'.*

P36: *'I was with my partner at all stages of the process and present at all active periods'.*

P37: *'I have followed the stages of initial contact with GP throughout referral, finding out about appointment dates, next steps etc.'*

Two participants stated that being aware of the importance of considering all options resulted in them adopting the role of Putting Decisions into Action:

P23: *'Encouraged her to go to family planning and discuss her options'.*

6. Role(s) Adopted, and Levels of Mood and Affect

The correlation matrix (see Table XIII Appendix I) displays the Spearman's Correlations for the different roles and the measures of mood and affect. The role of Bystander is significantly related to Anxiety ($r = .345$, $p<0.001$), Distress ($r = .259$, $p<0.05$) and Negative Affect ($r = -.307$, $p<0.001$). The role of Protector/Support is significantly related to Positive Affect ($r = .406$, $p<0.001$). This analysis did not produce any other significant results.

7. Masculinity Scores and Levels of Mood and Affect

At this stage it should be noted that on the masculinity scales, a low score corresponds to high masculinity, this should be considered when interpreting the following data. Scores on the Masculinity: Emotional measure ranged from 9 to 34 with a mean of 21.6 (std dev, 5.056). Scores on the Masculinity: Uncontrolled measure ranged from 7 to 22 with a mean of 16.2 (std dev, 3.314).

Table XIV: Correlation Matrix: Masculinity factors, Affect & Mood.

	Pearson Correlation	Masculinity: Emotionally Self Sufficient	Maculinity: Uncontrolled
Masculinity: Emotionally Self Sufficient	Correlation	1	-.250*
	Sig. (2-tailed)	.	.048
	N	63	63
Masculinity: Uncontrolled	Correlation	-.250	1
	Sig. (2-tailed)	0.48	.
	N	63	63
Positive Affect	Correlation	**-.394****	.214
	Sig. (2-tailed)	.001	.092
	N	63	63
Negative Affect	Correlation	.194	**-.335****
	Sig. (2-tailed)	.128	.007
	N	63	63
Distress (PANAS-X)	Correlation	.099	-.130
	Sig. (2-tailed)	.441	.309
	N	63	63
HADS Anxiety	Correlation	.132	**-.295***
	Sig. (2-tailed)	.304	.019
	N	63	63
HADS Depression	Correlation	.225	-.241
	Sig. (2-tailed)	.076	.057
	N	63	63

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

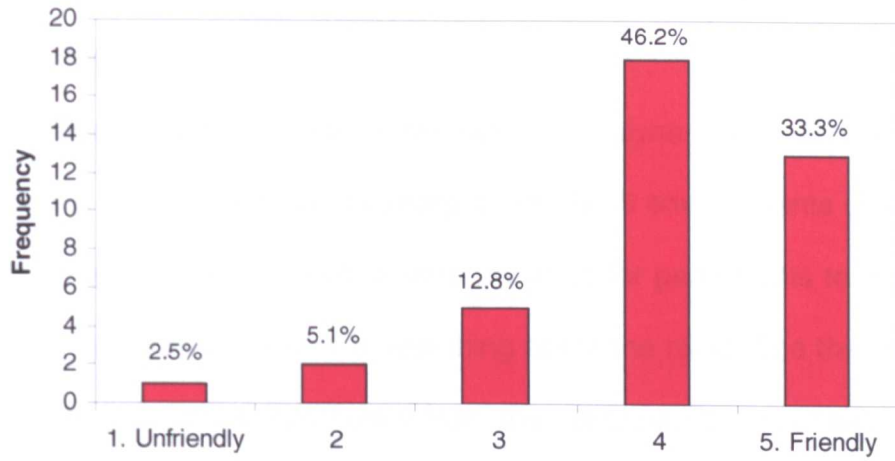
Masculinity: Uncontrolled appears to be negatively related to negative affect ($r=-0.335$, $p<0.001$). Masculinity: Uncontrolled also appears to be negatively related to anxiety ($r= -0.295$, $p<0.05$). Masculinity: Emotional appears to be negatively related to positive affect ($r= -0.394$, $p<0.001$).

8. Experiences of the NHS environments

Consultation Clinic

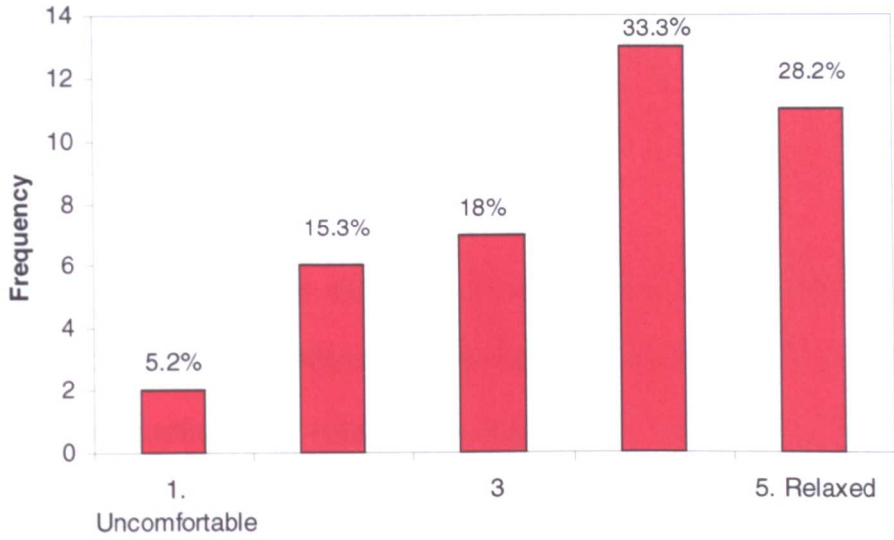
Those participants who attended the Consultation Clinic with their partner were asked to rate the friendliness and the comfort of the clinic environment on two Likert scales ranging from 1 to 5 (where 1= unfriendly & 5= Friendly:; 1= uncomfortable & 5= relaxed). As only 57.1% (N=36) participants were present at the Consultation Clinic, the frequency of responses are significantly lower than N=63. These responses are displayed in the graphs below.

Figure VII. How friendly the participants rated the consultation clinic environment.



As can be seen from Figure VII, the majority of participants rated the environment as 'Friendly. Only 1 participant rated the environment as 'Unfriendly'.

Figure VIII: How comfortable the participants rated the consultation clinic environment.



As can be seen from Figure VIII, the majority of the participants rated the clinic environment as relaxed, with only 2 participants rating the clinic as uncomfortable

A content analysis procedure was used to analyse the qualitative data from the open ended questions focusing on the NHS environments (Barker *et al.*, 2003). Open ended questions were provided for participants to comment on what they perceived was the best thing about the clinic. The themes and the frequency of themes composed from the participant's responses are shown in the table below.

Table XV: What was the best thing about the Consultation Clinic? Summary of themes.

What was the best thing about the Consultation Clinic?	
Themes	**Frequency**
1. The staff	13
2. Speed of proceedings	3
3. Aspects of the environment	3
Total	**19**

Some of the responses provided by participants were clearly relating to aspects of the Hospital Ward and not the Consultation Clinic. For example, a number of participants referred to aspects of the Hospital Ward waiting room. Responding to a question about the Consultation Clinic by making reference to the hospital ward is of particular interest. Many men stated that they were unable to comment on the Hospital Ward as they were not allowed onto the ward. Many men may therefore have viewed the Hospital Ward waiting room as the consultation clinic in that it was a very separate environment to that of the Hospital Ward that they were excluded from entering.

Similarly, participants commenting on the worst thing about the clinic environment tended to respond as if answering a question about the hospital ward. The themes comprising of these responses are shown below.

Table XVI: What was the worst thing about the Consultation Clinic? Summary of themes.

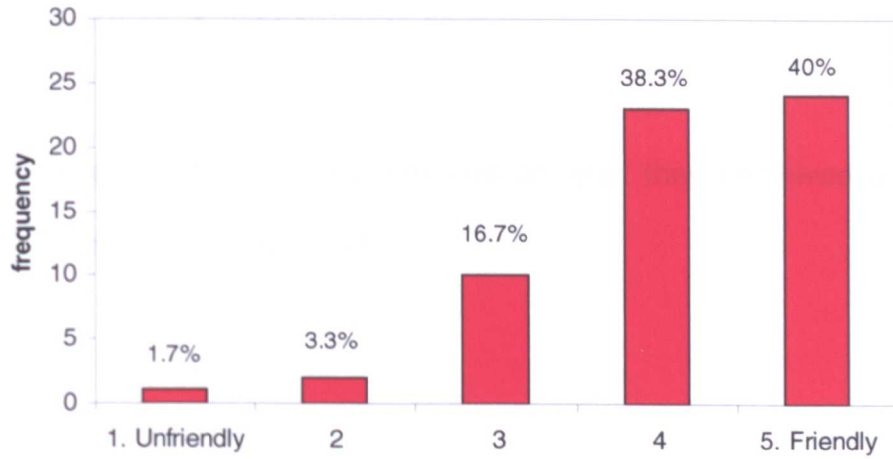
What was the worst thing about the Consultation Clinic?	
Themes	**Frequency**
1. 'Lack of information & Long wait'	6
2. 'Waiting room factors'	5
3. Staff	3
4. Being separated from your partner'	3
Total	**17**

The responses of two participants were not included into the above themes as their responses were clearly identified as relating to the hospital ward and not the Consultation Clinic.

Hospital Ward

Participants were asked to comment on the hospital ward environment using the same format that they were provided with to rate the clinic environment.

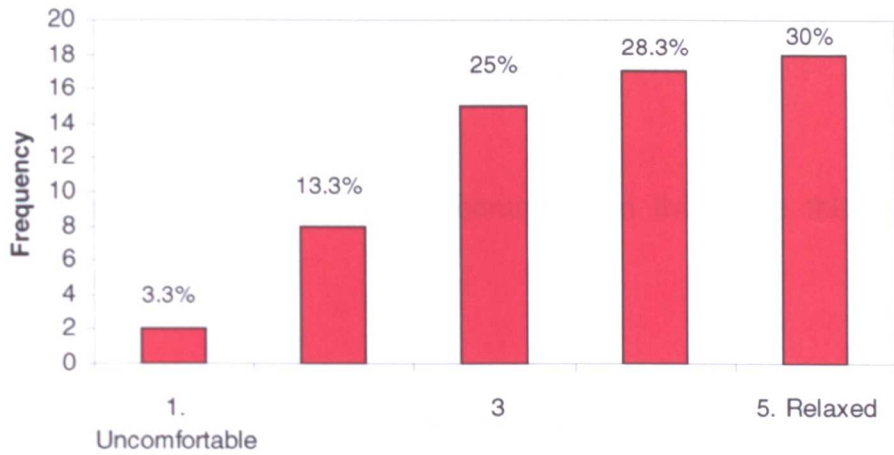
Figure IX: How friendly participants rated the hospital ward.



- N=60/63 (95.2%) participants responded.

As can be seen from Figure IX, the majority of participants rated the hospital ward as 'Friendly'.

Figure X: How comfortable participants rated the hospital ward.



- N=60/63 (95.2%) participants responded.

Figure X shows that the majority of the participants rated the hospital ward as relaxed, although a small proportion of participants did rate the hospital ward as 'Uncomfortable'.

Participants were asked to comment on what they perceived as the best thing about the hospital ward.

Table XVII: What was the best thing about the hospital ward? Summary of themes.

What was the best thing about the hospital ward?	
Themes	**Frequency**
1. Staff	17
2. 'Cleanliness and comfort'	6
3. 'Things to do in the waiting room'	5
4. 'This questionnaire'	4
5. 'Speed'	3
6. 'Unable to comment'	3
Total	**38**

Participants were then asked to comment on the worst thing about the hospital ward.

Table XVIII: What was the worst thing about the hospital ward? Summary of themes

What was the worst thing about the hospital ward?	
Themes	**Frequency**
1. Separated from partner and not knowing	15
2. Waiting room comfort	8
3. Waiting	4
4. 'This questionnaire'	1
5. No going back	1
6. Parking	1
Total	**30**

The majority of the participants commented that being separated from their partner and being unaware of what was happening to her was the worst thing about the hospital ward environment:

Information for Partners Leaflet

The final part of the NHS environment evaluation considered the Information for Partner's leaflet distributed to partner's at the Clinic Consultation. Once

again, participants were asked to comment upon the useful and impractical aspects of the leaflet via an open-ended question format. Responses were analysed using a content analysis procedure (Barker *et al.*, 2003).

Almost half of the participants (N= 31/63, 49.2%) said that their partners passed on the Information for Partners leaflet to them. Of these 31 who received the leaflet, N=30/31 (96.8%) stated that they had read the leaflet.

What was useful about the information for partners leaflet?

Of those participants who read the Information for Partners leaflet, N=22/30 73.3% commented on the useful aspects of the leaflet. Due to the arbitrary nature of the responses, they could not be clearly grouped into distinct themes that would assist the analysis of this question. A selection of the responses appears below to illustrate the nature of the responses:

P1: *'A little, given to me the night before!'*

P9: *'Telling me what to expect when she comes out'.*

P26: *'Explained in detail all the questions that were going through my mind'.*

P35: '*It confirmed what I should expect on the day of termination'.*

P61: *'Accessible/digestible layout'.*

Which aspects of the Information leaflet were not useful?

Of those participants who said that they had read the Information for partner's leaflet, N=4/30 (13.3%) commented on the aspects of the Information for partners leaflet that were not useful. These responses are displayed below:

P33: '*What we can do to help'.*

P40: *'It was mainly counseling'.*

P48: *'The possible future implications'.*

P55: '*A bit dumbed down in places'.*

9. How do men feel the service could improve from presentation to end of episode?

For this section of the study, participants were provided with open-ended questions that asked how improvements could be made to the consultation clinic, the hospital ward and the Information for Partner's leaflet. Once again, a content analysis approach was used to analyse the responses (refer to Barker et *al.*, 2003).

How could the Consultation Clinic be improved?

Table XIX:Summary of themes

How could the Consultation Clinic be improved?	
Themes	**Frequency**
1. Keep partner involved	5
2. Factors relating to staff	3
3. Waiting	1
4. Waiting room comfort	1
5. Sensitivity to patients	1
Total	**11**

How could the Hospital Ward be improved?

Table XX: How the Hospital Ward could be improved: Summary of themes

How could the Hospital Ward be improved?	
Themes	**Frequency**
1. Keep partner involved	11
2. Drink/food facilities	5
3. Comfier waiting area	5
4. Shorter waiting time	1
5. Appropriate MTOP area	1
6 Car parking	1
Total	**24**

The majority of participants stated that keeping them involved would improve the Hospital Ward experience:

How could the Information for Partners leaflet be improved?

Only 5/30 participants (16.6%) who read the Information for Partners leaflet commented on how it could be improved. Due to the small number of responses, it was not possible to utilise a Content Analysis, the five responses are therefore listed below:

P33: *'A general guide on how we can help'.*

P35: *'It could include possible psychological effects a partner may experience during the wait (days/weeks) prior to the termination'.*

P40: *'Explain the terminations easier, most of the terminations are for young people. I'm not stupid but it was a big read'.*

P48: *'I felt it was very generic and I had trouble relating to it'.*

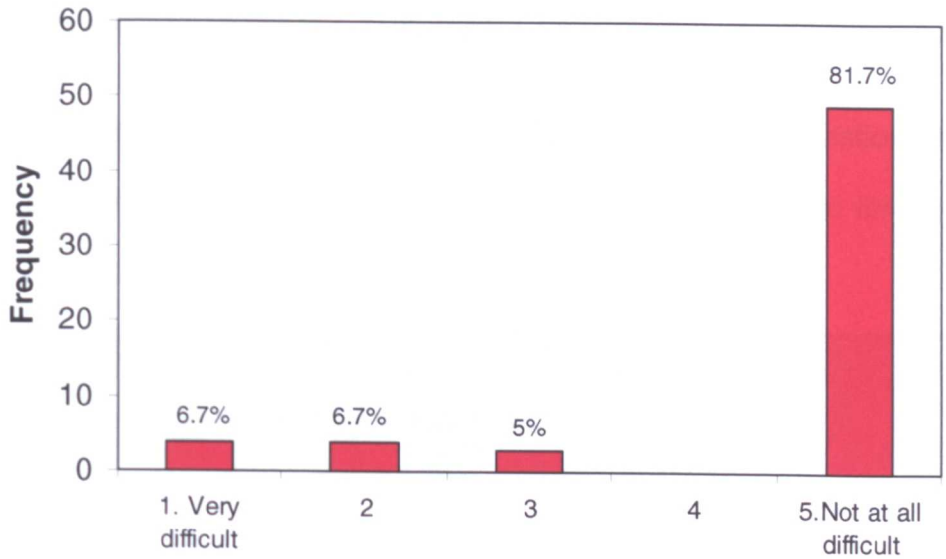
P62: *'Just explain what the sickness is about and it is O.K. for her not to eat. What we should do to help, i.e. give partners small drinks of water/food etc.'*

10. Why do some men fail to attend the termination of pregnancy procedure with their partner?

This research question could not be answered directly by the men who failed to attend the TOP appointments. Therefore, the men who were present at the TOP appointment were asked to give their opinion as to the possible reasons why some men may fail to attend these appointments with their female partner. Before asking the participants to give their opinions, it was felt that it would be useful to ask these men to describe the factors contributing to their decision making process of whether or not to attend the TOP. It was hoped that the responses to this question may shed some light on the decision making process that the non-attendees may have gone through when deciding whether or not to attend. Firstly, participants were asked to rate how difficult it was deciding whether or not to attend the TOP

with their partner, by rating their decision making process on a one to five Likert scale ranging from one 'Very difficult' to five 'Not at all difficult'.

Figure XI: Frequency of participants rating whether it was a difficult decision deciding whether or not to attend the TOP on a 1 to 5 scale.



- N=60/63 (95.2%) participants responded.

As can be seen from Figure XI, the majority of participants rated making the decision to attend as 'Not at all difficult'. A small number of participants rated the decision making process as 'Very difficult'.

Table XXI. Themes and frequency of themes for the factors contributing to male participants' decision to attend the TOP appointment.

Factors Contributing to the decision making process of whether to attend the TOP	
Theme	**Frequency**
1.. 'To support my partner/to be there for her	28
2. 'Justifying their decision to terminate'	6
3. 'Being equal partners'	3
4. 'Taking responsibility'	1
5..'Partner wanted me there'	1
6. 'Weighing up the advantages'.	1
Total	40

The majority of participants commented that they had decided to attend due to wanting to support/be there for their partner.

P25: *'I wanted to support my partner'.*

P36: *'To support my partner 100% over the period'*

P43: *'No other than just being there for my girlfriend'.*

Interestingly, 6 participants appear to have misread the question, instead commented on the factors contributing to their decision to go through with the TOP itself, two of these responses are shown below.

P2: '*Less attention to other two children and financially'.*

P60: *'Home circumstances and kids, health and well-being'.*

One participant commented on weighing up the advantages of attending the procedure:

P1: *'Can I be of support? What will I get out of it? What will my partner get out of it?'*

The responses of participants who rated the decision to attend as a 1 'Very difficult' or a 2 were then separated from the other responses. The researcher was interested in the different factors contributing to the complexity of the decision-making. Additionally, the researcher hoped to determine if any commonalities existed between the reasons given for experiencing the decision-making process as difficult.

Only three of the eight participants who rated making the decision to attend the TOP as a 1 'Very difficult' or a 2 commented on the factors contributing to their decision. These are shown below:

P1: *'Can I be of support? What will I get out of it? What will my partner get out of it?'*

P12: *'I wished to be there'*

P28: *'I don't like what we are doing but I have to stand by my partner because deep down I know she is right'*

10.1. Participants' thoughts as to why some men do not attend the termination process with their partner.

The table below shows the themes and frequency of themes that were constructed from the responses to the question 'Why do you think some men do not attend the termination process with their partner?

Table XXII: Why men fail to attend a TOP: Summary of themes.

Why some men fail to attend a TOP	
Theme	**Frequency**
1.. 'Scared'	11
2. 'Unsupportive'	10
3. 'Embarrassment/Guilt/Shame'	7
4. 'Don't agreee with decision to terminate'	6
5 'Relationship issues'	3
6. 'Feeling excluded'	2
7. 'Disown the 'problem'	2

The majority of participants felt that some men to not attend a TOP procedure with their partner because they are 'Scared', 'Unsupportive' or because they experience 'Embarrassment, Guilt or Shame'.

The most popular theme which centred upon being 'Scared' is further highlighted in the comments below.

P22:- *'Cowards'.*

P25: *'Scared of the worst'.*

Only two participants attempted to explain what these men may actually be scared of.

P12: *'Afraid to be there and accept it'.*

P31: *'Scared, apprehensive about being judged'.*

Theme 2, 'Being Unsupportive' included a number of comments that appeared to be judgmental of the men who fail to attend a TOP with their partner.

P10: *'Heartless'*

P15: *'Don't have the ability to be caring'.*

P35: *'Because they're weak unsupportive people with no sense of responsibility'*

P45: *'Because they are out of order. You have to stand by your partner at a time like this'*

Response to Theme 3 tended to mix the three emotions 'Guilt, Shame and Embarrassment' into their responses, by commenting on two or more of the emotions which are illustrated below.

P24: *'Probably out of guilt/shame'.*

P27: *'Embarrassed, ashamed, not bothered, at work and cannot get time off'.*

P29: *'Embarrassed, ashamed, don't care'.*

Among the responses that were grouped under theme four, 'Don't agree with decision to terminate' one response illustrated the extent to which men may feel neglected during a TOP process.

P43: *'Because despite most people's opinions, men have feelings too. It's not always what we want, some men look forward to being a parent'.*

Three participants made comments relating to theme five 'Relationship issues', these are shown below.

P9: *'Insecure relationship and frightened'.*

P23: *'They might have had a one night stand and didn't like the person when*

she said she was pregnant'.

P37: '*Issues regarding the relationship'.*

Only two participants made comments that could be grouped under theme six 'Feeling excluded', these are shown below.

P20: *'Not feel able to support partner as banned from the ward'.*

P49: *'Because they feel like they have no say in it'.*

Only two participants made comments that could be grouped under theme seven 'Disown the problem', these are shown below.

P30: *'Some men probably feel that they don't have to attend because it's not 'their problem''.*

P62: *'They can not face their mistakes and they are not really men! Thank you to all the nurses on the ward, made it easier for us thank you'.*

The response from one participant could not be grouped into any of the above themes, as they did not answer the question, instead they commented on how the men who do not attend may feel following a TOP:

P48: *'I can't comment on the decisions of others, but I feel they will regret it later'.*

CHAPTER FIVE: DISCUSSION

Overview

An exploratory study with a quantitative, questionnaire-based design was conducted with the aim of investigating men's experiences of a termination of pregnancy (TOP) in terms of their mood, affect and feelings. Also of interest were the roles adopted and the masculinity of these men. Existing relationships between these factors were investigated. Due to the number of research questions employed for the present study, this chapter is structured under broad headings relating to the research questions, in order to improve the clarity of the discussion. Relevant quantitative and qualitative findings will be discussed for each research question in turn. The theoretical and clinical implications of the findings will be discussed for each question. The final section of the discussion will consider the strengths and weaknesses of the present study, with the associated implications and suggestions for future research in this area.

1. Mood and Affect

The overall Negative Affect (NA) scores that participants obtained within the present study suggested that with the exception of a few outliers, the majority of participants did not have high levels of negative affect. Additionally, 25.4% reported feeling happy. These findings support the

results of Beckman and Harvey (1998) that many men react indifferently to a TOP due to the relief that they experience as a result of being free from fatherhood and the responsibilities that ensue.

The most commonly reported negative feelings experienced by the male partners were guilt, upset, nervousness and feeling irritable. However, these feelings were reported by less than a third of the sample, with the majority of the sample rating the negative feelings within the 'Very slightly or not at all/A little ranges. The fact that a minority of participants experience negative emotions suggests that a TOP is not an entirely negative event for male partners, once again suggesting that relief may be a significant factor in determining the manner in which men experience a TOP (Beckman & Harvey, 1998).

It is important to consider further the most commonly reported negative affect item by male partners. Almost one third of the sample reported feeling Guilty. Guilt is conceptualised as a moral emotion pertaining to the experiences and welfare of others (Gilbert, 2003). Guilt is believed to have evolved from the action of care-giving and the avoidance of causing harm to others (Gilbert, 2003). In this sense, it would seem that the male partners may be feeling responsible for their partner's pregnancy, which resulted in a medical or surgical procedure to terminate the pregnancy. Subsequently,

these male partners may perceive themselves as causing harm to their partner resulting in the feeling of guilt.

An alternative explanation for the experience of guilt could envelop the experience of exclusion that many men appear to have experienced when separated from their partner on arrival at the gynaecology ward. The experience of exclusion and the subsequent 'helplessness' experienced by the male partners clearly removes any opportunity for the male partner to provide care or respond to the welfare needs (Gilbert, 2003) of the female. In this sense, the male partners may have experienced guilt due to their inability to be responsive to their partner's needs at the time of the TOP.

The most commonly reported positive feelings included determined, strong, interested and active. More than one quarter of the participants reported experiencing these feelings. These results are somewhat unexpected as they suggest that a large proportion of these men experienced positive feelings during what may be perceived as an emotionally difficult time, due to limited research in this area, this comment is merely speculative. It is possible however, that these results also fall in line with the findings of Beckman and Harvey (1998); with the positive feelings reported representing the relief that many of these men may be experiencing.

Additionally, it was noted that many of the positive affect items on the PANAS-X were masculine in nature. Being determined, strong, active and interested draw parallels with the beliefs and behaviours that Courtenay (2000) describes as representative of Hegemonic masculinity; including appearing strong and robust. One possibility therefore is that these men were adhering to masculine norms when responding to the positive affect items. An alternative list of positive affect items related to masculinity to a lesser degree may have yielded fewer responses. Overall Positive Affect (PA) scores constituted a normal distribution curve, with participants obtaining overall (PA) scores of 13 to 42. Few participants obtained overall PA scores towards the extreme limits. This suggests that this sample of men did not experience extreme emotions and were contented during the TOP process.

Conversely, many of the items representative of negative affect on the PANAS-X appear to be in opposition of the beliefs and behaviours characteristic of Hegemonic masculinity (Courtenay, 2000). Feeling 'upset', 'nervous', 'afraid', 'distressed', 'scared' and 'jittery' challenge the need to appear strong and robust, to dismissing any need for help, and to remain in emotional control (Courtenay, 2000). Adherence to the hegemonic ideal may have resulted in the preponderance of participants to report positive feelings and not the non-masculine negative feelings available to choose from.

As mentioned previously, a number of items were removed from the PANAS-X for the purpose of the present study, in order to reduce the length of the measure, as well as removing certain positive items that the researcher deemed inappropriate for the purpose of the present study. However, the preponderance of positive feelings reported suggests that it was inappropriate to remove these items because as a whole, the sample tended to report more positive affect.

Using the HADS (Zigmond & Snaith, 1983) the present study found that the majority of men obtained depression scores that fell within the 'normal' range. However, a larger number of men experienced anxiety that fell within the 'borderline' and 'significant' ranges. The HADS measures an individual's level of psychological distress. Individuals are asked to rate the way they have felt over the past two weeks on a number of mood related items. The anxiety frequency data obtained in the present study suggests that a large proportion of the sample felt anxious during the period leading up to the TOP. This suggests that the referral process, including outpatient clinic visits is an anxiety provoking time for male partners.

The positive feeling of relief experienced by men following a TOP (Beckman & Harvey, 1998) implies that they are not entirely in favour of the pregnancy continuing. Although the PANAS-X does not include 'relief' as an item, one may assume relief to represent a positive feeling, opposite to the experience

of anxiety. The interim period between referral and the TOP procedure is likely to involve a degree of uncertainty and decision making regarding the pregnancy outcome. It would therefore make sense for these men to feel anxious until the TOP is carried out when any anxiety provoking uncertainty is removed.

2. Roles

2.1. Protector/Supporter

The majority of the sample reported adopting the role of 'Protector/Supporter'. Social roles are the expectations that exist within a group about the manner in which people should behave (Aronson et al., 2002). In this sense the majority of the participants fulfilled the role of 'Protector/Supporter' within the TOP setting. This role seems to be synonymous with the general long standing expectation for men to provide for and create security for their families (Cialdini et al., 1991).

Links can be made with the childbirth literature; Chapman (1991) identified the role of witness which involved providing emotional and moral support as the role most commonly adopted by fathers during childbirth. Additionally, Nolan (1994) recognised that during childbirth, men attempt to seek an active role in order to have more control, rather than just doing nothing. Associations may be made here between the need for control as a facet of

hegemonic masculinity (Courtenay, 2000). Participants may have sought an active role that would allow them to maintain a degree of control in order to conform to the hegemonic ideal.

The majority of participants who rated themselves as adopting the role of 'Protector/Supporter', attributed this to the fact that they felt they had been with their partner throughout the entire TOP process; 'Being there throughout'. This suggests that these men felt that they had the right to adopt a more active role as they had contributed more of their time to the termination process.

The second most common reason given for adopting the role of 'Protector/Supporter' was 'responding to the female's emotional needs. Nolan (1994) identified that during childbirth, a prominent worry for men is their partner's need for physical and emotional support. Within the TOP literature, Shostak et al. (1984) recognised that a female's emotional needs are of great importance to their male partner.

A number of participants reported adopting the role of 'Protector/Supporter' because they were 'The only one there for her', also due to 'The closeness of the couple's relationship'. These attributions suggest that these men felt that they had the right to adopt this role because of the quality of their relationship. One might therefore hypothesise that the male partners who do

not perceive their relationship with the patient as particularly close may not feel as if they have the right to assume an active role during what is often perceived as women's business (Burgess, 1998). Perhaps being in a relationship that one does not perceive as particularly close results in the male partner failing to attend the TOP.

2.2. Decision Maker

The proactive role of Decision maker was the second most commonly adopted role. Yet again, parallels can be drawn with the childbirth literature (Nolan, 1994) and hegemonic masculinity (Courtenay, 2000) when considering the adoption of an active role as men's attempts to gain some control. Additionally, the low levels of negative affect linked to the relief of avoiding fatherhood (Beckman & Harvey, 1998) may also provide an insight into the hypothesised need for control. If men are eager to end the pregnancy in order to be free from the responsibilities of fatherhood, it would make sense for them to be more active in the decision making process in order to ensure that their wish for a TOP is adhered to.

Little variation exists among the reasons given for adopting the role of 'Decision Maker'. The majority of participants stated that 'it was a joint decision'. These participants appeared to want to make it clear that 'the decision', (almost certainly this was the decision to terminate) was joint and

not made by either the male or the female alone. Moran-Ellis (1989) found that during childbirth, men became involved in making the decision of when to go to the hospital in an attempt to maintain a degree of control. It was considered important to maintain some control before the medical staff took charge. Men accompanying their partners to a TOP may have expected a lack of involvement on entering the hospital, and subsequently became more active in the decision making in order to grasp the only available opportunity for control.

Perhaps some of these men did not contribute towards the decision making, despite feeling as though they should have done. In order to justify their lack of involvement in the decision making process, it may have felt more comfortable for these men to label the decision as jointly made. Conversely, some men may have taken the role of sole decision maker, it has been recognised that men can influence their partner's decision to terminate (Bracken et al., 1974; Miller, 1992). These men may have felt awkward admitting that they had taken control during what is considered as a female oriented procedure (Simon, 1997). Stating that the decision was jointly made may allow these men to feel more comfortable about their involvement in the decision making.

Interestingly, responding to the question about decision making by referring solely to the decision to terminate represents the significance that these men have placed upon deciding whether or not to terminate. These men appear

to have been unable to consider any other decisions that they may have been a part of during the TOP process.

2.3. Bystander

The third most commonly adopted role was 'Bystander'. Dewey (1922) states that the motivation to adopt different roles comes from the fact that individuals are active within their social environment. The exclusion from the hospital ward that men experience during a TOP in many ways renders them inactive within the medical setting. Such inactivity may result in the absence of any motivation to adopt a specific role, resulting in these men experiencing their involvement as a passive bystander. Briggs, Glover and Guthrie (2005) identified the confusion as to the role that should be adopted as one of the main themes that male partners reported during a TOP. Boyle (1997) recognised that role uncertainty can leave the partner feeling excluded or marginalised. One hypothesis is that many men did in fact experience role uncertainty, with the subsequent feeling of exclusion resulting in them perceiving themselves to have adopted the role of Bystander.

The majority of participants rating themselves as adopting the role of 'Bystander' reported that they felt they had done so due to 'Feeling excluded'. It is possible that this feeling of exclusion developed as a result of being uncertain about which role to adopt (Boyle, 1997). Brown (1982) found

that during childbirth the manner in which the medical staff treats the expectant father can serve to emphasise the lack of a clear role for these men. Interestingly, in the present study, no participants attributed their role of Bystander to the medical staff. This could possibly be explained by the lack of involvement men have with staff once their partner is admitted onto the ward.

The second most common reason for adopting the role of 'Bystander' was 'feeling useless/restricted'. In drawing upon the childbirth literature, Nolan (1994) discovered that some men feel helpless during their partner's labour as they are unable to take her pain away. During a TOP, male partners are separated from their partners once the female is admitted onto the ward. Unlike during Labour, the focus during a TOP is not upon the amount of pain that will be experienced, although a degree of discomfort is felt. However, due to the separation from their partner once she is on the ward, these men may feel useless as a result of their inability to ease their partner's emotional pain. Additionally, Nolan (1994) found that during childbirth, men's inability to take their partner's pain away cause them to feel out of control as they are not used to this unfamiliar experience. Perhaps the inability to take away their partner's emotional pain created a feeling of loss of control and 'uselessness'. The absence of a sense of control is likely to threaten a man's masculine identity.

The remaining reasons given for adopting the role of 'Bystander' included 'it is the female's choice' and Feeling excluded but accepting of this'. Both of these reasons suggest that some men regard TOP as solely women's business and do not expect to be a part of the process. Perhaps these men support the argument put forward by Simon (1997) that any focus placed on men may add support to the argument for removing the elements of choice and privacy that a woman is entitled to.

2.4. Putting Decisions into Action

The roles 'Putting decisions into Action' and 'Information Gatherer' were the least commonly adopted. It is interesting to note at this stage that just under half of the participants accompanied their female partner to the clinic consultation. Failing to attend the clinic consultation may be indicative of a lack of involvement leading up to the TOP procedure itself. If this was to be the case, these men would be unlikely to fulfil the roles of 'Information Gatherer' and 'Putting decisions into Action' that one would expect to be adopted prior to the procedure itself. Non- Attendance at the clinic consultation may therefore be representative of failure to adopt these two roles.

The reasons given for adopting the role of 'Information Gatherer' were more varied than the responses for the previous roles. Many of the reasons were

only given by one participant. The variation of the responses suggests that there is an unclear reason why men would adopt this role, perhaps the reasons are specific to the individual. Two participants 'felt it was important for the female to be fully informed'. In many senses this feels as though these men saw it as their duty to make sure that their partner had all the correct information. As mentioned earlier, a large proportion of men reported experiencing the feeling of guilt, characterised by a failure to provide care and avoid the harming of others (Gilbert, 2003). In an attempt to reduce their experience of guilt, gathering and providing information may represent a means of compensating for their failure to provide care.

Being aware of all the risks and options was a reason given by two participants for adopting the role of 'Information Gatherer'. Wanting to be aware of all the options and possibilities before the TOP implies that these men were not absolutely certain about the decision to terminate prior to the procedure.

Once again, the explanations for adopting the role of 'Putting decisions into action' were varied. Being there for her throughout was described by three men as their motive for adopting this role. In this sense, it feels as though these men were able to get involved more actively as a result of being involved from the start.

Three men reported that it was a joint decision. This response suggests that these men felt it necessary to clarify that the decisions that they put into action were jointly made by the female and themselves. Wanting others to know that they were jointly involved in decision making may be an attempt to assert that they have some control in order to uphold their masculine identity.

Men reported adopting more than one role during the TOP process, with almost a third of participants adopting two roles. Over 40% reported adopting more than two roles. One might hypothesise that the adoption of numerous roles reflects the role uncertainty and the shock at the absence of a constructive role experienced by men attending a TOP, recognised by Naustatter, (1986) and Shostack et al. (1984) (cited in Boyle, 1997). Similarly, Briggs, Glover & Guthrie (2005) identified 'My Role' (confusion as to the role that should be adopted) as one of the main themes that male partners reported experiencing during a medical TOP procedure. The lack of clarity as to the role to be adopted, may force men into adopting a number of roles in an attempt fit into a role that is most suited to the situation and the needs of their partner and themselves.

Apart from one male, participants failed to report adopting additional roles. The roles provided in the questionnaire for the present study were taken from Locock and Alexander's (2006) study investigating men's roles during

the process of foetal screening. One possibility is that a TOP is very similar to the process of foetal screening, in terms of the position that men are placed, and the subsequent choice of roles they have to adopt. Therefore men may not have adopted any additional roles than those provided in the questionnaire package.

Alternatively, role uncertainty experienced by men during a TOP (Boyle, 1997) and the resulting experience of exclusion may have resulted in these men feeling as though they were unable to adopt any additional roles. Perhaps it is a difficult task for these men experiencing role-uncertainty to give a label to the role(s) adopted. Providing pre-defined roles within the questionnaire package may have assisted these men in identifying the role(s) adopted. One might argue that these men reported the roles that they adopted prior to the TOP hospital appointment, rather whilst present at the TOP appointment. One might conclude that the participants felt unable to adopt any role(s) whilst at the hospital appointment. Zurcher (1983) recognised that when roles are vaguely defined, our interactions with others assist the establishment of a workable role. During the process of data collection it was observed that unless the male partners attended with a friend or an additional family member, these men engaged in little if any interactions with others. Role confusion (Briggs et al., 2005) resulting from the vague definition of roles may render male partner's powerless when attempting to adopt a workable role.

3. Role(s) adopted, and levels of Mood and Affect

The role of 'Bystander' was related to anxiety, distress and negative affect. Drawing from the childbirth literature, the absence of a clear functional role caused men to feel helpless and out of control during their partner's labour (Nolan, 1994). This experience was found to be very alien for these men. In the present study, being excluded from the ward and consequently prevented from supporting their partner may have resulted in feeling out of control and helpless which may be responsible for the experience of anxiety, distress and negative affect.

4. Masculinity scores and the level of Mood and Affect experienced

As described in Chapter Two A (The development of the masculinity measure), some of the items on the original masculinity measure were removed. The remaining items were then split into two separate masculinity measures. The first measure was labelled 'Masculinity: Emotional' due to the tendency for the items to focus on aspects of an individual's emotional independence and ability to remain in emotional control. The second measure was labelled 'Masculinity: Uncontrolled' due to the nature of it's items to represent an inability to control one's needs, thoughts and aggressive responses (verbal and physical).

In no uncertain terms is the researcher claiming that these two measures represent hegemonic masculinity in its entirety. Firstly, the degree to which a man conforms to masculine ideals is likely to depend heavily on the cultural beliefs to which the male is socialised. For example, providing for one's family, opposing emotions (Frosh, 1997) and ensuring safety and security have long been considered characteristics of a 'real man' (Cialdini et al., 1991). However, many researchers believe that the influence of feminist thinking has resulted in a more fragile view of masculinity (Frosh, 1997). In this sense, men receive mixed messages regarding what it means to be a man, one message being that it is acceptable for men to show their true emotions. Similarly, certain populations appear to conceptualise masculinity in terms of physical strength, toughness, and aggression. Such men are often preoccupied with the size of their muscles, and regard displays of aggression as evidence of their manliness.

Hegemonic masculinity (Connell, 1995), is deemed as the idealised type of masculinity operating at a certain time or in a certain situation. This implies that men display various aspects of their masculinity dependent on the situation in which they are in. Therefore, the cultural masculine ideals held by a man are likely to be modified by the environment in which they find themselves.

The original masculinity measure attempted to provide an overall measure of masculinity, however this measure was found to be unreliable. Subsequently, the two measures produced by the factor analysis provided an insight into the possibility of two quite separate masculine trait descriptions. These factors and their impact upon a man's mood and affect when placed in an unfamiliar setting such as that of a TOP were investigated.

The mean of the scores obtained on the Masculinity: Uncontrolled measure was lower and therefore more masculine than the mean of the scores obtained on the Masculinity: Emotional measure. This suggests that the sample of men enlisted for the present study possessed more characteristics low in physical and emotional control, than aspects of emotional control and independence.

4.1. Masculinity: Emotional

Although a significant relationship exists between masculinity scores and affect, their values are not impressively high. Participants attaining more masculine scores on the Masculinity: Emotional variable experienced more positive affect during the TOP process. This suggests that being emotionally in control and independent allowed these men to remain positive through the TOP. Additionally, men who are emotionally more independent may be

comfortable when left alone. One of the items on the Masculinity: Controlled variable focused on being in charge and in control, this item was based on the observations of (Courtenay, 2000) that behaviours in support of hegemony include being in control physically and emotionally. Indeed it appears as though assuming these hegemonic behaviours have benefited participants' experiences throughout the TOP. However, Fejes (1992) stated that 'real men' operate form a rational mind and are expected to be in control of their emotions as well as the situation that they are in. A TOP involves the female patients being separated from their partners, many of the participants in the present study reported that they found this objectionable. It would seem as though the male partners are not in control of their situation whilst accompanying their partner to a TOP, as they have little choice as to their involvement once their partner is on the ward. This would suggest that the Masculinity: Controlled variable is not measuring the degree to which men are in control of their situation. The item 'I like to take charge and be in control' may have been interpreted as emotional control rather than controlling the situation.

Conversely, perhaps it is a misconception that because men are separated from their partners at the hospital they feel out of control. Prior to the procedure itself some male partner's may take control in other aspects of the TOP process that the present study has failed to measure. Perhaps being in

control before the TOP is enough to allow these men to experience positive affect during their period of isolation in the waiting room.

Courtenay (2000) commented that rejecting all that is feminine is crucial to hegemonic masculinity. Similarly, Pyke (1996) stated that in order to maintain gender inequalities, the beliefs and behaviours exhibited by individuals should reinforce that men are more powerful and less vulnerable than women. Perhaps being emotionally in control served to reject the feminine environment of the Gynaecology Ward in which they found themselves.

Not relying on others for help is another item on the Masculinity: Emotional variable. A number of participants commented that they were the only one there for their partner as she did not wish to tell anyone about the unplanned pregnancy. One can recognise the advantages of not needing other people for help when in a situation similar to a TOP where the focus is placed on the female and the male is left to cope in the waiting room, with only himself for company.

4.2. Masculinity: Uncontrolled

Participants achieving high scores on the Masculinity: Uncontrolled variable experienced more negative affect and were more anxious. This suggests

that individuals high in uncontrolled masculinity are not well suited to situations as potentially emotional as a TOP. The Masculinity: Uncontrolled variable measures behaviours that appear to be less controlled by the individual, and more reactive to the situation in which they are placed. Items included being unable to ignore one's own wants and needs, lashing out physically when provoked, always thinking about sex, often behaving aggressively and not being in control of the aggressive nature of one's voice and speech when in stressful situations.

When considering the negative reaction of the men scoring highly on the Masculinity: Uncontrolled variable, links can be made between the behaviours possessed and aspects of the TOP process. Long (1987) and Dutton (1998) recognised that men use aggression and hostility in order to replace feelings that they are trying to avoid, feelings such as fear and shame. Approximately 15% of participants reported feeling afraid and/or ashamed. Cialdini, et al. (1991) describe injunctive norms as expectations about how people should behave, in order to avoid the disapproval of others. Typically, aggression and hostility were not behaviours displayed in the hospital waiting room. Male partners who experienced fear and or shame may have been prevented from behaving in their usual aggressive manner, in an attempt to conform to injunctive norms that favour calmness and passivity in such a waiting room environment (Cialdini et al. 1991). Behaving in a way that is unfamiliar for men has been found to be an uncomfortable

experience (Nolan, 1994). Perhaps it was the uncomfortable experience of being prevented from acting aggressively, and thus being prevented from avoiding the fear and shame associated with the TOP that led to the increased anxiety and negative affect.

Secondly, these men reported being unable to ignore their own wants and needs. During the TOP process and the procedure itself, the needs of the male partners are unlikely to be catered for, with what feels like the entire focus being placed upon the female patients. It is possible that these men find it difficult to satisfy their own wants and needs during this time. Alternatively, these men may experience a certain degree of guilt for being preoccupied by their own needs whilst their partner is the patient undergoing the medical procedure. Nolan (1994) found some men to experience guilt when worrying that their partner might die during childbirth. Perhaps this guilt extends to a TOP procedure, with men experiencing guilt due to their concern that something might happen to their partner during the TOP procedure. If this was true, this guilt would undoubtedly combine with the guilt experienced for being preoccupied with one's own needs.

5. Male partner's experiences of the NHS environments?

Previous research has found being a patient in a medical environment to be a stressful experience (Wilson-Barnett, 1979). Carpman and Grant (1993)

identified aspects of a medical environment that can contribute towards the experience of stress. Factors such as being in an unfamiliar environment, experiencing a loss of independence and sense of control and the separation from one's friends and family.

5.1. Consultation Clinic and Hospital Ward

The majority of the participants experienced the consultation clinic as friendly and relaxed. Just over 5% of men rated the consultation clinic environment as uncomfortable. A similar pattern of results were found for the ratings of the friendliness and the comfort of the Hospital ward environment. The majority of participants experienced the hospital ward as comfortable and friendly.

These results suggest that the impressions formed about the service by the male partners were positive (Arneill & Devlin, 2002). Contrary to existing research, the results of the present study suggest that the male partners experienced the consultation clinic and the hospital ward positively and did not experience an identifiable amount of stress. One might hypothesise that because the male partners are not the TOP patient, they do not experience aspects of the environment as significant stressors, in the same way as the female patient might. However, we would expect certain aspects of the environment such as a loss of control and independence to be a stressful

and uncomfortable experience for these men as these factors challenge aspects of hegemonic masculine identity (Courtenay, 2000). One possible explanation could be that these men did in fact experience the loss of control and independence negatively, however, it is possible that they did not relate these factors to the friendliness and comfort of the environment, but to alternative variables.

Male partners were asked to write down what they perceived as the best and worst things about the consultation clinic environment and the hospital ward. Before reviewing this data, it is important to note that many of the participants appeared to be responding to questions about the consultation clinic in terms of the hospital ward. The males completed the questionnaires in the hospital ward waiting room, whilst the female partner was admitted onto the ward for the TOP. For the sample of men who attended both the consultation clinic and the hospital ward, at the point of data collection one might assume that the male partners were focused on the TOP and the environment in which the TOP was occurring, rather than aspects of the environments visited previously. The consultation clinic environment may have become insignificant to these men at this time.

The majority of participants perceived the staff as being the best thing about the consultation clinic, and the hospital ward, contrary to Banks (2001) who found men to be put off by female oriented environments. Professionals

working in the consultation clinic visited by participants were predominantly female, the nurses working on the hospital ward were all female. Not only did this fail to affect the environment ratings made by these men, but also they experienced the staff as the best thing about these two environments. Banks' (2001) study considered men as NHS patients, it is therefore possible that the participants will have been unaffected by the gender of the staff as they were not the actual patients.

Additional factors considered as the best things about the consultation clinic included the speed of the proceedings and aspects of the environment. The speed of proceedings at the consultation clinic appointment may be understood as a positive interaction between the patient and the staff, contributing to the perceived quality of care (Arneill & Devlin, 2002). A small number of participants also identified speed as the best thing about the hospital ward. Participants completed the questionnaires as soon as they arrived at the hospital ward, in this sense, these men could not be certain how long their partner's procedure and recovery time would take. One can therefore assume that these men were referring to the speed of the referral process, and not the speed of the TOP procedure itself.

Functional aspects of the environment such as the television and the restaurant were also identified as positives. These responses relate to the hospital ward and not the consultation clinic, similarly, things to do in the

waiting room was a common theme identified as a hospital ward positive. One might understand these responses in terms of masculinity. Fejes (1992) stated that real men are repeatedly shown to be found in a world of objects, rather than in a world of family and relationships. In this sense, men operate from a rational mind, rather than in response to their emotions, (Fejes, 1992). Focusing on functional aspects of the environment may have assisted these men in avoiding focusing on the more distressing and emotionally provoking aspects of their surroundings. Conversely, an appreciation for the functional aspects of the waiting room may highlight the boredom experienced by these men who are left alone for a number of hours. Additionally, one participant rated the questionnaire for the present study as the best thing about the hospital ward. A further explanation was not given. It is possible that the questionnaire was regarded positively as it provided something to do during a long waiting period, alternatively, the chance to have a say and be heard may have been welcomed in a female dominated research area requiring a more extensive exploration into the experiences of the males involved (Neustatter & Newson,1986).

Three participants stated that they were unable to comment on the hospital ward as they were not allowed in. Not only does this highlight a methodological limitation of the questionnaire to be discussed later, it emphasises the significance to which these men attached to the segregation of the females and their partners on the ward.

The majority of participants felt that the lack of information and long wait were the worst factors associated with the consultation clinic environment. Almost a third of those who responded identified waiting room factors as the worst thing about the consultation clinic. Responses included a lack of privacy and overcrowding. Winkel (1986) identified overcrowding and a lack of privacy as additional environmental stressors that can add to the pre-existing stress surrounding matters relating to medical professionals, health and illness.

Three participants identified the staff as the worst thing about the consultation clinic. Two of the three responses appeared to relate to individual cases in which the actions of a professional had caused the male to feel 'angry'. In these cases it is apparent that a positive interaction did not occur between the professional in question and the male partners, resulting in a reduced perception of the quality of care received (Arneill & Devlin, 2002). The third participant stated that he felt as though some of the staff were looking down on his partner for being at the clinic.

The most commonly experienced negative affect item was feeling guilty. Guilt is regarded as a cognitively assessed condition that results from the conflict of having done something that you believe you should not have done, in this case the unplanned pregnancy of his partner. The conscious personal devaluation resulting from the conflict of guilt can be

conceptualised as shame, which subordinates the experience of humiliation (Elison, 2005). Feeling guilty about the unplanned pregnancy and subsequent TOP may have caused this participant to feel humiliated, resulting in his perception of the staff as 'looking down' on his partner. It is interesting to note that although three participants regarded the staff as one of the worst aspects of the consultation clinic, many participants experienced the staff as one of the best things about the medical environments. One might assume that the men who experienced the staff negatively did so as a result of issues that arose specific to the individual. These men may have been experiencing negative affect to a greater degree than the majority. Experiencing negative affect such as humiliation may have resulted in the experience of others' interactions as judgmental and non-empathic.

Three men felt that the separation from their partner was the worst thing about the consultation clinic. Such separation from one's partner was the most commonly identified negative aspect associated with the hospital ward. These responses are in accordance with Carpman and Grant (1993) who identified the separation from one's friends and family as stressful characteristics of a medical setting. As mentioned previously, this separation may have caused some men to feel out of control as they are no longer aware of exactly what is happening, for those men rating high on the 'need to be in control' item on the masculinity measure may have experienced this separation more negatively. Not knowing was reported as a negative aspect

of the hospital ward, this further highlights the sense that these men feel out of control during their partner's TOP procedure. Lazarus and Folkman (1984) studied possible factors central to coping and controlling stress. The transaction between people and their environment, known as the 'Transactional Model' was central to their research. Lazarus and Folkman (1984) suggest that when an individual perceives themselves as possessing inadequate coping strategies, such as in an environment that is uncontrollable and unfamiliar, the experience of stress is likely to result. Waiting room comfort and simply waiting were also commonly reported as negative characteristics of the hospital ward. Waiting helplessly, unable to take an active role may therefore have been uncomfortable for these men as lack of control and familiarity can result in stress (Lazarus & Folkman, 1984), and being in control is a facet of hegemonic masculinity (Courtenay, 2000).

One participant identified the study questionnaire as the worst thing about the hospital ward. The fact that one participant identified the questionnaire as the best thing about the hospital ward highlights the varying needs of men attending a TOP with their partner. Some men may appreciate the chance to have their say, whereas other men may find the experience uncomfortable and inappropriate.

Participants were asked for suggestions on how the consultation clinic and the hospital ward could be improved. The majority of participants stated that

both the clinic and the ward could improve by keeping the male partner involved. These responses highlight once again the sense of exclusion and helplessness that these men experience when accompanying their partner to a TOP. Participants also felt that the ward could be improved by providing food/drink facilities on the ward itself. Having to leave the ward in order to get a drink/something to eat may have been difficult during a time when many of these men appear to have felt as if they should have been supporting/protecting their partner, rather than satisfying their own needs.

5.2. Information for partners leaflet

The number of men responding to the questions pertaining to the leaflet in relation to those who had read it was high, however a large proportion of the sample said that they had not received the leaflet and therefore had not been able to read it. This implies that in many cases the females did not pass the information leaflet on to their partner. Participant's responses regarding the most and least useful aspects of the information leaflet were varied. A minority of men identified aspects of the leaflet that were not useful. A much larger number of men commented on what they found useful about the leaflet. This suggests that all of these men knew limited information about a TOP as they all appeared to benefit in some way from the provision of the informative leaflet.

A minority of participants made suggestions for improving the leaflet. The overall sense was that these men wanted to know more information about the impact that the TOP might have on their partner in the days following the procedure. There was also a couple of men who stated that they needed more advice/information pertaining to how they could help their partner.

6. Male attendance at a TOP

Firstly, over 80% of the participants rated the decision of whether or not to attend the TOP with their partner as 'Not at all difficult'; with only a small number of participants stating that they found the decision of whether or not to attend as very difficult. The polarity of these results suggests that the majority of men who attend a TOP do so because they are clear in their mind that they should, or that they want to. One might assume therefore that the men who do not attend with their partners represent the sample of men who for one reason or another find it difficult to come to a final decision as to whether or not they should attend.

Participants were asked to consider possible reasons why some men fail to attend a TOP with their partner. Firstly, the majority of the responses were negative and highly judgmental in their description of the non-attendees. The most common themes were 'Scared', 'Unsupportive' and 'Embarrassment/Guilt/Shame'. Perceiving the non-attendees in this manner

suggests that participants positioned themselves as not scared, supportive and not embarrassed, guilty or ashamed.

Positioning oneself as not guilty or ashamed as an attendee suggests that the majority of men who did attend fully support the decision to terminate subsequently not experiencing any guilt or shame. One response stated '...they are not really men...' Male attendees appear to consider it more manly to support their partner, to face up to the situation and to be strong in the face of possible guilt/shame.

7. Strengths and Limitations of the Present Study

7.1. Strengths

The present study investigates the experiences of men accompanying their partner to one of the most commonly performed gynaecological procedures in England and Wales. The present study has therefore contributed to a body of research that until recently has failed to recognise the importance of understanding the experiences of the men involved (Conklin & O'Connor, 1995). This piece of research may also assist in developing an understanding of why some men fail to attend TOP appointments.

The present study comprises a quantitative and a qualitative element, adding to the richness of the data obtained. The quantitative element has introduced

two theoretical strands to the male TOP research Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000) are introduced in order to gain an understanding of possible factors influencing the manner in which male partner's experience a TOP. A greater understanding of factors influencing male partner's experiences could assist professionals in identifying the sample of men most in need of support and advice during this uncomfortable period.

Basing the present project on the psychology of reproductive health literature, specifically Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000) has allowed the research to remain thoughtful, without attempting to fit men's experiences of a TOP into a model that is perhaps too generic.

The qualitative element was employed in response to previous researchers who noted a lack of research pertaining to men's experiences of a TOP, allowing these men to have their say as to specific aspects of their experiences.

The helpfulness of the staff on the gynaecology ward is a definite strength of the present study. Their advice and assistance during the data collection period was invaluable to the planning of data collection and the subsequent number of participants recruited.

The high response rate was a major strength of the present study. Given that men are often considered a difficult group of individuals to gather data from, the present study has managed to achieve a high response rate from a female oriented research area.

Finally, the present study aims to prompt researchers to develop future research studies focused on the experiences of male partners and TOP. Incorporating Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000) will hopefully encourage researchers to develop research in this area.

7.2. Limitations

Employing Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000) to guide the present research may have been too prescriptive. Due to the lack of research into men and TOP, it is perhaps too presumptuous to assume that these experiences would be similar to men's experiences in other areas of reproductive health. In response to the mystery that currently exists with regards to men's experiences of a TOP, a more generic model such as the transactional stress-coping model (Lazarus & Folkman, 1984) may have allowed for a wider ranging and unbiased set of results.

The main researcher for the present study was female. It is possible that this prevented participants from approaching the researcher with queries and concerns. Many participants failed to complete every questionnaire item. It is possible that if participants felt able to approach the researcher with queries, these items may have been completed. Additionally, an interview element to the study design may have yielded more complete and rich responses.

Accompanying friends and family are allowed different access to the patient depending on the type of termination (MTOP/STOP). For patients attending for an MTOP, their family/friends are allowed onto the ward for the majority of the female's stay. Patients attending for an STOP are not allowed to be accompanied onto the ward unless they are under 16 years of age. STOP patients are allowed to return to the waiting room to see their family/friends following a one hour period of bed rest. It is considered that the presence of the female during questionnaire completion may have influenced the data obtained. Male partners may have been less open about the information they were willing to share whilst in the presence of their partner. Alternatively, female partners may have attempted to assist their partner in completing the questionnaire, thus resulting in information pertaining to the experience of the female, in turn producing less valid data. Additionally, it is possible that the different degrees of access granted to the partners of MTOP and STOP patients may result in the adoption of different roles, and differing TOP experiences.

Identifying which men were accompanying partners for a TOP was a difficult task. Females attend the gynaecology ward for a number of medical reasons, the researcher was therefore unable to approach every accompanying male. The researcher therefore had to rely on available members of staff to locate potential participants for the present study. Availability of staff meant that data collection was often delayed until potential participants could be identified.

The sample size used for the present study is relatively small, although a large proportion of the sample available on the data collection days was obtained. Due to time restrictions, it was not possible to collect a larger sample. A greater sample size would have added power to the statistical analyses.

The present study did not recruit participants that were aged below 18 years, or who were accompanying a female under the age of 18. A number of potential participants were prohibited from taking part in the present study as a result of being under the required age. Allowing male partners aged over 16 to participate in the present study would have resulted in a larger overall sample size. Furthermore, including this sub set of the population would provide data representative of a group of individuals frequently presenting with their partners for TOP appointments.

Certain items on the study questionnaire related to the consultation clinic attended prior to the TOP appointment. Participant's responses are therefore retrospective and may not be as accurate as they could be if the participants had been given these questions at the consultation clinic itself.

It became clear that certain participants would have valued the opportunity to discuss their experiences further than responding to restrictive items on a questionnaire. This suggests that qualitative interviews would have provided a more detailed account of these men's experiences.

Finally, the final section of the questionnaire focuses on the men who fail to attend the TOP appointment with their partner. The information gathered in response to this section is suggestive and does not provide a valid insight into the possible reasons why some men fail to attend TOP appointments.

8. Clinical Implications

The data obtained indicated that a small proportion of men were experiencing significant levels of anxiety and or depression. It is important that this sample of men is offered appropriate advice and support. Staff should have access to a screening tool that identifies the men experiencing significant levels of anxiety and depression. It is also important that all staff

are aware of the appropriate channels for referring men to the associated counseling service. During the period of data collection, one participant requested a referral to the counseling service presented on the information sheet. The response of the staff to this request suggested that counseling for the male partners is currently not high on the agenda in this department. One might predict that if male partners perceive their request for a counseling referral as atypical, their sense of exclusion may only be increased. It may be helpful for staff to be made aware of the need for this service and the appropriate channels needed to go through when making a referral. To their credit, the staff are identified by a large proportion of the sample as positive characteristics of the consultation clinic and hospital ward environments.

Many men commented that they felt excluded, and/or that they wanted to be allowed onto the ward to provide support to their partner. The reader should note that the researcher appreciates that there are many impracticalities with regards to allowing male partners on to the ward, primarily the lack of space. A similar finding included the relationship between adopting the role of Bystander and experiencing anxiety. Additionally, participants commented on a lack of information provision at the consultation clinic. Overall, men stated that they felt that they should have been kept involved more.

Each of these findings highlights the need for male partners to be provided with more information than is currently available to them. Information could be provided to male partners at the consultation clinic and at the ward, clearly explaining why they are unable to accompany their partner onto the ward. Greater efforts could be made to include the men who attend the consultation clinic in discussions and information delivery. Additionally, on arrival at the hospital ward, a more detailed explanation could be given to the males of what to expect in terms of the procedure. This explanation could be provided in a private space, away from the open and impersonal environment of the waiting room.

The majority of participants rated making the decision to attend as Not at all difficult. This suggests that the male partners who experience this decision as an extremely difficult one are the men who fail to accompany their partner to a TOP. It is possible that these men are so unaware of what a TOP involves, in many ways they fear the unknown. Once again the importance of informing these men is highlighted. Efforts could be made to access these partners at prior appointments. The researcher is aware of the difficulties involved as many men fail to attend consultation appointments also.

In response to the rationale for the present study, it is important to consider appropriate ways to increase and improve the opportunities available to engage the male partners who do attend the TOP. One major finding of the

present study is that the majority of these men feel excluded and the experience of adopting the role of 'Bystander' was related to increased anxiety. One possibility is that if men felt less like bystanders, there may be an increased opportunity to engage them in issues of sexual health. The above suggestions which focus on attempting to keep these men involved by providing more appropriate information may serve to lessen their sense of exclusion and their role as a bystander.

9. Theoretical Implications

The present study was guided by Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000), with the aim of investigating potential relationships between male partner's experiences of a TOP and these two theoretical strands. Social Role Theory was utilized as Boyle (1997) previously reported that many men are confused as to the role that they should adopt. The present study highlights the number of potential roles that are adopted, and the consequences of assuming these roles. The present study has identified a relationship between being a bystander in the process and anxiety, distress and negative affect. The importance of occupying a role is therefore highlighted.

Hegemonic Masculinity (Courtenay, 2000) was adopted in order to provide an insight into the impact masculinity can have on men's experiences of a

female dominated practice. The development of the masculinity measure used in the present study has shed light on the conceptualization of masculinity. The concept of a single masculinity description is somewhat challenged by the present study. The two masculinity factor measures that arose from the present study suggest that masculinity can take the form of quite distinct characteristics and behaviours, and not one single trait description. The present study identified the possibility of two quite separate trait descriptions; being emotionally independent and in control, and being physically and verbally out of control. The researcher is not suggesting that these two descriptions are accurate, or that they represent the variation of masculinity in its entirety. The identification of two factors does however suggest that masculinity takes several forms that require further investigation.

Additionally, the present study has proposed that possessing different masculine characteristics and behaviours may influence the manner in which varying environments and situations are experienced.

The findings of the present study may have an implication for the manner in which society views TOP. A subject that is widely regarded as taboo will hopefully benefit from greater exposure.

10. Suggestions for Further Research

The present study employed a quantitative design with a small qualitative element. Future studies using a qualitative methodology would hopefully provide rich data that is more insightful than the data obtained in the present study.

Including participants who are under the age of 18 would benefit a research study for two reasons. Firstly, a larger available sample size would be created, secondly, individuals under the age of 18 represent a large proportion of the sexual health 'at risk' population. An insight into the experiences of under 18's would assist in the engagement of these individuals and the development of preventative sexual health strategies.

Differences between the MTOP and the STOP methods are such that the male partners of females attending an MTOP are provided with greater opportunity to be next to their female partner throughout the majority of the time in hospital. Future studies could compare the experiences of men accompanying their partner to a STOP with men accompanying their partner to an MTOP. Research could investigate whether partners accompanying females to an MTOP experience the TOP more positively, with clearer roles available to be adopted.

Analysis of the data obtained in the present study highlighted the relevance of considering more closely the existing links between masculinity and social roles. Future research studies could set out to investigate the impact of masculinity on the roles adopted. It was recognised during the process of data analysis, that future research could benefit from a research question looking at making a prediction when considering the extent to which the roles adopted and the masculinity scores predict mood and affect, in this sense, we would hope to uncover which factor impacts most upon male partners' mood and affect during a TOP. Due to the explorative nature of the present study, research questions involving making predictions were not considered during the development of the study.

As mentioned previously, many of the items on the PANAS-X were deemed to either conform to the hegemonic ideal, or to oppose hegemonic masculinity. Future research investigating the affect of this sample of men would benefit from utilising an alternative self-report measure that is nether masculine or feminine biased. Additionally, further research would benefit from investigating the PANAS-X and the possibility that it is gender-biased.

The final section of the present study considers male attendee partners' thoughts as to why some men do not attend TOP appointments with their partner. Future research would benefit from asking these men directly, however such a study would bring up a number of issues of confidentiality as

questionnaires would need to be posted to these men. Asking this sample of men directly would hopefully provide more valid and insightful information that would inform professionals of the best way to engage these men.

11. Conclusion

In conclusion, the present study has provided a greater insight into the experiences of men accompanying their female partner to a TOP. Additionally, the present study has introduced two theoretical strands to the exploration; Social Role Theory (Eagly, 1987) and Hegemonic Masculinity (Courtenay, 2000). The study suggests men do not experience a TOP entirely negatively, although many of the male partners reported feeling guilty. Participants commented on feeling excluded, and their desire to be allowed onto the hospital ward with their partner. Participants reported adopting a number of pre-defined roles, adopting the role of bystander was found to relate to higher levels of anxiety. Two types of masculinity were considered. Men who rated themselves as higher in emotional control and independence experienced more positive affect. Men rating themselves as higher in uncontrolled aspects of masculinity such as verbal and physical aggression experienced more negative affect. Finally, the present study found that male partners present during their partner's TOP view the men who fail to attend a TOP with their partner in a very negative light. Consequently, it is hoped that the present study's findings will incite further

research to increase our understanding of the experiences of male partners during a TOP

REFERENCES

Arneill, A., & Devlin, A. (2002). Perceived quality of care: the influence of the waiting room environment. *Journal of Environmental Psychology*, **22**, 345-360.

Aronson, E., Wilson, T.D., & Akert, R.M. (2002). *Social Psychology*. New Jersey: Pearson Education, Inc.

Atkinson, J.W. & Birch, D. (1978). *An Introduction to Motivation*. New York: Van Nostrand.

Bandura, A. (1973). *Aggression: A social learning analysis*. Englewood Cliffs, NJ: Prentice Hall.

Banks, I. (2001). No man's land: men, illness and the NHS. *British Medical Journal*, **323**, 1058-1060.

Barclay, L., & Lupton, D. (1999). The experience of new fatherhood: A Socio-cultural analysis. *Journal of Advanced Nursing*, **29** (4), 1013-1020.

Barker, C., Pistrang, N., & Elliott, R. (2003). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners*. Chichester: John Wiley & Sons Ltd.

Barley, S.R. & Bechky, B.A. (1994). In the backroom of science: The work of technicians in science labs. *Work and occupations*, **21**, 85-126.

Bastien, D., & Hostager, T. (1988). Jazz as a process of organisational innovation. *Communication Research*, **15**, 582-602.

Beckman, L.J., & Harvey, S.M. (1998). *The New Civil War: The Psychology, Culture, and Politics of Abortion.* Washington, DC: American Psychological Association.

Bem, S.L. (1974). The measurement of Psychological Androgyny. *Journal of Consulting and Clinical Psychology*, **42**, 155-162.

Berman, P. & Pederson, F. (eds) (1987). Men's Transitions to Parenthood: longitudinal studies of early family experience. Hillsdale: Lawrence Erlbaum Associates.

Bohan, J.S. (1993). Regarding Gender: essentialism, constructionism and feminist psychology. *Psychology of Women Quarterly*, **17**, 5-21.

Boyle, M. (1997). *Re-thinking Abortion: Psychology, gender, power and the law.* New York: Routeledge.

Bracken, M.B., Hachamovitch, M & Grossman, G. (1974). 'The decision to abort and psychological sequelae', *Journal of Nervous and Mental Disease*, **158**, 154-162.

Briggs, J.,Glover, L., & Guthrie, K. (2005). Men's Thoughts and Feelings whilst their Partner is having a Medical Termination of Pregnancy. *Journal of Reproductive and Infant Psychology*, **23**, 259.

Brown, A. (1982). 'Fathers in the labour ward: Medical and Lay Accounts'. In McKee, L., O'Brien, M. (Eds). '*The Father Figure*'. London: Tavistock.

Burchard, W. (1954). Role conflict of military chaplains.' *American Sociological Review*, **19**, 528-535.

Burgess, A. (1997). *Fatherhood Reclaimed: The making of the modern father.* U.K: Vermilion.

Burk, L.R., Burkhart, B.R. & Sikorski, J.F. (2004). Construction and Preliminary Validation of the Auburn Differential Masculinity Inventory. *Psychology of Men and Masculinity*, **5** (1), 4-17.

Carpman, J.R. & Grant, M.A. (1993). *Design that cares: Planning health facilities for patients and visitors* (2nd ed.) Chicago: American Hospital Association.

Chapman, L. (1991). Searching: Expectant father's experiences during labour and birth. *Journal of Perinatal and Neonatal Nursing*, **4** (4), 21-29.

CDR, (2000). Aids and HIV Infection in the United Kingdom: monthly report, 10 (50), 453-4. Cited in DoH (2002).

Cialdini, R.B., Kallgren, C.A., & Reno, R.R. (1991). A focus theory of normative conduct. *Advances in Experimental Social Psychology*, **24**, 201-234.

Cialdini, R.B., & Trost, M.R. (1999). Social influence: social norms conformity and compliance. In D. Guilbert, S. Fiske & G. Lindzy (Eds.). *The Handbook of Social Psychology* (vol 2. p151-192). Boston: Mcgraw-Hill.

Conklin, M., & O'Connor, B. (1995). Beliefs about the fetus as a moderator of postabortion psychological well-being. *Journal of Social Psychiatry*, **39**, 76-81.

Connell, R.W. (1995). *Masculinities.* Oxford: Blackwell Publishers.

Courtenay, W.H. (1999). *Situating men's health in the negotiation of masculinities.* The society for the Psychological Study of Men and Masculinity Bulletin (The American Psychological Association), **4** (2), 10-12.

Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*, **50**, 1385-1401.

Cousins, A.N. (1951). Social equilibrium and the psychodynamic mechanisms. *Social Forces*, **30**, 202-209.

Cowan, C. & Cowan, P. (1987). Men's involvement in parenthood: identifying the antecedents and understanding the barriers. In Berman, P. & Pederson, F. (Eds). *Men's Transitions to Parenthood: longitudinal studies of early family experience.* Lawrence Erlbaum Associates, Hillsdale.

Crawford, J.R., & Henry, J.D. (1994). The Positive and Negative Affect Schedule (PANAS): Construct validity, measurement properties and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, **43**, 245-265.

Crawford, M., (1995). *Talking Difference: On Gender and Language.* Sage Publications, Thousand Oaks: CA.

Department of Health Website (2002). *The National Strategy for Sexual Health and HIV implementation action plan.*

Department of Health Bulletin (2005). *Abortion Statistics, England and Wales*: 2005. London: DoH.

Dewey, J. (1922). *Human Nature and Conduct.* New York: Holt, Rinehart & Winston.

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

Duncan, D. (1995). *Fathers have feelings, too. Modern Midwife*, **5** (1), 30-31.

Dutton, D. (1998). *The abusive personality: Violence and control in intimate relationships.* New York: Guilford.

Eagly, A.H. (1987). *Sex differences in social behaviour: A social-role interpretation.* Hillsdale, NJ: Erlbaum.

Eagly, A.H., Wood, W, & Diekman, A.B. (2000). Social Role theory of sex differences and similarities: A current appraisal. In T. Eckes, & H.M. Trautner (Eds.) *The developmental social psychology of gender* (pp123-156). Mahwah, NJ: Lawrence Erlbaum Associates.

Edley, N. & Wetherell, M. (1995). *Men in perspective: practice power and identity.* Cornwall: T. J. Press.

Elison, J. (2005). Shame and guilt: A hundred years of apples and oranges. New ideas in psychology, 23 (1), 5-32.

Enkin, M, Keirse, M., Renfrew, M., et al. (1995). *A guide to effective care in pregnancy and childbirth.* Oxford University Press: Oxford.

Fejes, F.J. (1992). *Masculinity as fact: a review of empirical mass communication research on masculinity.* In Burgess, A. (Eds) *Fatherhood Reclaimed: The making of the modern father.* U.K: Vermilion.

Flett, G, M, M., & Templeton, A. (2002). Surgical Abortion. *Best Practice & Research Clinical Obstetrics and Gynaecology*, **16** (2), 247-261.

Frosh, S. (1994). *Sexual Difference: Masculinity and Psychoanalysis.* London: Routeledge.

Frosh, S. (1997). Screaming under the bridge: Masculinity, rationality and psychotherapy. In J. Ussher (Ed) *Body Talk: The Material and Discursive Regulation of Sexuality, Madness and Reproduction.*

Geis, F.L. (1993). Self-fulfilling prophecies: a social psychological view of gender. In: Beall, A.E., & Sternberg, R.J. (Eds). *The Psychology of Gender. Guilford Press:* New York, p 9-54.

Gilbert, P. (2003). Evolution, social roles and the differences in shame and guilt. *Social Research*, **70** (4), 1205-1230.

Gilmore, D.D. (1990). *Manhood in the making: cultural concepts of masculinity.* New York: Yale University Press.

Glass, A.J. (1959). Psychological aspects of disaster. *Journal of the American Medical Association*, **171**, 222-225.

Goffman, E. (1961). *Encounters: Two Studies in the Sociology of Interaction.* Indianapolis: Bobbs- Merrill.

Golombok, S., & Fivush, R., (1994). *Gender Development.* Cambridge: University Press.

Good, G.E., Wallace, D.L. & Borst, T.S. (1994). Masculinity research: A review and critique. *Applied & Preventive Psychology*, **3**, 3-14.

Goode, W.S. (1960). 'A theory of role strain.' *American Sociological Review*, **25**, 483-496.

Gordon, R.H. (1978). Efficacy of a group crisis-counseling program for men who accompany women seeking abortions. American Journal of Community Psychology, 6, 239-246.

Gramsci, A. (1971). *Selections from the Prison Notebooks*. London: Lawrence & Wishart.

Grimes, D.A. (1997).Medical Abortion in Early Pregnancy: A Review of the Evidence. *Obstetrics & Gynecology*, **89** (5), 790-796.

Hadley, J. (1996). *Abortion: Between Freedom and Necessity*. London: Virago.

Harway, M., & Moss, L.T. (1983). Sex Differences: The Evidence from Biology. In M.B. Liss (Ed). *Social and Cognitive Skills: Sex Roles and Children's Play*. New York: Academic Press.

Hatcher, R. A. (1998). *Contraceptive Technology.* New York. Ardent Media, Inc.

Hearn, J. (1984). Childbirth, Men and the Problem of Fatherhood. *Radical Community Medicine*, **17**, 9-19.

Henderson, A. & Brouse, J. (1991). The experiences of new fathers during the first three weeks of life. *Journal of Advanced Nursing*, **16**, 293-298.

Henshaw, S.K., Singh, S., & Haas, T. (1999). The incidence of abortion worldwide, *International Family Planning Perspectives*, **25** (Supplement), 30-38.

Herrmann, C. (1997). International experiences with the Hospital Anxiety and Depression Scale- a review of validation data and clinical results. *Journal of Psychosomatic Research*, **42**, 17-41.

Holt, C.L, & Ellis, J.B. (1998). Assessing the current validity of the Bem Sex-Role Inventory. *Sex Roles*, **39**, 929-941.

Howitt, D., & Cramer, D. (2000). An introduction to statistics in psychology: a complete guide for students. (second edn). Prentice Hall: England

Humphrey, M. (1977). Sex differences in Attitude to Parenthood. *Human Relations*, **8**, 737-749.

Jakupcak, M., Tull, M. T., & Roemer, L. (2005). Masculinity, Shame, and Fear of Emotions as Predictors of Men's Expressions of Anger and Hostility. *Psychology of Men and Masculinity*, **6** (4), 275-284.

Janoff-Bulman, R. (1979). Characterological versus behavioural self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology*, **37**, 1798-1809.

Jefferson, T. (2002). Subordinating hegemonic masculinity. *Theoretical Criminology*, **6** (1), 63-88.

Jordan , P.L. (1990). Labouring for relevance: expectant and new fatherhood. *Nursing Research*, **39** (1), 11-16.

Kaufman, M., (1994). Men, feminism, and men's contradictory experiences of power. In: Brod, H., & Kaufman, M. (Eds). *Theorising Masculinties*. Sage Publications, Thousand Oaks: CA, p 142-163.

Kliman, D.G., & Kohl, R. (1984). *Fatherhood USA*. New York: Garland Press.

Kunst-Wilson, W., & Cronenwett, L. (1981). Nursing care for the emerging family: Promoting paternal behaviour. *Research in Nursing and Health*, **4**, 201-211.

Lamb, M.E. (1986). *The Father's Role: Applied Perspectives.* John Wiley & Sons: New York.

Lazarus, R., & Folkman, S. (1984). *Stress, Appraisal and Coping.* New York: Springer.

Lewis, C. (1983). 100 father's perceptions of pregnancy and birth. *Journal of Psychosomatic Obstetrics and Gynaecology*, **2**, 106.

Locock, L., & Alexander, J. (2006). 'Just a bystander'? Men's place in the process of fetal screening and diagnosis. *Social Science & Medicine,* 62, 1349-1359..

Long, D. (1987). Working with men who batter. In M. Scher & M. Stevens (Eds), *Handbook of Counselling and psychotherapy with men* (p305-320). Thousand Oaks, CA: Sage.

Mahalik, J.R. (2000). *A model of masculine gender role conformity. Symposium-Masculine gender role conformity: Examining theory, research*

and practice. Paper presented at at the 108th Annual Convention of the American Psychological Association, Washington DC.

Mahalik, J.R., Locke, B.D., Ludlow, L.H., Diemer, M.A., Scott, R.P.J., Gottfried, M. & Freitas, G. (2003). *Psychology of Men & Masculinity*, **4** (1), 3-25.

Major, B.N., Mueller, P., & Hildebrandt, K. (1985). Attributions, expectations and coping with abortion. *Journal of Personality and Social Psychology*, **48**, 585-599.

Major, B., Cozzarelli, C., & Testa, M. & Meuller, P. (1992). Male partners' appraisals of undesired pregnancy and abortion: Implications for women's adjustment to abortion. *Journal of Applied Social Psychology*, **22**, 599-614.

Marsiglio, W., & Diekow, D. (1998). Men and Abortion: The Gender Politics of Pregnancy Resolution. In L.J. Beckman, & S.M. Harvey (Eds) *The New Civil War: The Psychology, Culture and Politics of Abortion.* Washington: American Psychological Association.

Martin, C.L. (1995). Stereotypes about children with traditional and non-traditional gender roles. *Sex roles*, **33** (11/12), 727-751.

Masden, K.B. (1968). Theories of Motivation. Kent, OH: Kent State University Press.

Mathews, A. & Macleod, C. (1994). Cognitive approaches to emotion and emotional disorders. Annual review of psychology, 45, 25-50.

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

Miller, W.B. (1992). 'An empirical study of the psychological antecedents and consequences of induced abortion', *Journal of Social Issues*, **48**, 67-93.

Moran-Ellis, J. (1989). The role of the father in childbirth. *Midwife, Health Visitor and Community Nurse*, **7**, 284-288.

Mueller, P., & Major, B. (1989). Self-blame, self-efficacy and adjustment to abortion. *Journal of Personality and Social Psychology*, **57**, 1059-1068.

Murphy, S. (1992). *Talking about miscarriage*. London: Sheldon Press.

Neustatter, A., & Newson, G. (1986). *Mixed Feelings: The Experience of Abortion*. London: Pluto Press.

Nolan, M. (1994). Caring for fathers in antenatal classes. *Modern midwife*, **4** (2), 25-28.

O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff but that is to some extent how guys will operate': men's accounts of masculinity and help seeking. *Social Science & Medicine*, **61**, 503-516.

Oakley, A. (1981). *Becoming a mother.* Oxford: Martin Robertson.

Office for National Statistics (2002). *Health Statistics Quarterly*, **13**.

Osofsky, J.D., & Osofsky, H.J. (1972). The Psychological reaction of patients to legalized abortions. *American Journal of Orthopsychiatry*, **42** (1), 48-60.

Palkovitz, R. (1987). Father's motives for birth atterndance. *Maternal Child Nursing Journal*, **16**, 123-129.

Paul, M., Stubblefield, P.G., & Grimes, D.A. (1999). *A Clinician's guide to Medical and Surgical Abortion. Philidelphia*, PA: Churchill Livingstone.

Pipes, M. (1998). *Understanding Abortion.* London: The Women's Press Ltd.

Pirruccello, E., & Winikoff, B. (2000). Abortion with mifepristone and misoprostol: Regimens, efficacy, acceptability and future directions. *American Journal of Obstetrics and Gynecology*, **183** (2), 44-53.

Pleck, J.H., & Thompson, E.H. (1987). 'The structure of male norms', in M.S. Kimmel, Changing Men: New directions in research on men and masculinity, London: Sage.

Pleck, J.H. (1995). The Gender Role Strain Paradigm: An Update. In Levant,R.F., & Pollack, W.S. (Eds) A New Psychology of Men. New York: Basic Books.

Pleck, J.H., Sonenstein, F.L., Ku, L.C., (1994). Problem behaviours and masculinity ideology in adolescent males. In: Ketterlinus, R.D., Lamb, M.E. (Eds), Adolescent Problem Behaviours: Issues and Research. Lawrence Erlbaum, Hillsdale, NJ, p165-186.

Pyke, K.D., (1996). Class-based masculinities: the interdependence of gender, class and interpersonal power. Gender and Society, 10, 527-549.

Quarantelli, E.L. (1977). Disasters: Theory and Research. Beverly Hills, CA: Sage.

RCOG. (2001). What you need to know about abortion care: information from the Royal College of obstetricians and gynaecologists. London: RCOG Press.

RCOG Clinical Effectiveness Support Unit (2001). National Audit of Induced Abortion 2000, Report of England and Wales. London: Royal College of Obstetricians and Gynaecologists.

Rempusheski, V.F., Chamberlain, S.L., Picard, H.B., Ruzanski, J. & Collier, M. (1998). Expected and received care: Patient perceptions. *Nursing Administration Quarterly,* **12**, 42-50.

Salkovskis, P.M., Stoer, D., Atha, C., & Warwick, H.M. (1990). Psychiatric Morbidity in an accident and emergency department. Characteristics of patients at presentation and one month follow-up. *British Journal of Psychiatry,* **156**, 483-487.

Sarbin, T.R., & Allen, A.V. (1968). 'Role Theory'. In G.Lindzey & E.Aronson (Eds). *The Handbook of Social Psychology,* Vol 1. Reading, MA: Addison-Wesley.

Seidler, V. (1989). *Rediscovering Masculinity.* London: Routeledge.

Seidler, V. (1991). *Recreating Sexual Politics.* London: Routeledge.

Seidler, V. (1994). *Unreasonable Men.* London: Routeledge.

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

Shapiro, J. (1987). The expectant father. *Psychology Today.* **21** (1), 36-42.

Shifman, P. (1990). Involuntary Parenthood: Misrepresentation as to the use of contraceptives. *International Journal of Law, Policy and the Family*, **4** (3), 279-296.

Shostak, A.B., McLouth, G., & Seng, L. (1984*). Men and Abortion. Lessons, losses, and love.* New York: Praeger.

Sieber, S.D. (1974). Toward a theory of role accumulation. *American Sociological Review*, **39**, 567-578.

Simon, M.Y. (1997). *Male Partners and the Psychological Sequelae of Abortion: A Psychodynamic-Relational View.* New York: Lawrence Erlbaum.

Sjögren, B. (1992). The expectant father and prenatal diagnosis. *Journal of Psychosomatic and Obstetrics and Gynaecology*, **13** (3), 197- 208.

Snaith, R.P., & Zigmond, A.S. (1994). *HADS: Hospital and Depression Scale.* Windsor: NFER Nelson.

Strauss, A. L. (1978). *Negotiations: Varieties, Contexts, Processes and Social Order.* San Fransisco: Jossey-Bass.

Stryker, S. (1981). Symbolic Interactionism: themes and variations. In M. Rosenberg & R.H. Turner (Eds) *Social Psychology: Sociological Perspectives.* New York: Basic Books.

Turner, R.H. & Killian, L.M. (1972). *Collective Behaviour.* Englewood Cliffs, NJ: Prentice-Hall.

Volicer, B.J. & Volicer, L. (1978). Cardiovascular changes associated with stress during hospitilisation. *Journal of Psychosomatic Research*, **22**, 159-168.

Watson, D., & Clark, L.A. (1994). *Manual for the Positive and Negative Affect Schedule – Expanded Form.*

Watson, D., Clark, L.A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS Scales. *Journal of Personality and Social Psychology*, **47**, 1063-1070.

Wellings, K., Field, J., Johnson, A.M., & Wadsworth, J. (1994). *Sexual behaviour in Britain, The National Study of Sexual Attitudes and Lifestyles.* Penguin.

Whitmarsh, A., Koutantji, M., & Sidell, K. (2003). Illness perceptions, mood and coping in predicting attendance at cardiac rehabilitation. *British Journal of Health Psychology*, **8**, 209-221.

Wilde, B., Starrin, B., Larsson, G. & Larsson, M. (1993). Quality of care from a patient perspective. *Scandinavian Journal of Caring Sciences*, **7**, 113-120. Cited in Arneill & Devlin (2002).

Williams, J.E., Best, D.L., (1990). Measuring Sex Stereotypes: A Multination Study. Sage Publications, Thousand Oaks, CA.

Wilson-Barnett, J. (1979). *Stress in Hospital.* Edinburgh: Churchill Livingstone.

Winkel, G.H. (1986). The environmental psychology of the hospital: Is the cure worse than the illness? *Prevention in Human Services*, **4**, 11-33.

Wood, W., & Eagly, A.H. (2002). A cross-cultural analysis of the behaviour of men and women: Implications of the origins of sex differences. *Psychological Bulletin*, **128**, 699-727.

Zigmond, A.S., & Snaith, R.P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, **67**, 361-370.

Zoja, E.P. (1997). *Abortion loss and renewal in the search for identity.* Routeledge: London.

Zurcher, L.A. (1983). *Social Roles: Conformity, Conflict and Creativity.* California: Sage Publications Inc.

APPENDIX I

CORRELATION MATRIX FOR 7. ROLES ADOPTED AND LEVELS OF MOOD AND AFFECT.

	Spearman's rho	HADS Depression	HADS Anxiety	Distress	Negative Affect	Positive Affect	Bystander Role	Protector Role	Information Gatherer Role	Decision Maker Role	Putting Decisions into Action Role
HADS Depression	Correlation	1	.667**	.537**	.495**	-.356**	.212	-.126	-.086	0	-0.066
	Sig. (2-tailed)	.	.000	.000	.000	.004	.095	.323	.503	0.997	0.61
	N	63	63	63	63	63	63	63	63	63	62
HADS Anxiety	Correlation	.667**	1.000	.645**	.709**	-.219	.345**	-.013	.009	0.025	0.034
	Sig. (2-tailed)	0	.	.000	.000	.084	.006	.918	.942	0.847	0.796
	N	63	63	63	63	63	63	63	63	63	62
Distress	Correlation	.537**	.645**	1.000	.802**	-.409**	.259*	-.020	.050	-0.133	0.008
	Sig. (2-tailed)	0	.000	.	.000	.001	.041	.879	.695	0.298	0.948
	N	63	63	63	63	63	63	63	63	63	62
Negative Affect	Correlation	.495**	.709**	.802**	1.000	-.370**	.307*	-.018	-.058	-0.063	-0.032
	Sig. (2-tailed)	0	.000	.000	.	.003	.014	.889	.653	0.625	0.802
	N	63	63	63	63	63	63	63	63	63	62
Positive Affect	Correlation	-.356**	-.219	-.409**	-.370**	1.000	-.091	.406**	.116	0.109	0.147
	Sig. (2-tailed)	.004	.084	.001	.014	.	0.479	.001	.365	0.394	0.254
	N	63	63	63	63	63	63	63	63	63	62
Bystander Role	Correlation	.212	.345**	.259*	-.307**	-.091	1.000	.044	-.129	0.073	-0.056
	Sig. (2-tailed)	.095	.006	.041	.014	.479	.	.734	.312	0.572	0.668
	N	63	63	63	63	63	63	63	63	63	62
Protector Role	Correlation	-.126	-.013	-.020	-.018	.406**	.044	1.000	.394**	0.78	.287*
	Sig. (2-tailed)	.323	.918	.879	.889	.001	.734	.	.001	0.544	0.024
	N	63	63	63	63	63	63	63	63	63	62
Information Gatherer Role	Correlation	-.086	.009	.050	-.058	.116	-.129	.394**	1.000	0.031	.445**
	Sig. (2-tailed)	.503	.942	.695	.653	.365	.312	.001	.	0.807	0
	N	63	63	63	63	63	63	63	63	63	62
Decision Maker Role	Correlation	.000	.025	-.133	-.063	.109	.073	.078	.031	1	.353*
	Sig. (2-tailed)	.997	.847	.298	.625	.394	.572	.544	.807	.	0.005
	N	63	63	63	63	63	63	63	63	63	62
Putting Decisions into Action Role	Correlation	-.066	.034	.008	-.032	.147	-.056	.287*	.445**	.353**	1
	Sig. (2-tailed)	.610	.796	.948	.802	.254	.668	.024	.000	0.005	.
	N	62	62	62	62	62	62	62	62	62	62

APPENDIX II

ETHICAL APPROVAL DOCUMENTATION

Re: Men and the Termination of Pregnancy – REC: 06/Q1104/70

I am pleased to notify you formally that this study has been approved by the Trust and may now proceed.

Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study, you agree to comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance, and you must comply with Trust information management and data protection policies (see intranet Policies Nos: 134, 135, & 192). In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

- the study should follow the agreed protocol;
- all potential subjects should have enough information to make a free and informed decision about participation;
- participants should receive appropriate care while involved in the study;
- the integrity and confidentiality of clinical and other records and data generated by the study will be maintained;
- all adverse events must be reported forthwith to the Trust and other authorities specified in the protocol;
- any suspected misconduct by anyone involved in the study must be reported;

The Trust is required to return information on the progress of studies to the National Research Register, and to report research findings. We will, therefore, ask you every quarter for such updates, and would be very grateful if you would provide this information.

I would like to wish you every success with this project.

Re: Men and the termination of pregnancy

I am please to notify you formally that this study has been approved by the Trust and may now proceed.

I conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance, and you must comply with the Trust information management and data protection policies. In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

- The study follows the agreed protocol
- Participants should receive appropriate care while involved in the study
- The integrity and confidentiality of clinical, other records and data generated by the study will be maintained
- All adverse events must be reported to the Trust and other authorities specified in the protocol
- Any suspected misconduct by anyone involved in the study must be reported

The Trust is required to return information on the progress of studies to the National Research Register, and to report research findings. We will, therefore, ask you every 6 months for such updates. This includes full reference of any publications arising from the project.

I would like to wish you every success with this project

Yours sincerely

APPENDIX III

INFORMATION FOR PARTNERS LEAFLET

AT HULL AND EAST YORKSHIRE NHS HOSPITALS TRUST AND HULL AND EAST RIDING COMMUNITY HEALTH WE WELCOME YOUR VIEWS ON OUR SERVICE. IF YOU HAVE A COMMENT TO MAKE PLEASE CONTACT:

Background Information

Every year, tens of thousands of couples face unplanned pregnancies despite having used a method of family planning. Contraception can fail however careful you are.

About four women in every 10 have an abortion at some time in their lives. Abortion is legal in Britain if two doctors agree that certain criteria are met. Most of these relate to the effect that the pregnancy may have on the mental or physical health of the woman.

We make every effort to involve partners, although partners have no legal rights in relation to abortion and our main priority must be the safety and confidentiality of our patients.

What happens at the clinic/department?

- The first outpatient consultation can last up to 2 hours and your partner will see a doctor and usually a nurse. Your partner will also be offered the opportunity to see a counsellor and may also require an ultrasound scan to determine how far on she is in the pregnancy.
- You will be able to stay with your partner for most of the time, provided that this is what your partner wants. At some point in the consultation we will require to see her alone to give her the opportunity for a private discussion.
-

She had the abortion two weeks ago but is still upset. When are things going to be back to how they should be?
After an abortion, women can experience a variety of emotions and feelings, some of which may appear contradictory. They may feel relieved but also quite sad. Sometimes there are feelings of loss but these normally decrease with time. All women are different and there is not standard amount of time that it takes for a woman to put her abortion experience behind her. The clinic/hospital can provide post-abortion counselling at any time after the abortion and invite you to contact them if you feel this would be helpful.

I can't seem to say the right thing
It can be hard for a man to discuss an unplanned pregnancy. It may feel as though you are pushing a particular view if you keep raising the matter. Equally if you avoid the issue it may seem that you are distant or uncaring. The only guide here is to be led by your partner and ask her what she wants. However, be prepared that what she wants may well vary from day to day - even from hour to hour.

I feel helpless and excluded from what's going on
It is not surprising that some men feel isolated when their partner has an abortion. To some extent this is unavoidable given that the final decision about the future pregnancy must ultimately rest with the pregnant woman. You can ask your partner how she would like you to support her and by respecting her wishes you will be doing the best you can.

This is affecting our relationship. What can we do?
It can be very difficult to cope with an unplanned pregnancy, particularly if you both have different expectations from your relationship. One of the hardest situations can be when there is a difference of opinion over continuing the pregnancy. It may be helpful to seek professional help if you find that your relationship is suffering. Relate can sometimes provide professional counselling and can be contacted on: 01788 573241
Or www.relate.org.uk

The abortion Appointment:

- We will ask your partner not to eat and drink if she is having a general anaesthetic. It is important to follow these instructions, otherwise we will have to delay or postpone treatment.
- Facilities at our hospitals and clinics (where your partner will have her abortion) vary. If you wish to wait for your partner, please check parking arrangements and fees. Drinks and snacks are available on most sites.
- If you are unsure as to the location of the clinic/department where the abortion will take place, please let the staff know so that they can provide you with directions and/or a map.
- Be prepared for more waiting whist your partner is having the abortion. You will usually be allowed to stay with your partner until she is ready for treatment. We will let you know the time we anticipate that she will be able to go home. Usually there is no need for women to stay in the clinic overnight.
- We recommend that women have a check-up two to four weeks after their abortion. The doctor who referred your partner or the doctor who performed the abortion can do this.

Abortion procedures vary according to the stage of the pregnancy. Depending on medical advice, women are able to choose the procedure that they feel is most suitable for them and their circumstances. The procedures are described more fully in the following leaflets:

- Medical Termination of Pregnancy
- Surgical Termination of Pregnancy.

Your partner will be given copies of the appropriate leaflet along with a leaflet outlining what to expect at the first outpatient consultation. You are encouraged to read these together. The
doctors and nurses involved in your partner's care are happy to answer any additional questions you may have.

Abortion procedures, especially in the early weeks of pregnancy are very safe, but obviously no clinical procedure is entirely without risk. Your partner should discuss her choices of treatment and any possible complications and side effects with the doctor before she makes her decision.

Short term effects:

One of the highest risks after an abortion is infection. To minimise the risk, all our patients are given antibiotics. Women are also advised to avoid sexual intercourse until bleeding stops and to use sanitary towels instead of tampons.

It is usual for women to experience some bleeding for several days after an abortion. What exactly your partner can expect will be explained before she leaves the department, as it depends upon her procedure. However if she has any concerns over bleeding she can call the ward or department where she has received her care. Telephone numbers are provided on each of her information leaflets. Similarly if she feels unwell your partner should seek medical advice. It is always better to seek advice than worry unnecessarily. After treatment some women find their hormone levels swing quite dramatically whilst their bodies adjust. This may result in mood changes and it is common for women to feel a bit sensitive and irritable. This is perfectly normal, but you may find that your partner needs extra support and reassurance.

In early abortions there is a slight risk of continuing pregnancy. If your partner is still experiencing the symptoms of pregnancy two to three weeks after her abortion she should seek advice from her doctor.

Long term effects:

There are no increased risks to future fertility unless a woman contracts an infection and it is not properly treated. This is why it is important for your partner to follow our aftercare advice.

There is no evidence that abortion causes long-term depression or trauma. After an abortion some women feel a sense of loss even if they believe their decision was right. Others may feel relief. Feelings after an abortion depend on individual circumstances. Try to tae the lead from your partner and help her in the way that she feels is most supportive.

Questions Men Ask:

Can I tell my friends?
It may be useful for you and your partner to discuss where and how you would like to find additional support. You both may benefit from sharing your feelings with friends. However try to agree together whom you would like to involve. Your partner may prefer to keep this information a secret.

Will she feel differently about sex?
There are no reasons why an abortion will necessarily affect a woman's feelings about sex, but when contraception has failed this in itself might make her feel insecure and worry about further unplanned pregnancies.

How soon can we have sex?
Vaginal penetration should be avoided for two weeks or until bleeding stops. If you both find it impossible to wait use a condom to help prevent infection.

APPENDIX IV

CONFIDENTIAL INFORMATION SHEET

Confidential Information Sheet

You are being invited to take part in a research study. Before you decide whether you would like to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with friends/relatives if you wish to do so. Please inform/contact me if there is anything that is not clear or if you would like more information.

PLEASE READ THE FOLLOWING

What is the title of the research?

Men and the termination of pregnancy.

What is the purpose of the study?

Little research to date has considered the experiences and feelings of men accompanying a female through an abortion process. The main purpose of the study is to find out about men's experiences of accompanying a female going through the abortion process. This will hopefully increase the quality of services and information provided to men going through this process in the future.

Can I take part?

You can take part if you are male, and are accompanying a female through an abortion process.

UNFORTUNATELY, IF YOU OR YOUR PARTNER ARE UNDER THE AGE OF 18, YOU ARE NOT ELLIGABLE TO TAKE PART IN THIS STUDY

What will happen to me if I take part?

If you agree to take part in the study, you will be asked to complete a brief set of questionnaires whilst you are sitting in the waiting room. The questionnaires will ask you about your thoughts and feelings, and should not take longer than 20 minutes to complete.

Do I have to take part?

It is totally up to you to decide to take part. If you decide to take part please sign the attached consent form. If you decide to take part you can withdraw at any

time and without giving a reason. A decision to withdraw, or a decision to take part, will not affect the standard of care you or the female you are accompanying will receive in any way.

What do I have to do?

All you will be asked to do is answer some simple questions about your thoughts and feelings. The study is only interested in the experiences of men accompanying a female through the abortion procedure. Personal reasons for having the procedure will not be asked about at any time. You will also not have to write about anything you do not wish to.

What are the possible disadvantages of taking part?

By taking part in this study you may wish to share both positive and negative feelings. Thinking about these negative feelings may make you feel upset. There may be issues that you wish to share but would like further help with after the appointment. If this is so, help and advice will be given. Similarly, if you would like to talk to a trained abortion counsellor, arrangements for this can be made.

What are the possible benefits of taking part?

Little research to date has considered the experiences of men accompanying a female through the abortion process. Additionally, no research to date has asked men their opinion of the services provided to them throughout this procedure. Your experiences and opinions may help to improve the quality of the current services that are available to men accompanying a female through an abortion procedure. Your participation may also help provide an understanding of how men can be better supported through this procedure in the future.

What happens when the research study stops?

When all questionnaires are analysed, findings will be written up.

Will taking part in this study be kept confidential?

All the information obtained from the study will be anonymous, thus no individual will be identified by name. In addition no medical records will be used in the current research.

What will happen to the results of the research study?

The anonymous data will be shared with researchers on the Hull University Trainee course. The questionnaires will be stored in a locked cabinet in the

APPENDIX V

CONSENT FORM

PARTICIPANT CONSENT FORM

PLEASE COMPLETE THIS FORM IF YOU WISH TO TAKE PART IN THIS STUDY

Title of project: Men and the Termination of Pregnancy.

Name of researcher: Miss Emma Griffiths

Please complete by ticking the boxes

1. I confirm that I have read and understood the attached information sheet for the above study.(Version 2, 20/04/06) [ ]
2. I have been given enough time to consider whether I wish to take part. [ ]
3. I have received satisfactory answers to the questions I asked. [ ]
   N/A [ ]
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. [ ]

The study has been explained to me and I AM WILLING TO TAKE PART [ ]

Signed .....

Date .....

Researcher's signature.....

APPENDIX VI

DEMOGRAPHIC & ROLES QUESTIONNAIRE

Version 2
20/04/06

Men's experiences of a Termination of Pregnancy Procedure

Demographics Questionnaire

How old are you?

_____

What is your occupation?

_____

Please tick the box showing the highest qualification you have

No qualifications	[ ]	Diploma	[ ]
O-level/G.C.S.E's	[ ]	Degree/professional qualification	[ ]
A-levels	[ ]	Postgraduate degree	[ ]

Who are you accompanying today? Tick the appropriate box.

My current partner and the woman whom I made pregnant [ ]
My current partner, but not the woman whom I made pregnant [ ]
My Friend [ ]
My Spouse [ ]
My Sister [ ]
My daughter [ ]
Other (please specify) _____

Do you and the person you are accompanying live

Together [ ] Separately [ ]

If the person you are accompanying is your partner, how long have you been together?

_____

Do you have any children?

_____

If yes, how many?

_____

Have you attended an abortion procedure before? _____

If yes, how many times? _____

Version 2
20/04/06

Men's experiences of a Termination of Pregnancy Procedure

If known, how many weeks pregnant is the person you are accompanying?

_____

Who referred the person you are accompanying to the termination service?

GP	[ ]	(please tick)
Family Planning Clinic	[ ]	
Sexual Health Clinic	[ ]	
Hospital(as inpatient)	[ ]	
Other (please specify) _____		

Please indicate if you were present at the clinic consultation
(please tick)
Yes [ ]
No [ ]

What type of termination is the person you are accompanying having?
(please tick)
Medical [ ]
Surgical [ ]

Please rate the extent to which the following descriptions describe the role that you feel you have adopted throughout the termination process. (circle a number)

a) I feel as though I have been a bystander in the termination process

Not at all				Very much so
1	2	3	4	5

a)i) What is the reason for this?

_____

_____

b) I feel as though I have been a source of protection/support for the person I am accompanying to the termination service.

Not at all				Very much so
1	2	3	4	5

b)i) What is the reason for this?

_____

_____

c) I feel I had an important role in gathering information and advice regarding the termination process.

Not at all				Very much so
1	2	3	4	5

c)i) What is the reason for this?

_____

_____

d) I feel as though I've had an important role in decision making about the termination process.

Not at all				Very much so
1	2	3	4	5

d)i) What is the reason for this?

_____

_____

e)I feel as though I've had an important role in making sure that decisions regarding the termination process are put into action.

Not at all				Very much so
1	2	3	4	5

e)i) What is the reason for this?

_____

_____

f) If you feel as though you have adopted any additional roles please specify below.

_____

f)i) What was the reason for adopting these additional roles?

_____

_____

APPENDIX VII

MASCULINITY MEASURE

Below is a series of 5 point scales which describe a variety of characteristics. Select and circle the number from 1 to 5 that best describes you.
For example, the following scale is interested in how well you stand up under pressure. If you do not stand up well under pressure at all you would circle number 5. If you can only just manage under pressure, you would circle either number 3 or 4 etc.

I stand up well under pressure				I go to pieces under pressure
1	**2**	**3**	**4**	**5**

I cannot ignore my own wants/needs				I find it easy to put my own needs aside if necessary
1	**2**	**3**	**4**	**5**
My needs/wants are always my number one priority				I always put other people's needs in front of my own
1	**2**	**3**	**4**	**5**
I do not find it awkward asking for help from others				I am not comfortable asking for help from others
1	**2**	**3**	**4**	**5**
I have a very high pain tolerance				I have a very low pain tolerance
1	**2**	**3**	**4**	**5**
I don't find it easy to admit when I'm in physical pain				I find it easy to admit when i'm in physical pain
1	**2**	**3**	**4**	**5**
I don't find it easy to admit when I'm in emotional pain				I find it easy to admit when I'm in emotional pain
1	**2**	**3**	**4**	**5**
I am very vulnerable				I am not at all vulnerable
1	**2**	**3**	**4**	**5**
I never feel inadequate				I often feel inadequate
1	**2**	**3**	**4**	**5**
I am not at all emotional				I am very emotional
1	**2**	**3**	**4**	**5**
I never lash out physically when provoked				I always lash out physically when provoked
1	**2**	**3**	**4**	**5**

I come across as 'mentally tough' to others				I do not appear 'mentally tough' to others
1	**2**	**3**	**4**	**5**
I rely on for others a great deal for help				I do not rely on others for help
1	**2**	**3**	**4**	**5**
I hardly ever think about sex				I am always thinking about sex
1	**2**	**3**	**4**	**5**
I could not enjoy life without sex				I could enjoy life just as much without sex
1	**2**	**3**	**4**	**5**
I never behave aggressively				I often behave aggressively
1	**2**	**3**	**4**	**5**
In stressful situations, my tone of voice and content of speech are calm and controlled				In stressful situations my tone of voice and content of speech become uncontrolled and aggressive
1	**2**	**3**	**4**	**5**
Physically, I am more powerful than others				Physically, I am not as powerful as others
1	**2**	**3**	**4**	**5**
I am extremely dependent on others				I am very independent
1	**2**	**3**	**4**	**5**
I like to take charge and be in control				I tend to let things just happen and take their course
1	**2**	**3**	**4**	**5**
I cry very easily				I never cry
1	**2**	**3**	**4**	**5**
I stand up well under pressure				I go to pieces under pressure
1	**2**	**3**	**4**	**5**

APPENDIX VIII

PANAS-X ADAPTED

This scale consists of a number of words and phrases that describe different feelings and emotions. Read each word and then mark the appropriate answer (1-5) in the space next to that word. **Indicate to what extent you have felt this way during the past few weeks.** Use the following scale to record your answers.

1	2	3	4	5
Very slightly Or not at all	**A little**	**Moderately**	**Quite a bit**	**Extremely**

For example, if you have felt ***moderately annoyed*** in the past few weeks, you would answer like this **__3__ annoyed.** You should put a number next to each feeling.

_____ disgusted	_____ sad	_____ active	_____ angry at self
_____ strong	_____ afraid	_____ guilty	_____ down heartened
_____ scornful	_____ shaky	_____ nervous	_____ distressed
_____ irritable	_____ alone	_____ lonely	_____ blameworthy
_____ disgusted with self	_____ upset	_____ hostile	_____ frightened
_____ angry	_____ jittery	_____ interested	_____ blue
_____ ashamed	_____ loathing	_____ scared	_____ dissatisfied with self
_____ happy	_____ proud	_____ confident	_____ tired
_____ fearless	_____ calm	_____ relaxed	_____ alert
_____ attentive	_____ determined	_____ enthusiastic	_____ excited
_____ inspired			

APPENDIX IX

CLINIC ENVIRONMENTS QUESTIONNAIRE

Version 1
20/04/06

Men's experiences of a Termination of Pregnancy Procedure

Clinic Consultation
How would you rate the consultation clinic environment? (**Please Circle a number**)

Unfriendly 1	2	3	4	Friendly 5
Uncomfortable 1	2	3	4	Relaxed 5

What was the best thing about the clinic?

_____

_____

What was the worst thing about the clinic?

_____

_____

How could the clinic be improved?

_____

_____

Hospital ward
How would you rate the hospital ward environment?

Unfriendly 1	2	3	4	Friendly 5
Uncomfortable 1	2	3	4	Relaxed 5

What was the best thing about the hospital ward?

_____

_____

Men's experiences of a Termination of Pregnancy Procedure

What was the worst thing about the hospital ward?

_____

_____

How could the hospital ward be improved?

_____

_____

Information leaflet

Did your partner pass on an Information for Partners leaflet to you?
Yes [ ]
No [ ]

If yes, have you read this leaflet?
Yes [ ]
No [ ]

If yes, continue completing the other questions in this section.

What was useful about the information for partners leaflet?

_____

_____

Which aspects of the information for partners leaflet was not useful?

_____

_____

How could the Information for Partners leaflet be improved?

_____

_____

Version 1
20/04/06

Men's experiences of a Termination of Pregnancy Procedure

Deciding to attend the termination procedure

Was it difficult deciding whether or not to accompany your partner to the hospital for the Termination procedure?

Very difficult				Not at all difficult
1	2	3	4	5

Please describe the factors that contributed to your decision making process.

_____

_____

Why do you think some men do not attend the termination process with their partner?

_____

_____

THANK YOU VERY MUCH FOR YOUR HELP!!