FATHERS' WARMTH AND COMPETENCE

Maternal-Child Nurses' Social Judgments about Types of Fathers

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FATHERS' WARMTH AND COMPETENCE

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ABOUT TYPES OF FATHERS

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FATHERS' WARMTH AND COMPETENCE

Dedication

I would like to dedicate this work to my family and friends that have supported me and lifted me in prayer. I thank my husband, Todd, and my girls, Jill and Haley, for your love, support, encouragement, and prayers. I hope I have made you proud. Last, but certainly not least, I want to thank my Lord and Saviour, Jesus Christ. "For with God nothing will be impossible" (Luke 1:37).

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ABSTRACT

Nurses are affected by societal attitudes and are not immune to implicit social judgments. This mixed-methods study examined nurses': (1) perceptions about various types of fathers, (2) emotional reactions to the fathers, and (3) responses to questions raised by the fathers. The Stereotype Content Model (SCM) and nuclear family ideology were used as frameworks to guide this study. A sample of 167 maternal-child nurses participated in an on-line survey in which they responded to three randomized multiple segment factorial vignettes featuring five father types bringing a child to the clinic with different health conditions (e.g., a child with general health problems; a child with a chronic illness; a child with acute health symptoms). After reading descriptions of the father and child, nurses were presented with forced-choice questions about their perceptions of and emotional reactions to the fathers. They also were asked to answer questions raised by the fathers, using written responses. A series of one-way MANOVAs were conducted to examine nurses' perceptions and emotional reactions to the fathers. Content analyses were conducted on nurses' written responses. Although there were two significant statistical comparisons, the quantitative results suggested that nurses' perceptions of and reactions to the fathers were not affected by the fathers' marital and parental statuses. However, the qualitative data presented a more complicated and ambiguous picture. Nurses' written responses were not the same for all types of fathers. Social judgments may have affected how nurses responded to certain father types.

Chapter 1

SOCIAL JUDGMENTS, STEREOTYPES, AND NURSES

Social judgments, also known as cultural stereotypes, are ways in which people make sense of their social worlds (Fiske, 2012). When individuals encounter other people in social situations, they make judgments about the other person or group to help them know how to interact with that person or group.

Social judgments about any group of people consistently have been found to be comprised of two dimensions – warmth and competence (Fiske, 2012). The Stereotype Content Model (SCM) postulates that when encountering someone new, an individual first tries to assess what their intentions are – to harm or to help (i.e., the warmth dimension) – and then judges if the new person or group has the ability to act on their presumed positive or negative goals (i.e., the competence dimension). The SCM proposes that warmth and competence stereotypes result in appraisals of groups as: (1) high in warmth and competence (usually an appraiser's in-group and reference groups), (2) low in warmth and competence (outgroups, marginalized groups), (3) well-intentioned and warm, but incompetent (mixed or ambivalent groups), or (4) cold but competent (other mixed or ambivalent groups; Fiske, 2012). From these four stereotyped categorizations emerge four emotional reactions – admiration (for in-groups), contempt (for outgroups), pity (for warm but incompetent groups), and envy (for cold but competent groups; Fiske, Cuddy, Glick, & Xu, 2002).

Social judgments affect more than stereotyped cognitions and emotional reactions - behaviors directed toward members of stereotyped groups are cued by cultural stereotypes (Cuddy, Fiske, & Glick, 2007). For instance, warmth stereotypes cue active behavioral tendencies (engaging in either actively harmful or actively helping behaviors) and competence stereotypes cue passive behavioral tendencies (engaging in passively harmful actions such as neglecting or passively facilitating actions such as associating; Cuddy et al., 2007).

Emotions associated with stereotypes serve to activate behaviors (Cuddy et al., 2007). High-warmth-high competence groups trigger active and passive facilitation behaviors. Hated groups (cold-incompetent groups) have tendencies to elicit active and passive harmful behaviors. Envied groups (competent and cold) elicit passive facilitation and active harmful behaviors, and pitied groups (warm and incompetent) elicit active facilitation but passively harmful actions (Cuddy et al., 2007).

Nurses are educated to provide impartial care for all kinds of individuals, regardless of their backgrounds, family structures, race, ethnicity, or gender (American Nurses Association [ANA], 2010; 2015). The extent to which nurses achieve this professional goal varies, however, as there are studies that indicate nurses are not necessarily immune to prejudice, racism, discrimination, gender equality, and homophobia (Dorsen, 2012; Giddings & Smith, 2001; Institute of Medicine, 2011; Wells, 2016). Although nurses are trained to treat all patients and their families the same (ANA, 2015), it would not be surprising to find nurses engaging in social judgments about their patients and their families. Many social judgments operate as implicit biases about outgroups based on race, ethnicity, religion, age, gender, and other characteristics (Blair,

Steiner, & Havranek, 2015), and it would be unreasonable to expect that nurses would be immune to implicit social judgments.

Therefore, the first purpose of this study was to examine how nurses perceive various types of fathers on the two stereotyped dimensions of warmth and competence. A second purpose was to examine nurses' emotional reactions to various types of fathers. A third purpose was to examine nurses' responses to questions asked by various types of fathers. Fathers were chosen as the target group because fathers are often seen as unexpected visitors to clinics and other settings in which children are the primary patients (Garfield & Isacco, 2006; Wells, Massoudi, & Bergström, 2017). Relatively little is known about nurses' views about fathers; mothers are more often studied in nursing family research (Macfadyen, Swallow, Santacroce, & Lambert, 2011). Using multiple segment factorial vignettes, in this study I examined the effects of marital and parental statuses of fathers on nurses' perceptions of fathers' warmth and competence, emotional reactions to fathers, and responses to fathers' questions. Marital and parental statuses included married, divorced, remarried stepfather, single (never-married), and cohabiting fathers. For this study, a married father was defined as the biological father of a child who is legally united in matrimony with the child's biological mother. A divorced father was defined as the biological father of a child who is no longer legally married to the child's biological mother. A remarried stepfather was defined as the husband of a child's biological mother by an earlier relationship. A single father was defined as an unmarried biological father who is raising his child without the child's biological mother or a partner. A cohabiting father was defined as a biological father of a child who is living with the child's biological mother but is not legally married to her.

CHAPTER 2

LITERATURE REVIEW

A thorough review of research about nurses' attitudes towards fathers was completed by using the Academic Search Complete database and major databases for the disciplines of nursing (CINAHL), medicine (Medline), and psychology (PsycARTICLES and PsychINFO). Using a combination of the keywords nurse, nurses, nursing, nurses' attitudes towards, nurses' impressions of, stereotype, stereotyping, bias, biases, implicit bias, implicit biases, fathers, dads or fathers yielded several citations that were not specifically related to the subject of this study. Few studies were found that included all the subject keywords of nurses, fathers, and stereotyping. Next, a historical search of relevant studies obtained from the database searches was conducted. Additionally, author searches of individuals' known to conduct studies about fathers and nurses was conducted. This search yielded studies geared more towards nurses assisting mothers, with fathers mentioned only briefly, or the studies focused on fathers' self-efficacy rather than nurses stereotyping of fathers. In addition, research involving different types of fathers was included as well.

Theoretical Frameworks

Stereotype Content Model. One theoretical framework guiding this study was the Stereotype Content Model (SCM), which suggests that individuals judge other individuals or groups of people on two traits, warmth and competence (Caprariello, Cuddy, & Fiske, 2009; Cuddy, Glick, & Beninger, 2011; Fiske, 2012; Fiske, Cuddy, & Glick, 2007; Fiske, Xu, Cuddy, & Glick, 1999). The SCM postulates that the constructs of warmth and competence are the foundation of stereotyped cognitions about persons or

groups (Caprariello, et. al, 2009; Cuddy et. al, 2007; Fiske, 2012; Fiske et al., 2007).

These social judgments impact a person's emotions and behaviors toward a specific person or group of people in positive, negative, or ambivalent ways (Cuddy et al., 2011; Fiske, 2012; Fiske et al., 1999).

Many studies have verified the basic propositions of the SCM. In general, there is consensus regarding which social groups are viewed as warm and competent and which groups are seen as cold and incompetent (Fiske et al., 1999). The relative social status of a group of people predicts if they are perceived as competent, whereas judgments about the interdependence of the group members predicts how the group will be perceived on the dimension of warmth. Warmth traits are those related to perceived intentions or expected motives of group members, such as being friendly, helpful, sincere, trustworthy, and moral (Fiske et al., 2007). Competent traits are perceptions related to how smart, skillful, creative, and capable the group members are.

According to the SCM, four possible perceptions originate when a group is cognitively stereotyped – a group may be perceived to be high in both warmth and competence, low in both warmth and competence, high in warmth and low in competence, and low in warmth and high in competence (Fiske, 2012; Fiske et al., 2002). In-groups or reference groups are those whose members are stereotyped to be high in both warmth and competence. Groups of people described as both warm and competent in previous studies of Americans included people who were white, middle-class, heterosexual, and Christian (Cuddy et al., 2007). These in-groups are favored when an observer is a member of the group, but even people who did not identify themselves as with being a member of those groups, nonetheless rated them high in both dimensions.

Extreme out-groups are viewed as neither warm nor competent and include the poor, homeless, and drug addicts (Fiske, 2012).

In other studies, social groups characterized as warm but incompetent included housewives, working mothers, mentally disabled, and the elderly (Cuddy, Fiske, & Glick, 2004; Fiske et al., 1999). Although these groups may be perceived as low-status and incompetent, they may be liked because they are seen as warm. In contrast, groups found to be characterized as competent but cold included the wealthy, Asians, Jews, female leaders, and businesswomen (Cuddy et al., 2011; Cuddy et al., 2007; Fiske et al., 1999). These competent but cold groups may be envied and respected for their competence and considered a high-status group, but they may not be liked. These warm but incompetent or cold but competent groups are called outgroups (Fiske et al., 1999). There is ambivalence toward these outgroups as the stereotyping of the groups tends to be positive on one aspect (warmth or competence), but not positive on the other dimension. Ambivalent reactions to these mixed stereotyped groups typically only occur if the person judging is part of the targeted group.

Fiske et al. (2007) proposed that people often stereotype another individual's intentions of goodwill or ill will by judging the warmth dimension of the group to which they belong before they determine if the person is capable of carrying out those intentions. For instance, when a new person walks into the room, social judgments are made about the potential threat to wellbeing this new person may represent, as well as a judgment about the new person's ability to enact either positive or negative behaviors. A large man with a shaved head and wearing a leather biker jacket will likely elicit different social judgments than a woman pushing a stroller or a woman using a walker. This

judgment about warmth and competence is an aspect of the sensitivity needed to gauge potential threats, a primal survival need. Fiske et al. (2007) found that social judgments were reliable across cultures and consistent over time.

These social judgments are related to emotional reactions to new persons that are encountered, based only on the social groups to which they belong (Cuddy et al., 2007). In a telephone survey of 571 individuals in the United States (62% females and 38% males over the age of 18) researchers found that emotions of admiration, contempt, envy, and pity predicted behavioral tendencies and served as linkages between stereotypes and behavioral tendencies (Cuddy et al., 2007).

Nuclear Family Ideology. Although not a theory, a conceptual framework guiding this study has been called the nuclear family ideology (NFI; Ganong & Coleman, 2017). This is the implicit belief that first marriage, heterosexual nuclear families are the standard to which all other forms of families are compared, with the further assumption is that these other family forms are inherently less functional than the first marriage, heterosexual nuclear family. The NFI proposes that children fare more poorly on average and at greater risk for problems, relationships are less satisfying, and individual and family outcomes are generally deficit in comparison to the standard family form. This heterosexual nuclear family, also known as the Standard North American Family (SNAF; Smith, 1993), is seen as innately superior to other family structures (Ganong & Coleman, 2017). The nuclear family is also seen as “the natural family,” a designation that, while ignoring historical and cross-cultural variations in family forms, nonetheless asserts that nuclear family households consisting of a married man and woman and their biological children are the only natural form of family. Other family structures are seen as

unnatural, nontraditional, and fundamentally deviant (Ganong, Coleman, & Russell, 2015).

The NFI fits well with the SCM, in that implicit beliefs about the relative value of family structures and the individuals in various family structures may affect stereotyped perceptions of the warmth and competence of fathers from diverse family structures. For instance, research from multiple western cultures indicate that stepfathers are perceived less positively than biological fathers (Ganong & Coleman, 2017), and there are indications that biological fathers (Ganong, Coleman, & Mapes, 1990) and mothers (Ganong & Coleman, 1997; Ganong & Coleman, 1995; Ganong, Coleman, & Jones, 1990; Ganong, Coleman, & Riley, 1988) with different marital statuses are perceived differently than are parents in first marriages.

Nurses' Social Judgments

The Gallup Poll has rated nursing as the most trusted profession in the United States (Saad, 2015). Nurses are accountable to maintain their standards of practice and uphold ethical standards to establish relationships and provide care with respect and without prejudices (ANA, 2010). In addition, the nursing profession is expected to partner with not only individuals, but also families, communities, and broader groups to provide and promote quality care, safety, health and wellness to diverse populations, all while maintaining cultural sensitivity. Nurses are asked to address psychosocial issues with those under their care such as issues related to birth or death, growth and development, and relationships, role performances, and the processes of change that comes with those relationships and roles to diverse populations (ANA, 2010). Similarly, the International Council of Nurses (ICN) has stated that nurses should inherently respect

human rights, which includes cultural rights. Nurses are to provide care to individuals, families, and communities regardless of age, race, color, creed, nationality, gender, sexual orientation, disability or illness, social status, or politics (ICN, 2012).

Implicit Bias. Everyone, including nurses, has implicit biases about groups of people (Staats, Capatosto, Wright, & Jackson, 2016). Implicit bias is “The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Activated involuntarily, without awareness or intentional control” (Staats et al., 2016, p. 14). An individual may acquire an implicit bias as a child and maintain it into adulthood and may never be aware of their perceptual and cognitive judgments. An implicit bias can be positive or negative and is the result of cognitive associations formed by unintended and intended messages received from family, friends, schools, religion, media, social organizations, and other sources. Humans tend to label other groups of people with particular characteristics, even if the association is not, in fact, reality (Staats et al., 2016). An implicit bias can impact how someone interacts with another person (Cuddy et al., 2011).

Although nurses are educated to be impartial and unbiased providers of care for patients and their families, it is a normal process for nurses to cognitively categorize their patients based on physical, behavioral, and social characteristics (Devine, 1989; Ganong, Bzdek, & Manderino, 1987; Ganong & Coleman, 1997). Therefore, if a nurse has an implicit bias and disapproves of any characteristics, behaviors, or social groups of those under their care, the expected quality care may be affected. Specifically, the affective dimensions of meeting emotional and psychological needs of patients may be affected (Ganong & Coleman, 1997).

Nurses and student nurses have been found to have biases about patients and/or family members that can affect family participation in the care of not only children, but also in the care of adult cardiovascular patients (Luttik et al., 2017), mental health patients (Hsiao, Lu, & Tsai, 2015), obese patients (Sikorski et al., 2012; Waller, Lampman, & Lupfer-Johnson, 2012), the geriatric population (McLafferty, 2007; Price, 2013), and those in poverty (Wittenauer, Ludwick, Baughman, & Fishbein, 2015). Nurses' biases have also been found to be related to the management of adult patients' pain (Griffin, Polit, & Byrne, 2007).

Social judgments about fathers. The perceptions a nurse may have about fathers' warmth and competence can be influenced by cultural images about fatherhood and about how fathers should think, behave, and feel (Marsiglio, 1995). In addition, some nurses believe that fathers function only as a supporter of mothers, or they completely overlook fathers (Salzmann-Erikson & Eriksson, 2013; Scism & Cobb, 2017), even though the lasting health and social benefits for the family, including the mother and children when the father is involved, have been noted (Steen, Downe, Bamford, & Edozien, 2012). Nurses may have ambivalent attitudes toward fathers' caring capacity (Massoudi, Wickberg, & Hwang, 2011) and consequently may exclude fathers when parents seek advice or care for their children, causing fathers to feel like "a third wheel" (Cosson & Graham, 2012, p. 124).

In a study of stereotypes about working parents, Cuddy et al. (2004) proposed the comparison between working mothers and working fathers might reveal a double standard regarding gender roles. They found in a study of Princeton University undergraduates (72 women and 50 men) that childless women and men were perceived as

more competent and less warm than parents. However, stereotypes about working men who were fathers were higher in warmth and maintained high competence. In contrast, working mothers were perceived as less competent, yet warmer than a childless woman. Therefore, working mothers and fathers were higher in the warmth dimension than childless adults, working mothers were perceived as more warm than competent compared to working fathers, who were perceived as more balanced in both dimensions (Cuddy et al., 2004). Similarly, Fuegen, Biernat, Haines, and Deaux (2004) surveyed undergraduate students in the Midwest and found more severe judgments towards working mothers and more lenience in judgments about working fathers. Working mothers were judged less likely to be hired and promoted than a childless woman. Overall, both men and women who were parents were judged to be less committed to the job and less available than those without children. Being aware of these judgmental tendencies of people makes the SCM a useful framework to describe how nurses may cognitively process information about fathers they may interact with as they provide care for children.

Nurses have been identified as giving defensive responses and acting judgmental when fathers asked questions, but not when mothers asked questions (Cosson & Graham, 2012; Coyne, 2013). However, nurses recognize that having a good attitude and open communication with fathers will improve fathers' satisfaction with nursing care (Hammarlund et al., 2015; Poh, Koh, Seow, & He, 2014; Rostami, Hassan, Yaghmai, Ismaeil, & BinSuandi, 2015; Wells et al, 2017; Yagil, Luria, Admi, Moshe-Eilon, & Linn 2010).

Nurses' impressions or stereotypes of fathers have not often been studied in the United States. Most studies have been done elsewhere - in Sweden (Premberg, Hellström, & Berg, 2008; Massoudi et al., 2011; Wells, 2016; Wells et.al, 2017), Iran (Rostami, et al., 2015), Australia (Cosson and Graham, 2012), Ireland (Coyne, 2013), Singapore (Poh, Koh, Seow, & He, 2014), United Kingdom (Higman & Shaw, 2008), and Israel (Yagil et al., 2010). It is possible nurses in the United States may not realize they have developed implicit biases about fathers and are not aware of the impact these biases and stereotypes of fathers can have the quality of the nursing care when interacting with fathers.

Fathers' reactions to nurses. Nurses' beliefs about fathers and fatherhood can result in fathers being inhibited from participating in the care of their children. Fathers may feel alienated, disrespected, excluded, ignored, and even invisible causing them to feel they cannot participate in the decisions made on behalf of their children and influence the type of care their children receive (Scism & Cobb, 2017; Wells, 2016). As more fathers attempt to care for their children (Cassidy, 1999; Gage & Kirk, 2002; Lamb, 2010), they may delay or even avoid seeking care for their children if they sense a nurse is treating them as incompetent and/or treating them and their children unfairly (Garfield & Isacco, 2006). Fathers may view seeking support from nurses or other professionals as an admission of failure in their role, which suggests a concern about competence. This assumption of incompetence comes from a societal view that fathers cannot adequately care for children, particularly babies (Berlyn, Wise, & Soriano, 2008; Doucet, 2009; Wall & Arnold, 2007).

Fathers in Diverse Families

Men with children may have a number of marital and parental statuses – they may be single, married, or divorced fathers, or they may be stepfathers. These different family structures for fathers may elicit different social judgments by nurses as they encounter fathers. The U.S. Census Bureau (2017) revealed there were 72.2 million fathers in the United States in 2014, the most recent year data were available. In 2016, an estimated 24.6 million fathers were part of married-couple families with children younger than age 18. Of two-parent working families, one in five fathers was the primary caregiver of preschool children where the children spend more time with their fathers than in any other type of care arrangement (U.S. Census Bureau, 2012). Also, in 2016, there were two million single fathers living in the United States, of which 40% were divorced, 38% were never married, 16% were separated, and 6% were widowed. These single fathers are becoming more common; they are not only breadwinners, they are actively co-parenting their children, and sometimes are the sole parents of their children (U.S. Census Bureau, 2017). One of every six single custodial parents is a father (Grall, 2016). In addition, there are three million children under the age of 18 living with their fathers only (U.S. Census Bureau, 2016). In the 2010 U.S. Census, of 64.8 million children under the age of 18, at least 4% were stepchildren and 2% were adopted. In contrast, of the 1.3 million children under 18 living with at least one adoptive parent in the 2010 Current Population Survey (CPS), 90% were adopted by a stepparent (Kreider & Lofquist, 2014).

The culture of fatherhood with fathers as the primary caretaker or sharing the care of children is evolving (Fischer & Anderson, 2012). Fathers are more involved and have taken on more responsibilities in their role, and society's norms, beliefs, and attitudes

towards fathers must evolve as well (Lamb, 2010; Livingston, 2014; Salzmänn-Erikson & Eriksson, 2013; Wall & Arnold, 2007; Wells & Sarkadi, 2012). For instance, college students rated married and adoptive fathers as more positive than divorced nonresidential and never-married fathers (Troilo & Coleman, 2008). Divorced residential fathers were viewed more positively than those divorced fathers that were perceived as nonresidential. College students held more neutral views about stepfathers and held generally positive views of gay fathers (Troilo & Coleman, 2008).

Single fathers. In U.S. history, single fathers were not uncommon because many women died during childbirth. Today, the most common ways a man becomes a single father is by reproducing without marrying the mother of their child, and many fathers choose not to cohabit with the mothers of their children (Coles, 2017). Nonresident, unmarried fathers are at a higher risk than resident fathers of becoming disengaged from their child (Fagan & Palkovitz, 2007). Other findings showed the more educated a father the less likely he will be the head of a single household, and additionally, poverty is linked with fathers who are single (Livingston, 2013).

Single fathers may have different parenting concerns than those who are cohabiting or married. For instance, single fathers that are raising daughters may have concerns about discussing and assisting their daughters through puberty and providing education regarding sex and risks of some sexual behaviors (Coles, 2002). This would be an opportune time for nurses to provide support and education for these fathers.

Divorced fathers. Prior to the 20th century, fathers usually were awarded the physical custody of children in divorce cases. During the 1970s, laws and custody of children changed awarding fathers sole custody. In the U.S. today, divorced fathers may

be awarded sole or have shared custody of their children (Coles, 2017). Divorce can lead to a decline in the amount of time and quality of time parents spend with a child, especially if the parent does not share a residence with the child. The amount of time divorced fathers will spend with their children depends on legal and physical custody arrangements and the quality of the relationship with the mother (Nomaguchi, Brown, & Leyman, 2015). Although some people believe the child's gender should determine which parent has custody of the child, Faust, Ko, Alexander, and Greenhawt (2017) found that children benefit from living with either parent regardless of whether or not there is a gender match between the parent and child.

Stepfathers. The percentage of children living in stepfamilies and families created outside of marriage has become more common in the United States (Kreider & Ellis, 2011). For stepfathers, it is important to build supportive relationships with their stepchildren. Professionals that work with families, including nurses, can provide education, and support to help stepfathers (Marsiglio, Pettigrew, & Hendricks, 2017).

Purpose of This Study and Hypotheses

The purposes of this mixed-methods research were to examine maternal-child nurses': (1) perceptions about various types of fathers' warmth and competence, (2) emotional reactions to various types of fathers, and (3) written responses to questions raised by various types of fathers. The two hypotheses were:

H1: Maternal-child nurses' perceptions of the warmth and competence of divorced fathers, single fathers, cohabiting fathers, and stepfathers will be more negative than their perceptions of married fathers' warmth and competence.

H1: Maternal-child nurses' emotional reactions to divorced fathers, single fathers, cohabiting fathers, and stepfathers will be more negative than their reactions to married fathers' warmth and competence.

In addition, a research question was addressed (RQ1): Will maternal-child nurses' written responses to fathers' questions and comments be related to the fathers' marital and parental statuses?

The findings of this proposed research could advance knowledge about nurses' ability to nonjudgmentally accept all types of fathers' regardless of their perceived warmth and competence. As fathers are becoming more and more involved in childrearing, nurses must recognize any stereotypes and barriers they may have as they interact with these fathers. The knowledge gained through this research may provide the basis for interventions by nurse researchers to change attitudes and behaviors. Nurses must strive to consciously make changes in their thoughts and actions as they interact with all types of fathers.

CHAPTER 3

Method

Participant Identification and Recruitment

Maternal-child nurses were recruited through the Association of Women's Health, Obstetrics, and Neonatal Nurses (AWHONN), and the Illinois Perinatal Quality Collaborative (ILPQC). To achieve an approximation of power with a moderate effect size at a significance level of 0.05 and a beta of 0.80, a sample size of at least 148 was needed (Cohen, 1988). Therefore, a sample size of 150 was sought.

Prior to beginning the study, I met with hospital unit directors to explain the purpose of the study, time involved, and how the nurses could obtain access to the online survey, after first obtaining permission to conduct the study from the hospitals Institutional Review Boards (IRBs). When I met with the unit directors, I asked for permission to schedule a time to meet with staff during a regularly scheduled staff meeting to explain the study and encourage participation. In addition, I asked if they would be willing to post an advertisement flyer in the staff break rooms regarding the study that I shared with the directors at that time (See Appendix E).

Only one hospital had me attend their staff meeting. The other hospital unit directors felt that an email from me explaining the study with the link to the survey included in the email and forwarded to the staff was sufficient. Some of the unit directors stated they had already had their monthly staff meetings, or wanted to present my information themselves, or had numerous staff meeting times and did not feel it would be a good use of my time to drive to their hospital that was at least 100 miles away or farther.

At the staff meeting I explained the purpose of the study (See Appendix F). I encouraged the nurses to participate in the research by explaining that nurses have a huge impact on quality of care, which affects families and their opinions and interactions with the health care systems. I answered any questions asked by potential participants and explained the study procedures. The informed consent process was conducted in accordance with HS IRB requirements, using approved consent forms and HIPAA Authorizations. The inclusion and exclusion criteria, and all study procedures were explained to the potential participants, including the data collection procedures. I asked participants to check their work email account for a recruiting email that will be forwarded by the unit director to the staff.

In addition to the hospital nurses, maternal-child nurses were recruited through AWHONN. These maternal-child nurses were members of AWHONN and participated in a perinatal listserv. After receiving approval from the HS IRB, I sent the HS IRB and required AWHONN paperwork to Jacqueline Rychnovsky, PhD, RN, CPNP, FAANP, Vice President, Research and Public Policy for AWHONN in Washington, D.C. for approval. I was approved to post my recruiting email (See Appendix G) to a listserv since I am a member of AWHONN. The recruiting email included an invitation to participate in the survey, consent information, researcher contact information, and a link to the Qualtrics^{XM} webpage where they would find the survey.

Inclusion criteria for the study were that participants must: (a) be age 18 or older, (b) read/speak English, (c) be maternal-child registered nurses employed full or part-time or per diem in a maternity or pediatric hospital unit, community setting, current nurse educators, and retired nurses from any of these settings; (d) hold a diploma, associate

degree, baccalaureate degree; master's degree, or doctorate degree and (e) have at least six months of maternity or pediatric nursing experience. Participation was anonymous. Participants had the opportunity to withdraw from the survey at any time without consequences. There was minimal risk to the participants for completing the survey. At the end of the survey, participants had the option to provide an email address to be able to be entered for the chance to win one \$250 Amazon electronic gift card or one of five \$50 Amazon electronic gift cards. All email contacts were placed in a random drawing for the electronic gift cards.

Setting and Timing

The data collection occurred through a brief survey found on a Qualtrics^{XM} web page. I recruited nurses from several hospitals, through members of the Association of Women's Health, Obstetrics, and Neonatal Nurses (AWHONN), and the Illinois Perinatal Quality Collaborative (ILPQC). The hospitals included Women and Children's Hospital, Columbia, Missouri, Hannibal Regional Hospital in Hannibal, Missouri, Blessing Hospital in Quincy, Illinois, and Memorial Hospital in Springfield, Illinois. The University of Missouri (MU) Health Care Women's and Children's Hospital is a 157-bed hospital. Hannibal Regional Hospital is a 99-bed hospital. Blessing Hospital is a 306-bed hospital. Memorial Hospital is a 500-bed hospital.

AWHONN is a professional nonprofit 501(c)3 organization that promotes the health of women and newborns. In addition, they strive to strengthen the nursing by being a superior advocate, and providing research, education, and clinical resources to nurses and other health care professionals. According to the AWHONN Vice President of Research and Public Policy, Dr. Jacqueline Rychnovsky, 85% of the primary members of

AWHONN are obstetrical nurses with neonatal nurses following as the next largest number of members (personal conversation, December 5, 2017).

The Director and Associate Nurse Manager for Blessed Beginnings at Blessing Hospital in Quincy, Illinois posted my email with the link to my survey on the member listserv of the Illinois Perinatal Quality Collaborative (ILPQC). ILPQC strives to improve the health of pregnant women, mothers, and infants through their perinatal quality improvement initiatives. These initiatives are implemented by participating birthing hospitals across the across Illinois. ILPQC provides quality improvement infrastructure, resources, and data management support to over 100 hospitals across the state of Illinois.

Instruments

Multiple segment factorial vignette (MSFV) is a mixed-method design that combines both quantitative and qualitative methods (Ganong & Coleman, 2006). MSFV is a useful research approach when researchers want to collect data on attitudes, behaviors, judgments, beliefs, stereotypes, opinions, beliefs, and attributions and when the topics may be difficult or impossible to examine (Ganong & Coleman, 1997, 2006). The MSFV method provides participants a chance to answer questions after segments are presented in written, oral, or mediated formats. MSFVs allows participants to provide answers in a less threatening way when asked about sensitive topics. Researchers can also ask the participants if they have ever encountered situations that may be similar and how they would respond. Participants can answer more candidly and be less guarded in their responses. This approach allows researchers to control variables through random assignment of different versions of a vignette (Ganong & Coleman, 2006).

This study used written vignettes to examine nurses' social judgments about and emotional reactions to various types of fathers. In response to three vignettes, I investigated the effects of nurses' social judgments, emotional reactions, and written responses to five types of fathers: (1) married fathers, (2) divorced fathers, (3) stepfathers, (4) single (never-married) fathers, and (5) cohabiting fathers. All three vignettes were presented in one survey with nurse participants receiving randomized versions of three multiple-segment vignettes (See Appendices A, B, and C), followed by demographic questions (See Appendix D).

The structure of the three vignettes was the same. First, a father who has brought a child to the clinic for a specific reason is described as one of the five types of fathers. One vignette was a generalized health problem stating that a father bringing a child to the clinic because the child "seems tired all the time." In a second vignette, the presenting problem was a chronic health problem stating that the child "is a Type I diabetic whose blood glucose levels have been unstable." In a third vignette, the child "has a rash on the trunk of body, recent sore throat, and fever," which described an acute health problem. The nurse participants were asked, "What are your perceptions of this father?" to which they responded to 10 semantic differential items that measured warmth and competence. In each vignette the variable, "types of fathers," were randomly assigned by Qualtrics^{XM}. The 10 semantic differential items, which consisted of bipolar adjectives (e.g. cold-warm, responsible-irresponsible), also were randomly ordered. Positive and negative ends to these bipolar items were varied to avoid response set bias.

Each vignette had a second segment in which the portrayed father asks a question of the nurse. In the second segment of the vignettes, the question asked by the father was one of three questions that were randomized. These three questions were, "Why is Chris feeling like this?" (Vignette 1); "What am I doing wrong? What is Taylor doing wrong?" (Vignette 2); and "Is there anything I can do for my child?" (Vignette 3). Nurse participants were asked to answer as if they were the nurse in the vignette and the father had asked them the question. They provided their written answers in a text box. Finally, eight items were asked to assess emotions. For each of these items, nurses were asked, "To what extent do you feel the following about the father?" The eight stimulus concepts were contempt, disgust, admiration, respect, pity, sympathy, envious, jealous. Response choices ranged from 1 = *not at all* to 5 = *extremely*.

A pilot of the vignettes was completed with a convenience sample of professional registered nurses with advanced degrees (MSN, PhD(c), PhD) who were considered experts in their field. These nurses completed the survey and provided constructive feedback for improving the vignettes and for estimating the time it would take participants to complete the instruments. Based on their feedback, slight changes were made to the vignettes. The piloted surveys were completed in 10-15 minutes.

Quantitative Analysis Plan

Factor analyses. Prior to conducting analyses on the nurses' responses to the 10 semantic differential items designed to assess nurses' perceptions of the fathers, I conducted an oblimax rotation with Kaiser normalization (Field, 2018) for quantitative data from each of the first segments of the MSFVs. The purpose of the factor analyses was to derive empirical factors, or scales, representing the dependent variable of nurses'

In Vignette 1, the factor analysis yielded two factors that explained 58% of the variance (see Table 3.1). The first factor, *Perceptions of Competence*, consisted of five items (here I name only the positive poles): competent, loving, independent, responsible, and successful. The second factor, *Perceptions of Warmth*, consisted of three items: pleasant, warm, kind. Two of the original 10 items did not load on any factors: likeable and strong. These items were not analyzed further.

Total Variance Explained ^a									
Initial Eigenvalues				Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.219	52.194	52.194	4.806	48.063	48.063	3.168	31.681	31.681
2	1.345	13.455	65.648	.978	9.784	57.847	2.617	26.166	57.847
3	.751	7.511	73.160						
4	.643	6.429	79.589						
5	.486	4.856	84.445						
6	.437	4.369	88.814						
7	.330	3.298	92.112						
8	.293	2.931	95.043						
9	.270	2.704	97.747						
10	.225	2.253	100.000						
Extraction Method: Principal Axis Factoring.									
a. Only cases for which vignette = vignette 1 are used in the analysis phase.									

Table 3.3 Summary of Vignette Three-Segment One-Factor Analysis

Total Variance Explained ^a									
Initial Eigenvalues				Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.765	57.654	57.654	5.427	54.270	54.270	3.309	33.086	33.086
2	1.358	13.580	71.234	1.004	10.039	64.309	3.122	31.223	64.309
3	.687	6.872	78.106						
4	.578	5.776	83.883						
5	.376	3.758	87.641						
6	.318	3.178	90.818						
7	.274	2.736	93.554						
8	.256	2.555	96.109						
9	.228	2.275	98.385						
10	.162	1.615	100.000						
Extraction Method: Principal Axis Factoring.									
a. Only cases for which vignette = vignette3 are used in the analysis phase.									

The factors were treated as subscales of the semantic differential. Items were coded so that higher scores represented more positive perceptions. Items were summed to create *Perceptions of Competence* and *Perceptions of Warmth* subscale scores.

For the second segment of each vignette, prior to conducting analyses on the nurses' emotional reactions I conducted a varimax rotation with Kaiser normalization (Field, 2018) on the eight items designed to assess nurses' emotional reactions to the fathers. The purpose of the factor analyses was to derive empirical factors, or scales, representing the dependent variable of nurses' emotional reactions to the fathers. These scales were then analyzed as the dependent variables in multivariate analysis of variance tests.

For all three of the second segments, the same two factors were found (see Table 3.4). The first factor consisted of the items asking about these reactions: contempt, disgust, pity, envious, and jealous. I labeled the subscale comprised of these items, *Negative Responses*. The second factor consisted of: admire, respect, and sympathy. This subscale was labeled, *Positive Responses*.

Table 3.4 Summary of Vignettes One, Two, Three-Segment Two-Factor Analysis

Factor Transformation Matrix		
Vignette	Factor 1	Factor 2
Vignette One	.999	-.034
	.034	.999
Vignette Two	.936	.352
	-.352	.936
Vignette Three	.959	.285

	-.285	.959
Extraction Method: Principal Axis Factoring.		
Rotation Method: Varimax with Kaiser Normalization.		

SPSS was used to assess quantitative data. For each Segment 1 analyses, a one-way MANOVA was conducted, with one IV (type of father) and two DV (warmth, competence). If the MANOVAS were statistically significant, ANOVAs were run on each DV separately. For the second segments of the vignettes, the analyses for these segments consisted of one-way MANOVAs, with type of father as the IV and the DVs were the empirically-identified factors representing nurses' emotional responses to fathers. If the MANOVAS were statistically significant, ANOVAs were run on each DV separately.

Qualitative analyses. Dedoose software for qualitative data and pattern-matching methods by Miles and Huberman (1994) were used to analyze the qualitative data that were gathered when evaluating written responses to the fathers' open-ended question. A PhD nursing colleague with expert qualitative research experience reviewed the codes created, and assisted with refining the codes from the qualitative data.

CHAPTER FOUR

RESULTS

Sample

The sample consisted of at 167 registered nurses from area hospitals' maternity and pediatric units in Northeast Missouri, central Missouri, mid-central Illinois, and across the United States. Only 144 nurses completed the demographic items on the survey. The age range of participants was 22-68 ($M = 41$). Most ($n = 139$; 96.5%) were white, two (1.4%) were of Asian/Pacific Islander origin, and three (2.1%) specified their ethnicity as biracial, multi-ethnic, and one stated "white and black." One nurse chose "Not listed here (specify)" as their gender but did not specify; all others were female. Most respondents ($n = 111$; 77.08%) were married; 18 (12.5%) were single, never married; 11 (7.64%) were divorced; three (2.08%) were cohabiting; and one nurse (0.69%) was remarried. They had between 0 and 8 children, and 46 (32%) of the nurses had two children. One nurse reported having one child and four stepchildren.

Most of the sample reported living in Illinois (63) and Missouri (44). In addition, three nurses responded "Midwest", one stated, "Northeast", and one stated, "USA" (see Table 4.1).

Table 4.1 Residents of Sample Participants

State	Number of responses	State	Number of responses	State	Number of responses
Alabama	1	Illinois	63	North Dakota	1
Arkansas	1	Indiana	1	Ohio	2

Arizona	2	Iowa	4	Pennsylvania	1
California	1	Kansas	1	South Carolina	1
Colorado	1	Louisiana	1	Texas	1
Connecticut	1	Massachusetts	1	Virginia	1
Delaware	1	Michigan	1	Washington	1
Florida	1	Missouri	44	Wisconsin	1
Georgia	1	Nebraska	1		
Hawaii	1	New York	1		

Nurses in the sample were asked to describe the setting in which they lived, and 59 reported living in a small town, 38 (26.39%) in a rural setting, 34 (23.61%) in a suburban area, 10 (6.94%) were urban, and three (2.08%) chose “Other.” All of the nurses in the study were employed. Of those, 121 (84.03%) nurses described their employment status as full-time and 23 (15.97%) nurses worked part-time. Nurses were asked to report the number of years they had been employed in nursing. The range of years worked in nursing was 1-48 years, with a mean of 17 years. When asked, “How many years have you been a maternal-child nurse?”, the range was 0-43 years, with a mean of 14.4 years. Of the 144 nurses responding to this question, seven reported “0” as their answer, and one nurse reported “2 months”. These eight nurses should not have completed the survey as they did not meet the inclusion criteria. There was no way to determine which surveys were answered by these nurses as the surveys were anonymous.

Most were employed in a hospital as their primary work location ($n = 133$; 93.66%), two (1.41%) were employed in a clinic, and seven (4.93%) chose "Other employers," which included colleges of nursing. The majority ($n = 68$; 47.22%) were labor and delivery nurses. Twenty (13.89%) reported being pediatric nurses. There were 13 (9.03%) of the nurses working in postpartum. Eleven (7.64%) worked as nursery nurses, and three (2.08%) nurses worked primarily in the antenatal setting. Hospital unit-based education was chosen by 7 (4.86%) of the nurses. Five nurses worked in education-nursing programs and the 17 (11.81%) remaining nurses chose "Other (specify)."

Nurses had completed a variety of levels of education. There were 78 (54.17%) of the nurses with a baccalaureate degree in nursing, 19 (13.19%) with an associate degree in nursing, and four (2.78%) were diploma nurses. The total number of nurses with a Masters' degree in nursing was 27 (18.5%); six (4.17%) had a Doctorate of Nursing Practice (DNP), and three (2.08%) had a PhD in Nursing. Of the remaining nurses, seven (4.86%) reported having earned a graduate or professional degree in a field other than nursing (e.g., MBA; MS in Education; Education; Surgical technologist).

Vignette 1 (General Health Problem - Child Who is Tired)

In Vignette 1, Segment 1, using Pillai's trace, there was a significant multivariate effect on the father type with $V = 0.133$, $F(8, 284) = 2.54$, $p < .05$; $p = .011$. There were significant differences for Competence ($p = .023$), but not for Warmth ($p = .072$). Further tests were completed with the univariate analysis of variance (ANOVA) for Competence. Using the robust tests of equality of means test, Brown-Forsythe, Competence was significant at $p = .010$. Using the Post Hoc Test, Tukey HSD, for multiple comparisons,

the cohabiting father was seen as less competent than the married father. No other comparisons were significantly different.

In Vignette 1, Segment 2, using Pillai's trace, there was a significant multivariate effect on the father type with $V = 0.11$, $F(8, 272) = 2.08$, $p < .05$; $p = .038$. Differences in Positive Responses were significant ($p = .020$), but Negative Responses did not differ significantly ($p = .334$). Further tests were completed with the univariate analysis of variance (ANOVA) for Positive Responses. Using the robust tests of equality of means test, Brown-Forsythe, Positive Responses was significant at $p = .040$. Using the Post Hoc Test, Tukey HSD for multiple comparisons the never-married single father received more Positive Responses than the remarried stepfather. No other comparisons were significantly different.

Vignette 2 (Chronic Health Issue - Child with Diabetes)

In Vignette 2, Segment 1, using Pillai's trace, there was no significant multivariate effects, $V = 0.044$, $F(8, 274) = 0.766$, $p > .05$; $p = .633$. In Vignette 2, Segment 2, using Pillai's trace, there was no significant multivariate effect on the father type, $V = 0.55$, $F(8, 276) = 0.982$, $p > .05$; $p = .450$.

Vignette 3 (Acute Health Problem - Child with Persistent Rash)

In Vignette 3, Segment 1, using Pillai's trace, there was no significant multivariate effect on the father type with $V = 0.037$, $F(8, 272) = 0.646$, $p > .05$; $p = .738$. In Vignette 3, Segment 2, using Pillai's trace, there was no significant multivariate effect on the father type with $V = 0.77$, $F(8, 280) = 1.41$, $p > .05$; $p = .192$.

Analyses of Responses to Open-ended Questions

Responses to the open-ended questions raised by the fathers in the three vignettes were analyzed using Dedoose 8.0.42 software. In Vignette One (Child Who is Tired), the father asked the nurse, "Why is Chris feeling like this?" Nurses were then asked to answer this open-ended question: "What would you say to [this father] if you were the nurse?" In Vignette Two (Child with Diabetes), the father asked the nurse, "What am I doing wrong? What is Taylor doing wrong?" Nurses were then asked to answer this open-ended question: "What would you say to [this father] if you were the nurse?" In Vignette Three (Child with Rash), the father asked the nurse "Is there anything I can do for my child?" Nurses were then asked to answer this open-ended question: "What would you say to [this father] if you were the nurse?"

There were 426 open-ended responses recorded, with 145 of those from Vignette 1, 139 from Vignette 2, and 142 from Vignette 3. A total of 2,646 excerpts were coded from the three vignettes following an initial descriptive coding cycling method (Saldana, 2009). Initial First Cycle coding allows for assigning codes to data chunks. Using descriptive coding, data were labeled or coded by a word or short phrase. This assisted in identifying the topic and laid the groundwork for Second Cycle coding (Miles, Huberman, & Saldana, 2014; Saldana, 2009). After the first reading, a total of three general codes were developed with an additional three to five sub-codes per general codes (See Table 4.2).

Table 4.2 Initial First Cycle Codes

Initial First Cycle Coding					
Clarifying/Gathering More Information	661	Planning Care with the Father	599	Validating	333
Gathering data from father and child	209	Partnering	134	Reassuring	104
Integrating nurse/physician data	146	Offering Resources	9	Praising	86
Monitoring labwork	44	Engaging	47	Acknowledging feelings	19
		Problem-solving	171	Showing empathy	19
		Providing/Promoting Education	65		
Total	1060	Total	1025	Total	561

The Second Cycle coding method of pattern coding was conducted to refine the codes and sub-codes into a smaller number of sets. The excerpts were reduced from 2,646 to 1,177. Reviewing the first cycle of codes allowed me to assess them for commonality and patterns, which then allowed me to identify and develop emerging themes (Miles et al., 2014; Saldana, 2009). The pattern coding process narrowed the general codes to three common themes, with each theme having two to four codes. In theme two, the first code had 11 sub-codes (See Table 4.3).

Table 4.3 Second Cycle Themes and Codes

Second Cycle Coding					
Theme One: Validation of the Father		Theme Two: Information Gathering		Theme Three: Plan of Care	
1. Acknowledgement of feelings	18	1. Additional Information from father and/or child	94	1. Comfort measures	19
2. Empathy	20	a. Activity 26 b. Blood glucose levels 22 c. Care of the child 20 d. Diet 41 e. Length/Timeline of 17 illness/symptoms f. Medical history g. Medications 13 h. Recent changes 16 i. Recent exposure 25 j. Routine/Schedule /Pattern 13 40 k. Stress 6 l. Symptoms 21		2. Partner with father and/or child	88
3. Praise	87	2. Integration of nurse/physician findings	134	3. Problem-solve	260
4. Reassurance	111			4. Provide/Promote education	86
Total	236	Total	488	Total	453

The three common themes were *Validation of the Father*, *Information Gathering*, and *Plan of Care*. These themes, codes, and sub-codes reflect the ways nurses are taught to think and process patient information and provide care in a systematic client-centered

manner. *Validation of the Father* (N = 236 coded responses) were comments from nurses that showed support for the father. This theme included four codes labeled *acknowledgment of feelings, empathy, praise, and reassurance*. This theme reflected codes that were more psychological and emotional in nature. *Information Gathering* (N = 488 coded responses) focused on nurses' attempts to gain factual *additional information* and to *integrate nurse/physician findings*. Nurses sought more information from fathers or told the father that the nurses and/or the physician would be completing a physical assessment and obtaining lab work to gather more information about the child's condition (*integrate nurse/physician findings*). Examples of this latter code were, "The Doctor and I will assess him and figure out what is going on with him. Then we will make a plan to get him feeling better," and "Let me check him out and get the doctor in to see him."

Nurses then wanted to ensure the father and child were aware of the *Plan of Care* (N = 453 coded responses). *Plan of Care* contained four sub-themes: *Comfort measures, Partner with father and/or child, Problem-solve, and Provide/Promote education*. *Comfort measures* were defined as things the father could do to assist the child in making the child feel better. An example of this from Vignette Three is when a nurse answered the open-ended question with:

Absolutely. There are some different things you can do to keep your child comfortable while he is sick. You can give him Tylenol for his fever or Benadryl for his rash if it itches just to make him more comfortable physically.

Emotionally, you can also play quiet games with him to help distract him and just holding him will help him through his illness.

Partner with father and/or child was defined as the nurse joining with the father and/or the child to assist with the child's plan of care. An example from Vignette Two was when a nurse answered the open-ended question with:

Why don't you explain to me how you help Taylor with his Diabetes. I don't think either one of you are doing anything wrong, but let's try to work on this together and see what we can come up with.

Problem-solve was defined as working together with the father and child to explore what may be happening with the child. In Vignette One an example of this was when a nurse answered the open-ended question with, "Several things can make a child tired and sluggish so I can't say right now but we will do our best to figure out what is going on."

Provide/Promote education was defined as giving the father and child information to help them understand what is going on with the child and what they might do to make the child feel better. In Vignette Three, a nurse provided and promoted education with:

When Terry runs a fever, do you give him medication, like Tylenol or Motrin?
How does Terry like to be comforted? (Wait for responses) Those are all things you can do for Terry. Tylenol and Motrin may help with the fever and popsicles and ice cream may help with the sore throat.

This theme and subsequent codes reflected a combination of psychological, emotional, and factual responses from the nurses. The nurses wanted to provide/promote education, comfort measures, and problem-solve with the fathers while partnering with the father and/or child to provide care.

Overall, the most responses were made to the never-married single father (N = 255), and the least number of responses were made to the remarried stepfather (N = 213). The total responses to the married father was 245, cohabiting father, 241, and the divorced father, 223.

Vignette One (General Health Problem - Child Who is Tired) Open-Ended

Responses

The following table displays the themes, codes, and sub-codes for Vignette One (see Table 4.4). In this vignette, the child was tired all the time and the father wanted to know why.

Table 4.4 Vignette One Themes and Codes

Vignette One: Child is tired all the time					
Themes, codes, and sub-codes	Remarried Stepfather	Never-married Single	Married	Divorced	Cohabiting
Theme One: Validation of Father					
1. Acknowledgement of feelings	0	1	0	0	1
2. Empathy	2	0	1	0	0
3. Praise	2	2	4	4	2
4. Reassurance	4	5	3	12	2
Total Theme One:	8	8	8	16	5
Theme Two: Information Gathering					
1. Additional Information sought from father and/or child including:	18	22	30	18	16
Activity	0	2	5	2	2

Blood glucose levels	0	0	0	0	0
Care of the child	0	0	0	0	0
Diet	0	3	0	2	2
Length/Timeline of illness/symptoms	0	0	6	0	2
Medical history	0	2	2	2	0
Medications	1	0	2	0	0
Recent changes	2	7	6	3	2
Recent exposure	2	0	1	1	0
Routine/Schedule/Pattern	4	5	3	3	7
Stress	1	1	0	1	0
Symptoms	1	2	5	4	1
2. Integration of nurse/physician findings	9	12	14	15	13
Total Theme Two:	27	34	44	33	29
Theme Three: Plan of Care					
1. Comfort measures	0	0	0	0	0
2. Partner with father and/or child	4	5	6	2	8
3. Problem-solve	24	22	25	24	29
4. Provide/Promote education	4	0	0	3	0
Total Theme Three:	32	27	31	29	37
Overall Total: Vignette One	67	84	92	83	86

Validation of the Father. Divorced fathers received more validating responses than the other fathers. In particular, *reassurance* was given most frequently to the divorced father. For instance, nurses said, “We will do everything we can to figure out

what is going on.” “You and your son are in good hands, please let me know what I can do for you or how I can help you,” and “Several things can make a child tired and sluggish so I can't say right now but we will do our best to figure out what is going on.” The frequency of other validating responses did not differ based on the type of father to which the nurses were responding. Nurses may have assumed the divorced father was not the primary caretaker and therefore not as involved with the child, assuming that the divorced father needed reassured that the child's tiredness was not because of something the father had done wrong while the child had been under his care.

Information Gathering. Nurses wanted *additional information from the father/child* with more details about the child's health condition. For instance, nurses explained to the never-married single father, “We will gather information from you and assess your child to understand what is happening,” “Let's get a little bit more history on Chris and then we will have the doctor come in and see him,” and “Chris could be tired for a number of reasons. To find out, I will ask you questions about Chris.” A cohabiting father was asked to, “recall when he has noticed this and also if Chris is old enough talk with him,” “I'm going to ask several questions so I can get a better understanding of what is going on,” and “we will continue to do an assessment and ask more questions to see what may be causing his tiredness.”

Nurses sought additional information most often from married fathers (N = 44) and least often from stepfathers (N = 27), with never-married single fathers (N = 34), cohabiting fathers (N = 29), and divorced fathers (N = 33) falling in between. The information sought from the fathers about the child's condition were similar regardless of father type, however. It is not clear why the frequency of responses to married fathers

were greater. Fewer responses seeking information from stepfathers and cohabiting fathers may be related to assumptions that these fathers were less involved in childcare or less knowledgeable about the child's health history and current condition than other fathers.

Nurses asked the fathers similar questions specifically about Chris's *activity, diet, symptoms, routine/schedule/pattern, and medical history* based on the child's vague condition of tiredness and the need to gather a variety of data as part of the child's health history and physical examination. These questions included, "Let's start with do you notice a specific time of day or activity that makes Chris more tired? Any difficulty breathing, running a fever, etc.? Is there anything new or different that Chris is experiencing at this time?" "Have there been any recent changes in his routine/diet/home life? Has he been exposed to anyone who you know is sick? Can you give an estimate of how long he has seemed more tired than usual? (1 week/1 month?)," and "Can you tell us a little bit more about your concerns and how long it has been going on? Has anything else changed recently or any traumatic experiences? Any other symptoms you have noticed?"

Plan of Care. Nurses responded to the theme of *plan of care* overall with *problem-solving responses* to all of the father types. The nurses wanted to *problem-solve* and help the father (regardless of the fathers' family structure) determine why the child was feeling tired. Nurses' responses did not reflect biases towards the different father types. An example of *problem-solving* with the cohabiting father included, "We will do some digging, and figure it out," and "Let's do some more investigation and tests to look into it." The never-married single father received responses such as, "I'm not sure, we'll

do an exam and see if we can get some answers.” The other father types received similar responses.

Partner with father and/or child responses were offered to the never-married single father the most with eight responses, but the content of the responses did not differ between fathers. The nurses may have believed the never-married single father would need guidance more than the other father types due to not having a partner to share concerns over the child's condition. Nurses shared with this father, “I can see that you are concerned about Chris and we will join with you to try to figure out the cause of this change in his behavior,” and “Let's explore this together and see if we can come up with an answer to your question.” Similarly, the remarried stepfather was told, “Let's continue investigating and look deeper into this,” and “Let's talk a little more about what's been going on lately and discuss with the physician as well.” One nurse shared with the cohabiting father, “I would like to try to work with you and Chris to gather more information to be able to narrow down why feels tired,” and “We would collaborate together to devise a plan to determine what is making Chris tired and how to solve it.” One nurse responded to the married father, “We will assess and look into all that we can to help find out.” The divorced father was told, “We'll do what we can to figure out what Chris needs,” and “The Doctor will also come in to talk to both of you.”

It is noteworthy that overall responses in Vignette One to stepfathers were considerably less frequent ($n = 67$) than responses to other fathers. Conversely, responses to married fathers were the most frequent ($n = 92$).

Vignette Two (Chronic Condition - Child with Diabetes) Open-Ended Responses

In Vignette Two, the child is a Type I diabetic whose blood glucose levels have been unstable, and the father is unsure for how long. See Table 4.5 for the summary of themes, codes, and sub-codes.

Table 4.5 Vignette Two Themes and Codes

Vignette Two: Type I diabetic with unstable blood glucose levels					
Themes, codes, and sub-codes	Remarried Stepfather	Never-married Single	Married	Divorced	Cohabiting
Theme One: Validation of Father					
1. Acknowledgement of feelings	0	7	1	1	1
2. Empathy	0	7	4	2	1
3. Praise	0	7	3	2	0
4. Reassurance	11	12	17	6	13
Total Theme One:	11	33	25	11	15
Theme Two: Information Gathering					
1. Additional Information from father and/or child including:	27	42	25	34	28
Activity	3	5	2	2	3
Blood glucose levels	5	5	3	5	4
Care of the child	3	1	0	5	2
Diet	8	9	3	6	7
Length/Timeline of illness/symptoms	0	0	0	0	0
Medical history	1	0	1	0	0

Medications	1	5	0	1	1
Recent changes	1	2	2	0	0
Recent exposure	0	1	1	1	0
Routine/Schedule/Pattern	2	4	3	2	6
Stress	0	0	2	1	0
Symptoms	0	0	0	1	0
2. Integration of nurse/physician findings	1	1	3	1	2
Total Theme Two:	28	43	28	35	30
Theme Three: Plan of Care					
1. Comfort measures	0	0	0	0	0
2. Partner with father and/or child	7	4	8	2	11
3. Problem-solve	5	16	17	11	12
4. Provide/Promote education	4	9	10	6	10
Total Theme Three:	16	29	35	19	32
Total	55	105	92	71	78

Validation of the Father. For the theme, *Validation of the Father*, nurses were the most responsive to the never-married single father (n = 33), and next often to the married father (n = 25). They responded less often to the divorced (n=11) and remarried stepfather (n =11). Some assumptions may have been made by the nurses regarding how much the divorced father and remarried stepfather lived with the child and how much time the child spent in their care.

Of the codes within this theme, *reassurance* was shared most often to all types of fathers. In fact, remarried stepfathers received *reassurance* responses only (no other forms of validation). It is unclear why nurses gave the remarried stepfather *reassurance* only. Nurses may have wanted to let the stepfather know that he or the child was not doing anything wrong, but did not feel a need to *acknowledge* his *feelings*, *praise* him, or provide *empathy* to him. Examples of *reassurance* to the married father included, "I would respond that neither of them are doing anything wrong....," "Neither of you may be doing something wrong but let's go over Taylor's routine and typical day of food," and "Type 1 diabetes can be very difficult to manage, you guys are not doing anything wrong." The nurses told the divorced father, "In the meantime, just be Terry's buddy and hang out with him. Nobody feels good when they have these symptoms, so just be patient with him and comfort him," and "We will take good care of your son and help you to feel confident in his care and prognosis before going home."

In addition to providing *reassurance* to the fathers, for never-married single fathers, nurses also *acknowledged feelings*, expressed *empathy*, and *praised* him more consistently than they did for the other types of fathers. Nurses may have listened to the father and responded to his perceived needs based on their perceived level of competence a never-married single father may have with an unstable Type 1 diabetic child's condition. For example, within the code of *acknowledgment of feelings* nurses responded "There are many things that cause changes in blood sugar levels, it doesn't mean that you are doing anything wrong," and "I would say that they aren't necessarily doing something "wrong" but some additional education may be necessary to improve Taylor's blood glucose control."

Information Gathering. The theme of *Information Gathering* was identified in responses to all types of fathers but overall was most frequent with the never-married single father (N = 43 coded responses) and the divorced father (N = 35 coded responses). Although similar information was sought from all of the fathers, the least information sought was from the married father (n=25), the remarried stepfather (N = 28), and the cohabiting father (n=30). The main difference in the information sought from different types of fathers seemed to depend on whether or not they had coparents living with them. If they did (i.e., married, remarried, cohabiting), then nurses may have assumed these types of fathers might not know the information the nurses wanted. In contrast, nurses may have assumed that the fathers without coparents in their households, single never-married and divorced fathers, might be responsible for diet, diabetes treatments, and so would know more of this information.

One nurse responded to the never-married single father with this question, "Tell me about your lives recently. Has anything changed in your lifestyles?" For the divorced father, a nurse responded, "I would ask Evan if he understands what type 1 diabetes is and what the cares and responsibilities are that come along with having type 1 diabetes." A nurse responded to the remarried/stepfather with,

Why don't you explain to me how you help Taylor with his Diabetes? I don't think either one of you are doing anything wrong, but let's try to work on this together and see what we can come up with.

The topic of *diet* as a sub-code was most asked to the never-married single father, and least asked to the married father. Nurses asked all the father types about diet, which would be expected as a top priority assessment question when working with a diabetic

patient. Nurses asked the never-married single father, "Let's talk about what Taylor is eating, how much he is exercising, and his medications. Then we can see if something needs to be changed," and "What have his sugars been running? any changes in his diet?" The married father was told, "Neither of you may be doing something wrong but let's go over Taylor's routine and typical day of food." Perhaps nurses did not ask the married father as many questions about *diet* as they assumed the mother was the meal planner for the family.

The sub-code of *medications* was primarily asked of the never-married single father (N = 5). The married father received no questions specific to *medications* and the other fathers each received one question each in regard to *medications*. It was surprising that there were not more questions regarding medications (i.e. insulin) considering this vignette centered on a child with Type 1 diabetes. The nurses may have thought the father would not have as much knowledge about the child's insulin, but this could be an erroneous assumption. An example of a question regarding *medications* to the never-married single father was, "I would inquire on how Taylor's diet has been, how often she is checking her blood sugar, how much insulin she has been requiring." This response is what should be asked of someone with diabetes and unstable blood sugars.

Plan of Care. In Vignette Two, nurses responded the most often in the overall theme of *plan of care* to the married father (N = 35), the cohabiting father (n=32) and the never married father (n=29), and the least to the remarried stepfather (N = 16) and the divorced father (n=19). The code *partner with father and/or child* had the most responses (11) to the cohabiting father. The divorced father only had two responses. Examples of this code with the cohabiting father was, "We will find out a little more information

regarding Taylor's diet and activity and maybe we can determine if there are areas we can improve upon." An example of this code with the divorced father was, "We will help figure out what to do moving forward." Nurses may not have felt this was a priority over *problem-solving*, which would be their first instinct when answering the father's question of what he or the child are doing wrong.

The nurses responded most often by *problem-solving* to help the father determine why the child's blood sugars were unstable. Within the *problem-solve* code, the married father had 17 responses, while the never-married father had 16 responses. In comparison, the remarried stepfather only had five, responses leading me to believe the nurses assumed the remarried stepfather was not the child's primary caretaker, and therefore would not need as much information. An example of *problem-solve* with the married father was when the nurse asked,

Are they financially stable and able to afford her insulin for her diabetes? Is she at the point in her life that she's embarrassed about eating well around her friends? Has been sick or had a major stressor that has caused her blood sugar fluctuations?

An example of *problem-solving* with the remarried stepfather was, "Does this child have a plan of care and if so, has it been followed? If not, for how long?" This response to the father could be construed as a negative response to the stepfather with the nurse assuming if he did know if the child has a plan of care, perhaps he should find out. For the plan of care codes, it seemed that the nurses were most comfortable with ideas for fathers with coparent partners in the household (with the aforementioned stepfather as an

exception) and, because there was a great need as the lone caregiver to the diabetic child, they offered lots of ideas regarding plan of care to the single, never-married fathers.

As with Vignette One, in Vignette Two, overall the stepfather had the fewest responses ($n = 55$). The most frequent responses were to single never-married fathers ($n=105$), and then to married fathers ($n=92$).

Vignette Three Open-Ended Responses (Acute Health Problem - Child with Rash)

In Vignette Three, the child had a rash on the trunk of the body, recently had a sore throat and a fever. The father does not know what is going on and wishes the mother had come to the appointment. See Table 4.6 for the summary of themes, codes, and sub-codes.

Table 4.6 Vignette Three Themes and Codes

Vignette Three: Rash on the trunk of the body, sore throat, and fever					
Themes, codes, and sub-codes	Remarried Stepfather	Never-married Single	Married	Divorced	Cohabiting
Theme One: Validation of Father					
1. Acknowledgement of feelings	1	1	1	0	3
2. Empathy	0	0	1	1	1
3. Praise	16	15	9	8	13
4. Reassurance	4	3	4	11	4
Theme One Total:	21	19	15	20	21
Theme Two: Information Gathering					
1. Additional Information from father and/or child including:	8	9	7	7	7

Activity	0	0	0	0	0
Blood glucose levels	0	0	0	0	0
Care of the child	0	0	0	0	0
Diet	0	0	0	0	0
Length/Timeline of illness/symptoms	3	3	0	2	1
Medical history	1	0	2	2	0
Medications	0	1	1	0	3
Recent changes	0	0	0	0	0
Recent exposure	1	1	1	2	1
Routine/Schedule/Pattern	0	0	0	0	1
Stress	0	0	0	0	0
Symptoms	3	2	0	1	1
2. Integration of nurse/physician findings	14	12	12	9	16
Theme Two Total:	22	21	19	16	23
Theme Three: Plan of Care					
1. Comfort measures	5	1	4	5	4
2. Partner with father and/or child	7	3	4	2	4
3. Problem-solve	16	15	12	17	15
4. Provide/Promote education	9	7	7	9	8
Theme Three Total:	37	26	27	33	31
Total	80	66	61	69	77

Validation of the Father. For the first theme, *Validation of the Father*, nurses were the most responsive to the remarried stepfather (n=21) and the cohabiting father (N = 21), and the least responsive to the married father (N = 15). Overall, there were not substantive differences in the frequencies in which nurses validated different types of fathers.

The father's comment in the beginning of the vignette that he wished the child's mother was with him led nurses to respond frequently with *praise*. Of all of the codes in theme one, *praise* was the most frequent. The content of the responses were similar regardless of the father type, but nurses praised the remarried stepfather and the never-married single father the most for bringing the child to the clinic. This may be due to the nurses' perceptions that these two types of fathers were more unsure about handling the child's condition and being the one to bring the child to the clinic without the child's mother. An assumption that the married father was sent by the mother to accompany the child could explain why they received less praise. An example of *praise* for the remarried stepfather was, "In light of these symptoms, you have done the right thing bringing your child in to be seen by a provider," and "You have brought her in to be evaluated which is a responsible thing to do." The never-married single father received similar responses such as, "You did the right thing by bringing him in for care and evaluation." Although the divorced father only received eight *praise* responses, they were similar as well. One nurse responded, "You are off to a great start. Bringing him in to be evaluated was the right choice, especially since the rash is paired with a fever and sore throat."

The code *reassurance* was given 11 times to the divorced father, yet only three times to the never-married single father, and the other fathers each received only four

responses apiece. This has been in stark contrast to other responses the divorced father received in the other vignettes. The nurses' responses were similar in nature, and the nurses appeared to reassure the divorced father that even without the mother being present, he had done the right thing by bringing the child in to the clinic. It is unclear why the nurses did not reassure the other fathers as much as they praised them for bringing the child in. Examples of *reassurance* for the divorced father included, "We will take good care of your son, and help you to feel confident in his care and prognosis before going home," and "We will try to figure out what is causing his symptoms then let you know what you can do for him." One of the nurses told the divorced father, "In the meantime, just be Terry's buddy and hang out with him. Nobody feels good when they have these symptoms, so just be patient with him and comfort him." For the never-married single father a response was, "I think once we can figure out what is going on with Terry, we will make sure that you know what to do to take care of Terry."

Information Gathering. Overall, there were no differences in frequencies or the content of responses to fathers in regard to information gathering. The second set of codes for *information gathering*, *integration of nurse/physician findings*, was more frequent for all types of fathers than was seeking *additional information from father and/or child*. From the child's presenting symptoms, the nurses had more information to focus on compared to more vague conditions, such as the tiredness of the child in Vignette One. Father types were fairly even in the *integration of nurse/physician findings* with the cohabiting father receiving the most responses (N =16), and the divorced father only receiving a total of nine responses. Although nurses validated the divorced father through reassurance, they did not gather as much information from him. This may be due

to the divorced father being seen as not living with the child full-time and therefore not being the primary caregiver. Examples of this code for cohabiting fathers were, "We will look him over and likely do some tests that will give us more information." and "I'll take his temperature and vital signs." The divorced father was responded to with a nurse saying, "I will assess the rash and then we will come up with a plan to treat your child."

Plan of Care. In theme three, *plan of care*, the different types of fathers received similar number of responses, with stepfathers (n=37), divorced fathers (n=33), and cohabiting fathers (n=31) receiving the most. The code that received the most responses with all father types in theme three was *problem-solve*. The divorced father received the most responses in this code compared to the least amount of responses in the *partner with father and/or child* code. Nurses responding more positively to the divorced father with problem-solving when they stated, "We will figure out what is going on and get some answers for you as soon as possible," "I would have to do further evaluation and testing to determine the cause," and "We will probably do a throat swab to see if he has strep throat." Nurses may have felt the divorced father needed more assistance to problem-solve, but did not feel a need to partner with the father and/or child. Responses were similar to the other fathers. For example, nurses shared with the married father, "Well, first let's try to find out what is wrong with Terry and then we can figure out how to help him," and "Once we get his assessment done, we'll have a better idea of what you can do to help him feel better."

Chapter 5

Discussion

The quantitative findings in this study did not generally support the two proposed hypotheses. The first hypotheses stated that nurses' perceptions of divorced fathers, single fathers, cohabiting fathers, and stepfathers would be more negative than that of married fathers. This was minimally supported only in Vignette One where the cohabiting father was perceived as less competent than the married father. No other comparisons of father types differed significantly. The second hypothesis, that nurses' emotional reactions would be more positive to married fathers than to other fathers, was not supported.

These quantitative findings are not congruent with the SCM postulates that social judgments impact a person's emotions and behaviors toward a specific person or group of people (Cuddy et al., 2011; Fiske, 2012; Fiske et al., 1999). These findings are also not congruent with the NFI assertion that married fathers would be seen more favorably than other fathers. Although there was one significant statistical comparison, in general the quantitative results suggest that the nurses in the sample do not hold social judgments about fathers based on the fathers' marital and parental status and the nurses in this study show little implicit bias about fathers in their forced choice answers. There are several possible reasons for this.

First, maternal-child nurses are educated to be unbiased and fair when interacting with patients and their families. It is likely that most of the participants in this study had received more education regarding providing unbiased and fair care to patients and families since earlier investigations were conducted which found that nurses hold

stereotyped beliefs about patients and their families (Devine, 1989; Ganong et al., 1987; Ganong & Coleman, 1997). It may be that contemporary nurses are better at thinking about patients without biases. For several years, educators, websites, professional publications, and other media have been clear about the problems of implicit biases, so the participants in this study may have been highly aware of the dangers related to social judgments, and purposefully resisted inserting any biases they may have had regarding fathers' marital and parental statuses into their perceptions and reactions to the fathers, as assessed by their response to forced choice items in the study survey.

A second reason for the absence of quantitative differences in perceptions and reactions may be that nurses' social judgments about fathers have more to do with fathers who are involved in childrearing and childcare compared to fathers who are not. That is, the different types of fathers presented in this study, based on marital and parental statuses, may have been less salient to nurses than the fact that all the fathers in this study were taking children to a clinic. Their implicit comparison was not to fathers of other marital and parental statuses, but to fathers that are uninvolved in child rearing. The implicit positive bias of caring fathers as warm and competent may have been more powerful to these maternal-child nurses than social judgments about fathers' marital and parental statuses. According to this logic, all of the types of fathers would be seen favorably, simply because they were with the child in the clinic.

A third reason for the nonsignificant statistical findings may be due to the methods employed in this study. Although the MSFV is an excellent mixed-method design to obtain individuals' knowledge, perceptions, emotions, and potential responses about specific phenomenon that may otherwise be difficult to study (Ganong & Coleman,

2006), something about asking nurses to respond to three different scenarios about fathers and children may have affected the nurses' perceptions and social judgments. Responding to three different types of fathers, which was possible with random assignment of vignette conditions to the nurses, may have triggered nurses' awareness that we were examining social judgments about fathers, and such awareness may have dampened down their implicit beliefs when responding to the forced choice items in the survey. Future research should employ other ways to elicit nurses' social judgments about fathers, such as using video or audio stimuli, using other measures, or conducting MSFVs with nurses assigned to only one type of father.

Although the quantitative data clearly suggest that nurses' perceptions of fathers are not affected by fathers' marital and parental statuses, the qualitative data from this study presents a more complicated and ambiguous picture. There is evidence that nurses' responses are not uniform across all types of fathers. In written responses to fathers' questions, implicit biases may have an impact on the way nurses respond to certain father types. The nurses' responses indicate that they are using information about fathers' marital and parental statuses in forming their ideas about the child, father, family, and the child's health status. It is a normal process for nurses to cognitively categorize their patients based on physical, behavioral, and social characteristics (Devine, 1989; Ganong et al., 1987; Ganong & Coleman, 1997), so this is not necessarily a negative phenomenon.

It is important to note that nurses' responses to fathers of different marital and parental statuses also are influenced by the child's health condition; nurses are using contextual clues, including family structure of the child, to inform how they respond to fathers' questions. For instance, in the acute health problem shown in Vignette Three,

nurses generally treat all types of fathers similarly. There is adequate information about the symptoms presented in this scenario for nurses to “get to work” and essentially respond quite similarly to fathers, regardless of marital or parental status. In this situation alone, compared to the other vignettes/health conditions, stepfathers receive as many or more responses as the other fathers do, suggesting that family structure may be less relevant for nursing this ill child. However, in the chronic illness context (diabetes) of Vignette Two that involved daily treatments and a regimen of home care that could not be altered much, family structure is more important to the nurses as they focus on the fathers who they thought might be more involved with caregiving (i.e., married, cohabiting, single, never-married) and paid much less attention to those they assumed would not be (i.e., stepfathers, divorced fathers). The nurses also attend to the likely presence of mothers as coparents, responding differently to fathers who did and who likely did not have available coparents (at least the nurses implicitly paid attention to this). Fathers’ marital and parental statuses also were relevant when the presenting symptoms were vague and general complaints (i.e., Vignette One), at least when it came to validating some types of fathers more than others and seeking information more often from certain types of fathers. Plans of care were seemingly not affected by fathers’ marital and parental statuses when chronic fatigue was the complaint, but the frequency of support given to fathers varied by father type, as did the frequency with which information was sought from which fathers.

The open-ended data thus lend some support for the relevance of social judgments affecting nurses’ cognitions and behaviors (at least in a lab setting such as this online survey). So what? Was paying attention to fathers’ marital and parental statuses when

responding to fathers' questions and concerns a good thing to do or a bad thing to do?

Given that the frequency of responses differed between father types, but not the content of what was written, the answer is that it seems likely there is the potential for both good and bad.

Taking into account family structure information (i.e., fathers' marital and parental statuses) that might be relevant for children's care is appropriate – responses to fathers' concerns may be more on target and questions asked of fathers may be more useful and efficient if family structure information is considered by nurses. For example, if a certain type of father needs more reassurance because of his marital and parental situation, then giving this reassurance will be felt as positive by fathers in those situations. Time may be saved when assumptions about family structure are utilized when asking about daily treatments or children's health histories, for instance. Using family structure information may be damaging, however, if assumptions prevent nurses from being open to new data, and if assumptions are not confirmed with additional information. For example, nurses show some evidence of an implicit bias that the divorced father needs more reassurance than the other fathers because they assume the father is not the primary caretaker of the child, is not as involved in child care, and therefore he does not know as much about the child's condition because he does not live full-time in the same household as the mother, the assumed custodial parent (Noergaard, Ammentorp, Fenger-Gron, Kofoed, & Johannessen, 2017). If these assumptions are warranted, then the nurses' responses benefit the father and child, but if they are inaccurate, and the nurses do not seek disconfirming evidence for their assumptions, then implicit biases will impair the quality of nursing care.

In two of the three vignettes far fewer responses were given to remarried stepfathers than to other types of fathers. This was the only type of father that was not genetically related to the child, and this lack of genetic connection may have influenced nurses' responses. Some nurses also may have known that stepfathers normatively have no legal responsibilities or rights regarding their stepchildren, and that may have effected their responses, although this was not mentioned by anyone so it probably had little effect. It also may be that nurses were implicitly affected by stereotypes regarding stepfathers as abusive, uncaring, and mean (Ganong et al., 1990) and their judgments unknowingly affected how often they responded to the stepfathers. For whatever reasons, nurses respond to stepfathers differently than to other types of fathers – further research is necessary to explore why this was the case. Stepfathers may actively engage in children's care and treatments, and to assume they are not and respond differentially to them is potentially a problem with nursing care.

In support of an earlier speculation that the nurses perceive the fathers as warm and competent because the vignettes portrayed them bringing a sick child to a clinic, overall nurses were positive in their written responses regardless of the fathers' family structure. Nurses praised and reassured fathers for bringing the child to the clinic. They also wanted more information to assist finding out what was going on with the child. Nurses wanted to problem-solve regardless of the fathers' family structure more than they wanted to comfort, partner with, or educate the fathers; perhaps this reflects how nurses see themselves (i.e., as problem-solvers) more than it does how they perceived the fathers.

Limitations

The number of nurses that received the survey is unknown, so the true response rate is unknown. Nurses that responded may be different in some way than other non-respondents. The nurses that received the survey and chose not to respond may have had some type of bias towards fathers or specific father types that they feared may be discovered if they answered the survey. In particular, nurses receiving the survey in an email from their nurse managers may have felt they would somehow be identified and disciplined or lose their jobs if their answers revealed a bias.

The population of nurses surveyed primarily worked in labor and delivery units at hospitals. These nurses care for mothers and newborns as their primary patients, whether fathers are part of the family unit or not. Few of the nurse participants work in a clinical setting where a father would bring a child in to be seen with these type of health issues. This may have contributed to their answers being more neutral. These nurses may have responded differently if the vignettes had been written with a father and child in a hospital setting such as a neonatal intensive care unit (NICU), newborn nursery, postpartum, or pediatric unit. In contrast, had the vignettes created for this research been distributed to nurses working in pediatric clinics, the responses may have been differently as well.

Social desirability may have been a problem, particularly with the forced choice items nurses responded to. Nurses are educated to be very careful in showing biases and this may have impacted how they answered the survey. One of the nurse experts that had piloted the survey shared with me that she was careful in how she answered the questions because she didn't want to bias her answers. This may be what the nurses that completed

the survey for this research may have thought as well and impacted how they answered. Not knowing the exact amount of time it took the nurses to complete the survey may have been a limitation to the study. One of the participants took a couple of days to complete the survey, possibly due to being interrupted and having to return to the survey. If nurses took a longer time to answer the survey because they were reflecting on how to answer in order to not show a bias, the time to answer could have been a variable in the study.

Nurses may have had an empathetic leaning towards the fathers assuming they were the primary caregivers. Fathers and mothers can experience a double-standard when parenting roles come in to question, although, stay-at-home fathers are becoming more of the norm for family structures and as primary caregivers (Lee & Lee, 2018).

Another limitation could be nurses receiving the survey in a written format and not in a video format with actors playing the father, child, and the nurse in the vignettes. Some of the nurses' responses were construed as negative, but this is hard to determine with only the written word, without verbal tone, inflections of their voice, and nonverbal mannerisms. The use of video vignettes to measure health care providers and nurses' knowledge and quality of care are a good monitoring and teaching tool (Banuri et al., 2018).

Future Research

More research is needed in regard to maternal-nurses' implicit biases when working with families. This study could be used as a launching point for a trajectory of research with maternal-child nurses using the tool as an opportunity to provide an intervention of education and follow-up at intervals to see if the nurses feel their thoughts and actions have been changed through the awareness of possible implicit biases. A

future study could involve the creation of video vignettes allowing for nurses to respond in real-time and allowing the researcher to observe and listen to the nurses' verbal and nonverbal reactions.

Another future study could involve creating vignettes with fathers of newborns in particular for labor and delivery nurses, postpartum nurses, nursery nurses, and neonatal intensive care nurses. This type of study could focus more on potential scenarios the nurses could encounter with families from different socioeconomic levels, or social behavioral issues (i.e. drug-addicted mothers and sub-sequentially drug-addicted newborns; abusive partner, etc.).

An additional study could involve creating vignettes with fathers of a newborn or toddler randomizing the gender of the child. This study could focus on the maternal-child nurses' generational differences and potential attitudes as the nurses interact with the fathers. Another study could involve a variety of father types that include gay fathers and transgender fathers as well as the more traditional father types used in this study.

Conclusion

Assessing social judgments is difficult. Study participants do not want to show personal biases and want to be seen, and to see themselves, as people without preconceived beliefs about others. Social judgments are also a subtle phenomenon and our abilities to measure social judgments and their effects on cognitions and behaviors are crude and limited, making it a challenge to assess when social judgments are occurring. Despite the difficulties in doing this work, it is imperative that nursing scholars and researchers from other disciplines continue to examine how nurses and other helping

health care professionals perceive and interact with individuals and groups, particularly those with stigmatized or marginalized statuses.

The findings of this study suggest that nurses have implicit social judgments about fathers based on their marital and parental statuses. It appears as if these judgments do not negatively affect nurses' perceptions and emotional reactions to fathers, at least as measured quantitatively, but there is evidence that nurses may respond to fathers differently, at least in terms of the frequency of the nurses' responses. The design of this study does not lead to conclusions that nurses inappropriately use social judgments about fathers' family structures, however. More investigation is needed.

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*Appendix A***Vignette 1****Segment 1**

Jason is married and the father of a child, Chris. Jason brings Chris to the clinic because according to Jason, "Chris seems tired all of the time and we need to get to the bottom of this."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "When did you first notice that Chris seems tired all the time?" Jason replies that he does not know, but that lately Chris has seemed tired more than usual. He asks, "Why is Chris feeling like this?" What would you say to Jason if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 1

Segment 1

Jason is divorced and the father of a child, Chris. Jason brings Chris to the clinic because according to Jason, "Chris seems tired all of the time and we need to get to the bottom of this."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "When did you first notice that Chris seems tired all the time?" Jason replies that he does not know, but that lately he has seemed tired more than usual. He asks, "Why is Chris feeling like this?" What would you say to Jason if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 1**Segment 1**

Jason is remarried and the stepfather of a child, Chris. Jason brings Chris to the clinic because according to Jason, "Chris seems tired all of the time and we need to get to the bottom of this."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "When did you first notice that Chris seems tired all the time?" Jason replies that he does not know, but that lately Chris has seemed tired more than usual. He asks, "Why is Chris feeling like this?" What would you say to Jason if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 1**Segment 1**

Jason is a never-married single father of a child, Chris. Jason brings Chris to the clinic because according to Jason, "Chris seems tired all of the time and we need to get to the bottom of this."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "When did you first notice that Chris seems tired all the time?" Jason replies that he does not know, but that lately Chris has seemed tired more than usual. He asks, "Why is Chris feeling like this?" What would you say to Jason if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 1

Segment 1

Jason is the cohabiting father of a child, Chris. Jason brings Chris to the clinic because according to Jason, "Chris seems tired all of the time and we need to get to the bottom of this."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "When did you first notice that Chris seems tired all the time?" Jason replies that he does not know, but that lately Chris has seemed tired more than usual. He asks, "Why is Chris feeling like this?" What would you say to Jason if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity

6. sympathy
7. envious
8. jealous

*Appendix B***Vignette 2****Segment 1**

Evan is married and the father of a child, Taylor. Evan brings Taylor to the clinic because Taylor is a Type I diabetic whose blood glucose levels have been unstable, but Evan is not sure for how long.

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Evan replies that things are generally fine, but that lately Taylor has seemed to have trouble managing the Type I Diabetes. He asks, "What am I doing wrong? What is Taylor doing wrong?" What would you say to Evan if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 2

Segment 1

Evan is divorced and the father of a child, Taylor. Evan brings Taylor to the clinic because Taylor is a Type I diabetic whose blood glucose levels have been unstable, but Evan is not sure for how long.

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Evan replies that things are generally fine, but that lately Taylor has seemed to have trouble managing the Type I Diabetes. He asks, "What am I doing wrong? What is Taylor doing wrong?" What would you say to Evan if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 2**Segment 1**

Evan is remarried and the stepfather of a child, Taylor. Evan brings Taylor to the clinic because Taylor is a Type I diabetic whose blood glucose levels have been unstable, but Evan is not sure for how long.

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Evan replies that things are generally fine, but that lately Taylor has seemed to have trouble managing the Type I Diabetes. He asks, "What am I doing wrong? What is Taylor doing wrong?" What would you say to Evan if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 2

Segment 1

Evan is the never-married single father of a child, Taylor. Evan brings Taylor to the clinic because Taylor is a Type I diabetic whose blood glucose levels have been unstable, but Evan is not sure for how long.

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Evan replies that things are generally fine, but that lately Taylor has seemed to have trouble managing the Type I Diabetes. He asks, "What am I doing wrong? What is Taylor doing wrong?" What would you say to Evan if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 2**Segment 1**

Evan is a cohabiting father of a child, Taylor. Evan brings Taylor to the clinic because Taylor is a Type I diabetic whose blood glucose levels have been unstable, but Evan is not sure for how long.

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Evan replies that things are generally fine, but that lately Taylor has seemed to have trouble managing the Type I Diabetes. He asks, "What am I doing wrong? What is Taylor doing wrong?" What would you say to Evan if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

*Appendix C***Vignette 3****Segment 1**

Dave is married and the father of a child, Terry. Dave brings Terry to the clinic because Terry has had a rash on the trunk of the body, a recent sore throat, and a fever. Dave tells the nurse, "I don't really know what is going on. I wish Terry's mother would have come instead."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Dave replies that things are generally fine, but that lately Terry has had a rash on the trunk of the body, a recent sore throat and fever. He asks, "Is there anything I can do for my child?" What would you say to Dave if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy

7. envious
8. jealous

Vignette 3**Segment 1**

Dave is divorced and the father of a child, Terry. Dave brings Terry to the clinic because Terry has a rash on the trunk of the body, had recently had a sore throat, and a fever. Dave tells the nurse, "I don't really know what is going on. I wish Terry's mother would have come instead."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Dave replies that things are generally fine, but that lately Terry has had a rash on the trunk of the body, a recent sore throat and fever. He asks, "Is there anything I can do for my child?" What would you say to Dave if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 3

Segment 1

Dave is remarried and the stepfather of a child, Terry. Dave brings Terry to the clinic because Terry has a rash on the trunk of the body, had recently had a sore throat, and a fever. Dave tells the nurse, "I don't really know what is going on. I wish Terry's mother would have come instead."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Dave replies that things are generally fine, but that lately Terry has had a rash on the trunk of the body, a recent sore throat and fever. He asks, "Is there anything I can do for my child?" What would you say to Dave if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious

8. jealous

Vignette 3**Segment 1**

Dave is a never-married single father of a child, Terry. Dave brings Terry to the clinic because Terry has a rash on the trunk of the body, had recently had a sore throat, and a fever. Dave tells the nurse, "I don't really know what is going on. I wish Terry's mother would have come instead."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Dave replies that things are generally fine, but that lately Terry has had a rash on the trunk of the body, a recent sore throat and fever. He asks, "Is there anything I can do for my child?" What would you say to Dave if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

Vignette 3**Segment 1**

Dave is a cohabiting father of a child, Terry. Dave brings Terry to the clinic because Terry has a rash on the trunk of the body, had recently had a sore throat, and a fever. Dave tells the nurse, "I don't really know what is going on. I wish Terry's mother would have come instead."

What are your perceptions of this father?

1. Cold _____ Warm
2. Unpleasant _____ Pleasant
3. Likable _____ Unlikeable
4. Mean _____ Kind
5. Loving _____ Unloving
6. Successful _____ Unsuccessful
7. Competent _____ Incompetent
8. Responsible _____ Irresponsible
9. Weak _____ Strong
10. Independent _____ Dependent

Segment 2

In response to the nurse's questions, "How are things going?" Dave replies that things are generally fine, but that lately Terry has had a rash on the trunk of the body, a recent sore throat and fever. He asks, "Is there anything I can do for my child?" What would you say to Dave if you were the nurse?

To what extent do you feel the following about the father?" Please answer using these choices:

1 = *not at all*, 2 = *somewhat*, 3 = *neutral*, 4 = *quite a bit*, 5 = *extremely*

1. contempt
2. disgust
3. admiration
4. respect
5. pity
6. sympathy
7. envious
8. jealous

*Appendix D***Demographics**

Age: What is your age? (specify)

Ethnicity origin: Please specify your ethnicity.

White
Hispanic or Latino
Black or African American
Native American or American Indian
Asian/Pacific Islander
Other (specify)

Gender: What is your gender?

Male
Female
Not listed here (specify)
Prefer not to answer

Marital Status: What is your marital status?

Single, never married
Married
Living with a domestic partner (cohabiting)
Widow/Widowed
Divorced
Remarried

Children: How many children do you have? (specify)

Geographic Location:

What state or U.S. territory do you live in? (specify)

How would you describe the setting where you live?

Rural
Small town
Suburban
Urban

Other (specify)

How would you describe the setting where you work?

Rural
Small town
Suburban
Urban
Other (specify)

Work Location: Where do you primarily work?

Clinic
Hospital
Other (specify)

Nursing Specialty: In which area of nursing do you/did you primarily work?

Antenatal
Labor and delivery
Nursery
Postpartum
Pediatrics
Education (nursing program-specify type)
Unit Education
Other (specify)

Years of Experience:

How many years have you worked in nursing? (specify)

How many years have you been a maternal-child nurse? (specify)

Employment Status: Which best describes your employment status?

Employed, full-time
Employed, part-time
Not employed, looking for a position
Not employed, NOT looking for a position
Retired
Disabled, not able to work

Education: What is the highest degree or level of education you have completed?

- Diploma in nursing
- Associate degree in nursing
- Baccalaureate degree in nursing
- Master's degree in nursing
- PhD in nursing
- ND in nursing
- Graduate or professional degree in a field other than nursing

Thank you for completing the survey. Click on the link here if you would like to participate in a random drawing for one \$250 Amazon electronic gift card or one of five \$50 Amazon electronic gift cards. The link will take you to a screen in which you are asked to enter a contact email. All email contacts will be placed in a random drawing for the electronic gift cards. There is not a connection to the email provided for the drawing and the survey responses. Participants will be contacted if they have won.

Appendix E

Advertisement Flyer

VOLUNTEERS NEEDED

for a Research Project

Fathers' Warmth and Competence and Maternal-Child Nurses' Impressions

The purpose of this study is to examine nurses' perceptions about fathers.

You are invited to take part in this study if you:

- ❖ are age 18 or older
- ❖ read/speak English
- ❖ a registered nurse working full, part-time or per diem
- ❖ hold a diploma, associate degree, baccalaureate degree; master's degree, or doctorate degree
- ❖ have at least 6 months of maternity or pediatric nursing experience

What is involved in the study?

- ❖ Completing an on-line survey which takes approximately 15 minutes to complete
- ❖ Participation will be confidential
- ❖ Participants will have the opportunity to withdraw from the survey at any time without consequences
- ❖ There should be minimal risk to the participants for completing the survey.
- ❖ At the end of the survey, participants will have the option to provide an email address to be able to be entered for the chance to win one \$250 Amazon electronic gift card or one of five \$50 Amazon electronic gift cards.

The researcher is Jan Akright, Doctoral Student, University of Missouri-Columbia
Sinclair School of Nursing

Jan will be presenting more information of how to access the on-line survey at the next upcoming staff meeting

This study has been reviewed and approved by the University of Missouri-Columbia
Health Sciences Institutional Review Board

Appendix F

Script for Staff Meeting

Hi, everyone! I am Jan Akright and I am a doctoral student at the University of Missouri-Columbia, Sinclair School of Nursing. I am here to let you know about a study that I am conducting to examine nurses' perceptions about fathers. As you know, nurses have a huge impact on quality of care, which affects families and their opinions and how they interact with the health care systems. I want to invite you to participate in this research. I am asking approximately 150 maternal-child nurses to participate in this study.

I want you to know that you have the right to be informed about the study procedures so that you can decide whether you want to consent to participation. You will be asked to complete an online survey, which has questions about fathers who are described in brief scenarios. If you decide to participate in this study, you will receive an email from your director with a link to the survey that should take approximately 15 minutes to complete.

Please know that your participation is voluntary and I encourage you to complete it on your personal time, please. You do not have to be in the study if you do not want to. You may refuse to be in the study and nothing will happen. If you do not want to continue to be in the study, you may stop at any time without penalty or loss of benefits. There are no benefits to your individual participation. However, your participation will contribute to the knowledge about nurses. There are likely to be no risks to you by being in this study. If you find any questions distressing to you, you do not have to answer them

or you can discontinue the survey. I want you to know there is no cost to you for participating in the study and there should be no injuries sustained in participating in an online survey. You will also be informed of any new information discovered during the course of this study that might influence your health, welfare, or willingness to be in this study.

You do have the option of not participating in this study, or to stop the survey at any time, and you will not be penalized for your decision. If you choose to participate, your responses to the survey questions will be kept confidential. You will not be asked to provide any personal identifying information in the survey such as your name or address.

Information produced by this study will be stored in a locked file in my office and will only be identified by a code number only. The code key connecting your name to specific information about you will be kept in a separate, secure location. Information contained in your records may not be given to anyone unaffiliated with the study in a form that could identify you without your written consent, except as required by law.

At the end of the survey, you will see a link separate from the study data where you have the option to provide an email address to be entered for the chance to win one \$250 Amazon electronic gift card or one of five \$50 Amazon electronic gift cards. The odds of receiving a gift card will be dependent on the actual number of nurses who participate in the study. There is not a connection to the email provided for the drawing and the survey responses. Participants will be contacted if they have won an e-gift card.

If you have any questions, concerns, or complaints, please contact me at 409-673-7956. Also, if you have any concerns or complaints, you may contact the University of Missouri Campus Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-9585 or umcresearchcirb@missouri.edu.

If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel under any pressure to enroll or to continue to participate in this study, you may contact the University of Missouri Campus Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-9585 or umcresearchcirb@missouri.edu.

You may ask more questions about the study at any time. For questions about the study or a research-related injury, contact [Jan Akright](#) at [409-673-7956](tel:409-673-7956). Completing the survey indicates your consent to participate in this study. You may remove yourself from the study at any time without any problems.

Appendix G

Recruiting email

Hello! My name is Jan Akright and I am a doctoral student at the University of Missouri-Columbia, Sinclair School of Nursing in Columbia, Missouri. I am conducting a study to examine nurses' perceptions about fathers. I want to invite you to participate in this research.

You are being asked to complete an online survey, which has questions about fathers who are described in brief scenarios. If you decide to participate in this study, you will click on the link to the survey at the bottom of the Consent to Participate below. The survey should take approximately 15 minutes to complete.

CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

Researcher's Name(s): Jan Akright, PhD(c), RN

Project Number: IRB #2010241

Project Title: Maternal-Child Nurses' Perceptions of Fathers

INTRODUCTION

You are being asked to participate in a research study. This research is being conducted to examine maternal-child nurses' perceptions about fathers. When you are invited to participate in research, you have the right to be informed about the study procedures so that you can decide whether you want to consent to participation.

You have the right to know what you will be asked to do so that you can decide whether or not to be in the study. Your participation is voluntary. You do not have to be in the study if you do not want to. You may refuse to be in the study and nothing will happen. If you do not want to continue to be in the study, you may stop at any time without penalty or loss of benefits to which you are otherwise entitled.

WHY IS THIS STUDY BEING DONE?

The purpose of this research is to examine how nurses perceive fathers.

HOW MANY PEOPLE WILL BE IN THE STUDY?

About 150 people will take part in this study.

WHAT AM I BEING ASKED TO DO?

You will be asked to complete an online survey, which has questions about fathers who are described in brief scenarios. Your participation is completely voluntary.

HOW LONG WILL I BE IN THE STUDY?

Your participation in this study will take approximately 15 minutes to complete. You can stop participating at any time without penalty or loss of benefits.

WHAT ARE THE BENEFITS OF BEING IN THE STUDY?

There are no benefits to your individual participation. However, your participation will contribute to the knowledge about nurses.

WHAT ARE THE RISKS OF BEING IN THE STUDY?

There are likely to be no risks to you by being in this study. If you find any questions distressing to you, you may not answer them or discontinue the survey.

WHAT ARE THE COSTS OF BEING IN THE STUDY?

There is no cost to you.

WHAT OTHER OPTIONS ARE THERE?

You have the option of not participating in this study, or to stop the survey at any time, and you will not be penalized for your decision.

CONFIDENTIALITY

If you choose to participate, your responses to the survey questions will be kept confidential. You will not be asked to provide any personal identifying information in the survey such as your name or address.

Information produced by this study will be stored in the investigator's file and identified by a code number only. The code key connecting your name to specific information about you will be kept in a separate, secure location. Information contained in your records may not be given to anyone unaffiliated with the study in a form that could identify you without your written consent, except as required by law.

WILL I BE COMPENSATED FOR PARTICIPATING IN THE STUDY?

At the end of the survey, you will see a link separate from the study data where you have the option to provide an email address to be entered for the chance to win one \$250 Amazon electronic gift card or one of five \$50 Amazon electronic gift cards. The odds of receiving a gift card will be dependent on the actual number of nurses who participate in the study.

WHAT IF I AM INJURED?

There should be no injuries sustained in participating in an online survey.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

Participation in this study is voluntary. You do not have to participate in this study.

You will also be informed of any new information discovered during the course of this study that might influence your health, welfare, or willingness to be in this study.

WHO DO I CONTACT IF I HAVE QUESTIONS, CONCERNS, OR COMPLAINTS?

Please contact Jan Akright at 409-673-7956 if you have questions about the research.

If you have any concerns or complaints, you may contact the University of Missouri Campus Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-9585 or umcresearchcirb@missouri.edu.

WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel under any pressure to enroll or to continue to participate in this study, you may contact the University of Missouri Campus Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-9585 or umcresearchcirb@missouri.edu.

You may ask more questions about the study at any time. For questions about the study or a research-related injury, contact Jan Akright at 409-673-7956.

Completing the survey indicates your consent to participate in this study. You may remove yourself from the study at any time without any problems.

Click here to begin the survey.

VITA

Jan Akright was born in 1964 to Brownie and Phyllis Lewellen. She has two brothers and three sisters and grew up in Perry, Missouri. She attended Burge School of Nursing (now Cox College) in Springfield, Missouri where she received a diploma in nursing in 1985. In 1989 she graduated from Hannibal-LaGrange College (now Hannibal-LaGrange University) where she earned a Bachelor's of Science in Nursing (BSN). Jan attended the University of Missouri-Columbia, Sinclair School of Nursing, completing a Masters in Nursing with in 2001. She has worked as a registered nurse in the Women's Care Unit at Hannibal Regional Hospital, Hannibal, Missouri in labor and delivery, postpartum, newborn nursery, level-two nursery, childbirth education, and as a breastfeeding educator. She began educating nursing students in 1990, and is currently the Academic Dean at Blessing-Rieman College of Nursing and Health Sciences in Quincy, Illinois. In 2019 she completed the requirements for a doctoral degree in nursing at the University of Missouri-Columbia, Sinclair School of Nursing. Her research focus was maternal-child nurses' judgements about types of fathers. She is married to Todd and has two children, Jill and Haley.