"I’m not the person carrying the babies, I’m the one who has to deal with the fallout" - An Interpretative Phenomenological Analysis of Fathers' Lived Experience of High-risk Pregnancy.

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A thesis submitted in partial fulfilment of the requirements of the

University of East London for the degree of

Professional Doctorate in Counselling Psychology

September 2023

Wordcount: 32, 998

Abstract

Pregnancy can be a rewarding yet stressful journey for both parents, but the experience can change significantly when high-risk pregnancy is involved. Whilst the literature has predominantly focused on the mothers' and babies' needs, attending to the fathers' needs during high-risk pregnancies has been neglected. This research aimed to examine the lived experience of fathers who have been through a high-risk pregnancy. Six participants who volunteered through social media, including Facebook and Instagram, were interviewed using semi-structured interviews. The transcripts were analysed using an Interpretative Phenomenological Analysis.

Four Group Experiential Themes (GETs) were identified: Man as a responsible being; Fathers equally deserve recognition and support; Quadruple 'Whammy' of Powerlessness and Coping behaviours that help to adapt and build resilience. The finding reveals novel insights, such as the powerlessness of returning to work whilst their families were in the hospital. The pandemic restriction resulted in the exclusion of fathers from the hospital but also offered the opportunity to work remotely and spend more time with their families after discharge. Internal and external barriers that affected the development of attachment with the babies were identified. The journey increased fathers' admiration for their partners and strengthened their relationship. Fathers have found psychological support helpful; however, they expected it to be individualised to their circumstances.

Findings highlight that high-risk pregnancy has negative implications for fathers, and when their needs are neglected and overlooked, the whole family's needs are ignored. Suggestions for service providers and mental health practitioners, including Counselling Psychologists, are made, emphasising the importance of including fathers in appointments, conversations and support throughout the pregnancy and mental health practitioners to draw from their

integrative skills to offer individualised psychological support that can help address their emotional distress, trauma, improve bonding with babies and empower them for transition into fatherhood.

Dedication

To all the fathers trying to cope on their own throughout high-risk pregnancy.

Acknowledgements

Thank you to the fathers who graciously volunteered their precious time to participate in this study and be interviewed about a very sensitive and difficult time in their lives. It has been a great privilege to have met you all, heard your stories and had the opportunity to represent your unique stories within my research study.

I am incredibly grateful to my thesis supervisor, Dr. Lucy Poxon, who dedicated her invaluable time to reading through every page of this thesis. Her patience and expertise have encouraged and guided me along this challenging journey.

Thank you to my two beautiful parrots, Apollo, and Sky. Although they are not among us anymore, every time I felt overwhelmed, their presence throughout the three years has filled me with love, strength and motivation to continue and finish the Doctorate.

A big thank you to my husband, Amir, who held my hand throughout and supported me in every way he could to make this path easier for me. I was always busy reading or writing assignments, and you tolerated and understood my circumstances.

A big thank you to my parents, siblings, and in-laws, who were my crucial supporters and have been proud of my achievements. Through every breath of encouragement and motivation, they helped me believe in myself and my abilities. Without your support, completing this programme would not have been possible.

Moreover, I would like to extend my appreciation to my friends Gry, Jenny and Maisha, Sarah, Christina, and Nomsa for being there, for the laughter, support, encouragement, and for their invaluable friendship. And a big thank you goes to our cohort for being supportive and always caring. I am grateful to have all of you in my life.

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Abbreviations

HRP High-Risk Pregnancy

LRP Low-Risk Pregnancy

CP Counselling Psychologist

CoP Counselling Psychology

NHS National Health Service

IAPT Improving Access to Psychological Service

HCP Healthcare Professional

IPA Interpretative Phenomenological Analysis

PTSD Post-Traumatic Stress Disorder

NICU Neonatal Intensive Care Unit

Terminology

Perinatal: The period from the beginning of pregnancy to one year following birth.

Postpartum: The period after birth.

Introduction

I have worked in Perinatal Mental Health teams for over four years and was struck by the predominant focus on the mothers and the invisibility of fathers in the Improving Access to Psychological Therapy (IAPT) and the Specialist Perinatal Mental Health Services (SPMHS). Some of the fathers I had come across communicated an interest in receiving support but did not know that support existed for them. Moreover, whilst supporting these parents with their distressing journeys, I noticed that fathers experienced further social inequalities from society, maternity services, and health professionals. Later, I found that a close family member had received a diagnosis of high-risk pregnancy (HRP) when expecting their first child, and I found myself reflecting on the experience of the father and the absence of support for him throughout the pregnancy. When researching HRP, I found a paucity of research on fathers' experiences.

A high-risk pregnancy is a significant public health challenge (WHO, 2015), and more than 20 million women are at risk globally, with an estimated 830 deaths per day (Alkema et al., 2016) and seven deaths per 100 000 deliveries in the United Kingdom (WHO, 2019). It is reported that 130,000 births are affected by common gestational complications yearly in the United Kingdom (KCL, 2022). Consequently, one would expect that HRP would be a terrifying and traumatic experience for fathers, who could be significantly affected upon receiving the diagnosis.

Studies reported that 5-10% of fathers experience depression, and 5-15% experience anxiety (Darwin et al., 2021) and the risk of suicide increases during the perinatal period (Quevedo et al., 2011). However, this statistic could be much worse when a diagnosis of HRP is added. For example, a report showed that 14% of fathers were at greater risk of Major

Depressive Disorder (MDD), and 8.1% showed symptoms of PTSD following HRP (Cole et al., 2016).

This study is informed by the Bioecological system theory, which asserts that children do not develop in isolation. However, their development is influenced by systems: microsystem, exosystem, mesosystem, macrosystem and chronosystem (Bronfenbrenner, 1979). His theory also argues that the child's development also influences their parents' development (Bronfenbrenner, 2005), meaning that fathers cannot be considered in separation from the child and the family system. This demonstrates the complexity of each family role and their interdependence on one another, such as the mother and father, father and child, and father, mother, and child. When one person in the family is affected, the whole system is affected, including the broader context. One could argue that neglecting the father's needs means neglecting the mother's and the baby's needs. Therefore, exploring fathers' experiences and recognising their needs is crucial, as inherent repercussions could impact the whole family.

Historically, there has been a lack of mental health support for men during the perinatal period and after their child's birth, with insufficient attention given to fathers whose partner is going through or has had an experience with HRP. The NHS long-term plan aims to support 5 – 10 % of fathers who experience mental health difficulties during and after pregnancy (NHS, 2018; Paulson & Bazemore, 2010). A perinatal competency framework has been developed, acknowledging that it is paramount to understand the father's mental health needs (HEE, 2018). As part of the plan, the services are encouraged to keep the fathers in mind and offer mental health support to them and the birth partners of women who access SPMHS. However, this plan seems to consider a referral for fathers only if their partners have been referred or need support from SPMHS and does not seem to consider the fathers on their

own. Although there has been an increasing call to include and support fathers and the recommendation for taking a family-centred approach to care, the existing literature, maternity services, and mental health services have predominantly focused on the mothers and the babies and the experience of fathers who have been through HRP has mainly been neglected.

Almost all participants who volunteered in this study have experienced their HRP during the pandemic, which has further marginalised them due to the stringent distancing rules and restrictions. In the United Kingdom, strict social distancing measures have been introduced following a national lockdown in 2020 that urged people to stay at home to protect the people and prevent the spread of the virus. The hospitals were among the first to implement the rules, which considerably changed the care policies for many people around the country and introduced visitor restriction policies, which led to the exclusion of fathers from antenatal appointments and visiting their babies in the NICU (Topping & Duncan, 2020; Sanders & Blaylock, 2021).

Given that the NHS's long-term vision is to work toward increasing fathers' access to psychological services and the increased number of clinical roles in the NHS employing Counselling Psychologists (Nielsen & Nicholas, 2016) situates Counselling Psychologists (CPs) in a great position to support fathers in several ways. They are likely to come across fathers in their clinical practice or work in perinatal services, which means they could use their extensive skills to offer person-centred interventions to support fathers' emotional needs, empower and improve their confidence in parental involvement and prepare them for transition after the discharge. Counselling Psychology (CoP) has its roots in humanistic values and views the person beyond attaching a label to their emotional distress (Rizq & Target, 2008a). Consistent with their values, CPs could work in perinatal mental health

services and advocate for fathers' unique experiences through liaising with maternity services and offer training to HCPs to raise awareness about fathers' needs and encourage them to work toward understanding fathers' experiences and facilitating growth (Douglas et al., 2016).

The insufficient research in capturing their lived experience inspired me to take an Interpretative Phenomenological Approach (IPA) to explore the lived experience of fathers with HRP and offer fathers an opportunity to voice their unique stories and enhance our understanding of their experiences and needs, particularly how the COVID pandemic has impacted their experience. This research explores how fathers make sense of their lived experience of HRP. Therefore, it is believed that exploring fathers' unique experience of HRP is particularly important to the field of CoP. Moreover, this research will use the third person to describe the content in each chapter and the first person to describe the reflective processes to maintain academic professionalism and help the readers differentiate between reflexivity and the content.

Several key research findings made a distinctive contribution to understanding fathers' experience of HRP. Firstly, fathers had to deal with the uncomfortable dilemma of returning to work while their families suffered in the hospital. Secondly, COVID-19 exacerbated the powerlessness following exclusion from the hospital yet, at the same time, brought a blessing of extended leave during the national lockdown. Thirdly, several barriers delayed the formation of attachment with their babies. Lastly, the nature of the HRP strengthened fathers' relationship with their partners.

Chapter One
Literature Review

1.1. Overview

This chapter will critically review the literature relevant to fathers' experience of HRP. The chapter begins with the definition and the list of medical complications that are known to be high-risk. This study is informed by the Bioecological system theory (Bronfenbrenner, 1979), which will be introduced in this chapter. The role of fatherhood is summarised within the 'hegemonic' (Connell, 2003) and 'caring' masculinity (Lee, 2009) indexed by how society's perception has changed over the years. The literature review would extend to presenting an overview of fathers' emotional experiences, responsibilities and involvement in caretaking, the attachment between fathers and babies, the relationship between partners, fathers' experience of support services and the coping behaviours they utilise to help them get through the challenges that arise during HRP. Moreover, the chapter explores fathers' rights regarding statuary paternity leave, followed by how the COVID-19 pandemic might have influenced their pregnancy experience. Then, the chapter concludes with the research question addressed in this research study.

1.2 Defining High-Risk Pregnancy

There is no universally agreed definition of what constitutes a "high-risk pregnancy." A high-risk pregnancy is an umbrella term for complications experienced during or after pregnancy, which could threaten the life, health and welfare of the mother, the developing foetus or both, increasing the risk of morbidity or mortality before, during or after birth (Dangal, 2007). It can develop due to a chronic condition that predisposes women to complications during pregnancy or an unexpected medical complication that arises through pregnancy (Bayrampour et al., 2013; Lee, 2014).

High-risk complications can be categorised into medical and obstetrical difficulties. There are many medical complications, including but not limited to heart disease, thalassemia, cancer, and systemic lupus erythematosus, whilst obstetrical complications include pregnancy-induced hypertension, gestational diabetes, preeclampsia, placenta praevia, a raised BMI, and expecting multiples, including twins and triplets (Tanasirijiranont et al., 2019; Badakhsh et al., 2020). Pregnancy is also classified as high-risk when the labour begins before 37 weeks or after 42 weeks gestation (BSUH, 2016). A brief definition of these medical complications is given in Appendix A.

A scoping review found 15 published research studies on fathers with HRP from 1994 to 2019, 11 of which were conducted in high-income and the other 4 in low-income countries (Jackson et al., 2022). However, other studies have been found that have not necessarily used HRP as terminology, but the medical complications, such as premature babies, may come under the category of HRP. On the other hand, a systematic review used a high threshold score of 61% and above and found 17 published studies between 2006-2017 that targeted the psychological experience of women with medically complicated pregnancies (Isaacs & Andipatin, 2020). However, more research could have been conducted before 2006 and after 2017 that was not included in the study.

Almost three decades have passed, yet only a small number of studies focused on the experience of fathers with HRP, most of which are conducted outside the United Kingdom. The population included in most of these studies were native speakers who could read and write in their first language, thus indicating non-diverse populations. Interestingly, the experience of trauma is almost entirely researched by nurses and midwives trained in medical models and physical health. Hence, the existing literature is overwhelmingly informed by the medical model and ignored mainly by psychology researchers who could bring a

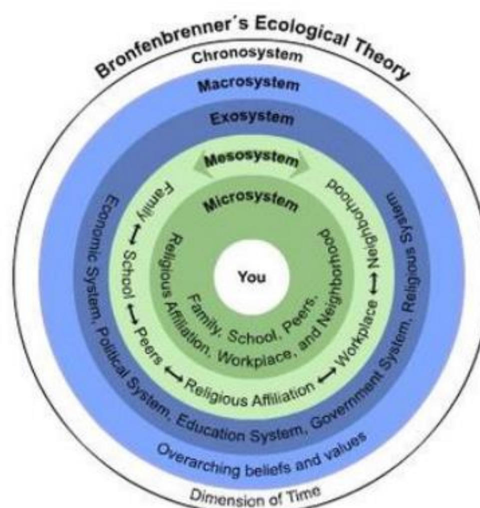
psychological theoretical lens to the research to understand fathers' experiences. One could argue that the medical model is reductionist and fails to acknowledge the complexity and impact of family systems and the wider context on fathers. This research will address this gap in the literature by drawing from a psychological theory to emphasise the complexity of relationships and family systems, which could bring an additional perspective to understanding fathers' experience and complement the medical model.

1.3 Bioecological System Theory

Bioecological system theory (Bronfenbrenner, 1979) has informed this study as fathers' experiences cannot be understood in separation from the family system. While it is helpful to put the baby at the centre of this model to understand how HRP and the complications impact the whole family, this study places the father at the centre to demonstrate how the exclusion of fathers and neglecting their needs could affect the entire family system (See Figure 1).

Figure 1

Bronfenbrenner's ecological systems theory



Note. Adapted from *Influences of the Ecological Systems Theory Influencing Technological Use in Rural Schools in South Africa*, by Herselman et al., 2018, P. 4. Copyright 2018 by Herselman et al.

The microsystem comprises the close relationships and interactions a father has with people in their surroundings, including romantic partners, children, parents, friends, co-workers, etc. There appears to be a bi-directional influence where others can affect the father, but also the father can affect the people in his surroundings.

The mesosystem encompasses the relationships among the father's microsystems, including the relationship between his partner and her midwife. These relationships can impact the stressors present in the father's environment. At the same time, the father's interactions with each system in the microsystem impact the whole system.

The exosystem is the more extensive social system in that the father does not have a direct interaction, yet he could feel the positive and negative impacts placed upon him. These could be policies around work and hospital visitors.

The macrosystem encompasses cultural values and laws and spirally impacts all the other layers' interactions (Berk, 2000b). For example, the culture that fathers grow up in influences their beliefs about masculinity, being a father and having a family, hence the importance of understanding how fathers experience HRP in the UK.

Lastly, the chronosystem looks at the dimension of time and all the changes and significant life events that influence a person's development. For example, the shift in perception from considering men as breadwinners to supporting their partners and being more involved in caretaking is an example of how the chronosystem impacts the father. Moreover, life events such as medical complications and having premature babies can significantly impact the father.

1.4 Masculinity and Fatherhood

Understanding masculinity could help us understand fatherhood due to the complex interplay between the two, as it could be too simplistic to separate them from one another. Fatherhood is complex, and different factors guide fathers' transition to fatherhood. Nevertheless, it is argued that the literature ignores many aspects of fatherhood and the critical factors that play a role in paternal involvement with their child (Lamb, 1987).

Historically, fathers were recognised as the 'breadwinner' of the family, which appeared to be the fundamental foundation of their identity (Hanlon, 2012; Medved, 2016). A 'good' father could provide for their family (Lamb, 2000; Miller, 2011), placing fathers within the traditional model of hegemonic masculinity (Connell, 1988). Whilst there is an ongoing debate about what differentiates hegemonic masculinity (Connell & Messerschimdt, 2005), the model approached men and their behaviour from a patriarchal perspective as the most desired masculinity (Connell, 2005). They are described as being successful, strong, in control and unemotional, and even if men do not live according to hegemonic masculinity, they could be conscious of its existence (Connell, 2005).

Moreover, in Western society, several characteristics have been attributed to men, such as suppressing needs, denying vulnerability, needing emotional and physical control, being strong, dismissing support, aggressive behaviours, and problem-solving (Courtenay, 2000; Gillon, 2008). This perception conveys different gendered attitudes among men and women (Addis & Mahalik, 2003). One could argue that this perception of putting men into categories fails to acknowledge individual differences.

Over the years, the role of fathers has changed to adopting a 'caring masculinity', suggesting that bringing up children is an activity that involves both parents (Lee, 2009), and fathers are fundamental to the family in way more than providers (Gettler et al., 2020). It is

recognised that men can adopt traditionally considered feminine characteristics, such as expressing their emotions, being sensitive, caring, etc., without rejecting their inner masculinity (Elliott, 2015). The shift in expectations reveals that fathers also have an opportunity to be involved at birth and in the caretaking of their babies (Latshaw & Hale, 2015). Simultaneously, they are expected to remain strong, provide for their families and shoulder more responsibilities during pregnancy, childbirth, and childcare (Draper, 2003; Phares et al., 2005; Yeung, 2012).

Once an official diagnosis of HRP is given, mothers may require hospitalisation or bed rest at home. The unanticipated medical complications and activity restriction for the mother could increase the father's stress and exert pressure on him to fulfil several roles and responsibilities (Condon et al., 2003; Mirzakhani et al., 2020; Morse et al., 2000). Accordingly, HRP can be stressful for both mothers and fathers and lead to losing control over the situation. Studies found that fathers tended to put their needs aside and prioritise their partners' and babies' needs, thus coping with the number of responsibilities through a change of focus from self to others (Maloni & Ponder, 1997; Pohlman, 2005). For instance, Hsieh et al. (2006) interviewed six Taiwanese fathers whose wives have received tocolysis (delaying birth) in the hospital. Their findings revealed that fathers' decisions were shaped by prioritising the babies. However, one could question the quality of this study and argue that its sample size is smaller than recommended for content analysis (Moser & Korstjens, 2018). The decision regarding the sample size and data saturation has not been discussed.

Some fathers reported feeling guilty for not being able to share the burden of the mother (Lindberg & Engström, 2013) and needed to control and conceal their feelings from their partners to appear strong and protect their families (Patel et al., 2018). As a result, the pressure to maintain a masculine identity and have a place in society under such a stressful

experience could impact fathers' perception of themselves and their emotional well-being. One could assume that focusing on the mother relegates fathers to supporting their partner and adopting multiple roles (e.g., managing household chores, work, and supporting their partners and babies). The re-organisation of the role and neglect of own needs could put fathers at greater risk of mental health difficulties (Patel et al., 2018). This demonstrates that gender and expectations developed by self or imposed by society can inform fathers coping with HRP.

The research argues that these demands exert additional pressure on fathers, and they may feel torn between managing pregnancy, household activities, supporting their partner, and wanting to be present for the babies (Lindberg & Engström, 2013). Some of these adopted roles may seem unfamiliar, yet there is an expectation that they should fulfil them when confronted with a crisis. Therefore, it is essential to understand these roles better, the relationship between them and the meanings fathers attach to them, which could enhance professionals' understanding of fathers and assist the healthcare system in developing support that specifically targets 'dads' needs.

1.5 Emotional Experience of Fathers

Over the decades, research has suggested that becoming a father brings up various changes and concerns for men, including role conflict, new identity due to the loss of their former life, and change in lifestyle, responsibilities, and relationships (Baldwin et al., 2018; Darwin et al., 2017), all of which could lead to emotional difficulties.

Pregnancy, in general, can be a rewarding journey where fathers may experience feelings of happiness, excitement, and joy (Baldwin et al., 2018; Ekstrom et al., 2013). Conversely, pregnancy can also evoke a range of emotions in fathers, such as worry, stress, confusion (Campbell & Field, 1989), anxiety, depression (Fenwick et al., 2012), panic attacks

and phobias (Baldoni & Giannotti, 2020). However, it is argued that this is much worse when HRP is diagnosed (Daniels & Chadwick, 2017).

Several studies have reported that fathers experience consistent emotions during HRP, such as shock, fear, anxiety, worry, depression, sadness, loneliness, disappointment, stress, mental exhaustion, and loss of control (Bratt et al., 2015; Dollberg et al., 2016; Hynan et al., 2013; Koppel & Kaiser, 2001; Matthey et al., 2003; Widarsson, 2015). This shows that fatherhood, along with HRP, can bring many challenges and emotional changes, meaning that this journey not only jeopardises the mother and the baby but also significantly affects the father both physically and mentally as he begins to switch roles within the family to look after their partner, children, and the house (Gupton & Heaman, 1997), thus making their adjustment to fatherhood difficult (Russel et al., 2014). Accordingly, it is argued that these stressors could impact their day-to-day life, including their work, relationships, behaviours and interactions with themselves, their partner, and the broader social network.

A combination of quantitative and qualitative studies has demonstrated that fathers' poor mental health, including depression, if not addressed, could lead to father-child conflict (Kane & Garber, 2004) and have a long-standing impact on children, particularly on early behavioural and emotional development and psychosocial well-being (Ramchandani et al., 2008; Kvalevaag et al., 2013), which overall, could affect the well-being of the family (Goodman, 2004; Price-Robertson, 2015). This finding emphasises that fathers are important to the development of their children, and supporting them throughout can help minimise the negative impact on the children. However, despite the psychological impact on the fathers and children and the importance of recognising their needs, studies concerning fathers' needs following HRP are under-researched.

Moreover, Tanasirijiranont et al. (2019) aimed to explore the processes of first-time expectant fathers following a HRP using Grounded Theory. They interviewed 23 first-time expectant fathers in Thailand, focusing on understanding their experiences, interactions, actions and how they coped during this period. One of their findings suggests that fathers experienced worry and uncertainty about their partners and unborn babies during HRP. Based on the four quality criteria (Yardley, 2000), although their research demonstrates *rigour, commitment,* and *sensitivity to context* through the detailed interview and rigorous analysis using triangulation, one could question the quality of this study as they have failed to demonstrate *coherence and transparency* through not evidencing their philosophical underpinning and reflexivity in their study, which in turn lead to little insight about the processes and fails to have an *impact and importance*.

Additionally, their study focused on first-time fathers, which raises the question that experienced fathers could also go through similar emotions and challenges in subsequent pregnancies, given their previous experiences. For instance, Darwin and colleagues (2017) compared first-time and subsequent fathers' experiences of LRP in the UK. They found that although subsequent fathers were familiar with and equipped by their past experiences, they were still concerned and anxious about birth and challenges with looking after children from current or previous relationships. This may be much worse for fathers with HRP, mainly if their previous experiences have been traumatic. Additionally, some fathers may have had LRP, but they may experience HRP during their subsequent pregnancies, which could be unfamiliar territory. Therefore, it is also crucial to explore the experiences of fathers who have older children.

Childbirth appeared to be a traumatic experience for fathers, as they felt vulnerable and fearful of what could happen to their partner and the baby. Fathers have reported feeling

powerless, helpless, and conflicted when waiting for their babies to be born (Patel et al., 2018). It appeared that worries and powerlessness did not end after birth, as the mother and the baby may have required care in the hospital, which could have been traumatic for the parents. For example, both parents who had their babies in the NICU described the environment as stressful (Ionio et al., 2016) and were at higher risk for depression, stress, anxiety, and PTSD than the general population (Arnold et al., 2013; Hynan et al., 2013; Koliouli et al., 2016). Fathers also reported fear of losing their jobs, separation from their partners and the babies and lack of knowledge about the NICU experience, which is reported to have affected their coping abilities to deal with a crisis (Shahkolahi et al., 2018).

Moreover, both parents reported experiencing grief reactions toward the hospitalisation of their babies in the NICU. However, these reactions are reported to be expressed more by mothers and not so much by fathers (Zamanzadeh et al., 2013). One could argue that lack of acknowledgement of fathers' role and their exclusion from care could place fathers at risk of suffering alone whilst being confronted with all these challenges, and their psychological well-being could be neglected. This study will attempt to explore and understand how and why fathers might experience grief reactions.

1.6 Relationship with the Baby

Bowlby's attachment theory (1969) has long privileged the role of the mother-infant relationship and described the father's role as ambiguous. However, fathers play a crucial role in their child's physiological, neurobiological, emotional, social, psychological, cognitive, and behavioural development (Hall et al., 2014; Lamb, 2010; Walmsley & Jones, 2016). Their involvement could increase their children's self-esteem, help them form better friendships, and obtain higher educational achievement (Layard & Dunn, 2009). Therefore, the fathers' presence and their role in showing support and love for their babies are as

important as the mother's presence (Arshadi et al., 2014), and their absence not only seems to impact the fathers but could leave negative repercussions on the babies.

Bowlby (1969) suggested that the first six months post-birth are crucial in developing a strong emotional bond between the primary caregivers and the baby. On the contrary, Brandon et al. (2009) argue that parent-infant attachment begins during pregnancy between the growing foetus and the parent. However, fathers reported that they could only perceive the pregnancy as real when they could see the ultrasound pictures, listen to the baby's heartbeat, and touch and feel the baby's movement (Tanasirijiranont et al., 2019). In contrast to the mother who might bond with their baby as soon as they find out about the pregnancy (Atashi et al., 2018) and when she feels the baby's movement (Flenady et al., 2019), the bonding between the father and the baby could develop gradually and strengthen at later stages of pregnancy and after birth (Awhonn et al., 2009), suggesting that the developing attachment can be different between parents.

Moreover, Klaus and Kennell (1984) propose that the first hour seems crucial to developing this bond, demonstrating the importance of having close contact with the baby from the beginning (Tessier et al., 1998). Therefore, physical contact with the baby is a crucial precursor to forming a strong attachment (Bowlby, 1969). When fathers go through HRP, they may experience additional stressors that could impact how soon they develop attachments with their babies. For example, Tanasirijiranont et al. (2019) found that most fathers did not prepare baby items due to uncertainty and fear that something would happen to their baby, thus affecting the bonding process. Additionally, most parents may not be psychologically prepared to give birth to a premature baby; hence, the birth process can be a frightening experience and can significantly impact their relationship with their babies (Ringler et al., 1978). In one study, fathers appeared less emotional and interactive than

mothers, partly due to the baby's fragile physical appearance, which hindered physical contact and interfered with their attachment to their babies (Walmsley & Jones, 2016).

Studies have shown that allowing, training, and preparing fathers to contribute to their baby's care in the NICU setting can significantly reduce fathers' anxiety levels (Mianaei et al., 2014). However, hospitalisation of babies in the NICU could mean that parents have restricted contact and may be required to follow specific guidelines to be able to physically touch their babies (Cummings, 2019; Shahkolahi et al., 2014; Walmsley & Jones, 2016), which indicates that their bonding with their babies could develop slowly. Consequently, it can be argued that a lack of preparation, support and knowledge can significantly impact fathers' psychological well-being and their interaction with their babies.

The bonding between fathers and babies has received little attention compared to the bonding between mothers and babies (Holditch-Davis & Miles, 2000). This could be due to the emphasis on bonding between mothers and babies. The association between a father's and children's mental health accentuates the need to understand how fathers experience bonding and enhance HCP and mental health practitioners' understanding that mothers and fathers experience psychological distress differently and that supporting fathers is equally important (Ramchandani et al., 2005).

1.7 Relationship with Partner

It is suggested that the father's role may depend on his relationship with the mother of his children (Lewis, 1990), emphasising that the couple's relationship is vital for the well-being of the three generations. While some men have expressed their respect and appreciation for their partner (Sapkota et al., 2012), a large body of research on LRP documents that father's relationships with their partners can change during their transition to parenthood, meaning that they have less time as a couple, and feel more distant (Boyce et al., 2007;

Darwin et al., 2017). Moreover, there has been an association between parental stress among fathers and poor marital relationships (Boyce et al., 2007). For example, Edie and Loewenthal (2007) found that all five participants felt the baby impacted their relationship with their partner. Additionally, Lee (2009) reported that one in five relationships ended the first year after their babies were born. Accordingly, the literature argues that the loss of previous closeness and relationship strain adds additional pressure on fathers to support their partner in her new role.

Conversely, little is known about marital relationships during HRP. For example, Trause and Kramer (1983) reported a higher divorce rate in the first year after giving birth to HRP. Moreover, Mirzakhani et al. (2020) reported that lack of or discontinuation of sexual intimacy among couples during HRP influenced their marital well-being. Nevertheless, this study focused on mothers, and it is not clear how fathers make sense of this reduction or lack of sexual intimacy during HRP. Another study reported that fathers of preterm babies were at greater risk of depression when they had relationship problems and financial difficulties in meeting the essential needs of their families (Winter et al., 2018). In comparison, a recent qualitative study reported that the increased risk during pregnancy strengthened the father’s relationship with the mother and the unborn baby (Buck et al., 2020). However, this study was conducted in the United States, and no studies have explored the relationships between partners in the UK. Hence, little information is available regarding the impact of HRP on fathers’ relationships with their partners.

Given the importance of the pregnancy, Scopesi and colleagues (1990) suggested that providing psychological support to couples before the arrival of their first child can help them come to terms with their feelings about three generations of their families, including their parents, themselves, and their expected child. Given that the journey of HRP can be

challenging, which could put a strain on the relationship with their partners, it is essential to explore fathers' relationships throughout pregnancy, which could then help mental health practitioners to address fathers' emotional states during and after HRP, as emotional support could alleviate a range of feelings such as worry, stress, and helplessness. Additionally, it could increase the sense of empowerment, which could help fathers better support their partners and children.

1.8 Experience of Support from Services

Fathers are often expected to support their partners and protect their babies, but they have no one to support them (Hajikhiani et al., 2018; Tanasirijiranont et al., 2019). Therefore, HRP could be anxiety-inducing for many fathers, which could have a multifaceted impact on their lives. Several studies have demonstrated that fathers have felt neglected, unprepared, excluded, devalued, and reported a lack of communication from HCP regarding the risk to their partners and babies (Lindberg & Engstrom, 2013). The absence of communication led to feeling unprepared for the worst possible outcomes, leading to anxiety and powerlessness (Kaye et al., 2014). A study conducted in Israel further supported this finding and showed that fathers of premature babies were more likely to develop depressive symptoms; however, their depression stayed for longer than the mother, which seemed to have stemmed from the absence of support (Elder-Avidan, 2011).

The lack of acknowledgement of the traumatic experience of HRP and support for the fathers to manage this trauma can prevent them from seeking emotional support for themselves (Moore et al., 2018). A survey explored parents' experiences in neonatal care across England and reported that parents were not offered emotional support. The information about their babies, medical conditions, treatment plans, and parent support groups was insufficient (Miss et al., 2015). Fathers may benefit more if medical health

professionals could be more active in providing information about the condition and psychological services and validating the fathers' experiences.

Effective communication and information sharing about the baby or partner’s condition were important in relieving fathers’ anxiety, increasing the perceived control over the situation, and alleviating their fears (Arockiasamy et al., 2008; Hollywood & Hollywood, 2011). However, several fathers found communication and information sharing inconsistent and inadequate. They expressed that lack of effective communication and support led to negative feelings such as stress, helplessness and increased insecurity, alienation, and role ambiguity about what could happen and how to support their families (Hollywood & Hollywood, 2011; Kaye et al., 2014; Lindberg & Engström, 2013). The exclusion, absence of support and lack of communication during pregnancy and after birth could be perceived as an additional burden and seems to exacerbate fathers’ stress, impacting their help-seeking behaviours (Aarnio et al., 2018; Hsieh et al., 2006; Moore et al., 2018). As a result, their abilities to support their wife and baby are hindered, consequently affecting their mental well-being (Boyce et al., 2007; Plantin et al., 2011).

Fathers stressed the importance of being acknowledged, receiving support and improved communication from HCPs (Koppel & Kaiser, 2001). Having more knowledge and adequate information from HCPs can help fathers feel secure and become more involved in their baby’s care (Walmsley & Jones, 2016). This information could help fathers feel in control at the beginning of the NICU stay, enhance a sense of security, improve their involvement in the baby’s care, and cope better, which in turn helps them better support their partners (Patel et al., 2019). Nevertheless, fathers’ experience of HCP was different, and they reported that they did not have the knowledge, skill, and emotional support to interact with their premature babies (Jouhki et al., 2015; Vallin et al., 2019). This finding indicates that a

lack of information and support can significantly impact the father's mental health, and they may need to deal with these emotions during the postpartum period alone (Jouhki et al., 2015).

1.9 Coping Strategies

While studies may describe how fathers emotionally feel during this period, there is insufficient knowledge about how they cope and how psychological services support fathers' mental well-being during HRP. This area is largely neglected in the broader literature that requires further attention.

The findings in the existing literature indicate that fathers have different needs and may use different coping strategies compared to mothers (Henwood & Procter, 2003). Pinelli (2000) reported that fathers used fewer coping strategies in social support than mothers. One could argue that men adhere to traditional masculine beliefs reinforced by society, such as the need to cope alone, which could create a sense of isolation.

Several different strategies are reported to help fathers cope with the stress of HRP and maintain a sense of control whilst staying in the NICU, such as exercising, going to work, spending time outside the NICU, distraction, hiding their feelings, attending religious gatherings, solving problems and regulating emotions through calming oneself (Arockiasamy et al., 2008; Provenzi & Santoro, 2015; Shaver & Mikulincer, 2002; Strauss et al., 2019). Although for some fathers, returning to work served as a distraction, for others, it added to their distress (Hollywood & Hollywood, 2011).

Research has shown that sharing experiences with others seems crucial and found that fathers actively sought emotional support from immediate family, friends, colleagues, support groups, books, and online resources (Bratt et al., 2015; Hsieh et al., 2006; Sloan et al., 2008;

Strauss et al., 2019). Although most fathers described a range of support networks that have helped them get through HRP, the literature has indicated the scarcity of research on fathers' coping strategies and specific resources tailored to address fathers' needs and preferences. Moreover, it is unclear in the literature how fathers have coped during the COVID-19 pandemic, particularly during the national lockdown. This remains a significant area for further research.

1.10 The Statutory Paternity Leave

The statutory paternity leave on the government website (n.d.) indicated that until July 2022, employed fathers could only take a maximum of two weeks of paternity leave, and this amount was the same for all fathers regardless of their circumstances. The paternity leave had to be taken within 56 days of the birth, and there was no consideration for fathers with complicated pregnancies.

Fathers who go through HRP may need to deal with medical complications, meaning that their babies or partners may require crucial intensive care for weeks or sometimes months before they can be discharged from the hospital. Hence, this could place the fathers under pressure to take their paternity leave as quickly as possible against their wishes or return to work whilst their families are at risk. Understanding how fathers make sense of and perceive their experience of returning to work while their families are fighting for their lives in the hospital is crucial.

A Scottish charity, Bliss, originally founded by parents of premature birth and sick babies, has campaigned and advocated for fathers whose babies require NICU stay. In July 2022, the government released a new law (Neonatal Care (Leave and Pay) Act, 2023), acknowledging that fathers whose babies require additional support in NICU after birth are entitled to 12 weeks of paid leave to be able to spend more time to offer crucial care to their

babies. While this is a huge step taken to support fathers, the new law fails to recognise that there are fathers whose partners go through critical conditions and require hospitalisation for some time, meaning the father may need to care for the baby alone. Thus, even with the new law, there will be fathers whose unique circumstances will not be considered by their employers and will be further marginalised.

1.11 Changes Introduced by the Pandemic

The pandemic has introduced significant changes to maternity services in the UK. After the announcement of the first lockdown in 2020, local authorities have introduced visitor restriction policies and enforced social distancing in healthcare settings, including maternity services, to protect individuals (patients and staff) and prevent the spread of COVID-19 (RCOG, 2020; Topping & Duncan, 2020; Sanders & Blaylock, 2021). One way to reduce the transmission was to prohibit fathers from attending antenatal appointments and, in some hospitals, prevent them from being present at birth (Andrews et al., 2022). Moreover, fathers and birth partners were not permitted to stay after birth, and it has been reported that many NHS services removed the partner visiting rules (Sanders & Blaylock, 2021). Most maternity services have excluded fathers and birth partners (NHS, 2021), meaning that fathers have missed important appointments (Lista & Bresesti, 2020). This indicates that many mothers had to go to these appointments alone, which has prevented fathers from supporting their partners, being part of this journey and spending time with their babies.

Having a retrospective understanding of fathers' experience of HRP could help practitioners, medical professionals, and policymakers gain insight into the short and long-term consequences of excluding fathers from appointments, birth and staying in NICU and the importance of offering and considering mental health support. It is hoped that having this insight could help the local authorities, hospitals, and policymakers become more conscious

of the impacts and plan more thoughtful and inclusive care should unprecedented circumstances occur.

1.12 Research Questions

Whilst many researchers have argued the need to increase support for fathers (e.g., Ramchandani et al., 2005; Fletcher et al., 2008), the existing literature has shown that lack of knowledge about fathers' experience and the emotional challenges of HRP and absence of specific idiosyncratic emotional support for fathers, has meant that fathers were seldom allowed to provide a personal account of their journey of HRP. Throughout the literature, the idea that fathers' needs are neglected or unheard (Kaye et al., 2014; Lindberg & Engstrom, 2013) indicates that they could benefit immensely from being recognised, acknowledged, and receiving support from maternity services and psychological practitioners, including CPs.

Having reviewed the literature on fathers with experience in HRP and identifying conceptual themes, several gaps are identified, which may benefit from further research. Firstly, it is imperative to understand fathers' unique experiences of HRP and the associated stressors to understand better ways of supporting them. Secondly, as most studies have paid little or no attention to ethnic diversity, it would be beneficial to invite cultural diversity to understand how cultural issues could shape fathers' experience and adaptation to HRP. Thirdly, the global pandemic and the restriction have excluded fathers from attending hospital appointments. It is important to understand how the pandemic shaped their experience of HRP. Fourthly, most studies outlined in this chapter are conducted mainly by the midwifery and nursing teams outside the UK. They primarily focused on fathers' experience of premature babies during pregnancy or when admitted to the NICU. Lastly, this research aligns with the NHS's long-term plan to increase access for fathers and birth partners to psychological support, emphasising the importance of including fathers in the

support and services. This client group does not benefit from equal access to support and resources, including psychological support. Therefore, further research is crucial to understand the experiences of fathers better.

The studies reviewed in this chapter are predominantly qualitative, and the three dominant methods used were content analysis and thematic approach. The absence of enough studies and support for fathers with HRP highlights the importance of understanding the meaning fathers attach to their experience of HRP. A study of this nature lends itself to a qualitative approach. Therefore, this study needs a research method that reflects and adheres to meaning-making and how fathers make sense of their experiences during HRP and following giving birth. An IPA is a compatible methodology as it places sense-making at the heart of learning about fathers' relationship to their world (Smith et al., 2021). Therefore, an IPA study is considered to explore the following primary and secondary research questions:

- How do fathers make sense of their experience of HRP?
    - How does the experience of being a heterosexual couple make a difference to this experience?
    - How does ethnic diversity make a difference to this experience?
    - How does the experience of pandemic lockdown make a difference to this experience?
    - How does bioecological systems theory help to explain fathers' experiences?

Chapter Two

Methodology

2.1 Overview

This chapter provides the rationale for choosing IPA as a suitable methodological approach to meet the aims of the study and offer fathers a voice to help the researcher make sense of their experiences. This chapter introduces the epistemological stance and the research design detailing sampling, recruitment process, quality assessment requirements, ethical consideration, data collection, analysis and reflexivity.

2.2 Research Paradigm

The research process is underpinned by learning the philosophy of science and how knowledge is acquired (Grix, 2014; Ponterotto, 2005). It is crucial that the researcher reflects on their epistemological position and the complexity of research paradigms whilst acknowledging that there is often no definite distinction between them (Madill et al., 2000; Willig, 2013). Understanding a paradigm can help the researcher reflect on the existing problem and guide them to use their beliefs to understand the world (Fraser & Robison, 2004; Ponterotto, 2005).

In quantitative studies, researchers adopt a realist ontology and a positivist paradigm, while qualitative research often tends to be informed by a relativist ontology and critical realist, constructivism-interpretivism paradigms (Ponterotto, 2005). Researchers might move between different paradigms; however, for each research, they are encouraged to adopt a position that matches their ontological and epistemological stances and communicates the beliefs guiding their research (Hays & Wood, 2011). Such awareness can help build the

foundations of a study and influence methodological choices (Denzin & Lincoln, 2000; Morrow, 2007).

As the current study aimed to capture the lived experience of fathers with HRP, a critical realist stance is adopted, which is positioned between realism and relativism (Willig, 2013). The researcher acknowledges that reality exists independently of humans' perceptions and thoughts (Bhaskar, 1990). In this case, the diagnosis of HRP is perceived as a 'reality' that can be observed and measured using the medical model. However, the researcher acknowledges that each person approaches reality from their perspective and experiences this journey differently depending on their subjective experiences, which are influenced by multiple factors such as their history, culture, and life experiences (Bhaskar, 1990; Willig, 2013). Therefore, HRP is phenomenologically experienced, and each father experiences it in their own way, depending on the meaning they ascribe to it.

As a critical realist, the researcher does not intend to pursue discovering a single truth but instead tries to understand the phenomenon grounded in the individual's experience (Pringle et al., 2011). Therefore, accessing reality and one's experiences with complete certainty is impossible and complicated (Guba & Lincoln, 1994; Morrow, 2007), and making sense of the participant's experience is achieved through a hermeneutic circle of meaning-making and interpretation (Larkin & Thompson, 2012; Maxwell, 2012; Willig & Rogers, 2017). Thus, epistemological beliefs are believed to align with interpretative phenomenology (Willig, 2013).

2.3 IPA Versus Other Qualitative Methodologies

Following the formulation of the research question and reflection on the epistemological stance (Willig, 2013), three qualitative methodologies: Narrative Analysis (Reissman, 2008), Discourse analysis (Jorgensen & Phillips, 2002), and IPA (Smith et al.,

2021) were considered to help reflect on the type of knowledge and find the most compatible approach with the research paradigm and epistemological position.

Discourse analysis was considered, as the core focus is on understanding how individuals use language to describe the underlying meaning behind their stories (Bondarouk & Ruel, 2004; Willig, 2013). This approach appeared to be a suitable methodology to scrutinise the language fathers use to reveal the hidden assumptions and how they produce meanings for their experience of HRP. However, discourse analysis perceives language as the truth and emphasises that reality is socially constructed; therefore, individuals use discourse to construct their versions of the world (Willig, 2013), which does not satisfactorily address the aim of the study and does not align with the researcher's epistemological views that there is a reality that is subjectively experienced.

Narrative analysis was also considered as it shares a similar focus with an IPA on how individuals make sense of their world through their stories (Murray, 2003; Reissman, 2008). The narrative analysis appeared to be a suitable methodology, given that narratives are a powerful tool that could help fathers talk about their world and give meaning to their experience of HRP. Similarly, narrative analysis adopts a social constructionist epistemological approach that claims there are numerous realities and individuals construct their reality through their stories (Berger & Luckmann, 1966), which conflicts with the researcher's critical realist stance.

Subsequently, phenomenological methods were considered, as the core focus is on the participant's lived experience, perception, and attitude toward the phenomenon (Willig, 2013). Phenomenology is not interested in exploring the causes but in understanding what constitutes the human world and how an individual might use interpretation to understand what it is like to be a human being to live in the world (Langdridge, 2007; Smith et al., 2009).

Therefore, Phenomenology is interested in understanding the experiential meaning of various types of experience, including thoughts, memory, emotions, bodily awareness, and perception (Chemero & Kaufer, 2015). In doing so, phenomenological researchers attempt to describe and interpret how the person perceives reality, which could produce rich information about how the individual makes sense of their unique experiences (Willig, 2013).

There are two types of phenomenology: descriptive (Husserlian) and interpretative phenomenology (Heideggerian). Descriptive phenomenology focuses on describing individuals' lived experiences and argues that it is possible to use epoché or bracket all the assumptions, preconceived ideas, and interpretations relating to the phenomenon to avoid contamination of the meaning of a particular experience (Giorgi et al., 2017; Willig & Rogers, 2017).

Interpretative phenomenology draws from hermeneutic theory and argues that description cannot be separated from interpretation (Willig, 2013). Through language, words, and interpretation, the researcher can translate the meaning and understand one's experience (Smith et al., 2021). Heidegger (1927) posits that consciousness could not be seen as separate from the world but formed through historically lived experience. Therefore, pre-understanding is a necessary aspect of being in the world, which entails the organisation of culture before one comes to understand and be part of the historical background. Hence, people cannot completely put pre-understanding aside as they carry them within themselves (Laverty, 2003). It argues that human beings exist in relation to culture, people, language, and objects (Heidegger, 1927, as cited in Chemero & Kaufer, 2015). Thus, they are influenced by their historical background and use interpretation in every encounter to understand the world. Although the researchers are encouraged to attempt to bracket their assumptions and biases, they will use interpretation to provide meaning to their participants' accounts while

simultaneously reflecting on how their presuppositions might position and influence them in their research (Willig, 2013).

The philosophical underpinning of phenomenology asserts that there are multiple experiential worlds (Willig, 2012), and the same situation (such as HRP) can have different meanings and is experienced differently by individuals. This indicates that there is no single way of interpretation, and the researcher has the epistemological flexibility (Larkin et al., 2006) to uncover a detailed understanding of the phenomenological experience through interpretation. This approach does not discount the existence of psychological structures but believes that an experience is best understood through interpretation (Willig, 2013). This study does not seek universal truth about HRP and thus rejects the realist, positivist approaches, which aim to measure the phenomena objectively. On the other hand, a pure relativist, constructivist approach is avoided as this would deny the HRP in the first place and does not fully address the main aim of this study.

Therefore, IPA is considered a suitable methodology for this study as it is closely aligned with the researcher's epistemological position and beliefs about the importance of interpretation in understanding and making sense of fathers' lived experiences. The researcher believes that her experience is embedded in interpretation; hence, her study is informed by Heidegger (1962). It is argued that there appears to be a gap in the existing literature regarding capturing fathers' in-depth lived experiences during and following HRP. Therefore, this study is committed to giving voice to a group of people that are primarily neglected (Larkin et al., 2006) and producing knowledge about their subjective experiences, highlighting the essence of the lived experience, which echoes the core humanistic and pluralistic values of CoP (Kasket, 2012).

2.4 Interpretative Phenomenological Analysis

IPA is a qualitative approach focusing on how the individual makes sense of their lived experience. It is a popular approach in psychology, and psychologists use this methodology to examine and understand psychological distress (Smith et al., 2021). This approach is inductive and is grounded in three core frameworks: phenomenology, hermeneutics, and ideography (Smith et al., 2009).

IPA has been inspired by prominent phenomenological philosophers, including Husserl, who was interested in capturing the essential qualities of an experience unique to each individual and believed that it is possible to access the content of an individual's consciousness through bracketing all pre-existing assumptions and presuppositions. On the other hand, Heidegger emphasises using interpretation to access the person's in-depth experience (Smith et al., 2021). This approach places the researcher at the centre where the hermeneutic tradition makes meaning-making possible (Smith et al., 2009).

The hermeneutic cycle provides space for the researcher to continually reflect on the relationship between the 'parts' in relation to the 'whole' and the 'whole' in relation to the 'part' through interpretation (Smith et al., 2009). It is argued that the interpretation of participants' accounts is shaped by the researcher's thoughts, values, and beliefs (Smith et al., 2012). Rather than pursuing to capture the 'real' world, the researcher collects detailed first-person accounts of a phenomenon and uses a concept called 'double hermeneutic' to make sense of the participant's experience through interpretation while the participants attempt to make sense of their experiences simultaneously (Langdridge, 2007; Smit et al., 2009). Hence, using the double hermeneutic, the researcher moves from understanding the real world to understanding the participants' meaning-making (Smith et al., 2012).

Furthermore, IPA adopts an idiographic stance towards analysis and attends to the specific rather than the general. The idiographic approach makes IPA unique and different from nomothetic psychological research, which seeks to generalise results to the population. The researchers must commit to the specific phenomenon and thoroughly examine participants' views and experiences in their unique contexts (Pietkiewitz & Smith, 2012). Through this, patterns of meaning can be identified, reflecting shared experiences among the participants (Smith et al., 2009).

IPA has also received several criticisms for its limitations. For example, the main aim of IPA is to understand a particular experience but fails to explain why these experiences occur (Touffour, 2017; Willig, 2008). Moreover, language is important to make sense of one's experience. Nevertheless, Murray et al. (2013) argue that IPA does not capture how language is used to understand the participant's inner experience. This study aimed not to generalise fathers' idiographic experiences or provide a reason why they have had such experiences or meanings. In contrast, the aim was to get as close as possible to the individual's experience and attempt to see the world through their lenses (Willig, 2013). Therefore, it is acknowledged that it may not be possible to capture a complete picture of an individual's experiences through interpretation as it is private to the participants (Smith et al., 2009).

2.5 Quality and Validity

This study followed Yardley's four evaluative criteria (2000; 2008) to assess the quality and validity and ensure rigour in an IPA study (Finlay, 2011; Smith, 2009). The four principles are sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Yardley (2000) emphasised that these principles are not meant to be followed strictly but instead encourage the researcher to use them flexibly in their study. A

section dedicated to reflexivity in this chapter ensures transparency and coherence by reflecting on each stage of conducting this study. These criteria will be discussed briefly in this chapter and in detail in Chapter Four to ensure the current study is aligned with the philosophical assumption of IPA, epistemological position, and interpretative phenomenological positioning (Willig, 2013).

2.6 Research Design

2.6.1 Sampling

This study encouraged fathers who have experienced HRP to share their journeys. IPA aimed to recruit a homogenous sample, and it was through purposive sampling that this aim was achieved. Six participants were recruited, which is sufficient for conducting an IPA study within a professional doctoral programme (Smith et al., 2009). The small number of participants facilitated adherence to idiographic detailed analysis and interpretation of the data that a larger sample might otherwise inhibit (Smith et al., 2012). Details of the participants are summarised in Table 1 (Page 41).

2.6.2 Inclusion and Exclusion Criteria

Homogeneity is important in the IPA study to ensure participants with experience of the phenomena are selected purposefully and the research question remains meaningful to the participants. It helps to analyse the phenomena in detail and report it from within a specific group of participants. The findings contribute to the literature, and with each founded detail that is prominent in the literature, gradually, more general claims can be made about some of the experiences and emotions fathers experience. Moreover, it is argued that a degree of flexibility can be employed to achieve a homogenous sample (Smith et al., 2009), which may vary in different studies.

This study considered inclusion criteria to ensure easier access to participants, follow ethical considerations, and maintain homogeneity. Four inclusion criteria have been considered for sampling: 1) adults over 18; 2) biological heterosexual fathers whose female partners had experienced HRP in the past three years; 3) speak and understand English; and 4) diverse geographical, cultural, and religious beliefs were welcomed. Therefore, narrowing the sample to a specific community or ethnic background would have limited recruitment due to stigma and cultural or religious beliefs. Moreover, the researcher was interested in having participants from various backgrounds to understand better how fathers experience and cope with HRP; hence, she decided not to choose a particular community.

Four exclusion criteria were considered: 1) participants who had a current or a history of psychiatric disorders or clinical diagnoses such as psychosis or personality disorders; 2) a current or history of suicidal ideation or self-harm; 3) Same-sex fathers or those who have had a child following HRP through surrogate mothers; and 4) fathers who have lost their partner or have experienced stillbirth following an HRP. These decisions were made to ensure ethical considerations were followed and participants were safe and could provide their consent. Additionally, this study aimed to understand if having a baby following HRP impacted the couple's relationship in the same way as LRP (Edie & Loewenthal, 2007), hence deciding on recruiting heterosexual fathers. Lastly, losing the partner or the baby can be experienced as trauma, and being a novice researcher, the researcher did not feel she had the necessary skills to contain these participants. Therefore, the final criterion was considered to minimise harm to participants.

2.6.3 Recruitment Strategy

The recruitment began by advertising the research poster online on social media platforms. Additionally, it was envisaged that snowball sampling could also help find fathers; hence, colleagues were informed and asked to advertise the research when possible.

The research poster included brief information about the study, inclusion criteria, the interview, and the researcher's contact details (see Appendix B). The poster was distributed online on Facebook, Instagram, Twitter, and relevant websites or forums specific to fathers in the UK, such as Dadsnet, Mumsnet, Dadsmatteruk, Seperateddads, Dadsinfo, etc. Participants from Facebook, Instagram and the Mumsnet website responded, showing an interest in volunteering. However, no responses from other social media platforms were received.

Recruiting participants from social media had several challenges. For example, recruitment on Facebook involved posting the research poster in parent-specific groups primarily created for mothers and/or fathers of HRP. Social media endeavours to protect individual users; each group has criteria to join that must be respected when sharing a post. Joining these groups on Facebook was challenging. The administrators of these groups had a right to reject the researcher's request to join the group as she was not a mother or father with experience in HRP. Instead, the researcher tried to explain the purpose of her request to join the group, yet her requests were rejected to protect the individuals and their ground rules. Some administrators cooperated and agreed to post the research poster on their page on the researcher's behalf.

Furthermore, social media monitors activities, and sharing a post can sometimes be automatically identified as violating the rules, meaning that Facebook can restrict access. Despite getting permission from the administrators, the research page was restricted by Facebook for 30 days, which was anxiety-inducing. Moreover, after contacting the Dads

Matter website, they pointed out that recruiting fathers for this research could be difficult as most fathers may be reluctant to talk about their traumatic experiences. However, a few administrators acknowledged this was important research. They approved the researcher's request to advertise the study, but frequent post-sharing by users meant that the poster was only visible on the front page for a short period. Hence, many fathers or parents may not have had the opportunity to see the poster.

2.6.4 Initial Screening of Participants

Ten responses were received via email from participants interested in learning more about the study. Only six participants responded to the follow-up email and expressed interest in having an initial screening meeting via Microsoft Teams or phone.

During the initial screening meeting, the purpose of the study, confidentiality, data storage, and their right to withdraw were discussed, and participation eligibility was assessed. A brief risk assessment was carried out to ensure that participants were safe participating in the study. Once they were happy to participate, a convenient date and time were agreed upon to conduct an online interview. Three separate documents were emailed to the participants, including the participant information sheet (see Appendix D), informed consent sheet (see Appendix E), and demographic sheet (see Appendix F), which outlined information about the study, confidentiality, the interview, their safety, and their right to withdraw during and after the interview. Participants agreed to allow up to 90 minutes for their interviews to be conducted online via Microsoft Teams, a secure platform to reach broader participants (Carter et al., 2021), particularly from across the UK. Participants were given time at the end of the initial meeting to ask any questions or concerns they may have had. They were told to read the participant information sheet in their own time and ask questions. In addition, they

were asked to complete the demographic sheet, sign an informed consent form, and return it via email before their interview.

2.6.5 Description of Participants

The researcher intentionally asked for minimal demographic details (age, religion, and ethnic background) to prevent participants from being identified (Table 1). All participants were assigned pseudonyms to respect their confidentiality.

The six participants were heterosexual men aged 25-45 living in the United Kingdom. Four fathers were first-time fathers, and two fathers had three children. All fathers had experienced HRP within the past three years. This was right before, during and after the COVID-19 pandemic. Due to the lack of diversity identified in Chapter One, this study aimed to encourage participants from diverse ethnic, cultural, and religious backgrounds. However, all participants interested in participating were from a white ethnic background. Four participants have described their religion or faith as none or atheist, one as agnostic and one as Jewish. Fathers' ethnicity and geographical locations were explored in the initial screening appointment; however, to maintain confidentiality, the researcher removed identifiable information such as ethnicity to protect confidentiality. It can be argued that the commonalities described above have fulfilled the IPA guidance for maintaining a small homogenous sample (Smith et al., 2009).

Table 1

Summary of participants' demographic information and the type of high-risk pregnancy.

Pseudonym	Age	Ethnicity	Religion	Diagnosis Type
David	25-34	White	None	MCDMA Twins
Oliver	35-44	White	Atheist	Previous Miscarriages
Emanuel	25-34	White	None	MCMA Twins

Jacob	25-34	White	Jewish	Pre-eclampsia & HELLP Syndrome
Benjamin	35-44	White	Agnostic	MCDMA Twins
William	25-34	White	Atheist	Obesity, Twins

2.7 Data Collection

Data was collected through semi-structured interviews. Due to its inductive nature, IPA recommends this method to enter participants' psychological and social worlds (Smith & Osborn, 2008) to capture in-depth, rich personal inner experiences (Smith et al., 2009).

The interview schedule was developed by evaluating the existing literature and following the supervision. It consisted of up to ten open-ended questions to facilitate the interview and help participants describe their lived experiences (see Appendix G). Further prompts, when possible, were used to invite the participants to expand on their answers (Smith et al., 2012).

2.7.1 Pilot Interview

A pilot interview was conducted with an acquaintance, a father with experience in HRP. The interview was conducted in a different language. The interview schedule seemed to help this father to give a narrative of his story, and he reported that recalling his experience has been therapeutic. Although the pilot interview allowed the researcher to observe how she might appear in the interview and become more accustomed to the research interview process, it was not conducted in English, which could mean the dynamic can change when interviewing in English.

The first interview with an actual participant was also considered a pilot interview. The data gathered from this participant is included in the analysis. The participant provided

constructive feedback that the interview offered new insights into his experience. He identified some gaps in his experience that he described as interesting.

2.7.2 Interview Procedure

Each interview lasted 60-90 minutes and was recorded using live transcription on Microsoft Teams. At the beginning of the interview, participants were reminded of their right to withdraw from the study and were allowed to ask questions. The participants confirmed that they were comfortable with some notes being taken. They were reassured that the purpose of the interview was to get to know their unique journey of HRP; hence, there were no right or wrong answers.

The interview schedule was followed flexibly to allow participants to share what seemed important to them (Knox & Burkard, 2009). Follow-up questions with additional prompts were incorporated into the interview to elicit further explanation or to clarify some aspects (Braun & Clarke, 2013). It has been suggested that building a good rapport with the participants can help them to self-disclose in greater depth (Braun & Clarke, 2013). Therefore, during the first screening, a conscious effort was made to establish a good relationship between the participant and interviewer and to continue this during the interview. The interviews were approached with sensitivity, a non-judgemental attitude, patience, and empathy, and non-verbal communication was used to foster rapport and capture the richness of their experience (Finlay, 2011; Pietkiewicz & Smith, 2014; Smith et al., 2009).

Participants were reminded that the interview was coming to an end. This prepared the participant for ending the interview. The final question asked was, "Is there any question you thought was important to ask?". This question helped elicit valuable data as it allowed the participants to share what was important to them that may not have been covered. This question also helped the interview to end smoothly.

At the end of the interview, fifteen minutes were allocated for debriefing to explore their feelings about the interview and introduce support services included on the Debrief handout (see Appendix H) should they wish to speak to someone about their experience. The debrief handout was emailed to them soon after the interview, and they were given three weeks to change their minds about participation, but no participant took this option. A verbatim transcript was produced for each participant soon after the interview. After three weeks, an idiographic analysis of the transcript began, retaining all utterances such as hmm, laughter, long pauses, grammatical errors, and other meaningful gestures to focus on semantic meaning (Pietkiewicz & Smith, 2014). Participants were randomly assigned a pseudonym, and any identifiable information, such as location, was changed.

After interviewing six participants, a sufficient depth and richness of data was believed to be achieved. It became clear that data saturation had been obtained to an extent as the narratives began to show repetitions (Fusch & Ness, 2015).

2.8 Ethical Considerations

This study adheres to the British Psychological Society Code of Ethics and Conduct (BPS, 2021) and the University of East London Code of Practice for Research (2015). Furthermore, ethical approval was obtained from the School of Psychology Research Ethics Committee at the University of East London before conducting this research to ensure the study adhered to the ethical guidelines (see Appendix C).

This study follows the main ethical principles of respect, competence, responsibility, and integrity to ensure professional, ethical, and humane judgements throughout the research process to protect participants' dignity, privacy, and autonomy and prevent potential psychological and physical harm. The Code of Human Research Ethics (BPS, 2014)

explicitly refers to the importance of moral principles throughout the research process, which will be discussed in more detail below.

The participants' autonomy, confidentiality and dignity were respected and ensured by providing an information sheet with details of the study and obtaining an informed written consent sheet. The informed consent form included a check box next to each statement, including an understanding of the aim of the study, confidentiality and its limits, the interviews and data collection, data storage, and duration of their right to withdraw, where participants were asked to tick each statement to indicate their consent to take part (see Appendix E). Participants were informed of their right to withdraw before, during, and three weeks after the interview. The researcher ensured that all boxes were ticked, and failure to do so prompted further clarification and review with the individual about their participation in the study. However, all participants provided consent to each of the statements.

At the end of the interview, time was allocated to debriefing to allow the participants to raise questions, share concerns or provide feedback. This also allowed the researcher to ensure participants felt safe recalling their experiences before leaving. All video recordings were securely stored electronically on UEL's One Drive; transcriptions were pseudonymised, and identifiable information was removed to protect individuals' confidentiality and prevent identification.

Moreover, participants were contacted for an initial call to conduct a risk assessment and monitor for trauma symptoms, current or history of mental health diagnosis and suicidal ideation. The screening call aimed to identify and prevent possible harm that may be caused to the participant and the researcher. Action plans were considered in the event of a risk, such as the possibility that participants might experience distress or discomfort while recalling their HRP experience.

Participants' emotional states were monitored during the online interview, and offered to debrief to ensure participants were safe before leaving the interview. After the interview, participants received debrief sheets with contact numbers for mental health support services. Participants reported their interview experience as positive and therapeutic; one father realised that there had been gaps in his story. Others appreciated the opportunity to talk about their experience and ask the questions they wished others would have asked them. One participant felt emotional and tearful while recalling his experience of seeing his twins for the first time. During the interview, he was offered a short break and was reminded of his right to withdraw. However, he confirmed his willingness to continue with the interview. During the debrief, time was allocated to reflect on his feelings; he reported no aversive feelings and mentioned feeling safe.

2.9 Analytical Procedure

The data was analysed using the new IPA terminology and analysis devised by Smith et al. (2021). Qualitative data analysis inevitably involves a degree of subjectivity (Willig, 2013; Smith & Osborn, 2008). Therefore, the steps were followed thoroughly but not dogmatically. The following steps have been repeated for each transcript, along with bracketing the ideas that have emerged from the initial transcript and maintaining individuality by committing to the idiographic nature of IPA (Smith et al., 2021).

Stage 1: Initial exploratory comments

The analysis began with immersion in reading and re-reading one transcript and listening to the interview recording several times to familiarise and engage fully with the participant's narrative; listening to the recording enabled considering the tone, silences, laughter and hearing the participant's voice (Smith et al., 2021). The transcript was presented in the middle column on a Microsoft document. The exploratory comments were recorded on

the right-hand margin. Whilst reading the transcript, initial notes were recorded, including thoughts, feelings, and observations, allowing room for reflection. This column explored the semantic content and language, including anything interesting or significant. To simplify the analysis, colour-coding was used to distinguish different types of comments, to avoid skimming over the data, and to separate the biased interpretations (Smith et al., 2009). Descriptive comments were coloured in dark blue to describe the summary of what the participant said. Linguistic comments were recorded in purple, focusing on how the participant used the language to describe his experience and their perception of the world. This included reflecting on non-verbal expressions. The conceptual comments were coloured in green, which focused on taking an interrogative stance toward the data, making possible interpretations, and questioning the data to enhance understanding of their meaning-making (Smith et al., 2021). The left-hand margin was left to record the Experiential Statements (see Appendix I).

Stage 2: Formulating Experiential Statements (ES)

This stage focused on working closely with the exploratory comments to develop them into ESs (Smith et al., 2021). The ESs represented phrases that captured what was crucial to the participant's unique experiences (see Appendix I). This stage involved the hermeneutic circle, where a part of the transcript was interpreted in relation to the whole and then the whole in relation to the parts (Smith et al., 2021).

Stage 3: Looking for Connections through Experiential Statements

This stage encouraged using creativity to organise the data (Smith et al., 2021). The ESs were transposed to sticky notes in the same order they appeared in the transcript to organise them in a way that helped capture the most important aspect of the participant's

narrative. All the statements were put on an A3 page and moved around, looking for possible connections. The related statements were organised into groups (see Appendix I).

Stage 4: Naming the Personal Experiential Statements (PETs)

A title was considered for each cluster of highly related ESs that reflected its characteristics. Following a linear fashion, the ESs were clustered and transferred into PETs. In some cases, similar PETs were placed together and considered sub-themes whose titles were written in bold lowercase. For these, another title had to be considered that reflected all sub-themes whose titles were presented in bold uppercase. Therefore, a PET comprises different sub-themes with ESs and four or five relevant excerpts (see Appendix J).

Stage 5: Cluster PETs to Develop GETs Across Cases

This stage focused on finding similar or different patterns across the PETs, highlighting the unique experiences, and exploring the convergence and divergence across all transcripts to develop a set of Group Experiential Themes (GETs). This step offered the flexibility of working with PETs, focusing on sub-themes and ESs, and re-organising them until a new set of GETs is developed (Smith et al., 2021). The PETs and all the illustrative quotes were presented in Microsoft Excel, and colour coding was used to differentiate the PETs that clustered together. Each GET is written in uppercase bold, and the sub-themes are presented in lowercase bold (see Appendix K).

2.10 Reflexivity

Reflexivity is an integral part of a qualitative study and IPA and enables the researcher to critically evaluate how their subjectivity influences the research.

2.10.1 Positionality

I was both an insider and an outsider to this topic. I am an outsider to the experience of fathers, firstly because I am a female and have no children. Hallway (1989) encourages the researcher to remain conscious of how their gender could impact the research. As a female, I have no experience being a father, but I have experience talking to fathers in my personal life and clinical practice. I questioned whether being female meant that fathers would not feel comfortable sharing their experiences fully and whether my gender would be a barrier to understanding fathers' experiences. My CoP training and its core values of listening to an individual's subjective and intersubjective experiences (Douglas et al., 2016), both said and unsaid, helped me approach fathers' unique experiences and emotions. I tried to stay as close to participants' narratives by writing my understanding of their experiences and re-writing with a fresh eye after a few days to help me compare and cover any missing gaps. Being female also meant I might approach fathers' experiences with fewer presuppositions.

I was also an insider and felt a sense of belonging due to my experience working with expectant parents in perinatal services. I was aware of some of the preconceptions I carried with me and reflected that I could not completely bracket them but could be aware of them and remain transparent throughout the research, particularly analysis and discussion, by keeping a journal. For more reflective journals, see Appendix L.

2.10.2 Data Collection

Conducting a semi-structured interview for a qualitative study was a new experience. I felt self-conscious about being inexperienced in facilitating a semi-structured interview and capturing good-quality data and was preoccupied with how I would ask the interview questions. This meant I did not use prompts as fully as I would have if I had been less anxious. For example, my mind sometimes went blank when looking for probe questions. I

was worried I might inadvertently ask leading questions or push the participants to a particular answer. Therefore, although rich data was gathered, there was perhaps more room for understanding the meaning-making in greater depth.

Building rapport online in a short period was challenging, particularly with the inherent power imbalance that can arise between the researcher and the participants (Raheim et al., 2016; Ripley, 2001) and the impact of this on shaping the data collection process. During the first interview, I noticed the tension of detaching myself from the therapist role and was cognizant of the desire to protect fathers from further trauma when recalling their memories. However, I remained mindful that my role was to be a researcher, not a clinician. Consequently, it was excruciatingly hard not to offer validation as we would offer to our clients. It sometimes felt informal, inhumane, and insensitive at times. I struggled not to paraphrase or acknowledge how those experiences might have been difficult. Reflecting on that, I was not trying to be a therapist but rather a human who can feel and empathise with the father who went through such traumatic experiences. As a result, I consciously chose to have therapeutic conversations when required to relay to the participant that I was listening, understanding, and appreciating their trust, yet simultaneously seeking the research data and engaging with the interaction in the here and now. For example:

David: I was certain that she had died, and it was just, yeah.

Elnaz: Yeah. that sounds difficult. Very difficult.

The interview questions were designed to be as open as possible to encourage participants to share their unique experience of HRP. One question appeared rather long, asking fathers to consider the time scale from pregnancy to birth to post-birth.

Elnaz: Umm, and I also like you to think, David, about pregnancy, birth and now, what's, what was your, how would you describe your relationship with twins?

Although using this question helped participants tell me about their experiences before and after birth, I realised that I might elicit more answers if I divided them into separate questions, which seemed to have a more successful outcome for Benjamin.

> **Elnaz:** But before I come to that, I like to ask you a little bit about your relationship with the twins during the pregnancy. So, can you describe your relationship with your twins?

On another occasion, when interviewing David, I was worried that the interview was ending and that questions remained to be covered. David provided a detailed narrative of what happened, but I was still unsure of his feelings. I asked David to describe his emotions using one word to get a sense of his feelings.

> **Elnaz**: Um, and I, if you were to describe your feeling when you received that call at 1:30 AM. If you describe it with just one word, what would that be?
>
> **David**: One word. Devastating.

When analysing the data, I was conscious of this question. I decided not to use this example from the transcript in my analysis as I wondered if my question pressured David to come up with a word to describe his feelings.

2.10.3 Challenges During Analysis

The initial stages of noting the exploratory comments were anxiety-provoking. I felt despair in writing down my observations and found myself entangled in repeating the father's words. I reflected on the fear of interpretation in supervision and acknowledged that interpretation and intersubjectivity were at the heart of IPA, which helped me appreciate that my subjectivity connected me with the participant's experience and helped me understand their narrative. I was encouraged to freestyle writing without censoring any thoughts and

hunches, which helped me approach the text differently and critically reflect on my observations, biases, interpretation and what the father was trying to convey. Then, the initial exploratory comments were shared in supervision for clarity and credibility.

When working with ESs, I felt confused between the exploratory notes and ESs, which I later found through reading that this was quite common with novice researchers (Smith et al., 2021). I was preoccupied with how close the ESs had to be to the original data, which prevented me from being myself for some time. I noticed this urge as if there was one right way of doing things, contradicting my epistemological position. Reflecting on this and further reading helped me ask myself a question each time: whether the written statements reflected my analytic work or just a re-arrangement of the participant's account.

I looked for similarities, differences, paradoxes and contrasting statements to help me arrange ESs into groups. I enjoyed this process as it helped me reflect on the hunches I experienced during the interviews. However, I felt overwhelmed by having too many ESs, thinking I had done something wrong. Following a discussion with other peers, IPA experts and my supervisor, I noticed this was normal and that the data would eventually get smaller. One way to manage this was to put almost identical ESs on top of one another. A few statements did not make sense, and I worried about removing them. However, further reading and supervision helped me discard the ones that did not seem relevant to the research question.

Understanding PETs was challenging and stimulating at the same time, as it demanded creativity and allowed me to think about how I would like to present my data. I desperately searched for a workshop and came across Smith's workshop on IPA. The virtual workshop helped me conceptualise how to put the PETs together and clarified the analysis

stage. Also, I had the opportunity to discuss some of the PETs and ESs in the classroom, which helped me reflect on and further challenge my interpretations.

Keeping a journal and reflecting on any ideas that emerged from the first transcript helped me be cautious of re-producing the same ideas. For each step in each transcript, I asked myself: What is this father trying to convey? I deliberately tried different words and statements to help me capture the father's experiences. This question helped put the initial ideas aside and allowed new ideas to emerge. Holding different lenses simultaneously as attending to PETs, sub-themes, and ESs was challenging. I was overwhelmed by the amount of data and struggled to group them. To negotiate this chaotic image in my head, I needed to sketch the plan on paper to demonstrate how I wanted to present the findings in a less complicated way. Then I started breaking things down and working from the inside out, first figuring out the sub-themes and then the GETs. Additionally, creating the title of GETs was difficult and time-consuming as I had to play around with the ideas and ensure that the name captured the sub-themes. I then decided to use participants' quotes for some sub-theme titles to demonstrate the underlying meaning behind the themes.

2.11 Chapter Summary

This qualitative study adopts a critical realist position, which positions itself between realism and relativism. An IPA methodology was used to recruit a homogenous sample of fathers who met the inclusion and exclusion criteria. Semi-structured interviews were conducted online, and the interview transcripts were analysed using the seven steps of IPA analysis outlined by Smith et al. (2021). Reflexivity was also included to demonstrate transparency throughout the research process. The findings are presented in Chapter Three, followed by a discussion of the implications and limitations of this study in Chapter Four.

Chapter Three

Analysis

3.1 Overview

This chapter presents the findings of an IPA study of six semi-structured interviews with fathers, exploring how they make sense of their HRP. The analysis produced four Group Experiential Themes (GETs) and thirteen sub-themes.

3.2 Introduction to the Themes

The four GETs account for the father's experience of HRP. The first GET highlights the responsibilities and obligations to support and protect their families as partners and fathers. The second theme introduces the father's need to be recognised, acknowledged, and supported by services, employers, and society. The third theme represents the powerlessness fathers experience during the HRP brought about by medical complications, traumatic experiences, and the pandemic. There is an underlying conflict between the first and the third GET, linking the feeling of being impelled to be responsible for their families but being confronted with situations that have likely contributed to feeling powerlessness, helplessness, and a perceived lack of control. The fourth theme summarises the coping behaviours that fathers engage with to build resilience and get through HRP.

3.3 Men as a Responsible Being

3.3.1 Prioritising others' needs over their own needs

3.3.2 A "round the clock" job of caring for the babies

3.4 Fathers Equally Deserve Recognition and Support

3.4.1 Count the dads in: "I'm having babies too."

3.4.2 Feeling let down by healthcare professionals

3.4.3 Negotiating the “rubbish dilemma” in the workplace

3.5 Quadruple ‘Whammy’ of Powerlessness

3.5.1 Feeling helpless to protect the family

3.5.2 A sense of inadequacy in sharing the burden

3.5.3 Feeling ostracised from maternity services by the Covid rules

3.5.4 Navigating the barriers to bonding: “They’re newborns for a really long time.”

3.6 Coping Behaviours that Help to Adapt and Build Resilience

3.6.1 Unique coping behaviours as an “Antidote” to losing control

3.6.2 The importance of relationships in building resilience

3.6.3 The lockdown did “a world of good”: Getting more involved with babies

3.6.4 The double-edge sword of using the Internet

3.3 MEN AS A RESPONSIBLE BEING

This cluster of sub-themes captures the significant increase in responsibility and how fathers view themselves as responsible beings from the moment they discover they are becoming fathers. The sub-themes capture fathers' different roles during and after the pregnancy to help and protect their families. Part of this responsibility includes a sense of obligation to endeavour and make this rough ride as easy as possible for their partner. As the dynamics of familial responsibilities evolve, the self becomes unimportant with pregnancy, and the sole focus becomes the baby and the mother, who must be prioritised above anything else.

3.3.1 Prioritising others’ needs over their own needs

This sub-theme captures the importance of prioritising, protecting, and supporting their families above anything else, even their own needs. All six participants described an

increased responsibility to make this challenging experience easier for partners and to give up themselves to dedicate their time and energy to their families. The self becomes unimportant as their world revolves around their partner and the babies. There is a sense that they need to stay strong in the family, support their partner and get their family together. This is illustrated by David's endeavour to make pregnancy look more real to his partner so that she can feel like an expecting mother. He seems to be referring to the loss of a normal pregnancy and baby bump where the medical complications prevented the babies from fully growing inside the womb.

> *"It just felt a bit kind of surreal, like she wasn't really having babies. She was just in hospital. Not sure I'm describing it properly. But I guess what I tried to do is just make sure she had as many photos as possible. Umm, and also to make it feel a bit more normal as well, rather than it being quite scary". (DAVID, 537-542)*

David's narrative suggests he and his partner could not see the fully grown baby bump, which likely explains the need to create a normal scenario to compensate for this loss of normal pregnancy. There is a sense of letting his partner down for being unable to protect her from the complications and people's comments. Moreover, complications appear to have made the pregnancy frightening and different. To alleviate some of his partner's fear, he tries to make her happy by attempting to create an opportunity so she can get a sense of normal pregnancy like other mothers. He empathises with her experience and refers to her needs, but he does not discuss his own needs, possibly because he perceives himself and his needs as insignificant to his partner. Emmanuel shared a similar feeling and mentioned that he could only think about caring for his daughters and spending as much time protecting and nurturing them as possible.

I think self, self-care was having a shower or having a cup of tea or coffee, umm, but that was probably about as, as extravagant as self-care got, I think, and it really was just all about, all about the girls". (EMMANUEL, 724-727)

He appeared worried about the difficult journey his partner has been through and felt a sense of responsibility to share her burden and contribute to this caretaking role to make it more manageable for the partner. It appears that when the babies fight for their lives, it becomes impossible to think about anything else but the "girls". It seemed important for him to be there for them; hence, this might capture his repetition of "all about" to reiterate their priority over anything else. Also, the COVID-19 restrictions seem to have imposed a sense of loneliness and separation from other sources of support, indicating he needed to be there for his partner, seeing himself entitled to little or no self-care.

Another participant, William, described his responsibility as a breadwinner and a housekeeper. His continuous work, both inside and outside his home, is to support his family, and there seems to be no place to feel physically tired due to his sense of responsibility toward protecting his family. His narrative indicates a sense of guilt that it took two people to make the baby, but only the mother could carry the babies and endure all the physical changes and hardships. He likely felt a sense of responsibility to remain stoical and do what was in his power to compensate for his inability to share the burden.

"It was just make sure she is relax as possible. I get off from work, I do cook and do the cleaning, just much I can do to make her life easy". (WILLIAM, 186-189)

William uses a powerful metaphor of "I'm on wheels" to show that he had no other option but to adjust to the new roles and manage different responsibilities simultaneously to protect the family.

"I agreed with the nurses, basically, that I would go back, and I would help as much as I could do with them basically. And I was getting to make myself come back home

maybe by 3-4 in the morning, back up at 6-7-8. I wasn't really sleeping, but it was just. I'm on wheels; I need to do this. This is my life now". (WILLIAM, 987-993)

The narrative suggests he is accepting the situation, "This is my life now", indicating that he has no choice but to stay strong and get on with the challenges. There appears to be no time for self-care, nor is it important to him, as his babies and partner need his attention the most. Oliver also reflected on the new roles he had to take on by becoming a father. He described adopting the additional role of attending to household chores to help his partner rest and have an easier pregnancy.

"I ended up doing a lot more around the house, and that was doing pretty, but all the housework and all the cooking and cleaning just cause my, my wife was struggling to move so much. Umm, then actually, yeah, I think it felt like me supporting her a lot more with this one rather than really feeling and needed support myself". (OLIVER, 319-325)

The narrative suggests he felt responsible for managing all household activities by himself as they were 'dumped on him'. There was a sense of responsibility to adequately care for and support his family, but there seemed to be no consideration for taking care of himself, possibly did not feel entitled or had the right to ask for support.

Benjamin described feeling obligated to be supportive during this journey, including respecting his partner's decision even though he might disagree. His smile indicated tension and disagreement between what he preferred and what his partner wanted.

"I was in the position of, like, I don't really want any risk [smiling] anymore risk in this pregnancy. There's been too much already. But I also completely respect and wanted to support my partner's decision cause it's her experience at the end of the day when she goes through that labour". (*BENJAMIN,* 362-367*)*

There was a sense that "it's her experience"; she was enduring all the pain and hardship; therefore, he did not see himself as eligible to have a say. He did not see himself as entitled to shape this decision when he was not carrying the baby or enduring complications and kept himself responsible for supporting his partner emotionally. He appears to see himself as less than his partner, which might explain why he puts his needs aside and supports his partner with her decision against his will.

Jacob's repetition of "I'll get it done" could emphasise that he had to remain strong for his partner despite what he witnessed and experienced. His wife's recovery was the most important thing, and he had to get on with things.

> *"I was still doing and just, you know, action was just everything I was doing. Like don't worry about me, I'll get it done. I'll get it done".* (*JACOB,* 591-593)

He likely perceived himself as obligated to hide his struggles from his wife and maintain a stoical attitude to not cause additional worry or concern. His wife already had a near-death experience, and it appears that he perceived his fears and struggles as insignificant compared to what she experienced.

3.3.2 A "round the clock" job of caring for the babies

Common to all six participants was a feeling that once the babies were born, they had an obligation to dedicate all their time to looking after their babies, which included continuous day and night caretaking with structured working hours and routines. This sub-theme closely overlaps with the first sub-theme; however, it is distinctively important as it captures the essence of fathers' difficulties. David analogises caretaking to a "job" and stated that attending to the babies' needs had similarities to his job in terms of working full time and following strict working hours. He also referred to the difference that seems to have a

positive connotation: spending time with his babies and being the father, he always wanted to be.

"It basically became like a job like, so wake up, go to work. But work was spending the day with the babies". (*DAVID,* 1317-1319*)*

Emmanuel mentioned that caring for both babies needed constant attention and continuous care. He described his experience as having "no distinction between day and night", communicating that the babies were still developing their sleep patterns and eating schedule, requiring constant attention to thrive. The days of the week seemed to have no significant meaning and importance, as his priority was to ensure the babies were well looked after.

"It really was uhm in terms of just round-the-clock care for them and uhh yeah because there's no distinction between day and night for babies that young. Uhm, so quite often I, I yeah, they, it would, they are like weekends and weekdays were no different". (*EMMANUEL,* 705-710*)*

There appears to be a sense of losing track of time and date when he was too busy carrying out his responsibilities of looking after his family, leaving no time for himself and other things to be considered or attended to. Benjamin also described the constant care and attention that his twins required. Not only did he need to attend to his twins' needs, but he also had to be present and look after his older son whilst his mother was absent to ensure he did not feel left out.

"One of us is with our son, whilst the other is with the twins. We wear the babies quite a lot. We have babies on in the sling a lot of the time. So, we can get on with jobs at home whilst they sleep on us. It makes it quite a lot more manageable. Umm, normally both of us or either of us has a baby on us as well as either having the son

or doing something like cooking or cleaning the house, so it's manageable."

(BENJAMIN, 710-717)

Benjamin referred to "both of us and either of us has a baby on us" to communicate that newborn babies require constant attention. They both seem to have solved the challenges of having twins and an older child by wearing the babies to manage other daily tasks that may otherwise have been impossible. This shows the different layers of responsibility he needed to consider as a father after his twins were born. There was also a sense that he needed to carry the babies on him, possibly to recompense for the earlier separation from them whilst they stayed in the NICU.

The experience was slightly different for Jacob as he had no choice but to be the main and the only primary carer when his wife was in the hospital recovering from the traumatic birth. He was responsible for being the mother and the father, highlighting dual roles and responsibilities compared to other fathers in this study.

"I was very much taking everyone write down how much she ate when she ate it. When does she do a poo? Here's an app. Let's record it in the app". (JACOB, 286-288)

What appears to have helped Jacob carry out this responsibility with zero experience and, in his partner's absence, was to set up and follow a very structured routine to ensure that he adequately met his responsibility of being the father and a protector.

3.4 FATHERS EQUALLY DESERVE RECOGNITION AND SUPPORT

Most participants spoke about feeling excluded and left out and advocated for their need to be seen, acknowledged, and recognised by maternity services, HCPs, and employers. This cluster of sub-themes demonstrates that fathers acknowledge the importance of focusing

on the mother and baby. However, they also emphasise that fathers are forgotten despite being part of this journey and are as equally impacted as mothers.

3.4.1 Count the dads in: "I'm having babies too."

All six participants spoke about their experience of being invisible and sidelined by the HCP despite being impacted by the HRP. They refer to fathers' lack of acknowledgement and inclusion in support and care and their need to have a seat at the table.

David described his experience of being excluded from appointments. He used the term "deal with the fallout" to communicate that he may not be the one to carry the baby, but he needs to remain strong and deal with the consequences and aftermath of premature birth. In his narrative, there is a sense that being a man and a father is a costly responsibility.

> *"I'm not the person carrying the babies; I'm the one who has to; I'm still around to deal with the, the, fallout and the fact that it can be very, very, very scary". (DAVID,* 19-22*)*

Nevertheless, his presence did not seem to matter to the maternity service. He needed to think about ways to keep his family together, sort out the challenges and protect them from further harm. He conveys a sense of injustice and unfairness about the lack of support that exists for fathers. His repetition of "very" indicates a sense of frustration and that the journey has been traumatic and had a negative impact on his mental health, but there was nothing for him. This was also shared by Emmanuel, who mentioned that a different type of support was considered for the mother. However, there needed to be more support and understanding from the HCP in including him in the support during this challenging period.

> *"There was absolutely nothing for me; it was never. I think they might have asked her how the relationships going, but they never really asked how the dad personally was". (EMMANUEL,* 742-745)

His experience demonstrates many layers and highlights exclusion, devaluation, a deep sense of isolation and abandonment by maternity services, and a sense that his existence and experience were unimportant. Oliver shared a similar experience where he felt he did not exist and was not part of this journey.

> *"It was forgotten that I'm having babies too, and obviously not going through the same thing, but. You know, we, we are pregnant. So yeah, everyone, no one. I said no one ever asked how I was feeling about things". (OLIVER,* 987-991)

There was a sense of being invisible and a lack of acknowledgement that he was in this, too. He used the term "we" to highlight that the pregnancy involves both the woman and the man, and it is teamwork, yet the professional fails to recognise and include the father. There was a sense of unfairness that everyone focused only on the mother and the baby and forgot to ask about his experience and feelings.

Jacob described a sense of unfairness in how the maternity services prioritised the mother and the baby and dismissed his needs.

> *"You've got, say, a toddler and an ill wife, and you don't have the network, then even more so just that support and then the, the emotional support ongoing in the same way that you would treat a mother who had trauma or had gone through that. Why? Why should there be services for one and not the other?"* (*JACOB,* 840-846*)*

There narrative suggests there were feelings of alienation and loneliness when caring for his baby alone. There was a sense of frustration for the inequality in support available for mothers and fathers and the injustice of offering service to one but not considering including the other. Notably, he calls for equality and similar support for fathers.

Benjamin described his experience of being isolated and lonely. His narrative indicates different layers. There was a sense that only some could understand his experience if they had been through a similar one.

"A lot of this pregnancy is just kind of mine. And I and I own that. But it's, it's kind of isolated in a way". (*BENJAMIN,* 968-970)

Benjamin seems to imply that there was a lack of understanding about fathers, their experience, and their needs, which seemed to have led to keeping himself to himself and being self-reliant, which reveals the lack of tailored support and resources for fathers. It seems that it was safer to be on his own than to receive support from someone who has no knowledge and understanding of what it feels like to be a father to HRP.

Fathers advocated for their rights and mentioned that they deserve better support, and HCP needs to take a moment and include asking how the father is doing. Despite his lonely experience, Benjamin highlighted that it is necessary for HCP to consider supporting the father or introducing and matching them to a support network with similar experiences so they could share their stories with someone who could understand their experiences.

"So, you know, support groups, some sort of way that connects people together that actually have gone through something that's similar." (BENJAMIN, 813-816)

William described feelings of loneliness and exclusion in his journey. He spoke about the importance of having someone to speak to and the need for HCPs to see the father, acknowledge their presence and take the initiative to ask the father how he is doing and the impact this journey has on them. The health professionals appeared to fail to acknowledge his needs in this journey.

"They should have the option of do you need anything at that point as well? Does your partner require a? Does your partner want to speak to someone? Does your partner want to do this or do that?" (*WILLIAM,* 1426-1430)

Emmanuel described a similar experience, where he explicitly mentioned that it could be challenging for a father to initiate a conversation about their struggles, thus conveying a

sense of disappointment and an expectation that HCP needs to count the fathers in and recognise they are equally affected.

> *"It's harder to pick up the phone and, and say I'm struggling than it is if somebody phones you and says how are you doing, might be a bit easier to open up, not rather than putting the onus on you, it's your job to tell me you're struggling uhm…" (EMMANUEL, 890-894)*

It appears that a conversation initiated by HCP would have made it easier for him to open up and empower him to feel confident and comfortable in expressing how he is feeling and how the journey is influencing his day-to-day life.

3.4.2 Feeling let down by healthcare professionals

Five participants spoke about the lack of communication and feeling let down by the HCPs in maternity services. The disappointment was mainly reported around how things were communicated to them during the pregnancy. Only one father felt that the communication was sensitive, transparent, and comprehensible, while others were disappointed by the HCP and thought they could have communicated better with fathers. Some fathers mentioned that the staff members were amazing and supportive during birth and in the NICU.

David spoke about his experience of how things have been communicated to him. Although he was told in advance about the challenges they might experience, there was a sense of frustration that it needed to be more transparent.

> *"I kind of wish they made that a little bit more explicit. Like the girls really could come very soon and then, like I said, the way that the, the, the way the doctor told us on the, the Thursday, I don't think it was very professional." (DAVID, 424-428)*

It appears that the communication was intimidating and did not meet his expectations of how professionals should communicate, and he felt professionals had disrespected their privacy and dignity. David described that he struggled to come to terms with the diagnosis throughout the pregnancy and found himself swinging back and forth in denial. It seems that his struggle with denial could have arisen from the mixed messages he received during pregnancy. This seemed to have made it difficult for him to accept the diagnosis and challenges, leaving him mentally unprepared and in a difficult situation.

William described his experience of not being allowed to be present at birth due to the COVID-19 rules. There was a sense of frustration and anger at the lack of communication about the rules when the C-Section was planned. This appears to differ from how he imagined and expected the birth experience.

> *"I'm not violent. I wouldn't punch anyone. But there's someone, "Oh, you come with me, Sir", and I was like, what? Like I was aware that we would have a C-Section, but I wasn't aware that it was going to be if it was an emergency, I wouldn't be able to be in there." (WILLIAM,* 636-641*)*

William was ready to fulfil his duty of supporting his wife during birth and be part of this journey, which seemed to have been crushed by finding out that he was not permitted to be present. It appeared that underlying this message was a sense that he was not important to have a place in the room, and the impact of this was not acknowledged or recognised. The HCP was in a position of power, and William was powerless and helpless. The lack of control seemed to provoke anger and frustration that he had to hold inside, leading to further powerlessness.

Oliver described his experience of not knowing what was happening or the problem. There is an underlying message that he saw the HCP in a position of power that is

knowledgeable, expert and experienced enough to have an answer about the cause and complications.

> *"I like ...someone to be able to say, right, yeah, we can see the problem. This is the problem. It's here. We fix that, and it's uh, yeah, we're going to be fine rather than, yeah, we. We don't really know, but we're going to do something." (OLIVER,* 239-243*)*

Oliver seemed disappointed when he discovered they were unsure of what was happening to his partner and the babies. Knowing the answers could have been a source of reassurance and helped them prepare for all the possibilities. It appeared that not finding an answer led to feeling let down and increased uncertainty about what could happen. He may have struggled to trust them and needed to find his answer through a different medium. This sub-theme intrinsically links with another sub-theme about using the internet (3.6.4) as it illustrates the importance of adequate communication with fathers.

Benjamin described feeling dismissed by the HCPs and expressed frustration that HCPs did not respect their choice and persuaded the mother to change her birth plan despite the risks involved.

> *"What we were sold wasn't what we were getting, so I was quite I was scared by that. I was quite cross about it, and I was quite worried afterwards that there could have been negative, negative impact or effect on the second baby.*" (*BENJAMIN,* 466-470*)*

There was a sense that professionals violated and devalued their decision, and he was forced to accept an unwanted intervention. This, along with the lack of consistent and transparent communication, seems to have caught him off guard, caused considerable stress, and put him in a powerless position where he had no control over the situation and was unprepared for the unpredictable changes that could happen. He found the decision unprofessional, which dismissed the impact it could have on him and his family.

Jacob described his experience where his wife's condition was devalued and downplayed. There was a sense of frustration and annoyance towards the HCP for not taking their circumstances seriously.

> *"People in the maternity unit who sort of a downplaying it, and we gradually went over space of two or three hours to you're gonna have your planned C-section next week anyway because the baby was breach to ok you might have it sooner to ok, we have to deliver this baby tonight." (JACOB,* 63-69*)*

He seems to be communicating that HCP has failed to carry out their job adequately, and the traumatic birth experience could have been preventable if they had detected or thoroughly assessed his wife's condition before it reached the critical point. There was a sense that the HCP had betrayed his trust and respect for them.

3.4.3 Negotiating the "rubbish dilemma" in the workplace

Over half of the participants spoke about the pressure to return to work while their babies or partners were hospitalised. They referred to the lack of acknowledgement of fathers' circumstances in paternity leave policies. Moreover, several fathers described their managers as supportive and cooperative, but their company had guidelines around how soon to take leave, dismissing the fathers' circumstances.

David described his experience of being unsure and feeling under pressure to make a difficult decision about when to take his paternity leave. He had to choose between being with his daughters or returning to work.

> *"Then, as a father, your immediate question is: When do I take my leave? You know, do I, do I try to go to work, you know, whilst my girls are in hospital so I can save my two weeks for when they're home, or do I use my two weeks when they're in hospital but then have no leave left to support my wife when they're home with us, and that's*

just shit. That's just rubbish. A rubbish dilemma to have to deal with as a father." (DAVID, 1213-1220*)*

There seemed to be an injustice regarding the duration of paternity leave for fathers, the tension of when they should take them and the need for recognition and inclusion of HRP in the policies. He used the term "rubbish dilemma" to communicate that the pressure to decide whilst his daughters were fighting for their lives in the hospital seemed to have added additional stress, leaving him helpless. He reflected that he preferred not to think about this dilemma when he already had a lot going on. This feeling was shared by Emmanuel, who had to make up his mind and the pressure exerted by his employer to decide when he would start his paternity leave.

"I had to just let them know when I was gonna take my paternity leave. But they did keep asking as the weeks went on, like when we be taking it, uhmm, because it was against my work policy to take it so late after they were born. Uhm, but thankfully my boss was quite understanding about it." (EMMANUEL, 514-519*)*

The narrative clearly shows that his circumstances and what he was going through were overlooked. He reflected on the tension that his manager was supportive and reassuring whilst the policy and the employer failed to acknowledge his hardships during HRP.

William described that he had to implore his boss to keep his job while looking after his twins in the hospital, who were on the verge of dying. William reflected on the gut-wrenching challenges of requesting leave and being unsure about how long it may take for his babies' condition to become stable.

"I'll find my boss and said look, this is the situation. I don't know. I'm going to be back because, at this point in time, the focus is that she's dead. It's as simple as that. He went, "Oh well, I can't keep your job open forever," and I'm like, that's not really

helpful. You've got a duty of care for me. I'm letting you know this, this issue you can choose not to pay me, that is absolutely fine." (WILLIAM, 1079-1089*)*

In his narrative, there was a sense of unfairness, helplessness, and disappointment in being dismissed and unsupported by his boss. It seemed that he had to endure the additional stress of losing his job and needing to care for his poorly twins. Here, he had to refer to his rights and consider an alternative option of unpaid leave despite being under pressure to maintain his job and provide financial security for his family.

Oliver spoke about his experience where he thought there were flexibilities in place for him to attend antenatal appointments but soon realised that it came with the cost of being unpaid.

"We have a policy you can take time off to go to any appointments. I so I didn't realise until later that that was unpaid." (*OLIVER,* 924-926*)*

There was a sense that policies for fathers have been punitive rather than supportive, forcing them to make difficult choices and prioritise one over the other. Jacob had a similar experience of having to return to work, although his journey was different to that of other fathers. In his narrative, the wife was at risk and needed treatment and time to recover from the traumatic birth experience. The duration required for his wife to recover was longer than the paternity leave considered for fathers, putting him in a difficult position where he had to consider taking care of his baby, attending to his wife's needs, and managing work.

"There was that little bit of hesitation about going back to work afterwards because it's two and half weeks after the baby's born, and Elisa still on the mend. But we found a way, and if she needed me, I would have worked from home." (JACOB, 684-688*)*

This seemed to have contributed to feeling anxious, stressed and under pressure. It appears that he had a supportive employer who prioritised family above everything else and offered him the option of working remotely, which meant he could spend more time looking

after his daughter while his wife was recovering. This seems to have removed the pressure from his shoulder and eased the stress considerably.

3.5 QUADRUPLE 'WHAMMY' OF POWERLESSNESS

The first two GETS, a sense of responsibility and the need for recognition are equally relevant and pervade through this theme. This theme captures the four-fold blows that hit the fathers during their HRP journey due to not having control over their situation. Fathers described their experience of finding themselves in a powerless position. Four sub-themes were identified to demonstrate the powerlessness experienced at different times of HRP. The first and the second sub-themes relate to a perceived inadequacy in the self and describe the helplessness to shield the family from harm and not being good enough in sharing the burden the mother carries, whilst the third and the fourth sub-theme focus on the impact of external factors in putting them in a powerless position such as COVID-19 rules and barriers to bonding.

3.5.1 Feeling helpless to protect the family

All participants described a perceived lack of control and power over shielding their families from further harm. They mentioned that the rapid and uncontrollable progression of medical complications placed them in a powerless position, where they found themselves incapable of carrying out their responsibility. There was a sense of failure and frustration that they could not do anything to change the situation or take the risks away. David used the paradox of "Schrodinger's Cat" to describe the difficult situation he was trapped in. Part of him wanted to confront reality and look into the box to see what had happened to his daughter, whilst the other part was terrified and wanted to avoid the possible sad news. This communicated that he was afraid of making a choice.

"And there was a bit of a Schrodinger's cat moment, like a like I wanted to get through to the doctors to be able to for them to tell us that she died. But I also didn't, at the that moment, I was in that room as long as I stayed in that room cleaning this stuff. Then I would never know." (DAVID, 1088-1093)

The analogy seemed to [1]symbolise chaos, disappointment, reward, and positivity at the same time. It appeared that he felt stuck, and as long as he did not open the box, he was shielded from the news, but he had no choice, and there was no room for further denial. He had to open the box and confront what was on the other side.

Emmanuel described a lack of freedom to touch or hold his babies whenever he wanted. He had to wait for permission to be granted by the HCP, placing the professional in a position of power and Emmanuel in a powerless position.

"It's really alien that you don't get to, like, touch them or hold them like you have to ask permission to do so. Uhm…and yeah, I think it's like, it's like, you really helpless as there's, there's nothing you can do. Uhm, and I think yeah, something fairly strange, like well, quite horrible about seeing a tiny like baby, small and I can imagine, just with an oxygen mask on." (EMMANUEL, 347-353)

There was a sense of a new identity and a responsibility to have a physical connection with his babies, and the lack of choice seemed to have undermined his power as a father, which seemed an uncomfortable feeling to tolerate. He used the term "alien" to describe his shock and fear of how different and unfamiliar this experience was compared to what he had seen or was the norm. He highlighted a sense of helplessness that his twins were so tiny that

[1] The Schrodinger's Cat is a thought experiment from Quantum Theory where a cat is placed in a sealed box with a lethal cyanide container which can kill the cat. However, until you open the box and observe the cat, the cat is simultaneously dead and alive.

he could not protect them, communicating a sense of failure for not being able to take away their suffering.

William recalls a different experience in which he had to take extra precautions before he was allowed to touch his baby. He described receiving the necessary guidance from the nurses to help him hold his twins. It appeared that waiting for direction from HCP seemed to be a safer option to prevent further harm to the babies. The powerlessness was strongly evident in his phrase, "You can peel the skin", highlighting the seriousness of the twin's conditions and the possible irreversible risk of touching the babies.

> *"Wash and triple wash your hands, which is fine again. Umm, make sure your hands are like super dry, like umm dried out. Most of them moisturised and like in between washing your hands, but also don't rub your finger on it, across their skin because if you do it, you can actually peel their skin back. And you're like, ok then, I can see my child's organs. I don't really want to touch them." (WILLIAM, 872-880)*

Furthermore, the phrase "I don't really want to touch them" demonstrates the conflict between the responsibility in protecting and powerlessness in his inability to protect them and the possibility of causing further harm if he does not carry out steps correctly. As a responsible father, he is to protect his babies. Nevertheless, he was put in a situation where one mistake could mean their lives were hanging by a thread, underlining the helplessness and reluctance to touch the babies against his wish.

Oliver described feeling powerless during the C-section. There was a sense of helplessness and being inadequate to help his wife as she was about to be cut open by an invasive medical procedure, which seemed like a violation.

> *"All I felt, kind of powerless, that it's, I want to help, but all I can really do is sit there and hold her hands." (OLIVER,* 427-429)

It appeared that Oliver was worried about possibly losing his wife and babies. This highlights the powerful emotion of feeling terrified and a perceived lack of control over the birth and fulfilling his duty as a husband and supporter. There seems to be an underlying guilt about being unable to contribute to birth other than being present and coaching her through holding hands.

In this excerpt alone, Benjamin described the double whammy he experienced in this journey. He referred to the possibility of losing the babies and the devastating impact of this loss on their long-term relationship.

> *"The negative outcome isn't just that we didn't get the babies that we thought we were going to have but would also be that we would have to carry with us this huge sense of loss and this huge trauma for the rest of our lives." (*BENJAMIN, 634-639)

It appeared that Benjamin felt that not only he had to grieve for his twins but also worried that the loss would have a ripple effect and crush their loving relationship, that they would never recover from it. The possibility of losing both babies and his relationship likely added to his distress and powerlessness. Jacob described a similar fear due to a lack of control over the situation. He used the phrase "bleeding out and then being taken away" to communicate the terrifying moment in his life and the lack of agency that left him powerless.

> *"Just witnessed the, the person that I love, bleeding out and then being taken away in a sort of fury of people and alarm bells." (*JACOB, 334-337)

There was a sense of responsibility toward protecting his wife and an underlying guilt for his inability to protect her from this traumatic experience. He seemed resentful and frustrated at himself for the lack of power and failure to protect his wife and at professionals for disappointing and betraying his trust, as described in sub-theme 3.4.2.

3.5.2 A sense of inadequacy in sharing the burden

Experiences of feeling inadequate in sharing the burden or supporting their partner and babies represent the frustration and guilt participants experience toward themselves for not being enough and not having the power to control or change the situation in favour of their partners and babies. All participants but one spoke about this sense of inadequacy in their journey.

David spoke about his struggles with his daughter's diagnosis and the impact of this traumatic experience on him so that he became ineffective and needed support from his wife to get through difficult moments.

"My one quite early struggle was there; there was a point when she, you know, was taking care of babies herself. But then, at times, probably also me as well, because when I wasn't really coping when I, when I, when I was, you know, really struggling with, um, you know, certainly around the meningitis diagnosis. There were, there were days when I just couldn't really function at all really, so that, that, that was certainly a mental load on, on Linda." (DAVID, 1104-1111)

In his narrative, he communicated that he had failed to carry out his responsibility, and there was a sense that he had been weak and had let down his wife and babies. David stated, "I wasn't really coping", highlighting that not only could he not protect and support his family, but he lacked the strength to cope and has been a burden on his wife's shoulder, bringing shame to his 'manliness. Moreover, there was a sense of being inadequate and not good enough of a partner and a father for his family. William shared a similar feeling when he described prioritising work over his wife's pregnancy and needs. It appeared that he felt guilt and remorse for not taking his wife's complications seriously.

"I'm at work. I can't do anything. You have to sit there, and you have to find out. You have to be. I don't think I said anything at all. But I think you just have to be

something along the lines of you just gonna have to get on with it. Because being the male, being an arsehole essentially at the time, the lack of any other way of putting it." (*WILLIAM,* 295-301*)*

There was a sense of failure and shame for not intervening at the right time. He used the phrase "being the male, being an arsehole", highlighting his deep shame and guilt for his insensitivity towards the seriousness of the risk to his wife and babies and that he failed to protect and fulfil the expectation set by himself and society, thus bringing shame to his 'manliness'.

Emmanuel described his sense of inadequacy about his twins. It appears that his babies were very premature and looked unhealthy, which felt surreal. It seems that he attributed responsibility to himself that he had to do something to help his babies breathe and survive.

"They were so small. Uhm, like smaller than I'd ever thought that a baby could be. But umm, and then they, they couldn't breathe on their own." (EMMANUEL, 331-333*)*

There was a sense of failing and powerlessness for not being able to do anything to protect them as their father. Oliver described his experience of not being good enough in his wife's eyes. He spoke about his effort to help his wife and care for the babies, but what he did was unsatisfactory.

"We had a bit of an issue where she wasn't happy with the way I held them to feed them, and I didn't, I didn't know why. Ohh, I didn't know what it was I was doing wrong." (OLIVER, 792-795)

His narrative suggests, he felt pushed out, disrespected and under scrutiny, and his role was overlooked when all he wanted was to have father-baby time and contribute to the

caretaking of the babies. The repetition of "I didn't know" highlights confusion and frustration and resonates with the powerlessness he had experienced in not being enough.

Jacob described his experience of guilt he has been carrying since his wife was on the brink of death.

> *"I feel tremendous guilt around what she went through because ultimately it's not something I could share the burden with." (JACOB,* 461-463)

It seems that he felt inadequate to protect his wife from suffering and attributed her suffering to himself, blaming himself for what she went through and not having the power to contribute to the pregnancy. There was a sense of guilt that he was physically fine whilst his wife was fighting for her life, highlighting a feeling of being deficient.

3.5.3 Feeling ostracised from maternity services by the COVID rules

The COVID-19 tragedy profoundly impacted everyone worldwide and induced feelings of powerlessness and lack of agency. The pandemic rules imposed strict social distancing restrictions and enforced closure and complete lockdown for several months. The hospitals were the first to enforce these and remove visitor rules, including fathers. Over half of the participants described feeling excluded and ostracised from the antenatal appointments or birth imposed by pandemic laws to prevent transmission of the COVID-19 virus. Fathers were completely at a disadvantage with the diagnosis, and it appeared that the pandemic had tripled the distress and the distance they had with their partners and babies.

David described feeling sad to be excluded from attending the appointment and that his wife had to process the diagnosis alone.

> *"You in an ideal world you wouldn't be alone when you've got that news. And it does upset me because, because, she could have got much, much, much worse news, right?"* (*DAVID,* 1399-1402)

There were three underlying layers to this narrative: a sense of unfairness for lacking the option to choose, helplessness in failing to fulfil his responsibility to emotionally support his partner and powerlessness brought forward by the loss of the precious moments he could not get to see whilst his babies were growing inside the womb.

Emmanuel described the restrictions and exclusion from appointments robbed him of precious moments of observing his twins grow.

> *"I wasn't allowed into any of them (scan). Uh, so I didn't hear their heartbeats or I hear any, any sounds from them". (EMMANUEL,* 213-214*)*

There seemed to be a sense of loss and grief of cherished moments that he could never get back. Moreover, it is likely that not taking part in the appointment created a separation from the babies and the pregnancy that he did not have control over.

William described positive feelings about the lockdown, thinking it would be ideal because he did not have to worry about going to work and balancing work and family. Instead, he saw lockdown as a gift of spending more time with his family.

> *"We locked down, and then I thought it was great. I feel I'm not working more. This is simple as that. I don't have to go into work because physically the pub cannot open. I've not got a job. And then they told us we couldn't actually go into the NICU because they locked down the NICU completely*." (*WILLIAM,* 1147-1154*)*

He highlighted that this positive feeling was crushed into sad news by the lockdown of the NICU, which meant he was not allowed to see his babies for the unforeseeable future. His exclusion from NICU seems to have contributed to his feeling of sorrow, powerless, isolated, and insignificant.

3.5.4 Navigating the barriers to bonding: "They're newborns for a really long time."

Most participants spoke about the uncontrollable challenges and barriers to bonding during pregnancy or their NICU stay. They described the desire to be with their babies and spend time with them but were either prevented or did not have the freedom other parents had in LRP. Some fathers mentioned that bonding was facilitated when the baby could interact and respond to the parents, which seemed to have taken a long time for some of these fathers. For example, Emmanuel described his experience of not feeling like a father for some time after birth. This was due to the babies being attached to medical equipment for support which prevented him from holding or cuddling his babies.

> *"To be honest, you're not a mom or a dad, and it's not, it's not normal really, it's not Iike a normal scenario to find yourself in where there's they're that small, there's that many sorts of tubes and wires and, yeah, you like, it was really quite an alien feeling, uhm any, any of my friends or family that have had, had kids, you, yeah, you get to like bond with your first child straight away. Uhm, whereas we had to wait two months or so, and so, we, we had we held them for the first time two days after they were born." (EMMANUEL, 413-422)*

The limited contact and physical separation from the babies seemed to have obstructed their initial bonding. In his narrative, he compares his experience with his friends, and it appears that this was a surreal experience that he could not come to terms with for some time. He stated, "We had to wait two months", which highlights a sense of grief for being robbed of special moments of not bonding immediately with babies. William described a similar experience where he had to wait weeks to be able to hold his babies. Limited physical contact with his twins seemed to contribute to the reduction and gradual bonding with the babies.

*“There was no direct contact for about three weeks, and even then, it wasn't direct contact for me. It was skin-skin for mum, so it was…um… It was disbelief. It was confusion.” (*WILLIAM, 896-901).

Even when the baby was older, he still was not the one to have skin-to-skin contact with his babies, reiterating the sense of exclusion, helplessness, and invisibility, which links this sub-theme closely with the sub-theme (3.5.3). He talks about “disbelief”, which seems to indicate the powerlessness in the lack of having a role to be with his babies.

Oliver described waiting a long time before he could feel confident that there was a relationship between him and his twins. It seems that bonding developed when his twins were able to interact and respond to cues, which seems to take longer for premature babies than full-term babies.

“There's a long, long period of newborn and not really doing much, but then into that second, second maybe third month of right you're actually, yeah, we can actually have a relationship.” (OLIVER, 850-854*)*

There appears to be a sense of helplessness in being the father and an inability to form the relationship. This may indicate a sense of isolation and detachment from other fathers who could bond immediately. The experience of NICU and medical equipment, as well as the babies’ slow growth, seems to be an external barrier to building immediate attachment. He also appears to have distracted himself by attending to the practical care of the babies as a compensatory attempt to build a relationship with them.

Moreover, three participants described postponing their excitement during the pregnancy as there was a genuine risk that the babies would not make it; thus, the risks seem to have prevented them from forming attachments during pregnancy. A small minority described engaging with the baby in the womb during pregnancy and felt it facilitated bonding with the babies. Benjamin mentioned that his fear of losing his twins prevented him

from experiencing excitement and bonding with twins during the pregnancy. He stated that "odds are stacked against you" to communicate that obstacles along the way made the pregnancy challenging to succeed and have a positive ending.

> *"You could try to hold back on our excitement for that, for fear of disappointment, and the odds were bad. You know, the odds are stacked against you, and that's just that definitely stops you being able to [laughing] be excited about something*." (*BENJAMIN,* 142-147*)*

Benjamin's narrative suggests that he may have repressed his joy of becoming a father to avoid disappointment and prepare himself for the worst possible scenarios. It appears that the complications and the fear acted as a barrier to bond with his babies possibly leading to creating a wall between himself and the babies to protect himself from shock, disappointment, and despondency.

3.6 COPING BEHAVIOURS THAT HELP TO ADAPT AND BUILD RESILIENCE

This theme captures the coping behaviours that fathers utilised in the absence of resources and support to get through their HRP. The theme contains four sub-themes highlighting the different activities or actions to cope with this painful and distressing journey. The sub-themes refer to the unique ways fathers have employed to build resilience and regain balance and control over their lives, including their endeavour toward strengthening their relationship and seeking support from family, the merits of the COVID lockdown in coping and the use of internet browsing that brought both positive and negative outcomes.

3.6.1 Unique coping behaviours as an "Antidote" to losing control

All participants described unique ways to bolster their resilience to overcome painful emotions and reclaim control and normal life. One participant, David, described a different

way of coping than others. He described his struggle to accept that his babies were at risk. He used the word “denial” throughout his interview, highlighting his belief that if he did not acknowledge the truth about having premature babies, then it would not happen.

“I remember even, even the week the girls were born, I didn't really, even though they were telling us the girls are probably gonna be born quite soon, I didn't really believe it until they told us the girls are going to be born tomorrow.” (DAVID, 187-191)

The fear of something happening to babies seemed unbearable and difficult to confront, and he needed to use denial as a defence mechanism to protect himself from pain and avoid losing control. This appears to be his way of coping, acting as a barrier to pain and masking how much he was struggling.

Three participants described using practical approaches such as distraction to overcome difficult days. Emmanuel spoke about going for an outdoor exercise to take his “mind off”.

“I often went out for far more than an hour. Uhm… like whether it was running, cycling and, umm yeah, anything to take my mind off.” (EMMANUEL, 182-185*)*

There was a sense of fear that handling emotions would become out of control, and there were not many options on the list due to the COVID-19 restrictions. Therefore, he took advantage of outdoor exercise, which seemed to help him lose track of time and distract his attention from the distressing experience, even for a short time. Similarly, William used “switch off” and “it’s been too much” to communicate the need to take a breather to turn off the mind from the distressing moments.

“You go up there seeing my son. Talked about it with my other half. Go for drive and get outside home showered, new clothes and this. Take an hour or so to myself because I need to sort of switch off with this. It's just been too much.” (*WILLIAM, 1068-1074)*

It appeared that the emotional burden of premature babies, the fear of losing them and powerlessness depleted his energy and resulted in physical and mental exhaustion. By distraction, he seemed to take a short break, regain some energy, and reclaim a degree of control between balancing his work and home responsibilities and attending to his family's needs.

Benjamin described having an older child as a distraction to take his mind off the worries. He used the word "antidote" to illustrate the worries as a poison that had a detrimental effect and his need to use distraction to counteract the impact of the poison.

> *"I think having a four-year-old or three-year-old that was well was very much like an antidote to the worries as well. You know, he was a shining light in a sense that would just that just distract you from something that's worrying you.*" (BENJAMIN, 243-247)

Benjamin used the phrase "shining a light" to communicate that his older son represented life and joy, and it seemed that spending time with him illuminated his day and allowed him to see things differently, hence regaining control and energy to cope with the difficulties.

However, Oliver described the need to speak to a couple of friends with lived experience about his experience of slow bonding.

> *"Speaking to other friends who've been in a similar position, it was, they're saying no, that's quite normal, which was reassuring. Um, but it's strange".* 832-834 - *OLIVER*

Within this narrative, it appeared that his difficulty bonding with twins immediately after birth meant something was wrong with him, which did not feel right. He seemed to need to check with friends to confirm or disconfirm his experience and to seek validation that his feelings were valid and appropriate.

Three participants sought psychological support themselves and were referred through GP or NICU staff members. One participant, Jacob, mentioned that he was contemplating seeking psychological support as he was coming to the end of their second HRP. Emmanuel described being referred to a computerised CBT called Silvercloud. Despite his ambivalence toward completing the course, he pushed himself to complete it and found it helpful.

"I was able to apply a lot of the things from the CBT, quite like ohh always, I think I got a lot more disciplined once the girls were born". (EMMANUEL, 835-837)

The knowledge he gained through psychoeducation seems to have helped him manage his daily routine, concentrate better, and feel in more control of his emotions and life when caring for the babies. On the other hand, David described his experience attending a stress management workshop. He talked about learning strategies that were helpful in other aspects of his life, such as managing catastrophising cognitions. However, he added that the workshop targeted general day-to-day stress and was not tailored to his experience.

"I went on that stress management course. Umm, which I think was a little bit, it's like fighting a fire with a, with a water pistol". (DAVID, 1146-1149)

He appeared confused about how to apply stress management strategies to his acute stress of possibly losing his babies. He used the term "fighting a fire with a water pistol" to show that his difficulties were bigger and different to the normal stress people were experiencing. There was a sense of conflicted feelings about being supported and disappointment in the absence of individualised support.

3.6.2 The significance of relationships in building resilience

Most participants spoke about the loss of social support enforced by social distancing rules during the pandemic and found the isolation and separation from family and friends challenging. The absence of inclusion and support from the hospital had already affected

fathers, and the limited contact with families and friends brought about by the pandemic had further deprived and isolated fathers and forced them to cope independently. However, the adversity has strengthened their relationship with their partner and brought them closer. Family members' physical and emotional presence, particularly with the ease of lockdown restriction, was a significant support. In the first theme, fathers talked about the different layers of responsibilities that could be overwhelming, resonating with this sub-theme that additional help from family members helps improve their mental well-being and reduce their distress.

Half of the participants mentioned that the additional support from family helped and empowered them to attend to their duties of caring for the babies. For example, Jacob described his experience of being unprepared for the baby's sudden arrival. He needed to move to his in-laws for additional support. It seemed that support from family members helped him put his entire attention on his daughter's needs and not worry about other things that needed to be prepared or assembled.

> *"So, I ended up moving into my in-laws that first night with the baby. Uhm, and in that time, you know, my father and all my brother-in-law went to my house, and my keys got the cot that we were gonna do, set it up in their house while I was dealing with the baby, you know, I had all this support around." (JACOB, 378-384)*

Taking her daughter to her in-laws is likely a compensatory approach to cope and compensate for the feeling of guilt for what his wife went through during labour.

Most participants mentioned that the COVID restriction and medical risks improved their relationship with their partner. For example, Emmanuel described that his relationship with his partner was stronger than ever and appreciated the unique relationship they developed further during this journey.

"Our relationship I don't think I could have asked for it to be any stronger, and I don't think at any point ever really changed." (EMMANUEL, 582-585)

There was a sense that due to social distancing, they only had each other to rely on, and it seemed that the challenges of HRP could not shake the foundation of their loving relationship. It seems that they lived this experience together, and no other person on this earth than his partner can understand what they went through. They likely have been understanding, emotionally present and supportive of each other whilst going through this difficult journey.

Benjamin described going through moments where they had to prepare themselves for the possibility of losing their babies. He had witnessed the willingness of his partner to sacrifice her life without blinking an eye to go through a surgical operation and vaginal birth despite the complications and risks to maximise the chance of their twins' survival.

"I mean having to, that you know, having gone through that and having come out the other side, on the right side of all of those probabilities, we're full of a lot of gratitude and a lot of love for each other." (*BENJAMIN, 676-680*)

In addition, it seems that his patience, respect for her decisions, and his role as protector to shield her from further harm added another layer of strength and admiration for each other. This narrative demonstrates the significance of holding each other's hands throughout to get past the bumpy roads waiting ahead.

3.6.3 The lockdown did "a world of good" in spending more time with the family

Five fathers had gone through HRP during the pandemic, and only one father experienced their first HRP before the lockdown and the second pregnancy after the restriction was eased. Fathers mentioned that the lockdown brought unforeseen positive changes that benefitted them and their families. This sub-theme contradicts the sub-theme

(3.5.3), highlighting that the lockdown had further led to the exclusion of fathers and negatively impacted them when their partners or babies were in the hospital. It also offered an opportunity to spend more time with their families after discharge.

Emmanuel mentioned that he was grateful for the lockdown due to the flexibility of working remotely. This opportunity seems to have removed some of his worries about his wife caring for two babies alone.

> *"I was thankful for like the COVID situation, allowing me to work from home. Umm, cause I, if had, I had to have gone into the office, I don't think my wife would have coped*." (*EMMANUEL,* 713-716*)*

It appeared that the lockdown was a blessing; it offered him the opportunity to spend more time with his babies and fulfil his duty of supporting his wife with the caretaking of his twins. In normal circumstances, this may not have been possible, and he may have needed to take the dual task of physically returning to the office and caring for his babies when at home, which seemed stressful. This resonated with William as he spoke about the great benefit of the pandemic on his situation when he stated, "COVID hit did me a world of good". The pandemic seems to have offered the extended paternity leave he was craving.

> *"But not having to go to work because COVID hit did me a world of good. Umm, did my partner a world of good. Definitely. It meant I could be there support Her, I could be there for the kids*." (*WILLIAM, 1182-1186)*

This appears to have been helpful for his well-being, confidence, and self-worth in fulfilling his responsibility of supporting and caring for his family. The lockdown partly seems to have relieved him, meaning he did not need to worry about dividing his time between work and family to be on top of things. For Jacob, the lockdown seemed to have had the additional advantage of strengthening his bonding and relationship with his daughter.

Working from home was an opportunity that gave him more time to spend with his daughter and see her grow.

"Um, and we have a very, very strong relationship, probably also fostered out of lockdown as well. I think it's harder to tell because, you know, she was 3-4 months old when something I'm working from home full-time and a lot more available to help out, which was just great." (JACOB, 642-647)

It is also likely that working remotely meant that Jacob could be of greater help to his wife in caring for their daughter, thus carrying out his responsibility as a partner, father, and protector, which is closely related to the first GET.

3.6.4 The double-edge sword of using the Internet

Most participants needed to understand what was happening to their partner and described the urge to use the internet to look up more information about medical complications. This sub-theme captures the notion of using this strategy to achieve a positive outcome, but it turned out to be a negative experience. David uses the metaphor "down a bit of rabbit hole" to describe his experience of using Google. In his narrative, he tried to communicate that he tried to use this platform to gain certainty and reassurance that things would work out fine but found himself in a chaotic and difficult situation to get out of as more information unfolded about the diagnosis.

"So, by googling that, something we find out TTTS, we google that and then go down a bit of a rabbit hole." (*DAVID,* 210-212*)*

It appears that he used the internet as an attempt to prove that his denial was valid. He may also highlight that looking up information on Google was extremely engrossing and eventually futile. Instead of reducing his anxiety, it left him more worried about the long-term repercussions on his babies. Exclusion from appointments and lack of communication with

professionals likely led him to search the Internet for answers. Emmanuel shared a similar experience of finding vast information that seems to have evoked greater anxiety and stress.

> *"We went on Google a lot and looked it all up, and we found out a lot about it, but and then I think when you read into the details, we started getting really, really worried about it.*" (*EMMANUEL,* 41-44*)*

There was a sense that not only did the information reassure him, but he was also introduced to intricate details and negative stories that made the diagnosis more real and serious. Equally, William described his experience using the internet to find answers to his questions and regain control. Still, he added that instead of making him feel better in the end, he comes out of the internet feeling a lot worse.

> *"You then go to Google, and then you find stuff you shouldn't find on Google, and they make everything worse." (WILLIAM,* 1481-1483*)*

There was a sense of confusion, stress, and helplessness with the wealth of negative stories and information shared on the internet. Using the internet seems to be a compensatory approach for the lack of communication by HCP as he felt there were no other resources than surfing the internet, which is related to the sub-theme of feeling let down by HCP (3.4.2).

Benjamin spoke about his experience that the internet encouraged him to build internal protective armour to shield himself against negative stories with sad endings.

> *"You put up a bit of an emotional shield to the negative stuff once you start really digging in into it, you almost become a bit cold or a bit more emotionless about the way you face it."* (*BENJAMIN,* 212-215*)*

Browsing online seemed a helpful coping strategy to desensitise and brace him for the worst and nasty surprises. Reading all those stories seems to have indicated that there would be no nasty surprises. There was a sense that reading assisted in forming a detachment from the pregnancy, which seemed to have prevented bonding with babies until they were born.

Jacob used the internet for a different reason to find information and resources for himself. He appeared eager and open to seeking support following the traumatic birth experience and needed to surf the web pages for resources tailored explicitly to fathers. Here he highlighted the absence of resources and support for fathers, which is resonant with the second GET.

> *"I go on, you know, birth trauma association, you go to the father's bit, and it's either about depression or which is small paragraph for it. It tries to lead you to another site which leads you another site, and then it's just Samaritans or mind, and it just comes under general mental health."* (*JACOB,* 741-747)

There seem to be websites that acknowledge and briefly talk about the fathers; however, he highlights that the number of support services available in the UK is very limited. It appeared that searching led him nowhere. He also used the term "comes under general mental health", conveying that fathers' experiences and struggles are not considered as important and that there was a lack of understanding that fathers have different needs and require tailored support.

3.7 Chapter Summary

The analysis presented four GETs from an IPA study with supporting excerpts from participants. The first theme introduces the fathers' experience and their additional roles and responsibilities during and after pregnancy to look after their families. It highlights how the 'self' becomes less important, and the focus primarily shifts toward prioritising the family's needs above their own. Participants demonstrate their endeavour to support their partner, make the pregnancy less frightening and an easier journey for her, and take part in the continuous task of caretaking their babies when they are born.

The second theme builds on the sense of being invisible, unrecognised, and overlooked by maternity services and employers and necessitates the need for more

recognition and support for fathers. There is a sense of advocating for the father to be treated fairly and equally as they are on this journey together with mum and are similarly, if not equally, affected. The findings revealed a lack of acknowledgement and inclusion of fathers' experiences in communication, support, and paternity leave, which likely led to frustration, disappointment, and let-down.

The third theme reveals the four huge blows of powerlessness that participants experience during the HRP, from feeling eclipsed by helplessness brought by the rapid progression of medical complications. Several participants felt powerless and inadequate to support their partners and babies better. Notably, participants described their experience of exclusion from antenatal appointments and during the pandemic and how the lockdown deprived them of being part of their babies' precious moments and supporting their partners, describing how this further contributed to feeling devalued, insignificant, forgotten and like a failure. The data uncovered that the medical complications and the babies needing intensive care during NICU stay likely have contributed to the excruciatingly gradual development of attachment.

The final theme represents the helpful and unhelpful coping behaviours used to cope with challenging experiences and emotions in the absence of support from services. The first sub-theme aimed to capture the unique coping behaviours of each father to demonstrate how they engage in certain activities and behaviours to reclaim normality and prevent losing control. The second sub-theme emphasises the importance of being in a relationship with others and relying on family members and on each other to gain validation, strength, and energy and grow stronger together. COVID-19, in the third sub-theme, may not be a coping behaviour, but the opportunity it created seemed to offer fathers plenty of time to be with their families. The last sub-theme represents a double-edged sword of using the internet,

which demonstrates a desire to gain reassurance but find themselves reading stories that have likely contributed to additional distress and sadness.

Chapter Four

Discussion

4.1 Overview

This chapter presents a consolidation of the findings of a study of fathers experiencing HRP using an IPA methodological approach in relation to the existing literature presented in Chapter One and the broader context, reflecting the nature of the IPA that the analysis will take the research into a "new and unanticipated territory" (Smith et al., 2021, p.116). The discussion will also present the most recent studies that have found similar findings whilst this research was in the recruitment process and write-up and, therefore, did not inform the design of this study.

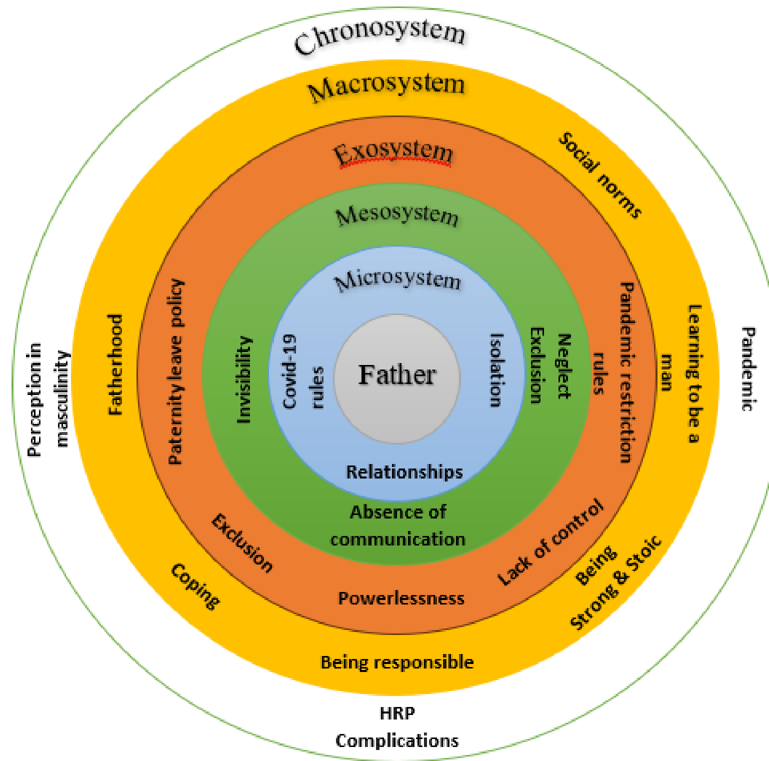
Much of the context of the findings has been explored in the contemporary literature, such as adopting new responsibilities (Phares et al., 2005; Yeung, 2012), lack of acknowledgement and support for fathers (Kaye et al., 2014; Lindberg & Engström, 2013) and feeling powerless throughout HRP (Ionio et al., 2016; Patel et al., 2018). However, the study highlights novel findings discussed in this chapter. The implications for CoP and the wider context will be discussed. The findings of this study will be compared and assessed against Yardley's quality guidelines to ensure the study meets the quality criteria. The identified limitations are discussed, and the chapter concludes with possible suggestions for future research.

4.2 Incorporating findings into Bioecological system theory

The diagram aims to represent this study's findings and help understand how the bioecological system theory explains fathers' experiences (See Figure 2).

Figure 2

Findings incorporated in bioecological systems theory



(Diagram created by author)

Although this theory might not directly address the voice of fathers, it shows the complexity of the family and wider system and their impact on the father and the whole family. The insight gained from the findings of this study could help medical professionals, midwifery teams, psychological practitioners, and policymakers to work together towards careful planning before making decisions and consider the impact of these systems on the father and the whole family. Inattentiveness to the influence of layers on fathers can result in paternal distress and affect the father, mother, and babies.

4.3 Men as a Responsible Being

This impactful theme reveals fathers' devotion to their families to the extent that they see their needs as unimportant and perceive themselves as entrusted with prioritising and protecting their families. They seem to struggle to allocate time to themselves or consider self-care and give up themselves entirely for their partners and babies. This is likely due to the expectations set and reinforced by society on masculinity and fatherhood, which could explain the additional responsibilities they adopt to be on top of things such as being the breadwinner and managing the household activities to help their partner and provide for the family. Also, fathers feel guilty that their partners put themselves in danger of giving birth to their babies. This places fathers in a weak and powerless position that they cannot carry the babies and share the complications endured by their partners. They perceive themselves as less than the mother and thus minimise their own needs and question the legitimacy of their right to seek support.

There are multifaceted factors that could play a part. They likely feel that they do not deserve to attend to their needs when their partners' lives are at stake whilst enduring complications. Society could play a part in shaping and building on how fathers define their masculine identity as the breadwinner, such as needing to be strong enough to protect and provide for their families. Moreover, it appears that due to feeling guilty for what the mother endures, they feel worthless and unconsciously endeavour to compensate in different ways for their lack of contribution to the pregnancy. As a result, they devote all their attention and energy to protecting their partners and babies from the associated risks, a new identity to which they need to adjust. The finding is consistent with previous studies that fathers give of themselves throughout HRP and accept various responsibilities at the expense of their own needs (Hsieh et al., 2006; Koppel & Kaiser, 2001; Pohlman, 2005). However, limited research explored this sense of guilt that fathers experience for what the mothers go through

and perceive themselves as responsible for helping in any way they can to contribute to sharing the load and compensate for their inability to carry the baby and endure the complications.

The health condition of the mothers and giving birth to premature babies meant that fathers needed to support their partners and constantly attend to their babies' needs all day without stopping, which seems to have made it difficult to distinguish between the hours of the day. Some participants explicitly described that caring for the babies included following specific routines across the hours, always wearing the babies, and looking after older children. Fatherhood brings new changes and identities where fathers' lives revolve around supporting their partner in caring for the babies or being the primary caregiver until the mother feels well enough to take over. The size, fragility, and fear of losing their premature babies likely have encouraged fathers to become overprotective and wrap their babies in cotton wool.

The responsibilities placed on fathers' shoulders are not a new concept, and prior studies have highlighted fathers' increased commitment and involvement in sharing childcare duties (Gómez-Cantarino et al., 2020; Noergaard et al., 2017). In contrast, the current research also highlights that fathers assign expectations to themselves and experience multiple layers of stress due to the constant demands of the babies and the pressure of fulfilling different roles. The worry of losing the babies or partners or long-term complications and the powerlessness over the inability to take their suffering away can leave fathers feeling responsible for becoming more involved in the caretaking, which in return could help them reclaim the lost control and their endeavour to fulfil their responsibilities can lead to a sense of meaning and confidence.

4.4 Fathers Equally Deserve Recognition and Support

Within the literature, there appears to be a contradictory message between an increasing call to recognise the fathers' needs and include them in support (NHS, 2019) juxtaposed against the ongoing invisibility of fathers in services, appointments, and communication (Aarnio et al., 2018; Elder-Avidan, 2011; Lindberg & Engstrom, 2013). The data in this study mirrors previous studies in that support is considered for mothers and babies but not for fathers. Multiple reasons driving this were their negative experience of feeling left out, devalued, and ignored from appointments, communications, and support by maternity services. Nevertheless, they were treated as if they did not exist, resulting in injustice and inequality in how they were treated.

Strikingly, the participants explicitly described that they were equally affected by the journey and showed a strong desire to be treated equally to the mother by HCP and maternity services. This desire seems to conflict and contrast with perceiving themselves as less than the mother and undeserving of attending to their own needs. The absence of support and lack of acknowledgement of fathers was not only experienced during pregnancy. However, it was extended after birth for some fathers, negatively impacting their psychological well-being and sense of self in fulfilling their responsibility as a partner, father, and protector. The exclusion from support and services has led to frustration, isolation, powerlessness, and distress, further affecting their sense of worth and impeding their ability to support and protect their partners and babies. The resulting powerlessness represents the power imbalance between professionals and fathers, demonstrating how decisions made for fathers could put fathers' mental well-being at risk (Figure 2). Moreover, the lack of acknowledgement and exclusion of fathers from support can reinforce hegemonic masculinity (Courtenay, 2000) and push fathers into suppressing their feelings, remaining strong, and coping independently.

The current findings support previous studies, highlighting a lack of acknowledgement and support for fathers, which impacted their perception of their roles during pregnancy and prevented them from supporting their families (May 1994; Plantin et al., 2011; Vallin et al., 2019). The quote chosen for the title of this thesis, “I’m not the person carrying the babies; I’m the one who has to deal with the fallout" (*David, 19-22*), demonstrates that HRP jeopardises not only the mothers but also the fathers. In addition, overlooking and neglecting the father's needs and well-being can also mean that the mother’s and the baby's well-being and needs will be neglected, thus affecting the whole family and the wider society (Bronfenbrenner, 1979).

Most fathers expressed a need for HCPs to keep them in mind, approach them and ask how they cope. This finding reveals implicit social norms attached to men and fathers to fit the ‘hegemonic masculinity’. These qualities seem to have been internalised by the participants of this study, which includes that they should be able to cope on their own and asking for help brings shame to their masculinity. This may help to explain the difficulties fathers experience in talking about their feelings. Therefore, the finding highlights that it could be easier for fathers to talk about their experiences and feelings if the HCP approaches them, hence showing the importance of the HCP adopting a curious stance and asking how the father is doing, which appears less present in the literature.

Some participants described their disappointment in HCPs for the absence of communication, lack of knowledge about the cause, and disrespect for their decisions. Not knowing what could happen to their partners and babies left fathers in a state of uncertainty, looking for answers. The absence of communication (represented in the mesosystem) contributed to anger, frustration, distress, and powerlessness, which appear to have impacted their sense of worth, control over the situation, and their role as protectors and supporters and caused uncertainty about what could happen to their families. This shows the complexity of

the fathers' direct and indirect relationship with HCP (Figure 2). Being included and receiving simple and transparent communication was crucial for fathers to feel supported, reassured and involved. This finding confirms the previous studies that highlighted fathers perceived communication as insufficient and inconsistent (Hsieh et al., 2006; Hollywood & Hollywood, 2011; Lindberg & Engström, 2013). The absence of communication and failure to notice and include fathers have provoked strong feelings, such as frustration, betrayal, and distrust in the HCP, and the unwillingness from the HCP likely made it more difficult for them to seek communication or support. This finding appears to be less present in the existing literature.

One of the most striking findings highlighted the unfairness resulting from being entitled to the same amount of paternity leave as fathers with LRP, which led to feeling unimportant and forgotten. Their employer had strict policies around paternity leave, highlighting a lack of acknowledgement of fathers’ unique and challenging circumstances. The paternity leave policy represents the power of the exosystem, leaving fathers feeling powerless and lacking control, which could increase paternal distress (Figure 2). This seems to have left fathers under pressure to return to work whilst their babies or partners were still in the hospital fighting for their lives. This appeared to conjure various feelings such as anxiety, worry, anger, frustration, and helplessness in fathers. They appeared to be under immense pressure to balance work commitments and caring responsibilities to keep their job and provide for their families. This may help explain how society, including work and maternity services, perhaps inadvertently reinforces the fathers to neglect their own needs.

The system shows that when fathers are not given a voice before making decisions about them, it can result in a range of feelings in fathers, which could impact their partners and babies. Fathers might not be in the right mental state to focus on work, which could impact their work performance. Hence, it is crucial for employers to consider the father’s

circumstances and for fathers to be considered part of the family and one unity when making policies. This finding contradicts the previous findings that returning to work was a distraction and therapeutic (Feeley, 2012; Hollywood & Hollywood, 2011; Lundqvist et al., 2007). Only two studies briefly referred to work constraints on fathers whilst their babies stayed in the NICU (Hollywood & Hollywood, 2010; Thomson-Salo, 2014). Previous studies have seldom explored the pressure to return to work and the impact on fathers.

4.5 Quadruple Whammy of Powerlessness

The findings reveal that participants found themselves in a powerless, vulnerable position at different times whilst navigating HRP, where they felt they lacked control over complications, birth, and their time in the NICU. In this study, powerlessness manifested itself in four ways, some explored in previous studies.

The perception of masculinity has changed over the years from supporting the mother to having a shared responsibility (Johansson & Klinth, 2008), representing the chronosystem. Fathers have developed a more caring attitude and are expected to be more present and involved in caring for their children (Bekkengen, 2003). This study revealed a compelling finding that the fathers felt inadequate and incompetent when they could not contribute to the pregnancy and protect their partners and babies. They felt a sense of guilt and failure, resulting in powerlessness for letting their partners down and their inability to take the burden off their shoulders. Powerlessness appears inevitable in HRP due to unexpected complications and complicated birth. This negatively impacted their psychological well-being, such as feeling stressed, helpless, weak, defeated, and frustrated, and their sense of self as fathers and protectors. Looking at the systems, these feelings do not only result from unpredictable complications but also from decisions taken for fathers by medical professionals, policymakers, and local authorities, impacting how fathers feel about

themselves and how they cope and support their families. Therefore, this study suggests that if fathers' psychological needs are unattended, their mental health could be compromised, which in turn could impact their families and their relationships with family members, friends, and work colleagues, hence the importance of recognising their needs and including them in support. This finding is consistent with previous findings, which highlighted that medical complications could lead to feeling inadequate in caring for their families (Condon et al., 2004; Ionio et al., 2016; Morse et al., 2000).

However, it appears that for some participants, the inability to help, powerlessness and sense of inadequacy contradicted their 'caring masculinity' and threatened parts of their masculine identity, particularly the need to be strong and protect the family. Feeling like a failure can likely arise from feeling ashamed of themselves as men and the inability to fulfil the roles and expectations assigned to them. Consequently, fathers may experience a conflict between not knowing where they should fit between 'hegemonic' and 'caring' masculinity (Connell, 1988; Latshaw & Hale, 2015). Therefore, understanding shame and how fathers define masculinity is essential to understanding how fathers perceive and relate to themselves. It is crucial for mental health practitioners to support fathers in exploring and working on their sense of self, inadequacy, and powerlessness.

The study aimed to understand fathers' experiences of the pandemic. An additional layer of powerlessness was brought about by COVID-19, which seems to have resulted in further exclusion and marginalisation of fathers from appointments, birth, and separation from babies in the NICU. This research has revealed the value the fathers place on proximity to partners and babies during HRP and birth as it offers them the opportunity to protect and support. Separation from the partners and babies has led to feelings of powerlessness, frustration, anxiety, grief, disappointment, isolation, and devaluation, leaving fathers helpless and vulnerable. The psychological well-being of the parent is suggested to improve following

attending antenatal care (Burgess, 2011). However, the option of being present at appointments and birth, supporting their partner, and caring for the babies in the NICU was taken away from them. This likely reinforced the idea that fathers are the least significant person in the family and that their presence and needs are not important. In addition, the microsystem shows that the strict rules around the country also meant that fathers had less contact and interactions with family and friends (Figure 2), leaving fathers feeling isolated with fewer coping tools to manage the challenges of HRP and fatherhood in the pandemic.

Excluding the father from appointments prevents both partners from sharing and processing emotions (Coutinho et al., 2016). Therefore, including fathers in appointments, births, and hospitals after birth is crucial for different reasons. It allows fathers to support their partners and feel acknowledged and involved. The finding confirms previous research that fathers generally felt ostracised by maternity services and experienced a sense of loss of precious memories that they could never take back (Andrews et al., 2022; Tarrant et al., 2022). However, these studies only focused on LRP and research on the impact of COVID-19 on fathers' presence is limited (Kostenzer et al., 2022).

A strong narrative also appeared, demonstrating that bonding develops gradually and takes longer for fathers with HRP, which can increase emotional distress, frustration, and anxiety. Bonding can be affected by both internal and external barriers. The internal barriers, such as the inner protective guard, led to holding back from the excitement and helped adopt a detached stance toward pregnancy to protect themselves from later disappointments. Multiple reasons driving this postponement were the fear of loss, disappointment, despair, and lack of control, which led to a gradual bonding and likely developed a separation from the pregnancy and babies. Additionally, this detached stance likely helped fathers to cope, and it was a conscious decision to help them remain strong to keep the family together if something were to happen to the babies. There is a limited exploration in the existing

literature highlighting that fathers preferred not to prepare for their babies due to uncertainty that something would happen to them (Tanasirijiranont, 2019).

There were also external barriers such as complications, medical equipment, the size and appearance of the babies, and COVID-19 preventing fathers from having physical contact with the babies and cherishing special moments they envisaged they would have. Fathers had to patiently wait weeks or months before they could interact and bond with their babies, meaning that they were left with grief for the loss of contact and the absence of immediate bonding and had been robbed of these precious moments that they could never regain. They had to be granted permission by professionals and go through a series of steps before they could hold their babies. Moreover, fathers patiently endured the stress and uncertainty, hoping that the risks would end with the birth of babies. However, they were heartbroken to discover they did not have the parental autonomy to hold or physically touch their babies whenever they wanted. Fathers suppressed and sacrificed their needs and desire to hold their babies for two reasons. They were terrified and ambivalent about touching and holding their babies. They were particularly worried that by moving them, they would dislodge the machines or tubes, which could cause more harm and put the babies at greater risk. This could stir up feelings of fear and inadequacy in fathers, which could explain the powerlessness and helplessness fathers feel in being unable to reduce their babies' suffering and struggling to bond.

The lack of physical contact with the babies appeared to delay attachment formation. This finding corroborates the previous studies that separation from babies in NICU resulted in restricted contact with the babies due to special medical requirements (Shahkolahi, 2014) and disrupted the bonding process (Rahimi et al., 2022). This evoked complicated feelings for the fathers, including grief and sadness, as their experience appeared to be different from the norm or what they had imagined it would be. The powerlessness in preventing further harm

and protecting their babies provoked great fear and emotional distress. The current finding supports the previous study that fathers experience fear and anxiety about having physical contact with their babies if they cause further harm (Hollywood & Hollywood, 2011; Lee et al., 2009). This finding adds to our understanding that fathers experience trauma and several challenges throughout HRP and the NICU, and it suggests that an improved response from HCP needs to consider the conflicted response, e.g., increasing contact to address the disrupted bonding may induce more fear and detachment from fathers. Thus, this study provides a deeper understanding of the nuanced experiences of fathers, and it reflects on the importance of developing services and encouraging HCPs and mental health practitioners to monitor fathers and offer them psychological support.

Furthermore, this study highlights that COVID-19 and the exclusion from services have left fathers traumatised, increased their anxiety, and led to further isolation and marginalisation. The exclusion from maternity services during the pandemic is consistent with recently published studies (Adama et al., 2022; Govindaswamy et al., 2023). Since the pandemic happened, there has been a lack of literature on the impact of the pandemic on HRP, particularly in the UK, which makes this research timely and impactful. Exclusion from appointments and reduced paternal engagement brought about by COVID-19 restrictions have likely further disrupted the bonding. Limited studies highlighted the impact of COVID-19 restrictions on fathers' bonding with their babies following HRP.

4.6 Coping Behaviours

This theme encapsulated the unique ways in which fathers have coped with the distressing moments of HRP. These are using distraction to take their mind off the tormenting moments, spending time with older children, seeking support from family and friends, and following a rigid structure. Distraction and seeking support from families are consistent with

some coping behaviours explored in previous studies (Hollywood & Hollywood, 2011; Strauss et al., 2019). The coping behaviours found in this study are interpreted as an attempt to regain energy and reclaim the lost control over worries but also to get away from the challenges and escape to what is known as familiarity and safety. One father described being in denial since receiving the diagnosis, which helped him get through the HRP. Denial is a primitive unconscious defence mechanism that facilitates escape and avoidance of an intolerable situation (Freud, 1936), which seems to have helped him maintain control over the situation by keeping himself at a distance and avoiding the unpleasant and painful reality of the diagnosis.

It seems that it is impossible to escape from reality, but it becomes easier when it is done mentally through distraction and avoidance. It appears crucial for fathers to hide that they are falling into pieces due to their responsibility toward their family and the desire to demonstrate their masculine self through being on top of things. This study demonstrates the uniqueness of fathers' experiences and their engagement in protective/primitive coping behaviour to distort their perception of reality to cope with the challenges of HRP.

Most participants sought or thought about seeking psychological support through their GP or NICU setting. The trauma, anxiety and stress from near-death experiences consumed much of their time, energy, and concentration and affected their daily functioning. It appears that the distraction and avoidance used as coping strategies became ineffective, and they have exhausted all the limited resources they could find. Hence, there was a need for professional support not to lose control and be able to feel like themselves again, mainly when their babies were in the NICU or after they were discharged from the hospital.

Fathers had to look for and ask for psychological support themselves. Although psychological support was beneficial in addressing the general stress, it was not tailored to

the specific experience of some fathers. The emotional support provided fathers with a toolbox of psychoeducation and coping strategies to help them manage their day-to-day stress. However, fathers preferred to have support tailored to them and offered by a professional who understands fathers' experiences. This means that offering psychoeducation alone might not be sufficient and can discourage fathers from seeking emotional support. Therefore, considering fathers' subjective experience is crucial to conceptualising their presenting problems and interventions. This finding is limited in previous studies as midwifery teams and nurses have conducted most studies. Only one study explored the benefit of psychotherapy sessions on fathers (Lakatos et al., 2019). Hence, the paucity of research studies indicates that it is paramount to understand how fathers feel about psychological support and the need to offer psychological support to help them process their emotions and trauma.

This study also aimed to understand how the experience of being in a heterosexual relationship made a difference in fathers' experiences. The novel finding was that all participants mentioned that their relationship with their partner strengthened during the HRP. Previous research demonstrated that sharing experiences with other fathers and families was a vital resource and support for fathers (Baldwin et al., 2019; Sloan et al., 2008; Hsieh et al., 2006; Bratt et al., 2015). However, during the pandemic, this opportunity was taken from them due to social distancing rules and the closure of the services and network groups, meaning that expectant parents were prohibited from seeing friends and families during the national lockdown, which seemed to have put more pressure on them to adopt more responsibilities. Therefore, if a thoughtful care plan can be considered for fathers, considering the systems to ensure the impact is minimised, particularly in unprecedented circumstances, fathers might start to feel more supported and have more coping tools in their toolbox. Bronfenbrenner's theory does not explicitly represent coping behaviours. However, the

undesirable power at each layer and its impact on fathers may force the fathers to utilise limited coping behaviours to cope with power imbalances, injustice, inequality, and lack of support.

The only support they were left with was to hold on to each other, which increased their admiration and appreciation for their partners when they saw what they had to endure to give birth to their babies. They seem to idealise their partners for their determination and giving up on themselves to give life to their babies. Thus, their sacrifice encourages the father to foster and deepen their romantic relationship. This finding contradicts the previous studies (Mirzakhani et al., 2020), although only one study reported that 12% of their participants felt that their relationship was strengthened by their experience of having premature babies (Stefana et al., 2021).

Another finding was that the pandemic had merits for fathers. Although it had taken away special moments and isolated them, most fathers perceived the pandemic as a blessing, providing them with the extended paternity leave they desired. The national lockdown offered them the flexibility of working remotely or being on furlough, meaning they could stay home, support their partner, and spend more time with their babies, which might not have been possible otherwise. Further exclusion from appointments, birth and NICU caused by the pandemic and the loss of being present with the babies in their early hours or days was compensated by the gift of national lockdown. The pandemic took away something special but offered a unique opportunity to fathers. The finding of this study reveals that the national lockdown, despite its consequences, alleviated fathers' distress and took a layer of anxiety off fathers' shoulders as they did not need to worry about returning to work, mainly when their babies were discharged from the hospital. So far, only one recent study found that fathers

enjoyed the flexibility of working from home (Andrews et al., 2022), and little is known about the benefit of COVID-19 on fathers.

The result also revealed the double-edged sword of seeking online information as a coping strategy. The urge to seek information online likely stems from compulsion, intolerance of uncertainty, reassurance seeking, and mistrust in medical professionals. It can result in cyberchondria, a term used to show the aggravation of anxiety following repeated online searches (Starcevic, 2017). Fathers were bombarded with details and stories that resulted in more worries, confusion, and regret. Being excluded from appointments during the COVID-19 pandemic and the lack of information and conversation for fathers leaves no space to get their questions answered. This seems to leave fathers in a vulnerable and powerless position where they experience an urge to find answers through possible different mediums, and the internet is one of them. The intention seems to be about finding hopeful information and real-case scenarios that went well, but they were confronted with the opposite. One father mentioned that he used the internet purposefully to expose himself to the worst-case scenarios to desensitise himself so that when confronted by the sad news, he could be shielded from the shock reaction. The masculine identity seems to play a big part in this, perhaps needing to prepare oneself and be the strong one in the family to prevent the family from falling into pieces. This novel finding is less present in the existing literature.

4.7 Quality of Research

It is proposed that the quality of this study is assessed against Yardley's quality criteria (2017) outlined in Chapter Two. The sensitivity to context was established through drawing from the literature review, which provides a comprehensive understanding of the historical assumption of fatherhood and the fathers' unmet needs during HRP. The researcher

strove to remain sensitive to the idiographic nature of the participant's unique experience. This has been achieved through reflexivity and maintaining transparency throughout all stages of this study, including recruitment, interview process and analysis.

Yardley (2000) defined rigour and commitment as the researcher's engagement with the topic, the data collection and analysis. Commitment and rigour were considered in all aspects of the research. Researchers are encouraged to listen carefully to what the participants say, which can help develop a good rapport and put them at ease (Pietkiewicz & Smith, 2014). The interview schedule was thoroughly developed following a discussion with the supervisor, which helped to make the necessary adjustments to the probing questions. The researcher tried to remain sensitive to how the participants described their stories, including paying close attention to the words, feelings, and non-verbal cues to facilitate further exploration. During the interviews, the researcher offered her undivided attention and curiosity, actively listened, and remained present with each participant, ensuring they felt safe to share their sensitive story, which could be potentially upsetting. Journaling has helped the researcher to reflect on how the interviewer might have influenced or shaped the interview, the story, and the participants and become more conscious of her biases. The analysis was thoroughly conducted, including reflecting on the interpretations with peers and the research supervisor and using a reflective diary to ensure the interpretative themes closely represented the participants' unique experiences.

Maintaining transparency throughout was achieved by being open and honest about participant selection, data collection and detailed steps of analysis (Smith et al., 2021). The idiographic analysis of each transcript led to the development of explicit themes and sub-themes for the pertinent interpretations made and presented quotes from the interview transcripts. A detailed example of each analysis stage is shown (see Appendix I-K). As a

result, the readers can smoothly follow how the researcher analysed the data and reached the presented findings (Yardley, 2008). Moreover, the researcher endeavoured to demonstrate further transparency by sharing her interpretations with the research supervisor to discuss the themes. Supervision was used to adjust the themes meaning and negotiate any disagreement that may have arisen to ensure the quality of the research was maintained.

Informed by critical realism, the researcher strove to maintain coherence throughout the study by clearly demonstrating and reflecting on the compatibility of the philosophical assumptions and the chosen methodology and how IPA was selected compared to other methodologies. The researcher presented and checked the GETs and sub-themes with an experienced researcher and supervisor to ensure the themes formed a strong argument. By focusing on understanding fathers' rich and detailed lived experience with HRP, it is argued that the research question, epistemological position, methodology and analysis are all aligned in maintaining coherence. In addition, coherence does not end with this study but carries on post-analysis when the research is being written up.

Impact and importance refer to research findings' contribution and practical implications to theoretical knowledge, clinical practice, and the broader field (Yardley, 2000). Good quality research entails telling the reader something meaningful, important, and engaging. The implication is discussed below, and it is hoped that this research's impact and importance have been achieved by offering a fresh perspective on the dilemma and challenges fathers experience through HRP.

4.8 Implication for Counselling Psychology and Wider Context

Both the NHS Long Term Plan (2019) and research studies have been increasing awareness about supporting fathers to reduce their suffering in silence. Growing evidence shows that fathers experience emotional difficulties, affecting their mental health throughout

and after HRP. Although the participants of this study have experienced various challenges and their mental well-being has been compromised following HRP, it is not argued that their experience is representative of the general population. However, several striking themes have been consistent in the existing literature, demonstrating that clinical implications deserve consideration.

Psychological services, including IAPT and mental health services, are encouraged to increase access for fathers (NHS, 2019). With the increased number of clinical roles employed by CPs in the NHS services (Nielsen & Nicholas, 2016), they may encounter fathers in their clinical practice. This means that mental health practitioners, including CPs, need to have a solid understanding of fathers' experiences to formulate and provide tailored psychological support to help fathers process their emotions and traumas.

Even though an online or group psychoeducational workshop might be beneficial in improving fathers' understanding of their thoughts, feelings, and behaviours and help them learn coping strategies, it does not necessarily consider their traumatic experiences. Therefore, CPs are well placed to take an integrative approach, including an attachment theory (Bowlby, 1969), CBT and person-centred therapeutic interventions to specifically address the trauma, guilt, uncertainty, and grief to help fathers develop a stronger sense of self, understand how their unique journey impacts their mental well-being and encourage fathers to cultivate self-compassion to reduce the sense of failure that could emanate from the obligation to be a protector and supporter.

The literature emphasises the importance and advantage of acknowledging and addressing fathers’ emotional needs for their own sake, families, and wider society (Bronfenbrenner, 2005; Gómez-Cantarino et al., 2020; Hall et al., 2014). However, there seem to be no official therapeutic guidelines on how to support fathers in the UK. This could

mean health professionals and clinicians have insufficient training and might feel incompetent to support fathers throughout HRP (Baldoni et al., 2020). Therefore, it is recommended that psychologists, including CPs, work together with BPS and other organisations to develop therapeutic guidelines, advocate for fathers, and spread psychological knowledge about fathers' needs via training and community involvement. Developing such a guideline and training could offer services and health professionals adequate knowledge to enhance awareness about how this journey could affect fathers throughout HRP.

The researcher hopes this study will help maternity services, NICU settings, and paediatricians acknowledge that fathers also play an essential role and that HRP can bring challenges and pressure on fathers and the whole family. The study could also encourage employers and policymakers to consider fathers' circumstances and mental state during HRP, hoping that employers will consider adapting their paternity leave policies to meet the needs of fathers during and after HRP, including fathers whose partners need intensive care in the hospital.

4.9 Limitations

One of the limitations of this study could be that although participants were from diverse geographical locations in the UK, they were all White British. In some cultures, the father's presence at birth is discouraged, which shows that different cultures could attribute different meanings to masculinity and fatherhood, affecting how fathers experience HRP (Sapkota et al., 2012). Similarly, religion and spirituality could influence fathers and their involvement with their babies (Isacco & Delany, 2022), which is critical to consider more diversity and inclusivity in the study. Despite the endeavour to encourage fathers from

diverse backgrounds to come forward, the sample of this study does not represent cultural and ethnic diversity.

Another limitation could be that the experience of same-sex couples and fathers who had their babies through surrogate mothers was not included in this study. This was because this research explored the relationship between mothers and fathers. However, the researcher acknowledges that it is equally important to understand the unique experience and the challenges of same-sex couples and those becoming fathers through surrogacy throughout HRP. It is equally important for future studies to explore how same-sex couples or fathers who had their babies through surrogacy experience HRP.

Recruiting participants through social media was challenging and depended on admins to accept advertising the research on their page. Several admins were reluctant to distribute the research poster, possibly to protect their followers from what they may have perceived as traumatic experiences. This meant that the researcher had restricted access to fathers with diverse diagnoses and could only advertise the project on certain pages, such as premature twins, pre-eclampsia, etc. As a result, most participants who volunteered do not represent diversity in medical complications. This lack of diversity in diagnosis is also evident in the existing literature, as most studies are focused on fathers with twins and premature babies, and limited knowledge is available about other complications. For example, Jacob had a different experience than the other fathers. His partner suffered from pre-eclampsia and HELLP syndrome, meaning that the pregnancy was smooth until a few weeks before the due date when an unexpected complication changed the pregnancy and placed the mother at risk of death. It is important to understand how fathers experience the journey following pre-eclampsia.

4.10 Suggestion for Further Research

In terms of future research, there is a need for further research to explore the experience of immigrant fathers and those from minority ethnic backgrounds. Psychologists are encouraged to acknowledge cultural differences and understand the discrimination that people from diverse backgrounds experience (BPS, 2017). Therefore, it is crucial to understand better the cultural and religious roles and the meanings people from different backgrounds attach to their experiences of HRP. It is important to think creatively about different ways of engaging fathers from diverse backgrounds, as talking about their experience and mental health may be discouraged by the cultures; hence, this might explain their absence in participation.

Moreover, all the participants were in a relationship with their partners. Some fathers might separate from their partners during HRP and may need to go through this journey alone. Therefore, further research must explore the experience and some of the challenges that separated and non-residential fathers experience during HRP.

There is limited research on other medical complications that come under the diagnosis of HRP. They may have their own unique experience and accompanying challenges, which would be crucial to understand and include those fathers. Recruiting these fathers may be difficult as they may be reluctant to discuss their traumatic experiences, but it would add to our understanding of HRP.

Many parents, including fathers, have lost their jobs during the COVID-19 pandemic, mainly families from low-income backgrounds (Karpman et al., 2020; Ker et al., 2021), which could mean that they might have experienced more significant distress. Future research is recommended to explore how being redundant might have shaped the journey of fathers with HRP.

The researcher aims to disseminate the research in the NHS perinatal clinical setting where she works. This would involve sharing the findings of this research, engaging in discussion with MDT members about the diverse needs of the fathers and promoting a reflection on the individual needs of these fathers. The discussions align with the NHS long-term plan, emphasising that perinatal mental health services should consider offering assessment and psychological support to fathers. Furthermore, the researcher will continue to work with MDT team members and liaise with other HCPs, including midwives, to reflect on considering the impact of pregnancy on fathers.

Chapter five

Conclusion

This study aimed to give fathers a voice to tell their journeys and explore the meaning they attach to their experience of HRP. Semi-structured interviews were conducted with six fathers who volunteered to participate in this study through social media. An IPA of six transcripts produced four GETS and thirteen sub-themes, which provided greater insight into how fathers make sense of their experience of HRP.

The participants' accounts revealed that fathers feel obligated toward their families and adopt various responsibilities to support and protect them during and after HRP. This leaves no space for them to think about their own needs. Thus, becoming a father involved giving up on themselves and dedicating all their time and energy to supporting and protecting their families.

Despite increasing calls for support for fathers, the participants felt that there was a lack of acknowledgement and an absence of support for them. The research highlighted that the HCP did not value their decisions and preferences, and more transparent communication with fathers was needed. Concerning paternity leave, this study highlighted that fathers experienced conflicted feelings to find out that they were only entitled to two weeks' holiday, and the lack of consideration of fathers' experience in the policies meant that they felt under pressure to return to their work whilst their babies or partner were in the hospital. Fathers have reflected on the inequalities they experienced and expressed that they deserve more and want equal support from HCPs and their employers.

The study highlighted that fathers felt powerless during the pregnancy when they had to deal with unexpected complications and following birth when their partner or babies

needed critical intensive care to survive. They thought they failed their responsibilities as protectors and supporters and perceived themselves as doomed fathers. The pandemic appeared to have aggravated feelings of exclusion and isolation from antenatal appointments, birth and NICU stay. Internal and external factors contributed to a delay in bonding between fathers and babies, which meant that they grieved for the loss of immediate bonding after birth.

Various coping strategies were used to navigate the HRP, including distraction, looking after the older child, relying on family and friends, and seeking psychological support. Despite its negative impacts, the pandemic also had the unexpected advantage of allowing fathers to spend more time with their families during the national lockdown. Fathers have supported and received support from their partners, strengthening their relationship during the HRP. The double whammy of using the internet meant that fathers expected to find their answers on the internet and gain reassurance but were confronted with distressing stories.

This research emphasises the greater need for maternity services and health professionals to acknowledge fathers and understand that they are equally affected by this journey, and excluding them from support could impact the whole family. It is essential that HCPs take their time to approach fathers, ask them how they are feeling, and offer access to emotional support. Mental health practitioners, including CPs, could raise awareness about the importance of having support and offer individualised psychological support to address feelings such as uncertainty, powerlessness, inadequacy, loss, and trauma during and after HRP. It is hoped and expected that professionals working in maternity and mental health services take a more open and sensitive approach towards fathers, make them feel recognised, valued, and visible, and offer them a different experience than they have experienced.

The current study supports contemporary studies on some of the challenges and psychological distress fathers experience throughout complicated HRP (Jackson et al., 2022). This study has made unique contributions to CoP and fatherhood research. Firstly, it highlights that HRP significantly impacts fathers and leaves them feeling traumatised; secondly, it reveals that fathers experience the injustice of not being acknowledged by maternity services and employers, and there is a lack of support for fathers whilst their families are battling for their lives. Thirdly, it reveals that fathers may need to look for psychological support for themselves rather than being offered to them, which can put fathers at risk of suffering in silence. Moreover, this study emphasises the need to recognise and acknowledge fathers. It encourages maternity and mental health services to consider and put the subjective experience of fathers at the centre of their support.

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Appendices

Appendix A

Definition of Medical Complications

Pregnancy-induced hypertension is a form of blood pressure during pregnancy which can lead to pre-eclampsia and HELLP Syndrome (NHS, 2021).

Gestational Diabetes refers to developing high blood sugar during pregnancy, which usually disappears following birth (NHS, 2022).

Preeclampsia is a medical complication that can happen during the second half of the pregnancy or following birth. Early signs include high blood pressure and proteinuria, known as protein in the urine (NHS, 2021).

Placenta praevia refers to a condition in which the placenta attaches to the neck of the uterus and impacts the vaginal birth (NHS, 2021).

MCMA stands for Monochorionic Monoamniotic Twins, meaning that the twins share the placenta and the same amniotic sac (known as the pocket of fluid). The twins are at greater risk of further medical complications such as miscarriage, stillbirth, cord entanglement and fetal anomalies (HDFT, 2018).

MCDMA stands for Monochorionic Diamniotic Twins. The twins share the same placenta but are in separate amniotic sacs. These twins are at greater risk of complications such as twin-twin transfusion syndrome (TTTS), unequal placental sharing (UPS), and physical malformations (HDFT, 2018).

Appendix B

Research Poster

FATHERS!

Have You Experienced a High-Risk Pregnancy?

Are you a father of a child born to a High-Risk Pregnancy?

You may be eligible to take part in a research study!

WHAT IS THE PURPOSE OF THIS RESEARCH STUDY?

To date, there has been little research exploring how fathers experience high-risk pregnancies. We hope this research will help us better understand what needs fathers with experience in high-risk pregnancy have and how they could be supported in the future.

WHAT WOULD THE STUDY INVOLVE?

We are interested to hear about your unique experience as a father. You will be asked to attend an online interview via Microsoft Teams which will ask you questions about your experience of high-risk pregnancy.

ARE YOU ELIGIBLE?

- You are aged 18 and above, living in the UK
- You are a father of a child born to a high-risk pregnancy
- Your female partner has experienced a high-risk pregnancy
- You can understand and speak English

WHAT NEXT?

If you are interested in taking part or would like further information, please email Elnaz Mihanmehr, Trainee Counselling Psychologist – u2050281@uel.ac.uk.

This study has been reviewed and has received ethical approval from the University of East London Ethics Committee.

Recruitment poster version: 2, 29.04.22
Study Title: Understanding fathers' lived experience of high-risk pregnancy

Appendix C

Ethical Approval from UEL

School of Psychology Ethics Committee

University of East London

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Volker Thoma**
Supervisor:	**Lucy Poxon**
Student:	**Elnaz Mihanmehr**
Course:	**Prof Doc in Counselling Psychology**
Title of proposed study:	Please type title of proposed study

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further

	detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments
Please clearly detail the amendments the student is required to make
Clarify 4.1 (NO selected but Pseudonym indicated)

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	YES ☒	NO ☐
	If no, please request resubmission with an **adequate risk assessment.**	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:

HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	Volker Thoma
Date:	**28/03/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and

University of East London

confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**Elnaz Mihanmehr**
Student number:	**U2050281**
Date:	**31/03/2022**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

Approval of request for title change

School of Psychology Ethics Committee

<u>REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION</u>

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Elnaz Mihanmehr**
Programme of study:	**Professional Doctorate in Counselling Psychology**
Title of research:	Understanding fathers' lived experience of high-risk pregnancy: an Interpretative Phenomenological Analysis
Name of supervisor:	**Dr Lucy Poxon**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Understanding fathers' lived experience of high-risk pregnancy: an Interpretative Phenomenological Analysis
New title:	"I'm not the person carrying the babies, I'm the one who has to deal with the fallout" - An Interpretative Phenomenological Analysis of fathers' lived experience of high-risk pregnancy.
Rationale:	The first title is generic and focuses on fathers' general experiences However, the proposed title is phenomenological and captures the father's lived experience by using a quote from the participant's narrative. When reading the title, it gives a clear sense of what the project is about and captures the readers' attention.

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature)	**Elnaz Mihanmehr**
Date:	**14/07/2023**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**17/07/2023**	

Appendix D

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Understanding fathers' lived experience of high-risk pregnancy.

Elnaz Mihanmehr

Trainee Counselling Psychologist

u2050281@uel.ac.uk

You are being invited to participate in a research study that is being done as part of a Professional Doctorate in Counselling Psychology at the University of East London (UEL). This study is being supervised by an experienced researcher and a counselling psychologist.

Before you decide whether to take part or not, please carefully read through the following information to understand the research and what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email. After you decide to take part, I will go through the information sheet with you and try to answer any questions you may have regarding participation.

This research aims to understand your unique experiences of high-risk pregnancy. In addition, this research will reveal how you have adapted or managed this period in your life. This research could

serve to benefit fathers, mental health practitioners, researchers, mental health services, talking therapies, and perinatal services.

Who am I?

My name is Elnaz Mihanmehr. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying Professional Doctorate in Counselling Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into exploring and understanding the experiences of fathers whose partner has had high-risk pregnancy. Traditionally, most research studies have focused on mothers. While there have been increasing calls to consider fathers' needs, there is still comparatively very little research on fathers' high-risk pregnancy experiences. This research aims to understand better how fathers experience high-risk pregnancies.

Why have I been invited to take part?

To address the aim of this study, fathers who have experienced high-risk pregnancies are invited to take part in this research study. I am interested in your experience as a father and how have you managed or adapted to the high-risk pregnancy and fatherhood.

If you think you meet the following criteria, you are eligible to participate in the study, and we look forward to hearing from you.

- Your female partner has received a diagnosis of and experienced a high-risk pregnancy.
- Your baby is born following a high-risk pregnancy
- You are 18 years old and over
- You live in the UK
- You are a first-time father, or you have more than one child
- You are living with your partner, or you have separated from your partner
- Your partner and the baby have survived the high-risk pregnancy
- You can communicate and understand English.

We value diversity and welcome fathers from different ethnic backgrounds and any faith and religious beliefs.

Please note that it is entirely up to you whether you would like to take part or not; participation is voluntary.

What will I be asked to do if I agree to take part?

If you choose to participate in this study, you will be contacted to ensure you meet the criteria for this study. Once you are eligible to participate in the study, you will be asked to complete a written consent form and a demographic sheet that will ask a few questions about your demographics. You will be asked to participate in an interview with the researcher, which will take place online via the Microsoft Team. The interview will be an informal chat that could last approximately 60-90 minutes and will be recorded by the researcher. The interview aims to capture your unique experience of high-risk pregnancy and what it is like to be a father of a baby born to a high-risk pregnancy.

While we do not anticipate that participating in this study will be too distressing, you will be encouraged to take a short break if it becomes clear that recalling or describing your experience becomes distressing. In addition, you will be given information about support services that you contact, should you wish to speak to someone about your experience and

you will be encouraged to contact your GP for further support.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage, or consequence. If you would like to withdraw from the interview, you can do so by letting me know. Your data will not be used as part of the research when you withdraw.

Separately, you can also request to withdraw your data from being used even after you have taken part in the interview, provided that this request is made within **a period of 3 weeks after the interview is conducted**. Please note that the data analysis will begin after this period, and withdrawal will not be possible.

Are there any disadvantages to taking part?

Talking about your personal experience of high-risk pregnancy can evoke discomfort or distress. I will continuously monitor how you feel during the interview. If it becomes clear that you experience distress, you will be advised to consult your GP for advice and information about support services will be shared with you should you wish to speak to someone about your experience.

How will the information I provide be kept secure and confidential?

The answers you provide will be pseudonymised to maintain your confidentiality. However, if there appears to be a risk to yourself or someone else, I will need to breach confidentiality and inform your GP as a researcher. Please note that I will inform you about this before taking action.

All the data gathered will be stored and locked in a protected filing cabinet, password protected UEL One Drive, encrypted password-protected external hard drive, which will be accessed only by the researcher, supervisors and other authorised individuals that may monitor the study is being carried out ethically. Everyone will have a duty of care to ensure your confidentiality as a participant. Your personal details will be stored in a separate sheet, in a locked storage cabinet, UEL One Drive, encrypted password-protected external hard drive. The interview recording and pseudonymised transcripts will be stored in a locked storage cabinet or encrypted password-protected external hard drive and will only be listened to by the members of the research team, such as the researcher and supervisors. The transcripts and data will be shown to the researcher’s supervisors to monitor the analysis. The data will be transferred via secure UEL emails.

As part of the thesis submission, the transcript verbatim will be shared on a password-protected account for access by the examiners. Examples of analysed sections of the transcripts will be shared in the appendices chapter of the thesis.

All the transcripts will be kept for five years for publication purposes in accordance with guidelines set out by the British Psychological Society. After this time, all the transcripts and relevant documents will be destroyed.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for an assessment. The thesis will be publicly available on UEL's Online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, the public, etc.) through journal articles, conference presentations, talks, magazine articles, and blogs. In all material produced, your identity will remain anonymous in that it will not be possible to identify you personally as your identifiable information, such as your name, will be replaced with a pseudonym, and your geographical location will be removed; hence your data will remain anonymised to the readers.

You will be given the option to receive a summary of the research findings once the study has been completed, for which relevant contact details will need to be provided.

The anonymised research data will be securely stored by the researcher and Dr Lucy Poxon for a maximum of 5 years, following which all data will be deleted.

Who has reviewed the research?

This research study has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about this research or have any questions or concerns about any aspect of this research, please do not hesitate to contact me. I will endeavour to answer your question to the best of my ability.

Elnaz Mihanmehr

Trainee Counselling Psychologist

U2050281@uel.ac.uk

If any of the answer provided does not resolve your concerns or you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lucy Poxon. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: l.poxon@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

What do I do now?

Once you have read all the information provided to you, the researcher will ask you whether you would like to participate in this study. If you have decided not to participate, we would like to thank you for your time reading this information. If you have decided that you would like to participate, the researcher will give you an opportunity to ask any questions that you might have. You will be then asked to sign a form confirming that you provide consent to participate in this study.

Thank you for taking the time to read this information sheet. Please contact me if you are interested in taking part in this study or if you think you require further information.

Appendix E

Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding fathers' lived experience of high-risk pregnancy

Elnaz Mihanmehr

Trainee Counselling Psychologist

u2050281@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 29/04/2022 (version 2) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have **three weeks** from the date of the interview to withdraw my data from the study. I understand that my data could not be withdrawn from the study after three weeks from the interview.	
I understand that the interview will be recorded online via Microsoft Teams or using a Dictaphone.	
I understand that my personal information and data, including audio/video recordings	

from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my experience may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………………………

Participant's Signature

…………………………………………………………………………………………

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………………

Researcher's Signature

…………………………………………………………………………………………

Date

……………………………………………………………………………

Appendix F

Participant Demographic Sheet

PARTICIPANT DEMOGRAPHIC SHEET

Understanding fathers' lived experience of high-risk pregnancy.

Elnaz Mihanmehr

Trainee Counselling Psychologist

u2050281@uel.ac.uk

Please complete the following information. Your answers to the following questions will be used as part of this research, and your demographic details will be kept confidential.

Participant's Name (BLOCK CAPITALS)

………………………………..……………………………………………………………………

Age:

18-24☐ 25-34☐ 35-44 ☐ 45-54 ☐ 55-64☐ 65 and over☐

Ethnic Background:

White☐ Asian☐ Black-African☐ Black-Caribbean☐

Black-Other☐ Middle Eastern☐ Mixed ethnicity☐

Other, please specify……………………….

Religion:

Agnostic☐ Atheist☐ Buddhist☐ Christian☐ Spiritual☐ Jewish☐

Muslim☐ Sikh ☐ None ☐ Other, please specify……………………..

Thank you for completing this demographic sheet.

Appendix G

Interview Schedule

This interview schedule was used as a guide to help the researcher get a better sense of fathers' experiences.

Warming up question:
What was eye-catching about the research poster that you saw on social media?

1) What was it like when you first found out about the diagnosis of a high-risk pregnancy?

   Possible follow-up questions: What was the diagnosis? How far into the pregnancy you found out about the diagnosis? How did you feel? What was your reaction to the diagnosis?

2) Can you tell me about your experience after you received the diagnosis?
   Possible follow-up questions:

3) How have you managed the high-risk pregnancy?

4) Can you tell me about your experience when your baby was born?

5) I'd like you to think of a timescale from pregnancy to birth to now, can you tell me what your relationship was like with your partner?

- Has there been any differences between the time during pregnancy and once the babies were born?

6) I'd like you to think about pregnancy. Can you tell me about your relationship with the babies during pregnancy?

7) What was your relationship like, after your twins were born?

8) Can you tell me a little about your experience of support from services, if any?

- What support have you received?
- What were you hoping to receive from those services?

9) What support do you think fathers with experience in HRP may need?

Ending question: Are there any questions you would have wanted me to ask you that you thought it was important to ask?

Additional relevant questions depending on the experience:

1) Your baby has been born during the COVID-19 pandemic. Can you describe your experience of COVID-19?

- How did COVID-19 shape your experience?

2) What was your experience like when you found out your baby had to stay in NICU?
    - How did you feel when the babies were separated from you?
    - What has helped you to manage those feelings?

Appendix H

Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Understanding fathers' lived experience of high-risk pregnancy

Elnaz Mihanmehr

Trainee Counselling Psychologist

Thank you for participating in this research study. The aim of this research is to understand fathers' unique experiences of high-risk pregnancy. In addition, this research will reveal how you have adapted or managed this period in your life. This research could serve to benefit fathers, mental health practitioners, researchers, mental health services, talking therapies, and perinatal services. This document offers information that may be relevant in light of you having now taken part in the study.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for an assessment. The thesis will be publicly available on UEL's Online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as your identifiable information such as your name will be replaced with a pseudonym and your geographical location will be removed, hence your data will remain anonymised to the readers.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by the researcher and Dr Lucy Poxon for a maximum of 5 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Families Need Fathers

Telephone: 0300 0300 363

The helpline is available from 9 am – 10 pm Monday - Friday and from 10 am – 3 pm at weekends.

Website: https://fnf.org.uk/help-and-support-2/helpline

Mental Health Support

Helpline provided by Mental Health Matters. Text the word Kent to 85258 or phone 0800 107 0160 available 24/7.

Mind

Please call on 0300 123 3393

Email info@mind.org.uk

NHS Talking Therapies Services (IAPT)

https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Name of researcher: Elnaz Mihanmehr

Email address: u2050281@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lucy Poxon. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: l.poxon@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix I

Initial Stages of Analysis (Benjamin)

Assembling a love barrier between self and the babies for fear of disappointment	748 with us already. I think I again like there's a little bit of 749 a reluctancy to, it was the same thing about not being 750 able to look forward. There's a bit of reluctancy to sort 751 of fall in love too much with the idea of those babies 752 because of the fear that you might not... get to see 753 them alive, but as the pregnancy progressed, once we 754 got into the sort of 30 week area, then I think we could 755 both relax into the idea that like these babies were 756 coming and they were gonna be fine. Umm, you	Not bonding too quickly. Postponing bonding until later. Gradual bonding. Not wanting to get disappointed. Not wanting to feel let down. Not wanting to get hopes high. Disinclined to form attachment with babies that were not sure they would make it. Protecting self from shock? A way of self-protection? Bonding strengthened or increased when babies were safe. Having more certainty about their survival.
	757 always kind of give identities, we do, we give identity 758 or we have to our to the babies before they're born. 759 You know, ones a bit more wiggly than the other or 760 kicks a bit more. So, we always will worried about, 761 more worried about, umm the little, who was originally 762 the, the little baby but later became actually and when	One baby being more vulnerable than the other, being overprotective of the most vulnerable, worrying that he would not be able to fight for life
Wanting the time to pass quickly to have the babies safely	763 she was born she was slightly bigger. Umm, yeah, I was 764 worried about them. I was, I, when Amelia was 765 pregnant. I kind of wanted the pregnancy to end. I, you 766 know, I would rather they once they were big enough. I 767 was like they were safer for out of the womb or keep 768 them in? So, it was a mixed feeling really.	Confusion? Not knowing how to feel? Feeling strange or weird? To end = Wanting this difficult time to end. Wanting them to be safe. Wanting to protect them. Being in two minds about what was best for them. Being torn between wanting them grow inside and wanting them to come out.

769 Elnaz: And how did you feel toward them after they

Bonding is facilitated by learning their language of love: staying close, touching and holding	769 **Elnaz**: And how did you feel toward them after they 770 were born? What was your relationship like then? 771 **Benjamin**: Well, my, yeah, my relationship is just really 772 good with them because I get to spend a lot of time 773 with them. I think I, like I said, we wear them a lot. So 774 they're in a in a baby carrier on me. I've normally got a 775 baby on me throughout the day. I don't at the	Bonding strengthened after birth. Spending time with them, interacting with them, physically holding them, touching them, feeling them. Being close to them, being in proximity with them.
	776 moment. Amelia got all the children. So I feel a really 777 strong attachment to them. Umm, I've got a very, very 778 strong bond with our son as well. We're very, very 779 close. So, I guess I have confidence from that as well 780 that I can be a father and Im good at that. So, there's a	Previous experience of fatherhood. Having the skills, knowing what's it like, getting motivation from it. Feeling confident in self. Believing in his ability. Trusting himself. He could bond with his son, he could bond with babies too? Already passed the test of being a father?
Being a father involves dividing the time between each child	781 sense of leaning in almost into that relationship with	Responsible to look after son? Not wanting him to feel excluded or affected by the arrival of new babies. Feeling responsible toward son's

	782 them at a much earlier stage. Umm and I get a bit less	transitioning and getting used to having sibling. Having to divide his time between them. Fulfilling his duty as a father? Feeling guilty for how son might feel?
	783 time with them than I would like because I spend a lot	
	784 of time with our son. But no, uhh, I and I enjoy	
	785 spending all the time I get with them really.	
	786 **Elnaz**: Great. Thank you. I'm just looking through some	
	787 of the questions to make sure I don't miss anything.	
	788 Umm, yeah. I think I've asked most of my questions.	
	789 Umm, I think what I'd like to also know is as a father	
Being a father in HRP is like being a spectator, nothing physically changes in you but your life transforms	790 what type of support do you think fathers might need	Not riding it, not having control. Not being in charge. Going wherever it takes. Going with what comes up in the journey. Taking an observer role?
	791 during high-risk pregnancy or even after?	
	792 **Benjamin**: Yeah, it's, I mean, being a father throughout	
	793 pregnancy is kind of funny already because you're a bit	
	794 of a passenger. It feels like, you know, I've talked to	
	795 this about this to some of my friends as well, that the	Not having the direct intrauterine contact with them. Not feeling them. Not having the special biological closeness. No physical change developed in self that indicates fatherhood.
	796 woman immediately goes through physical and	
	797 physiological changes in their body and the father,	
HRP is a lonely journey: others cannot comprehend what you're going through	798 nothing changes from the moment that you find that	
	799 your partner is pregnant. Umm, so it's a strange thing	
	800 to be a father of a pregnancy anyway. Umm, fathers	An isolated journey. Feeling lonely. Not having resources or support. Not having a space.
	801 deal with it that in different ways. Umm, but there's	
	802 certainly a sense of like, uhh, that you're a little bit on	The need to have someone, a space to talk. To be able to lean on someone, to

Experiential Statements

The darker side of HRP sensitised him to approach preg with fear + stress

HRP means continually thinking + worrying about the babies

Grappling with constant fear that something would happen to the babies

Putting moral judgement and emotions to a side, unwillingly opting in to what is offered because clock is ticking

Having to risk losing the babies for an over 1% chance that they will survive.

Benjamin.

Having no option but to take risk for a slight chance that babies will survive.

If the worst happened once, it could happen again

Struggled to connect into the idea that babies will make it

HRP means there will be a constant worry even when the babies are born.

It is difficult to stop worry and feel fully reassured even when the Drs say it.

Terrified that HRP can breaking the family into pieces + leaving irreversible changes.

Vaginal birth meant babies were at greater risk and he did not have control over the situation

You don't realise how much it affected you until after the babies are born.

Enduring HRP is not knowing what he was throwing himself into.

HRP is nothing like a normal pregnancy.

Being in better control by self-educating + keeping their story to themselves

Needing to be independent, self-reliant and self-sufficient

Wanting the time to pass quickly to have the babies safely.

Challenges of HRP seems indeterminable + infinite

(7) Powerlessness. Lack of control.

Having a normal preg tricks you into the idea that subsequent preg will be similar

Birth was more chaotic + messy for him than the wife.

Being cautious of covid to prevent postponement of the operation.

The need to get up to speed to minimise risks.

10

Appendix J

PETs for One Transcript (Benjamin)

THE POWER OF POWERLESSNESS	
A sense of powerlessness and helplessness over the distressing changes	Cluster 7 Struggling to convince himself into the idea that babies will make it *The entire pregnancy changed fundamentally at that point from being, you know, just having carrying twins or carrying babies, which should be fine to, uh, very scary, every, every day, almost worrying about whether or not you get through the next day or next week.* 106-111 Putting moral judgements and emotions to a side, unwillingly opting in to what is offered because clock is ticking *Where you just shut, shut some of that stuff down because it's the only thing that you can do, but it's incredibly upsetting. Inside you want to just cry because once again going up against that, but you kind of are already in a bit of a surreal world.* 312-317 Terrified that HRP would break the family into pieces and leave irreversible damages *The negative outcome isn't just that we didn't get the babies that we thought we were going to have but would also be that we would have to carry with us this huge sense of loss and this huge trauma for the rest of our lives.* 634-639 Entering HRP is not knowing what he was throwing himself into *We didn't really think I was rolling the dice on possibly having a really traumatic experience that I might have to live with for the rest of my life.* 643-646 Challenges of HRP seem indeterminable and infinite *You end up in a slightly strange world where you've kind of the babies have been born, but you're definitely not going home yet for quite a while [laughter]. You just move into another phase… really. It was like a little bit like you're on a treadmill in that phase, you just going, going, going.* 533-538
The pregnancy progressed in an uncontrolled way	Having no option but to take risk for a slight chance that babies will survive. *If we don't do the surgery, it's a, it's 100% that you lose both the babies. So, this is the best shot that you have.* 308-310 Vaginal birth meant that babies were at greater risk and he did not have control over the situation *I thought we'd agreed this. I thought, you know, I thought everybody had advised against doing this and then you know right the last minute you changed your mind.* 376-382 HRP means that there will be a constant worry even when the babies are born *It just being a high-risk pregnancy and they're being sort of every step of the way, there was something that made it quite challenging really right up to the point of delivery.* 413-417 Birth was more chaotic and messier for him than for wife *For me it was stressful for her I think it was quite good [laughing].* 421-422 The darker side of HRP sensitised him to approach pregnancy with fear and stress *Somewhere in my brain and much more likely to think, ohh, but there are lots of risks. Lots of bad things can happen.* 610-612
NEEDING TO TAKE BACK THE CONTROL LOST DURING HRP	
Needing to take back the control lost during HRP	Cluster 10 The need to get up to speed to minimise risks *Within 48 hours of the diagnosis in Country B, we flew straight home. We were back within 24 hours and within 24 hours of being in the UK, we were seeing, we were referred and seen at Fetal Institute.* 153-156 Wanting the time to pass quickly to have the babies safely *I kind of wanted the pregnancy to end. I, you know, I would rather they once they were big enough. I was like they were safer for out of the womb or keep them in?* 765-768 Needing to be independent, self-reliant and self-sufficient

Appendix K

PETs Clustering Across All Cases to Develop GETs

	A	B	C	D	E	F
1	David	Emmanuel	William	Oliver	Benjamin	Jacob
2			PETs			
3	HAVING TO FULFIL THE ROLE OF A PROTECTOR AND SUPPORTER	HAVING A RESPONSIBILITY TO PRIORITISE PROTECTING HIS FAMILY OVER HIS NEEDS	BEING A MALE IS BEING RESPONSIBLE	BEING A FATHER IS HAVING TO FULFIL AN OBLIGATION TO SHARE THE LOAD AND PROTECT THE FAMILY	HAVING A RESPONSIBILITY TOWARD THE FAMILY	BEING RESPONSIBLE FOR SAFEGUARDING WIFE AND BABY
4		Subthemes: Becoming a father is taking the responsibility to devote his life to protecting his family	Subthemes: Having a significant role in emotionally and physically supporting the wife and babies		Subtheme: Being a man requires shouldering responsibility for the care of a partner and babies	
5	*It just felt a bit kind of surreal, like she wasn't really having babies. She was just in hospital. Not sure I'm describing it properly. But I guess what I tried to do is just make sure she had as many photos as possible. Umm, and also to make it [pregnancy] feel a bit more normal as well, rather than it being quite scary.* 537-542	*I wasn't allowed in to be by her bedside for that uhm so yeah, that's when I had to stay outside.* 290-291	*I'm like, ok... now I've got to focus on another being, and my partner, which is fine.* 488-489	*I think it felt like me supporting her a lot more with this one rather than really feeling and needed support myself.*323-325	*I took on the role of sort of doing the reading and the research and in a sense being the sort of gatekeeper or barrier to Amelia so that she could, she didn't have to over medicalize and read all of this nasty scary stuff.* 180-184	*I was sort of a single parent for the first few days will be it with family support. Um and sort of slowly helping my wife recover.* 173-176
6	*I just went through a playlist that we used at our wedding and got rid of songs that were maybe not baby appropriate and made it nice and relaxing and just prepared playlist of relaxing music for my wife and then and then at the birth itself* – 640-644	*So, she, so couldn't really, move very easily. Uhmm I, yeah, for me personally, I was completely overwhelmed, uhm and I didn't really know what, what I was doing like so we spent like 20 hours or so each day at the hospital.* 431-435	*Asked her, what do you mean I can't be out of the room? you know, I said to my other half that I would be there.* 649-651	*I ended up doing a lot more around the house and that was doing pretty, but all the housework and all the cooking and cleaning just cause my, my wife was struggling to move so much.* 319-322	*I tended not to talk to Amelia about it too much when I, when I was worried about it because I wanted to shield her from that.*238-240	*My whole goal was, making sure that that our daughter was okay was, you know, doing as much normal things as we could* 269-271
	So, like my job then was just to be very, just hold her hand, tell her it was gonna be OK, and then we're gonna just, like, snuggle in together – 649-651	*It was very much be at the hospital or be at home sleeping. Uhm, yeah, quite a, it in terms of your personal health, both physical and mental, it was quite draining because we didn't eat or sleep very well and we*	*There's a lot of ethics to it. There's a lot of stuff that goes into the thought process and you've got to think like at the time you're trying to, you're trying to process it. It's, it's you. It's the only thing you can do.*795-799	*They were also my concerns lot too, yeah, look, this was the from the emotional side it was just talking, talking about it.* 327-329	*I sort of stood back and observed, but as soon as Amelia had given birth to the first baby, I went to be by her side to be with her.* 488-491	*I moved into hospital with the baby. The baby got admitted to be alongside my wife. It was her and then I moved in and just stayed there.* 393-395

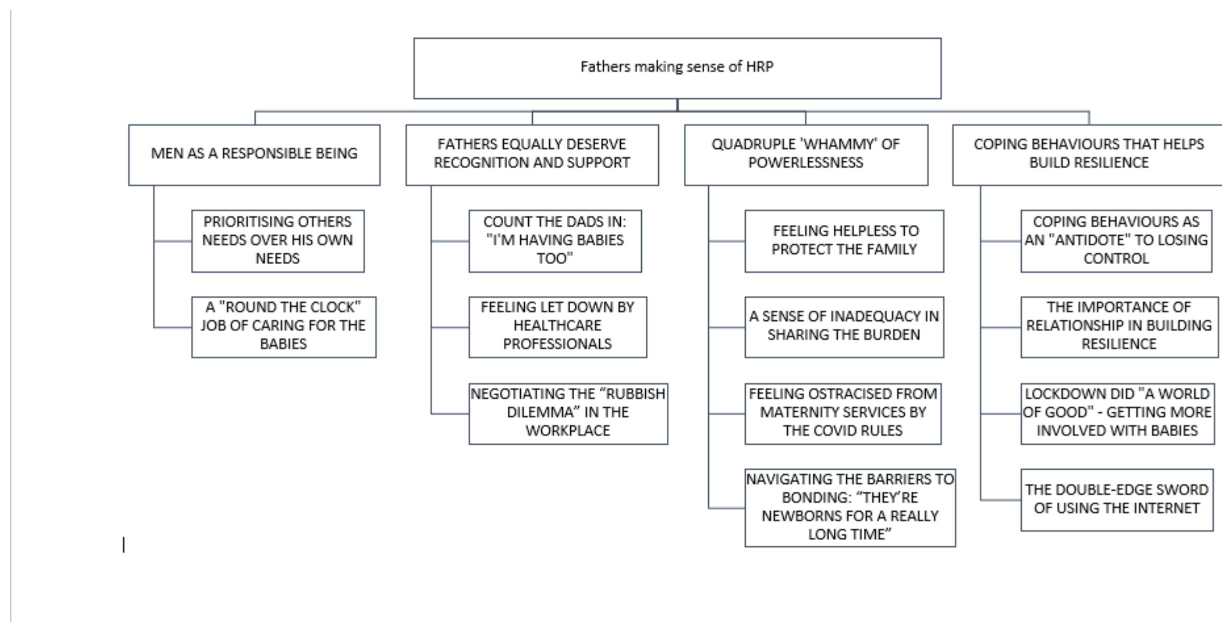
	A	B	C	D	E	F
8	*We're obviously incredibly overjoyed they're home, but also, it's very, very, very hard dealing with two babies at the same time.* 1121-1123	*Even when you couldn't do anything at the hospital, you just sit there by that bedside or that incubator side doing nothing.* 550-552	*I wasn't in a position where I could pick my child up and take it out of the hospital and look after it as you should do as a parent.* 906-908	*I remember trying to feed them for the first time and changing a few more nappies.* 603-605	*Umm, normally both of us or either of us has a baby on us as well as either having the son or doing something like cooking or cleaning the house so it's manageable .* 715-717	*I would do, you know sing to the belly and talk to the belly and things like that* .633-636
9			*So, I was just being a support her as much as I could be.* 1210-1211	*I was to change the one of the nappies, and, and that was I remember we're thinking I don't know what I'm doing, but that was, I think it was, yeah, another moment when it felt extra real .* 672-575	*We are full time sort of parenting here with twins. It's a lot of work.* 720-721	
10	**Attending to babies needs**	**Babies were the priorities**	**Being a father means being on top of things**		**Putting own needs to a side and prioritising family's needs**	
11	*It basically became like like a job like, so wake up, go to work. But work was spending the day with the babies* 1317-1319	*I went home to sleep for about 3 hours [laughing] and then went back, another, yeah, just completely overwhelming uhm and completely helpless really.* 437-440	*Get on with it, take load of her a little bit as much as I can do and do as much as I can. Just make sure she can relax as much as possible .* 195-198		*I was in the position of like I don't really want any risk [smiling] anymore risk in this pregnancy. There's been too much already. But I also completely respect and wanted to support my partner's decision cause it's her experience at the end of the day when she goes through that labour* .362-367	
12		*It really was uhm in in terms of just round the clock care for them and uhh yeah because there's no distinction between day and night for, for, for babies that young. Uhm, so quite often I, I yeah, they, it would, they are like weekends and weekdays were no different.* 705-710	*I'm trying to focus on the monitor of her, monitor of my partner trying to relay from baby to partner and work out what is actually going on. Plus trying to work out if the other one, the one that hasn't come out yet is going to come, come out.* 497-502		*I have to go home, partly to look after the other child umm and, and then, but also because I can't stay in the hospital.* 523-525	

B12 | It really was uhm in in terms of just round the clock care for them and uhh yeah because there's no distinction between day and night for, for, for babies that young. Uhm, so

	A	B	C	D	E	F
13		*I think self, self-care was having a shower or having a cup of tea or coffee umm, but that was probably about as, as extravagant as self-care got, I think and it really was just all about, all about the girls. 724-727*	*Was getting up in the morning and going to, going upstairs, could we. We both lived there, both going upstairs, seeing children, going back down, changing, going to work . 976-979*		*It wouldn't be what I would choose if, if I didn't have to come home and have other responsibilities, I would have wanted to be there and not being able to be there would have been a shame.* 560-563	
14			*I agreed with the nurses, basically that I would go back and I would help as much as I could do with them basically. And I was getting to make myself come back home maybe by 3-4 in the morning, back up at 6-7-8. I wasn't really sleeping and but it was just. I'm on wheels I need to do this. This is my life now. 987-993*		*I'd rather no one talked about how difficult pregnancy could be so that everyone else can just enjoy it naively. But on the other hand, you know, you also want to be able to, you don't want it to feel like a taboo, that fact, that actually a lot of people go through, some really challenging stuff with pregnancy.* 998-1004	
15			*You got two children that are either in hospital in intensive care or high dependency, or you've got two critically ill children back at home. Yeah, you don't have to think about yourself. 1393-1397*			
16	**FAILING TO FULFILL RESPONSIBILITY IN SUPPORTING THE FAMILY (Taken from subtheme of powerlessness)**		**THE SHAMED MALENESS: BEING A MAN IS BEING THOUGHTLESS AND INSENSITIVE**	**BEING UNDESERVING COMPARED TO THE MOTHER**		**FEELING LESS IMPORTANT THAN THE MOTHER**
	It meant that she was, she just became a, a pincushion. They were having to find different arms or legs where they could get a cannula is only last about two to three days – 945-948		*I hadn't thought about actually what high-risk entails. I mean, from being a male, a pregnancy is just, a baby, there's a pregnancy, baby come and you go home and that's it.* 105-109	*I was invited over to go and see them, but Rebecca was still on the on the operating table and so that was a bit strange.* 406-408		*For me a lot of guilt about being the first person to, to hold her after my wife has spent, you know, ten months, you know, making that baby.* 272-275

Sheet1 | Sheet2 | Sheet3 | Sheet5 | GETs | ONLY GETS AND SUBTHEMES

Pictorial Representation of GETs and Sub-themes



GETs With All Quotes Selected For The Analysis

GET1: MEN AS A RESPONSIBLE BEING	
SUBTHEME: PRIORITISING OTHERS NEEDS OVER HIS OWN NEEDS	*It just felt a bit kind of surreal, like she wasn't really having babies. She was just in hospital. Not sure I'm describing it properly. But I guess what I tried to do is just make sure she had as many photos as possible. Umm, and also to make it*

	[pregnancy] feel a bit more normal as well, rather than it being quite scary. 537-542 – DAVID *I think self, self-care was having a shower or having a cup of tea or coffee umm, but that was probably about as, as extravagant as self-care got, I think and it really was just all about, all about the girls. 724-727- EMMANUEL* *It was just make sure she is relax as possible. I get off from work, I do cook and do the cleaning just much I can do to make her life easy. 186-189 – WILLIAM* *I agreed with the nurses, basically that I would go back and I would help as much as I could do with them basically. And I was getting to make myself come back home maybe by 3-4 in the morning, back up at 6-7-8. I wasn't really sleeping and but it was just. I'm on wheels I need to do this. This is my life now. 987-993 – WILLIAM* *I ended up doing a lot more around the house and that was doing pretty, but all the housework and all the cooking and cleaning just cause my, my wife was struggling to move so much. Umm, then actually, yeah, I think it felt like me supporting her a lot more with this one rather than really feeling and needed support myself 319-325 – OLIVER* *I was in the position of like I don't really want any risk [smiling] anymore risk in this pregnancy. There's been too much already. But I also completely respect and wanted to support my partner's decision cause it's her experience at the end of the day when she goes through that labour*.362-367 – *BENJAMIN* *I was still doing and just, you know, action was just everything I was doing. Like don't worry about me, I'll get it done. I'll get it done.* 591-593 – *JACOB*
SUBTHEME: A "ROUND THE CLOCK" JOB OF CARING FOR THE BABIES	*It basically became like like a job like, so wake up, go to work. But work was spending the day with the babies* 1317-1319 – *DAVID* *It really was uhm in in terms of just round the clock care for them and uhh yeah because there's no distinction between day and night for, for, for babies that young. Uhm, so quite often I, I yeah, they, it would, they are like weekends and weekdays were no different.* 705-710 – *EMMANUEL* *It was very, very on, cooking was difficult. Eating was difficult. Drinking was difficult. So, I knew was get up shower, go to the kids. Go back down. Maybe leave the hospital for a little walk or a cigarette and that was it. Umm but yeah and then*. William - 1099-1104 *One of us is with our son, whilst the other is with the twins. We wear the babies quite a lot. We have babies on in the sling a lot of the time. So, we can get on with jobs at home*

	whilst they sleep on us. It makes it quite a lot more manageable. Umm, normally both of us or either of us has a baby on us as well as either having the son or doing something like cooking or cleaning the house, so it's manageable. 710-717 – *BENJAMIN* *I was very much taking everyone write it down how much she ate when she ate it. When does she do a poo? Here's an app. Let's record it in the app. 286-288 – JACOB*
GET2: FATHERS EQUALLY DESERVE RECOGNITION AND SUPPORT	
SUBTHEME: COUNT THE DADS IN: "I'M HAVING BABIES TOO"	*I'm not the person carrying the babies, I'm the one who has to, I'm still around to deal with the, the, the fallout and the fact that it can be very, very, very scary.*19-22 – *DAVID* *There was absolutely nothing for me, it was never. I think they might have asked her how the relationships going, but they never really asked how the dad personally was.* 742-745 -*EMMANUEL* *They should have the option of do you need anything at that point as well? Does your partner require a? Does your partner want to speak to someone? Does your partner want to do this or do that?* 1426-1430 – *WILLIAM* *It was forgotten that I'm having babies too, and obviously not going through the same thing, but. You know, we, we are pregnant. So yeah, everyone, no one. I said no one ever asked how I was feeling about things.* 987-991 -*OLIVER* *A lot of this pregnancy is just kind of mine. And I and I own that. But it's, it's kind of isolated in a way.*968-970 -*BENJAMIN* *You've got say a toddler and an ill wife and you don't have the network, then even more so just that support and then the, the emotional support ongoing in the same way that you would treat a mother who had trauma or had gone through that. Why? Why should there be services for one and not the other?* 840-846- *JACOB* *A lot of this pregnancy is just kind of mine. And I and I own that. But it's, it's kind of isolated in a way.* 968-970-*BENJAMIN* *So, you know, support groups, some sort of way that connects people together that actually have gone through something that's similar. 813-816- BENJAMIN* *They should have the option of do you need anything at that point as well? Does your partner require a? Does your partner want to speak to someone? Does your partner want to do this or do that?"* 1426-1430, *WILLIAM*

	It's harder to pick up the phone and, and say I'm struggling than it is if somebody phones you and says how are you doing, might be a bit easier to open up, not rather than putting the onus on you, it's your job to tell me you're struggling uhm…" 890-894- EMMANUEL,
SUBTHEME: FEELING LET DOWN BY HEALTHCARE PROFESSIONALS	*I kind of wish they made that a little bit more explicit. Like the girls really could come very soon and then, like I said, the way that the, the, the way the doctor told us on the, the Thursday, I don't think it was very professional. 424-428 – DAVID* *I'm not violent. I wouldn't punch anyone. But there's someone "ohh you come with me, Sir" and I was like what? Like I was aware that we would have a C-Section, but I wasn't aware that it was going to be if it was an emergency, I wouldn't be able to be in there.* 636-641 – *WILLIAM* *I like …someone to be able to say, right, yeah, we can see the problem. This is the problem. It's here. We fix that and it's uh, yeah, we're going to be fine rather than, yeah, we. we don't really know, but we're going to do something.* 239-243 – *OLIVER* *What we were sold wasn't what we were getting, so I was quite I was scared by that. I was quite cross about it and I was quite worried afterwards that there could have been negative, negative impact or effect on the second baby.* 466-470 – *BENJAMIN* *People in the maternity unit who sort of a downplaying it and we gradually went over space of two or three hours to you're gonna have your planned C-section next week anyway because the baby was breach to ok you might have it sooner to ok we have to deliver this baby tonight.* 63-69 – *JACOB*
SUBTHEME: NEGOTIATING THE "RUBBISH DILEMMA" IN THE WORKPLACE	*Then as a father, your immediate question is: When do I take my leave? You know, do I, do I try to go to work, you know, whilst my girls are in hospital so I can save my two weeks for when they're home or do I use my two weeks when they're in hospital but then have no leave left to support my wife when they're home with us and that's just a shit. That's just a rubbish. A rubbish dilemma to have to deal with as a father.* 1213-1220 – *DAVID* *I had to just let them know when I was gonna take my paternity leave. But they did keep asking as the weeks went on, like when we be taking it, uhmm because it was against my work policy to take it so late after they were born. Uhm, but thankfully my boss, my boss was quite understanding about it.* 514-519 – *EMMANUEL* *I'll find my boss and said look, this is the situation. I don't know. I'm going to be back because at this point in time, the focus is that she's dead. It's as simple as that. He went "oh well, I can't keep your job open forever" and I'm like that's*

	not really helpful. You've got a duty of care for me. I'm letting you know this this issue you can choose not to pay me, that is absolutely fine. 1079-1089 – *WILLIAM* *We have a policy you can take time off to go to any appointments. I so I didn't realize until later that that was unpaid.* 924-926 – *OLIVER* *There was that little bit of hesitation about going back to work afterwards because it's 2 and half weeks after the baby's born and Elisa still on the mend. But we found a way, and if she needed me, I would have worked from home.* 684-688 – *JACOB*
GET 3: QUADRUPLE 'WHAMMY' OF POWERLESSNESS	
SUBTHEME: FEELING HELPLESS TO PROTECT THE FAMILY	*And there was a bit of a Schrodinger's cat moment, like a like a I wanted to get through to the doctors to be able to for them to tell us that she died. But I also didn't, at the that moment I was in that room. As long as I stayed in that room cleaning this stuff. Then I would never know.* 1088-1093 - DAVID *It's really alien that you don't get to like touch them or hold them like you have to ask permission to do so. Uhm…and yeah, I think I's like, it's like, you really helpless as there's, there's nothing you can do. Uhm and I think yeah, something fairly strange like well quite horrible about seeing a tiny like baby, small and I can imagine, just with an oxygen mask on. 347-353 -EMMANUEL* *Wash and triple wash your hands, which is fine again. Umm make sure your hands are like super dry, like umm dried out. Most of them moisturized and like in between washing your hands but also don't rub the, your finger on it, across their skin because if you do it, you can actually peel their skin back. And you're like, ok then, I can see my child's organs. I don't really want to touch them. 872-880 – WILLIAM* *All I I felt, kind of powerless, that it's, I want to help, but all I can really do is sit there and hold her hands.* 427-429 - *OLIVER* *The negative outcome isn't just that we didn't get the babies that we thought we were going to have but would also be that we would have to carry with us this huge sense of loss and this huge trauma for the rest of our lives.* 634-639 - BENJAMIN *Just witnessed the, the person that I love, bleeding out and then being taken away in a sort of fury of people and alarm bells.* 334-337 – JACOB
SUBTHEME: A SENSE OF INADEQUACY IN SHARING	*My one quite early struggle was there, there was point when she, you know, was taking care of babies herself. But then, at*

THE BURDEN	*times, probably also me as well, because when I wasn't really coping when I, when I, when I was, you know, really struggling with with, um, you know, certainly around the meningitis diagnosis. There were, there were days when I just couldn't really function at all really, so that, that, that that was certainly a mental load on, on Linda. 1104-1111- DAVID* *They were so small. Uhm, like smaller than I'd ever thought that a baby could be. But umm, and then they, they couldn't breathe on their own.* 331-333 *-EMMANUEL* *I'm at work I can't do anything. You have to sit there and you have to find out. You have to be. I don't think I, said anything at all. But I think you just have to be something along the lines of you just gonna have to get on with it. Because being the male, being an arsehole essentially at the time, the lack of any other way of putting it.* 295-301 – *WILLIAM* *We had a bit of an issue where she wasn't happy with the way I held them to feed them and I didn't, I didn't know why. Ohh, I didn't know what it was I was doing wrong.* 792-795 *OLIVER* *I feel tremendous guilt around what she went through because ultimately it's not something I could share the burden with.*461-463 *-JACOB*
SUBTHEME: FEELING OSTRACISED FROM MATERNITY SERVICES BY THE COVID RULES	*You in an ideal world you wouldn't be alone when you've got that news. And it does upset me because, because, she could have got much, much, much worse news, right?* 1399-1402 – *DAVID* *I wasn't allowed into any of them (scan). Uh, so I didn't hear their heartbeats or I hear any, any sounds from them.* 213-214 – *EMMANUEL* *We locked down and then I thought it was great. I feel I'm not working more. This is simple as that.I don't have to go into work because I physically the pub cannot open. I've not got a job. And then they told us we couldn't actually go into the NICU because they locked down the NICU completely.*1147-1154 – *WILLIAM* *So, I did end up driving her there and then going and sitting in the car. But however long the main I see they're starting to think, hang on, this is this is taking a bit too long and I'll get a text saying I'm just about going in now and then taking care, you're taking a while. Is this bad news? Is it good news?* 956-962 – OLIVER
SUBTHEME: NAVIGATING THE BARRIERS TO BONDING - "THEY'RE NEWBORNS FOR REALLY LONG TIME"	*To be honest, you're not a mom or a dad and it's not, it's not normal really, it's not Iike a normal scenario to find yourself in where there's they're that small, there's that many sort of tubes and wires and, yeah, you like, it was really quite an alien feeling , uhm any, any of my friends or family that have*

	had, had kids, you, yeah, you get to like bond with your first child straight away. Uhm whereas we had to wait two months or so and so, we, we had we held them for the first time two days after they were born.413-422 – EMMANUEL *There was no direct contact for about 3 weeks, and even then, it wasn't direct contact for me. It was skin-skin for mum, so it was…um… It was disbelief. It was confusion.* 896-901 -WILLIAM *There's a long, long period of newborn and not really doing much but then into that second, second maybe third month of right you're actually, yeah, we can actually have a a a relationship.* 850-854 -*OLIVER* *You could try to hold back on our excitement for that, for fear of disappointment, and the odds were bad. You know, the odds are stacked against you and that's just that definitely stops you being able to [laughing] be excited about something.*142-147 -*BENJAMIN*
GET 4: COPING BEHAVIOURS THAT HELPS BUILD RESILIENCE	
SUBTHEME: COPING BEHAVIOURS AS AN "ANTIDOTE" TO LOSING CONTROL	*I remember even, even the week the girls were born, I didn't really, even though they were telling us the girls are probably gonna be born quite soon, I didn't really believe it until they told us the girls are going to be born tomorrow. 187-191 – DAVID* *I often went out for far more than an hour. Uhm… like whether it was running, cycling and, umm yeah anything to take my mind off.* 182-185 – *EMMANUEL* *You go up there seeing my son. Talked about it with my other half. Go for drive and get outside home showered, new clothes and this. Take an hour or so to myself because I need to sort of switch off with this. It's just been too much.* 1068-1074 – *WILLIAM* *Speaking to other friends who've been in a similar position, it was, they're saying no, that's quite normal, which was reassuring. Um, but it's strange.* 832-834 – *OLIVER* *I think having a four year old or three-year old that was well was very much like an antidote to the worries as well. You know, he was a shining light in a sense that would just that just distracts you from something that's worrying you.* 243-247 – BENJAMIN *And I was very much taking everyone write it down how much she ate when she ate it. When does she do a poo? Here's an app. Let's record it in the app. And it was I was quite regimented in that becausein hindsight, it was probably the only things I could control and I I'm quite processed driven anyway. Umm and it was just, you know, to balance*

	everything. I think that's how I dealt with it all. 286-293- JACOB *They are essentially supports psychologist and they will help mum and dad doesn't matter. If you ask for help, they will help you. It's amazing. It's a really good service. That they had expertise help me.*1327-1332 - William *I was able to apply a lot of the things from the CBT, quite like ohh always, I think I got a lot more disciplined once the girls were born. 835-837- EMMANUEL* *I went on that stress management course. Umm, which I think was a little bit, it's like fighting a fire with a, with a water pistol.* 1146-1149 David
SUBTHEME: THE IMPORTANCE OF RELATIONSHIP IN BUILDING RESILIENCE	*We were relying on parents and my brother-in-law to drive us everywhere because we couldn't drive it drive ourselves. 916-918 – DAVID* *Our relationship I don't think I could have asked for it to be any stronger and I don't think at any point ever really changed. 582-585 – EMMANUEL* *We both are always does stuff for each other. Both trust and respect everything is deeply as possibly can do. 1202-1204 – WILLIAM* *They've been very helpful. Yeah, looking after them for, for a few hours here and there. I don't really think I had many others.* 876-878 – OLIVER *I mean having to, that you know, having gone through that and having come out the other side, on the right side of all of those probabilities, we're full of a lot of gratitude and a lot of love for each other. 676-680- BENJAMIN* *So, I ended up moving into my in-laws that first night with the baby. Uhm, and in that time, you know, my father and all my brother-in-law went to my house and my keys got the cot that we were gonna do, set it up in their house while I was dealing with the baby, you know, I had all this support around. 378-384 – JACOB*
SUBTHEME: LOCKDOWN DID "A WORLD OF GOOD" - GETTING MORE INVOLVED WITH BABIES	*I was thankful for like the COVID situation, allowing me to work from home. Umm, cause I, if had, I had to have gone into the office, I don't think my wife would have coped*. 713-716 – *EMMANUEL* *But not having to go to work because COVID hit did me a world of good. Umm, did my partner a world of good. Definitely. It meant I could be there support Her, I could be there for the kids. 1182-1186 – WILLIAM* *Um and we have a very, very strong relationship, probably also fostered out of lockdown as well. I think it's harder to,*

	to tell because, you know, she was 3-4 months old when something I'm working from home fulltime and a lot more available to help out, which was just great. 642-647 – *JACOB*
SUBTHEME: INTERNET BROWSING AS A WAY OF BRACING SELF FOR NASTY SURPRISES	*So by googling that, something we find out TTTS, we google that and then go down a bit of a rabbit hole.* 210-212 – *DAVID* *We went on Google a lot and looked it all up and we found out a lot about it but and then I think when you read into the details, we started getting really, really worried about it.* 41-44 – *EMMANUEL* *You then go to Google and then you find stuff you shouldn't find on Google and they make everything worse.*1481-1483 – *WILLIAM* *I really was wrong. I probably shouldn't have done, but doing my own reading about it.* 232-233 – *OLIVER* *You put up a bit of an emotional shield to the negative stuff once you start really digging in into it, you almost become a bit cold or a bit more emotionless about the way you face it.* 212-215 – *BENJAMIN* *I go on, you know, birth trauma association, you go to the father's bit and it's either about depression or which is small paragraph for it. It tries to lead you to another site which leads you another site and then it's just Samaritans or mind and it's just comes under general mental health.* 741-747 - *JACOB*

Appendix L

Journal Entries

Writing the chapter analysis - 01/05/ 2023

I am about to embark on this journey of writing the analysis chapter, which is entirely different to how the quantitative analysis chapter is written. I have to use language to articulate my interpretations and how I made sense of my participant's experiences. I am staring at the screen blankly, not knowing where to start. I am still worried and uncertain about misinterpreting my participant's experiences and letting them down. However, simultaneously, I am concerned that the language barrier will be an obstacle in writing this chapter. I know that my first mother tongue language had never developed fully before I moved to countries at a young age. My supervisor encouraged me to write my hunches in any language I felt comfortable with to capture the essence of the participants' meanings. This excellent suggestion encouraged me to use the three languages I know to help me enter the participant's worlds. Whenever I feel stuck in expressing my hunches, interpretations, and experiences, I close my eyes, pay attention to how I feel in the body, and try to connect with the participant's story through whichever language I can. I think about the interview and try to use my Bank of vocabulary to draw from a phrase closest to the participant's account. For example, in the first subtheme, "prioritising others over self", the closest phrase to participants' experiences was influenced by a Turkish expression called "Kendinden Vazgecmek". I am conscious that translating a phrase, or a word might lose some of its meaning along the way, and giving one up for the sake of others might not be the exact meaning of "Kendinden Vazgecmek", but it is closely related and tells the story. Similarly, I had another Turkish hunch when I wanted to write about fathers' conflict between wanting to protect their babies and the powerlessness, they experienced for inability to do so, and this Turkish phrase was, "Uzerine titremek" which is somehow translated to being overprotective

of fragile tiny babies and wanting to prevent harm happening to them. Accordingly, I sometimes use different languages to get closer to the participant's experiences.

Writing exploratory notes for the first transcript - 17th Jan 2023

I know I am an insider by working in a perinatal setting and supporting fathers who have been through loss or traumatic experiences at birth. However, as I am reading the first transcript, I can feel the father's pain and realise that I am closer to their experiences than I envisaged. I empathise with them and acknowledge the challenges they experience. I believe that fathers are not given enough attention and are treated as if they are not affected. Fathers are neglected and seen as less important than the mother. I am conscious that society expects a lot from fathers and that society and culture have shaped fathers' experiences to encourage them to be the strongest in the family and that they are not allowed to struggle. I witnessed how fathers are treated as invisible, and pregnancy is regarded as if the mother only creates and carries the baby. I am terrified that my assumptions and work experience might prevent me from staying close to the participant's account. I am thinking of ways to separate myself from this assumption or, as Husserl mentioned, bracket the preconceptions. To do this, I attempt to write down all my beliefs and preconceptions about fathers and their experiences during and after pregnancy that I have found out through my work experience. Once I think I have exhausted all that came to my mind, I save this document in another folder, keeping it aside so that I can return to it later if needed. Should these come up in the analysis, what could help me is to put my beliefs with what I have written about the father in front of me, read them and compare and reflect on how much of it comes from my experience and how much is relevant to the participant idiographic experience, hoping that in this way, I could remain conscious of my assumptions and stay close to the participant's experience.

Moreover, I acknowledge that my beliefs and this study are informed by the Bioecological system theory (Bronfenbrenner, 1979), which could influence and shape my understanding of fathers' experiences. At the same time, my beliefs are informed by Heidegger, as I believe that bracketing my assumptions is not fully possible. I will need to use language and interpretation to make sense of other's experiences. As a result, what could help me is being conscious of my presuppositions and trying to bracket to some extent by putting this theory aside while analysing each transcript so I can attend to the uniqueness of each story.

My inner reaction to what was said during the interview – 05th Oct 2022

When one participant said they had sought psychological support but were referred to a computerised psychoeducation programme, I was shocked. They have not mentioned anything negative about this type of CBT. Having worked in an IAPT service and used this platform for mild psychological distress, I was surprised to see that such a traumatic experience was not considered for individual therapy sessions. I noticed all these thoughts racing through my mind during the interview and had negative feelings toward this platform, given that his experience sounded traumatic. I had to bring myself to the present moment, stay neutral and prevent these ideas from shaping my probing questions. When analysing this part of the transcript, I was careful and conscious of my thoughts and beliefs about the suitability of this platform for this father with such an experience. I tried to bracket it through reflection while writing my exploratory comments, experiential statements, etc. Reading through the excerpts several times helped me distance myself from my own thoughts and attend to the father's experience, which helped me capture his positive experience and his internal conflict with engaging with the programme.