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Original Article

Biopsychosocial Challenges of Fathers with a Child with Severe Hemophilia in Iranian Culture: a Qualitative Phenomenological Study

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Abstract

Introduction: Hemophilia can impose various biopsychosocial challenges on fathers with affected children. Identifying their experiences can lead to a broader understanding of social norms and challenge expectations regarding gender roles in caregiving. Increasing awareness of the biopsychosocial challenges and their coping strategies can improve support for their needs, foster a more supportive community, and reduce social labeling and isolation. The study aimed to identify the biopsychosocial challenges faced by Iranian fathers who have a child with severe hemophilia.

Methods: This phenomenological study was conducted using Van Manen's six-step framework and involved purposive sampling of 12 participants. Data were collected through semi-structured interviews conducted by male psychologists. The study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines to enhance the reliability of the findings.

Results: A total of 557 codes were extracted, comprising 7 themes and 28 subthemes. The most frequently reported findings concerned "challenges in parenting, especially feelings of helplessness in this role," "difficulties with emotion regulation, particularly the emotional mirroring performed by parents," "cultural stereotypes, especially the depersonalization and stigma associated with fathers expressing emotion," and "the challenge of breaking bad news, focusing on the relationship between healthcare staff and patients, along with the accompanying invalidation of emotions."

Discussion: Parenting is an area in which fathers often feel neglected and believe their opinions go unheard. In Iran, the distinction between adherence and compliance presents cultural ambiguities that can challenge the medical relationship. Fathers' intense emotional mirroring of their children's distress may lead to overprotection and anxiety. Breaking bad news is a key challenge for healthcare staff, indicating a need for further training. Effective, empathetic communication may reduce fathers' sense of loneliness and emotional invalidation. Cultural stereotypes and the suppression of fathers' emotions negatively affect their interactions, underscoring the importance of recognizing their emotions and needs.

Keywords:

Hemophilia
Emotional invalidation
Biopsychosocial challenges
Fatherhood
Phenomenological study
Cultural background

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1. INTRODUCTION

Hemophilia is an inherited bleeding disorder, with two of its most common types linked to the X chromosome. This genetic pattern means that women are typically carriers, while their sons are the ones who exhibit the physical symptoms of the disorder [1]. Caring for a child with moderate to severe hemophilia imposes significant physical and treatment-related restrictions, requiring constant vigilance, lifestyle adjustments, and ongoing readiness from the parents [2, 3]. This caregiving, though potentially purposeful, significantly affects parents' social, family, and occupational activities, as well as their physical and mental health [4]. Family disruptions and functional inconsistencies—particularly in parenting, the division of domestic responsibilities, and the coordination of medical care—play a crucial role in shaping the psychosocial well-being of both children with hemophilia and their caregivers, and limited psychological understanding between spouses and disagreements about illness management can further strain family dynamics and affect the functioning of caregivers and healthcare providers [5, 6]. Although caregiving for a chronically ill child may provide a sense of purpose and meaning, it requires sustained vigilance, readiness, and often significant lifestyle adjustments [7]. Moreover, the chronic nature of hemophilia introduces persistent stressors—such as financial strain, high treatment costs, and potential income loss—that can exacerbate existing psychosocial difficulties [8-10]. Caregivers have reported experiencing both executive and emotional difficulties in managing treatment routines at home, particularly in repetitive, stressful tasks such as performing intravenous injections for their sons [3].

While a substantial body of research has focused on the medical complexities of hemophilia, a notable gap exists in the literature addressing the emotional, social, and psychological impact on parents—particularly fathers [11, 12]. The traditional narrative of caregiving in pediatric chronic illness often marginalizes the paternal experience. It predominantly emphasizes maternal roles, an oversight that neglects fathers' distinct roles within the caregiving ecosystem and their unique psychosocial challenges. Anxiety associated with repeated hospital visits, medication shortages, intravenous procedures, and tendencies toward overprotection adds further strain to parents, and the division of domestic and external responsibilities, as well as inconsistencies in parenting styles between fathers and mothers, differs markedly between Iran and more developed countries. In Iran, single-parent households are rare, and traditional gender roles, religious beliefs, and sociocultural values distinctly shape the parental experience [6].

The diagnosis of hemophilia can evoke complex emotions in fathers, including guilt, anxiety, and a deep sense of responsibility, and these inner conflicts often coexist with social expectations for emotional resilience. Furthermore, the chronic nature of the disease leads to long-term stressors such as financial pressure from high treatment costs, bureaucratic challenges, and potential loss of income, which can intensify existing psychosocial problems [13-15]. A key qualitative study by Myrin Westesson et al. [9] in Sweden illustrated that fathers undergo a process of accepting a new paternal role, a “tortuous road toward capable fatherhood,” often marked by grief, helplessness, and a loss of their identity as an “ordinary father” [9]. This gap in understanding is particularly significant in specific cultural contexts: in Iran, where fathers play a prominent role in the family as providers and patriarchs, they face multiple emotional, psychological, social, and economic challenges, and the chronic nature of hemophilia intersects with traditional gender roles to create specific and distinct emotional experiences for fathers, especially those who emphasize emotional resilience and self-reliance.

A recent qualitative phenomenological study conducted at the Mofid Hemophilia Comprehensive Care Center (MCCCH) in Tehran [5, 6] explored the lived experiences of mothers of children with hemophilia—many of whom were carriers themselves—and revealed their biological, psychological, and social challenges. However, despite their crucial role in family functioning, no similar study has, to date, investigated the lived experiences and biopsychosocial challenges of Iranian fathers of children with hemophilia.

Given these sociocultural factors, several important questions arise: What specific disease-related stresses do Iranian fathers experience? How common is self-blame among them? How do these fathers manage their relationships with their spouses? In what ways have their social connections changed? How do they maintain balance between work and family life? And, crucially, how has the illness affected their paternal identity? Therefore, this study aims to identify the biopsychosocial challenges faced by Iranian fathers who have a child with severe hemophilia. By placing the paternal perspective at the forefront, this research seeks to illuminate their unique struggles—from the emotional burden and altered family dynamics to changed social relationships.

Ultimately, the study aims to support better recognition of their needs, strengthen community support, and reduce social stigma and isolation. Fundamentally, this research represents an essential step toward acknowledging and

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validating this often-overlooked group of caregivers—one whose experiences have the potential to shape future clinical practices, interventions, and health policies for families affected by hemophilia. The findings are expected to provide a foundational understanding necessary for designing future culturally adapted psychological interventions and support systems to improve the well-being of these fathers and their families.

2. METHODS

2.1. Research Design and Methodological Framework

This study employed a qualitative phenomenological methodology to conduct an in-depth investigation of the biopsychosocial challenges experienced by fathers of children with severe Hemophilia A or B within the Iranian cultural context. The research constitutes one component of a larger project examining the lived experiences of these fathers.

2.2. Participant Selection and Eligibility Criteria

In accordance with standard qualitative research procedures [16], participants were selected via purposive sampling from among Iranian fathers who had one son with severe Hemophilia A or B. This son was to be their only child with the condition. The inclusion criteria were: Iranian nationality, married, under 50 years of age, cohabiting with the affected child's family, and proficiency in Persian. Furthermore, participants were required to have an official registered file at the Mofid Children's Hospital Comprehensive Hemophilia Care Center in Tehran (affiliated with Shahid Beheshti University of Medical Sciences)—the main treatment hub for this disease in Iran. They also needed to visit this center at least monthly with their affected child and obtain approval for interview participation from both the head nurse of the department and a specialist in hematology and oncology (the department head). Only fathers who demonstrated the capacity to continue with the research process based on the defined objectives and who provided informed consent were included. Exclusion criteria consisted of: a significant history of psychiatric disorders (to the extent that response validity would be compromised), inability to allocate approximately 90 minutes of uninterrupted time for the interview during their center visit due to child care concerns, illiteracy, or being divorced and not living with the affected child's family.

2.3. Data Collection Procedures

The data collection process was conducted between April 29 and June 21, 2024. During this period, twelve comprehensive, semi-structured, in-person interviews were administered by two male therapists working under the supervision of emotion-focused therapy. The selection of male interviewers was aligned with Iranian cultural expectations and ethical guidelines, aiming to reduce potential reluctance in participants when disclosing personal information.

The initial three interviews were treated as pilot sessions to refine the interview protocol and ensure preparedness for the main study. The remaining nine interviews comprised the core dataset for analysis. Each session lasted between 40 and 95 minutes, with an average duration of approximately 55 minutes.

Interview questions were developed in accordance with Creswell's phenomenological framework [17]. The structure of the interviews began with a broad, open-ended question, followed by exploratory “what” and “how” inquiries, and concluded with a more confrontational prompt. For each thematic domain, one or two principal questions were posed alongside five to seven supplementary questions, keeping the total number of items within the range of 12 to 15 [18]. Throughout the interviews, the trained therapists applied standard emotion-focused therapy techniques—including empathetic engagement, active listening, verbal and non-verbal feedback, summarization, bridging, and compassionate confrontation—to foster participant openness and enhance the credibility of the responses.

2.4. Sample Size Justification and Theoretical Saturation

According to established qualitative research literature, participant numbers typically range from 5 to 25 individuals, with theoretical saturation generally guiding the endpoint of data collection. It is commonly advised to conduct an additional 3 to 4 interviews beyond the point of saturation to ensure comprehensive coverage of experiential variance. In the present study, saturation was reached following the ninth interview. Nevertheless, to more thoroughly capture the diversity of participant experiences and in alignment with the consensus of the research team—which included three principal researchers, a professor of health psychology from the University of Tehran, and a hematology-oncology specialist from Shahid Beheshti University of Medical Sciences—data collection was extended to include 12 interviews.

In addition to qualitative agreement, empirical validation supported the saturation point. Specifically, analysis of the

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12 interviews yielded 557 distinct codes, organized into 28 subcategories and 7 overarching categories, all demonstrating substantial reproducibility. These findings reflect a robust frequency and breadth of thematic coverage, affirming the adequacy of the sample size in representing the full range of participant experiences.

2.5. Analytical Framework and Rigor Strategies

For the analysis and coding of data, the research team employed van Manen's six-step framework for phenomenological inquiry within the health domain [19, 20], which facilitated a nuanced, contextually grounded, and semantically rich interpretation of the fathers' lived experiences. In Step 1, the researchers engaged deeply with the phenomenon by immersing themselves in the participants' environment—spending time at the Comprehensive Hemophilia Care Center, consulting with experienced medical staff (including a hematology-oncology specialist and a nurse with over 18 years of experience), observing the prophylactic injection process, and conducting open-ended interviews. This phase was further supported by a systematic review of relevant literature and analytical sessions with a health psychology professor from the University of Tehran. Step 2 involved exploring the lived experience through 12 semi-structured, in-depth interviews conducted by two male therapists under emotion-focused therapy supervision. Beyond verbal data, the researchers observed participants' interactions with their children and their navigation of treatment and administrative systems, supported by sustained collaboration with the center's permanent staff to ensure objectivity. In Step 3, hermeneutic reflection was carried out through thematic analysis, which included repeated listening to audio recordings, multiple transcript reviews, and both individual and group coding sessions. The process unfolded in three stages: open coding, selective coding, and final categorization, with sentence-by-sentence coding performed collaboratively and themes refined through iterative review. Step 4 focused on maintaining a clear and consistent orientation to the phenomenon by aligning emergent codes with research objectives after each interview, conducting additional observations or interviews as needed, and consulting regularly with both the health psychology professor and clinical staff. In Step 5, the researchers ensured analytical balance by continuously shifting between granular data, initial codes, and overarching themes to preserve both detail and holistic insight. To reinforce the rigor and trustworthiness of the findings, the study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ). The final analysis was validated through team consensus, expert review by psychologists and clinicians, and member checking with selected participants. Additional strategies—including triangulation, literature comparison, and re-evaluation of codes by three methodological and content experts—were employed to enhance the validity, coherence, and reliability of the results, in accordance with Van Manen's principles and COREQ guidelines [20, 21]. An overview of the study design, participant recruitment, data collection procedures, analytical framework, and rigor strategies is presented in **Figure 1.**

2.6. Ethical Considerations

Throughout all phases of the study—prior to, during, and following data collection—the principal investigator adhered strictly to professional ethical standards, guided by the ethical codes established by the American Psychological Association. This commitment encompassed securing informed consent from all participating fathers and ensuring their rights were fully respected. These rights included a clear explanation of the study's primary objectives, assurance of confidentiality, the option to withdraw any statements post-interview, the right to decline answering specific questions, and the freedom to exit the research process at any point. Additional ethical guidelines relevant to this type of study are referenced in source [22].
The principal investigator also confirmed the absence of any conflict of interest and guaranteed that all interview questions and procedural steps were faithfully aligned with those outlined in the approved research proposal. Ethical approval for the study was obtained from the Children's Congenital Hematologic Disorders Research Center, affiliated with the Pediatric Health Research Institute of Shahid Beheshti University of Medical Sciences, under the ethics code IR.SBMU.RICH.REC.1402.021. This research center, affiliated with Shahid Beheshti University of Medical Sciences, served as a beneficiary of the project.

3. RESULTS

The findings of this study can be interpreted within the framework of the biopsychosocial approach. This perspective is grounded in the principle that human health is not solely the result of biological or physiological processes, but is also influenced by individual thoughts, emotions, and behaviors, as well as by social and cultural contexts. Within this framework, the biological dimension refers to the physiological and bodily aspects of health; the psychological dimension emphasizes the role of cognition and emotion in the experience of illness and adaptation to

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Figure 1. Schematic overview of the study design, participant recruitment and eligibility, data collection, the analytic procedure (Van Manen's phenomenological framework), and the resulting thematic structure. Ethical considerations and rigor/trustworthiness strategies, which were applied throughout the research process, are shown as cross-cutting elements.

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it; and the social dimension concerns the ways in which relationships, culture, and social structures affect health and disease. The integration of these three dimensions highlights that health is not only altered at the biological level, but also shaped by the individual's perception of illness and by the surrounding social responses, both of which play a decisive role in the lived experience and quality of adaptation to chronic conditions [23]. The seven main themes and their corresponding subthemes identified through the phenomenological analysis are summarized in **Table 1.**

3.1. Theme 1: Challenges in Receiving Social Support

Receiving social support was identified as a dual-source experience that could both provide emotional relief and facilitate adaptation to disorder, yet at the same time represent a psychological and cultural challenge for fathers when seeking or accepting help. The influence of social support depended on three key factors: (1) the nature of support (emotional, informational, or instrumental), (2) the cultural context of the extended family, and (3) the structure and nature of the father's occupation. Each of these factors defined the boundaries of available support and shaped fathers' experiences of responsibility and shame.

Table 1. Thematic map of the psychosocial experiences of fathers of children with severe hemophilia, organized by the seven main themes and their 28 constituent subthemes derived from the interview data.

Theme	Subtheme
1. Challenges in Receiving Social Support	1.1 Cultural Resistance to Accepting Support from the Extended Family
	1.2 Workplace Instrumental Support and the Psychological Burden of Reciprocity
	1.3 Challenges in Securing Social Support for the Child and the Consequences of Overprotection
2. Challenges in Breaking Bad News	2.1 Incomplete Disclosure as a Source of Ambiguity
	2.2 Improper Communication Undermining the Therapeutic Relationship
	2.3 Appropriate Sharing of Breaking Bad News as a Factor Strengthening the Therapeutic Relationship
	2.4 Downward Comparison as an Ineffective Soothing Strategy
	2.5 Emotional Invalidation and Minimization During Disclosure
3. Parenting Challenges in the Context of Hemophilia	3.1 Parental Helplessness
	3.2 Snowplow Parenting Style
	3.3 Permissive Parenting Style
	3.4 Authoritative and Attachment-Oriented Parenting Style
	3.5 Authoritarian Parenting Style
	3.6 Differential Treatment Among Siblings
	3.7 Inconsistency in Parenting Styles
4. Cultural Stereotypes	4.1 The Cultural Taboo of Emotional Expression
	4.2 The Illusion of Omnipotence
	4.3 Self-Sacrifice and Self-Neglect
	4.4 Diagnosis Through Circumcision
5. Parents' Struggle to Position Themselves in the Treatment Process	5.1 Desire for Participation (Therapeutic Adherence or Medical Collaboration)
	5.2 The Challenge of Therapeutic Compliance
6. The Interference of Treatment Follow-Up with Everyday Life	6.1 Interference of Treatment Follow-Up with Employment
	6.2 The Interference of the Child's Illness with Marital Life
7. Difficulties in Emotion Regulation	7.1 Incomplete Emotional Processing
	7.2 Sympathetic Over-Identification After Diagnosis
	7.3 Intense Sympathetic Identification with the Child's Physical Pain
	7.4 Sympathetic Identification with the Child's Psychological Pain
	7.5 Emotional Mirroring

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3.1.1. Subtheme 1: Cultural Resistance to Accepting Support from the Extended Family

Fathers reported that although their extended families were generally a reliable source of help, the feeling of being a burden and the concern about upsetting others often prevented them from openly asking for or accepting support. Participants explained that despite having accessible family networks, they tended to withhold their requests for help due to a cultural norm of "not saying too much" and protecting the emotions of others. This resistance was rooted in social values surrounding family responsibility and preservation of honor, which led to the concealment of personal needs. For instance, Father No. 3 shared his experience as follows:

"Our families really helped—both my wife's side and mine. I've got three brothers and two sisters, and they've always been with us. But, you know, some things you just shouldn't tell people. They already have their own troubles, and if you tell them this, they'll only get upset."

3.1.2. Subtheme 2: Workplace Instrumental Support and the Psychological Burden of Reciprocity

Support from colleagues in the workplace—especially covering one's duties during hospital visits—was a significant form of instrumental assistance. While such support generated gratitude, it also evoked a sense of obligation to repay, which in itself became a source of psychological pressure, particularly for fathers whose jobs lacked flexibility. As Father No. 8 explained:

"My workplace and colleagues really helped us out. When I had to go to the hospital, they cooperated. But for people who have their own workshop or a small business, it's way harder."

3.1.3. Subtheme 3: Challenges in Securing Social Support for the Child and the Consequences of Overprotection

Fathers noted that managing their child's social interactions with other children was a constant struggle. Continuous warnings and excessive supervision aimed at preventing injury often led to discomfort, social withdrawal, or frustration among peers, reinforcing the child's sense of being different. Such overprotection could hinder the development of social skills and autonomy. As Father No. 5 described—a statement that vividly reflects the tension between physical protection and allowing normal social experiences:

"When they're playing, I keep telling them, 'Just don't bump into him, okay? Be careful! You can run a bit slower than usual.'"

3.2. Theme 2: Challenges in Breaking Bad News

One of the most difficult stages in the therapeutic relationship—especially in chronic, life-threatening, or life-limiting conditions—is breaking bad news to the patient or family. Breaking bad news refers to informing them about an unfavorable medical diagnosis or condition, which may include the disclosure of a serious illness, relapse, or treatment failure. The manner in which this information is communicated has a profound impact on the doctor–patient relationship, emotional reactions, and mutual trust. The World Health Organization emphasizes that an effective physician–patient relationship forms the basis of successful treatment. Honest communication, when combined with emotional support, helps maintain trust and enhances the patient's ability to make informed decisions [24].

Receiving bad news—such as the diagnosis of hemophilia in a child—can trigger reactions like anxiety, depression, anger, or denial, all of which influence the family's quality of life and relational dynamics. However, patients and families who receive sufficient emotional support and clear information generally show better adjustment to the new situation [25].

3.2.1. Subtheme 1: Incomplete Disclosure as a Source of Ambiguity

In several cases, fathers described how the diagnosis was communicated incompletely, abruptly, and without considering their psychological readiness. Such communication often led to emotional flooding—a state of shock, intense anxiety, and confusion. Father No. 5 recalled:

"The doctor suddenly said right there in the operating room, 'It's a tumor...' Then it took thirty-two days before they finally told us directly that it really was a tumor—and those days just wore us out! They never told us clearly what was going on. It was such a shock... I swear we didn't sleep for a week, and in the end, it turned out it wasn't even that!"

3.2.2. Subtheme 2: Improper Communication Undermining the Therapeutic Relationship

An inappropriate way of breaking bad news, especially when coupled with misdiagnosis, seriously damaged the therapeutic relationship and eroded parents' trust in the healthcare system. This issue appeared repeatedly across interviews, highlighting its significance among fathers. Father No. 4 explained:

"I got really anxious. I took my kid straight to the doctor—he said, 'This isn't my area, take him to Bahrami Hospital.' They admitted

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him to the ER, took blood, then moved him to ICU. They said they had to take spinal fluid; I didn't allow it, so they did a CT scan. Then they said he had a brain hemorrhage. We were devastated. One doctor said he needed emergency surgery, that he might even die. I said, 'Whatever God wills.' They operated–but later we found out it hadn't been necessary at all. My kid had hemophilia, and all that pain and suffering was for nothing."

3.2.3. Subtheme 3: Appropriate Sharing of Breaking Bad News as a Factor Strengthening the Therapeutic Relationship

According to Buckman [25], adherence to the SPIKES protocol (Setting up the interview, Assess the patient's Perception, Invitation, Knowledge sharing, respect Emotions, Summarize and strategize) and related communication principles can foster a healthy therapeutic relationship, promote hope, enhance cooperation, and improve treatment outcomes. In this study, fathers who received bad news in line with these principles—accompanied by psychological techniques such as buffering, pacing, normalization, and supportive reframing [26]—reported greater emotional relief and higher satisfaction with the disclosure process. Father No. 10 shared:

"The diagnosis really shocked us–we'd never seen anything like it. His mother even got sick for a while. We said, 'Well, I guess this is just our fate.' But the doctor talked to me and said, 'Your son is healthy in every way; you just need to watch his knees and elbows.' And you know what? He's so playful–he goes through a pair of sneakers in a month! The doctor explained that since his blood is thinner, we just need to be careful. When he told me that, we calmed down. God bless him."

3.2.4. Subtheme 4: Downward Comparison as an Ineffective Soothing Strategy

In some cases, bad news was broken through forced downward comparison, where physicians attempted to comfort parents by comparing their child's condition with that of more severely ill patients. Although meant to reduce anxiety, this approach often invalidated fathers' genuine emotions of shock, fear, and sadness. Father No. 2 described:

"The doctor said, 'It's nothing serious... Your child's treatment is easy. Some kids with thalassemia spend all day in the hospital.' I felt kind of relieved–but also kind of hurt."

3.2.5. Subtheme 5: Emotional Invalidation and Minimization During Disclosure

Several fathers reported that their emotional reactions were ignored or minimized during the breaking of bad news, often through insincere reassurance or false optimism. This led to feelings of anger, confusion, and distrust toward the medical team. Father No. 3 said:

"They told little white lies–'He's better now, he's improving'–but we could see it wasn't true. They just said it so we wouldn't get upset."

3.3. Theme 3: Parenting Challenges in the Context of Hemophilia

The nature of the illness and the need for continuous, specialized care shaped a range of distinct parenting styles, which emerged across seven main subthemes.

3.3.1. Subtheme 1: Parental Helplessness

This subtheme reflects fathers' feelings of inadequacy and exhaustion caused by the ongoing demands of caring for a child with hemophilia. Continuous caregiving pressure and illness-related stress led to emotional, physical, and psychological fatigue. Many fathers described themselves as unable to manage their child's resistant behaviors or the complexities of treatment. Father No. 1 vividly expressed this experience:

"Mohammad is kind of stubborn–it's really hard to bring him to the hospital. He doesn't cooperate and doesn't understand what hemophilia is. We could barely get him here... even when he did come, it took two people to hold his arm still so the factor injection could be done. That's been such a huge challenge for us."

3.3.2. Subtheme 2: Snowplow Parenting Style

In this style, parents are constantly clearing, covering, or removing obstacles from their children's path before they encounter them. Their intention is not harmful—they simply wish to give their children every possible advantage and spare them from life's hardships [27-29]. Father No. 2 illustrated this approach:

"I make up for all their shortcomings. If my son says, 'I want this phone today,' I'll get it for him... I don't hold back financially, so he won't ever feel deprived."

3.3.3. Subtheme 3: Permissive Parenting Style

In the permissive style, parents set few limits and tend to satisfy the child's needs immediately, often out of fear of causing additional stress to the ill child. Parents become less engaged in monitoring or controlling behavior, allowing the child greater freedom [30]. Father No. 2 explained:

"When we go somewhere and he wants something, I can't tell him, 'Let's keep going, I don't have money.' I just bought it. You have to live in the moment–maybe you're here today, maybe not tomorrow. Whatever he wants, I get it for him right away."

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3.3.4. Subtheme 4: Authoritative and Attachment-Oriented Parenting Style

This balanced style combines reasonable boundaries with warm emotional connection. Parents adopting this approach set firm but fair limits while maintaining empathy and affection, achieving a balance between necessary protection and promoting the child's independence. Father No. 3 and No. 11 shared:

"We've just learned to go along with it. We don't tell him not to do things. We let him play whatever games he wants... but we watch him. We've raised him to be independent—he's sensitive, but I think we've done the right thing."

"We never scold him for playing football or anything like that... we just stay with him and make sure he's safe."

3.3.5. Subtheme 5: Authoritarian Parenting Style

This style is characterized by strict control and close supervision of the child's behavior. Parents pay less attention to emotional needs and often maintain a distant relationship. In the context of chronic illness, such behavior often stems from fear of complications and an overwhelming sense of responsibility [30]. Father No. 8 noted:

"I always point out even the smallest mistakes so they can fix them—I criticize the tiniest things."

3.3.6. Subtheme 6: Differential Treatment Among Siblings

Having a child with hemophilia often led to unequal standards of treatment within families. This could manifest as unequal attention, expectations, rules, or rewards [31]. Differential treatment—also observed by Eshghi et al. [6] among mothers of children with severe hemophilia—was often driven by parents' desire to compensate for the child's suffering or avoid adding to their pain. It typically appeared as greater leniency and attention toward the affected child. Father No. 8 mentioned this challenge:

"I try to treat both of them equally, but it's not completely possible. Like, I tell my other son, 'He's sick—let him have a bit more.' So, yeah, there's a little difference between them."

3.3.7. Subtheme 7: Inconsistency in Parenting Styles

Differences in parenting attitudes and methods between spouses became more pronounced in the context of chronic illness. Such inconsistency often stemmed from varying levels of stress tolerance, understanding of the illness, and differing priorities for the child's needs. In environments where parents frequently disagreed about rules and expectations, children experienced instability and insecurity, which could heighten anxiety [32]. Father No. 8 described this dynamic:

"My wife and I disagree on some things... like, I let my daughter go out alone when she turned sixteen, but my wife doesn't allow it. I used to be kind of strict—she's not. Honestly, we think we're in control, but we're really not. Still, yeah, we do have our differences."

3.4. Theme 4: Cultural Stereotypes

The findings of this study revealed that cultural stereotypes imposed on men play a significant role in shaping the lived experiences of fathers of children with hemophilia. These stereotypes consist of social beliefs and expectations that define men as strong, independent, omnipotent, and invulnerable individuals. Such expectations not only render the expression of emotions and vulnerability socially unacceptable but also confine men to traditional roles of financial provision and authority within the family. As a result, many fathers in this study described how social and cultural pressures prevented them from expressing their needs and emotions, leading to emotional suppression, self-imposed pressure, and even self-neglect. These findings align with theories of masculinity, which highlight the social reproduction of male roles and their psychological consequences [33-35].

3.4.1. Subtheme 1: The Cultural Taboo of Emotional Expression

Across many cultures, stereotypical expectations discourage men from showing emotion or vulnerability, instead urging them to display control and strength. Masculinity theory argues that this cultural taboo constrains the definition of male identity, leading many men to internalize these stereotypes as natural truths [33-35]. For instance, Father No. 2 felt that he should suppress his emotions to avoid burdening his wife, who was already under great stress due to their child's illness. He viewed showing emotion as improper and as an additional strain on the family, evaluating his emotional restraint as a positive behavior despite his psychological fatigue:

"From the first day of our marriage until now, I've never shown my wife when I'm upset. Even if I was sad or didn't have the energy, I'd keep it to myself—just hold it in and see how things go."

3.4.2. Subtheme 2: The Illusion of Omnipotence

Among the fathers, a sense of obligation to be all-powerful was evident. This stereotype dictates that men must always be strong, emotionless, and "stone-faced," never revealing

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weakness or vulnerability. Father No. 11 believed that showing weakness would reduce his respect in society and before his child, so he hid his emotional struggles to appear strong.

"People don't like weak men. Kids don't love a weak father. I never talk about my struggles, because the stronger you look, the closer people get to you. My pain and frustration—they're only for a few trusted people to see."

3.4.3. Subtheme 3: Self-Sacrifice and Self-Neglect

As noted earlier, cultural stereotypes lead men to see themselves only within restricted provider roles, often ignoring their personal needs. Some fathers viewed complete self-sacrifice for their children as a source of pride and duty. Father No. 3 described:

"Yeah, it's shockproof—bought it for my kid. I don't care about the cost. Money doesn't matter to me at all. My money, my whole life, it's all for my kids. It doesn't matter. Whatever happens, I just have to fight through the hardships—I'm used to it."

3.4.4. Subtheme 4: Diagnosis Through Circumcision

In the Iranian–Islamic cultural context, circumcision posed a significant cultural and religious challenge for fathers of children with hemophilia. In many cases, the diagnosis was first discovered during or after circumcision. Fathers who were already aware of their child's condition faced a moral and psychological conflict between fulfilling their religious duty and fearing life-threatening bleeding. This finding underscores the importance of culturally sensitive psychological guidelines in Iranian–Islamic contexts. Father No. 7 recounted how his child's diagnosis unfolded:

"Artin was nine days old. We took him for circumcision to just get it done. The doctor did the procedure, and when we brought him home, he started bleeding—from the stitches on his penis. We took him back right away, and the doctor said the stitches hadn't held. But the bleeding kept coming, and eventually they ran tests—PT and PTT—and found they were very low. That's when they said it was probably hemophilia."

3.5. Theme 5: Parents' Struggle to Position Themselves in the Treatment Process

The findings of this study showed that one of the main challenges fathers face when dealing with their child's illness is figuring out how they should position themselves within the treatment process and what kind of relationship they should have with the healthcare professionals. In this context, two concepts—therapeutic adherence (the active involvement of the patient and the family in the treatment process) and therapeutic compliance (passively following the doctor's instructions)—become especially important [36, 37]. In practice, this theoretical distinction (adherence vs. compliance) is not clear to many parents—or even to some healthcare professionals—which leaves the therapeutic relationship in a kind of suspended state. This ambiguity can lead to negative emotions such as anger on both sides of the relationship and may ultimately weaken this essential connection. Therefore, clarifying this distinction and teaching it to both parents and medical staff seems to be a cultural as well as clinical necessity.

3.5.1. Subtheme 1: Desire for Participation (Therapeutic Adherence or Medical Collaboration)

Some fathers expressed a strong desire to take an active part in the treatment process. They felt that when they had a more equal relationship with the medical staff, they experienced greater safety and calm, and they could act as part of a shared team while having a genuine sense of choice. This desire for adherence continued even in non-face-to-face settings such as online platforms. For example, Father No. 2 described this experience:

"Sometimes I call the secretary, the nurse... or at least in the online groups we have. If there's a problem, we post it, and they answer. Here they handle things well. They tell me, like, 'Sir, the medicine arrived today,' or 'It didn't come,' 'We have it,' 'We don't have it.' Here it's much better, we're more comfortable, because we make decisions and plans, and we have this freedom of choice."

3.5.2. Subtheme 2: The Challenge of Therapeutic Compliance

Negative experiences in the relationship with healthcare staff—especially when accompanied by authoritative behavior, lack of transparency, or a top-down attitude—can lead parents to resist therapeutic compliance. In such situations, they feel as if they are treated merely as executors of medical instructions and deprived of their right to participate in decisions about their child's treatment. This experience becomes even more difficult when the delivery of bad news is handled poorly, intensifying the sense of inequality and exclusion from the treatment process. As a result, some fathers chose to reclaim their role by independently deciding to stop or change the treatment course. For example, Father No. 2 shared this experience:

"How was that even supposed to work? He said the kid must have surgery. I said okay, but at least let me look into his tests... He was admitted so they could operate. I said fine. Sir, we kept him here for ten days, then ten days turned into twenty, and then it became twenty-five. Every two days they would come to check on him, but

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in the end I didn't give consent. I said forget the surgery; just leave it. They didn't give us any information at all!"

3.6. Theme 6: The Interference of Treatment Follow-Up with Everyday Life

The findings showed that treatment follow-up for a child with hemophilia is not only a medical task for fathers but is closely linked to their social and family roles. Society expects them to provide financially, support their spouse emotionally, and care for their child simultaneously, creating role conflict and significant psychological and social strain. Viewing treatment follow-up as their personal responsibility intensifies this tension, and when they feel unable to meet all roles adequately, they experience social pressure along with emotions such as guilt (e.g., toward their wife) and feelings of shame and stigma.

3.6.1. Subtheme 1: Interference of Treatment Follow-Up with Employment

Father No. 9 explained that following up on his child's hemophilia treatment interfered with his job to the extent that he was forced to shift his focus entirely to his child's care. This situation brought significant financial strain and emotional exhaustion. He also described a strong sense of guilt, feeling that the heavy burden of treatment had fallen on his wife, who was managing most of it alone—something he saw as a major reason for leaving his job. The following excerpt reflects part of his experience:

"When my kid's condition got like this, I was working at a company, but I just couldn't work and follow his treatment at the same time. My wife was doing almost everything; all the pressure was on her, and if he started bleeding, I wasn't even there. In the end, I quit my job. I said my child's health is more important—what's the use of money then?"

3.6.2. Subtheme 2: The Interference of the Child's Illness with Marital Life

The child's illness created tension in fathers' marital relationships, as balancing treatment responsibilities with expected emotional support for their spouse led to conflict and emotional strain. Father No. 12 described this experience as follows:

"Well, for example, we had a kid. Things were really different before and after the diagnosis. I don't know... when you don't have a kid, the relationship is more romantic, but when a child comes, you get distant from many things. Maybe part of it was because we were dealing with this illness. But anyway, we had to take care of our child's condition."

3.7. Theme 7: Difficulties in Emotion Regulation

The findings showed that fathers of children with hemophilia face major difficulties in processing and regulating their emotions after the diagnosis. Emotional processing involves identifying, understanding, expressing, and managing emotions [38], and problems in any of these stages can lead to psychological symptoms such as anxiety, depression, and behavioral issues [39]. In this study, some fathers struggled to identify or analyze their emotions, while others became overwhelmed by their child's emotions, leading to excessive empathic involvement. Such difficulties often resulted in maladaptive responses—such as suppression, denial, irritability, or overprotectiveness—which negatively affected their relationships and quality of life.

3.7.1. Subtheme 1: Incomplete Emotional Processing

Some fathers experienced disruptions in all stages of emotional processing after hearing the diagnosis. Their difficulty in identifying and analyzing their emotions—especially in the early stages—prevented them from understanding the meaning of their experience and from responding in a constructive way. For example, Father No. 4 described it as follows:

"It was really hard. I just couldn't digest such a word at all. It just wouldn't sink in for me, honestly."

3.7.2. Subtheme 2: Sympathetic Over-Identification After Diagnosis

Some fathers experienced sympathetic over-identification, becoming so immersed in their child's emotions that personal boundaries blurred. This often led to overprotectiveness and "snowplow parenting" [40], as they absorbed the child's distress as if it were their own. Father No. 9 described his experience as follows:

"He said the results would come in a month; it took almost a month and a half. One day I went by myself and picked up the results. When I saw them... Well, I'm human. My whole mind and nerves just collapsed; he's my precious kid, and I was devastated. And even now I still can't believe it. It was like I was the one feeling all that pain."

3.7.3. Subtheme 3: Intense Sympathetic Identification with the Child's Physical Pain

The findings showed that some fathers developed intense sympathetic engagement and emotional identification with their child, unconsciously merging their own feelings with

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the child's suffering. This deep identification led them to feel both the child's physical and psychological pain, and at times the intensity of this reaction even interfered with essential treatment tasks, such as administering factor injections. Father No. 9 described his experience as follows:

"They say the pain shouldn't go to the child—it should go to the parents! I'm the one suffering... I just can't handle it at all."

3.7.4. Subtheme 4: Sympathetic Identification with the Child's Psychological Pain

Some fathers, in addition to sharing their child's physical pain, also sympathetically absorbed the child's psychological distress. This form of identification was accompanied by feelings of loneliness on behalf of the child and a constant worry about the child's future, placing an additional psychological burden on the parent. Father No. 11 described his experience as follows:

"Look, suffering really bothers a person; that's how I am. The suffering your child goes through—the pain that is always there in your kid—that's very distressing. We're upset because our child is alone. Like I told you, he's alone in his suffering... alone in his pain. The pain is with him, the sadness is with him. And when he grows older—like I said—I'll still be worried! But what really hurts me the most is that there's this constant pain in my child."

3.7.5. Subtheme 5: Emotional Mirroring

Emotional mirroring occurs when parents recognize and reflect a child's emotions; when balanced, it fosters healthy emotional development and empathy [41]. However, dysregulated mirroring can have negative effects. In this study, many fathers showed strong emotional reactions during factor injections, which disrupted the treatment process by increasing the child's anxiety, heightening staff stress, intensifying perceived pain, and reducing the child's openness. Fathers No. 5 and 6 described this experience as follows:

"Even when the kid is getting the factor injection, I've seen it with my own eyes many times—the vein tears, he cries... The mother screams, and the father holds it inside and later cries alone in private."

"When talking to kids—especially kids with hemophilia—you shouldn't say things like, 'What happened?' 'Why weren't you careful?' 'Why did you do this?' Why? Because when you ask these whys, the child can't say, 'I'm in pain, I got hurt.' Because he sees the sadness in your eyes, he notices your emotional turmoil, and that makes him hide the pain instead of saying it."

4. DISCUSSION

When families face a chronic, genetic illness such as hemophilia, the lived experience of parents—especially fathers—is shaped by numerous psychological, social, and cultural pressures. Examining these experiences shows that fathers' challenges extend well beyond managing medical treatment to encompass broader aspects of their social relationships, occupations, and parenting styles. The findings of this study showed that cultural stereotypes play an important role in shaping the lived experience of fathers of children with hemophilia: these stereotypes, which portray men as strong, all-capable, and invulnerable, not only render emotional expression inappropriate for them but also confine fathers within traditional roles as providers and heads of the family. In cultures such as Iran's, vulnerability may be regarded as a form of stigma, which further complicates how fathers seek support and manage stress. This finding is consistent with masculinity theory [33-35], which addresses the social reproduction of male roles and its psychological consequences.

One important aspect of these stereotypes was that emotional expression itself was viewed as undesirable. Fathers in this study reported that, in order to maintain the image of a "strong father," they suppressed their emotions and avoided showing sadness or worry; although this was intended to protect their wife and family, it ultimately led to mental exhaustion and increased internal pressure. The belief in being "all-capable" was similarly strong among fathers: many believed that showing weakness would cost them respect and social acceptance, an attitude that not only heightens psychological pressure but also prevents them from receiving effective social support. In addition, some fathers, driven by these cultural stereotypes, practiced self-sacrifice and devoted themselves entirely to their child, to the point of neglecting their own needs and well-being; although this pattern stems from a well-intentioned desire for self-sacrifice, it can lead to exhaustion and a diminished quality of life for parents [42].

This finding is consistent with previous research showing that traditional masculinity norms discourage men from seeking emotional support and increase self-imposed pressure [35], underscoring the need to raise awareness and reduce stigma around these issues for fathers. Sharing responsibilities, seeking social support, and learning about the concepts underlying masculinity theory are all important components of this awareness-raising process [33-35]. Beyond these internalized pressures, another critical dimension of fathers' experiences relates to their positioning within the treatment process itself: how they are perceived and engaged by healthcare providers plays a decisive role in shaping trust, emotional adjustment, and the overall quality

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of care. The challenge of positioning parents within the treatment process revealed that the boundary between adherence and compliance remains unclear in fathers' experiences, an ambiguity that can weaken the therapeutic relationship and generate negative emotions. At the same time, fathers' desire for active participation suggests that fostering more equal, team-based interactions between parents and healthcare providers can strengthen trust and improve the quality of the treatment process.

These internalized pressures arising from gender stereotypes can intensify when fathers face real external challenges, manifesting in different ways. One of the first and most critical of these external challenges concerned how the illness was announced and how fathers navigated the cultural practice of circumcision. One cultural-stereotype dimension identified in this study was the set of challenges related to circumcision as a religious and cultural duty: for some fathers, the diagnosis of their child's illness began with this procedure, while for others, learning of the illness created a conflict between their religious duty and their fear of bleeding. This finding indicates that psychological and educational guidelines in Iran must be sensitive to cultural and religious factors and attentive to such specific situations. Families should not be blamed or judged for proceeding with circumcision, since it is a cultural practice—particularly because the moment of disclosure often coincides with the moment the first bad news is delivered. For this reason, depending on the severity of the news, the medical team needs to apply communication techniques such as the SPIKES protocol, pacing the information, softening the message, and remaining genuine, attentive, and honest. These techniques help preserve the therapeutic relationship and prevent the harmful delay and uncertainty that fathers might otherwise experience; they are essential for building a sound therapeutic relationship. As a result, circumcision became closely linked, in this study, to physicians' communication skills when delivering bad news. Many fathers explained that their distressing diagnostic experiences, including feelings of shock, arose because these communication principles were not followed when the diagnosis was disclosed following circumcision. Failure to follow these principles damaged trust, honesty, and transparency in their relationship with the medical team. This finding is consistent with Buckman's view [25], which emphasizes that delivering bad news should be done with honesty, empathy, and proper communication steps such as the SPIKES protocol, in order to prevent shock, anxiety, and mistrust.

In this study, fathers who received news of their child's illness in an incomplete, rushed, or mistaken manner experienced confusion, severe anxiety, and distrust toward the medical team. These experiences show that an improper approach to delivering bad news can not only cause "emotional flooding" for parents but can also seriously damage the therapeutic relationship. Furthermore, forced downward comparisons or invalidation of parents' emotions—even when intended to provide comfort—cause their genuine feelings to be dismissed and increase anger and mistrust. These findings are consistent with previous research showing that the quality of doctor–patient communication in crisis situations determines patients' and families' level of adjustment and satisfaction [43].

The negative experience of receiving bad news, combined with the heavy cultural weight surrounding circumcision, not only affects fathers' initial relationship with the medical team but can also lead to maladaptive strategies such as concealing the illness from society. As Hallahan and Kauffman [44] have noted, professionals are not always the most effective source of help for families of people with disabilities, and informal sources such as relatives and friends often work more effectively. In this context, one important challenge is the belief that the illness must be kept secret from relatives, coworkers, school, and friends—a belief that becomes a psychological struggle for fathers and pushes them toward defensive, immature actions, such as denying the name of their adolescent child's illness. This belief is rooted largely in cultural stereotypes about fathers (such as the notion that "a father must be strong") and in fear of social labeling; as a result, fathers avoid seeking social support and bear greater pressure and responsibility both at work and in daily life. In addition, constantly concealing the illness from others creates a heavy cognitive and emotional burden that, according to Selye's theory [45], can lead to psychological burnout. Although concealment begins as a defense mechanism against social stigma, over the long term it can limit access to the very social networks that might otherwise reduce the burden of the illness—illustrating the dual and paradoxical role that "social support" plays in these fathers' experiences.

The findings of this study showed that social support for fathers of children with hemophilia functions both as a facilitating resource and as a psycho-cultural challenge. Although social support can reduce emotional pressure and improve family adjustment [46], fathers' experiences showed that receiving this support is not always simple. Cultural resistance to accepting help from family, concerns about being a burden, and a wish to protect others' feelings often lead fathers to conceal their need for social support. Receiving social support is important for another reason as well: because chronic blood disorders such as hemophilia—

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which is most often maternally inherited—carry social stigma and shame, others may respond in ways that invalidate fathers' feelings or trigger further shame. This finding aligns with previous research showing that cultural values and norms related to preserving social reputation can hinder the full use of available support resources [47].

Implementing a cognitive-restructuring process to increase perceived social support around this belief is another consideration healthcare providers should bear in mind, supported by proper training from psychologists. Helping caregivers become familiar with, and gain access to, social support in the context of their own lives—rather than focusing on potential negative outcomes such as social labeling—can be very helpful for parents coping with the illness. Using a cost–benefit or balance-focused approach in motivational interviewing, in which positive and negative aspects are discussed without triggering resistance or emotional invalidation, can effectively guide fathers toward seeking and perceiving greater social support. In the collectivist Iranian culture in particular, seeking help from relatives can create more opportunities for fathers to attend to their personal lives and reduce potential burnout. Similarly, seeking support from spouses or colleagues (especially colleagues) can significantly reduce the major challenge of conflict between daily marital or work life and treatment responsibilities. This work–family–treatment conflict was one of the main concerns of fathers in this study, and this approach can help alleviate it.

Workplace support, particularly colleagues covering job responsibilities during treatment, played an important role in reducing daily pressure. However, the resulting sense of obligation to reciprocate this support itself became a source of psychological stress; this finding is consistent with studies showing that workplace social support can be both a source of resilience and a source of stress [48]. Furthermore, when managing their child's social interactions with peers, fathers face the challenge of overprotection, often feeling obliged to constantly supervise their child or repeatedly caution other children to be careful. This behavior can frustrate other children or stigmatize the child with hemophilia. The study by Broadhead et al. [49] shows that excessive support, broad empathy, and overprotection of children with chronic illness—stemming from concern for their condition—can lead to numerous developmental problems, as such behavior hinders children's communication skills with peers and disrupts their social adaptation.

Cultural pressures, together with limitations in receiving support, place the main burden of care and emotional responsibility on fathers and the nuclear family. This heavy burden inevitably affects and reshapes the most fundamental layer of family life: parenting styles. The findings of this study show that social support, while important in reducing emotional pressure, cannot on its own alleviate the psychological burden of parenting. Indeed, fathers' experiences show that social and cultural challenges are directly intertwined with their parenting styles. The next section therefore turns to "parenting challenges in the context of chronic illness," revealing new dimensions of this pressure and these parenting styles.

The findings of this study indicate that parenting a child with a chronic illness such as hemophilia is a complex, multilayered experience that places parents into different, and sometimes contradictory, parenting styles. Pressures arising from the need for special care, worry about complications of the illness, and efforts to compensate for the child's perceived deprivation give rise to different parenting patterns, ranging from helplessness and exhaustion to authoritative, balanced styles, a finding that aligns with previous literature indicating that a child's chronic illness can significantly affect parenting structure and quality [50]. One of the main challenges was a sense of helplessness in parenting, stemming from continuous caregiving pressure and the child's resistance to treatment—an experience consistent with previous research indicating that parents of children with chronic illness are susceptible to emotional and psychological fatigue [51]. In contrast, some parents adopt compensatory styles such as "snowplow" or permissive parenting, in which they attempt to compensate for all of the child's perceived shortcomings and limitations; although these approaches are motivated by a desire to support the child and alleviate their suffering, they can foster excessive dependency and reduce the child's resilience in facing life's challenges [27, 28].

Among the observed styles, an "authoritative, attachment-oriented" style emerged as a more balanced model that, while setting reasonable limits, also emphasizes a warm emotional relationship and fosters the child's independence. This style corresponds to Baumrind's [30] findings, which show that authoritative parenting can promote healthier social and emotional development in children—even in the context of chronic illness. In contrast, authoritarian or overindulgent styles, although adopted with the aim of protection or compensation, can create a sense of injustice among siblings and increase family tension [52]. In addition, inconsistency in parenting styles between parents was identified as an important challenge; such differences, stemming from differing understandings of the illness and differing levels of stress tolerance, can leave children feeling unstable and insecure. This finding is supported by Cowan and Cowan's 1992 research, which

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shows that parenting conflict can increase anxiety and behavioral problems in children [32]. Educating parents and raising their awareness of different parenting styles and the potential long-term consequences of these interactions—both for the family's readiness to cope with the illness and for the shaping of the child's personality—can guide parents toward modifying their cognitive and behavioral frameworks and toward seeking psychological support for behavior change.

The experiences of fathers showed that after their child's diagnosis, they not only empathized with the child's suffering but also became deeply immersed in the pain, experiencing it as their own personal distress; this excessive empathic involvement weakened emotional boundaries between father and child and, in some cases, led to overprotective behaviors and difficulties in treatment follow-up, reflecting both the intensity of fathers' emotional involvement and the complexity of the parenting experience when facing a child's chronic illness. Among all observed parenting styles, one of the deepest and most challenging components was this intense emotional engagement with the child's suffering—a phenomenon referred to in the research literature as excessive emotional mirroring. Excessive emotional mirroring may lead children to suppress and conceal their emotions and pain: when a child observes intense and distressing parental reactions during bleeding episodes or experiences of pain, the child may hide symptoms and emotional distress in order to protect the parent. The child comes to believe that expressing pain or reporting bleeding will cause the parent further suffering and emotional disturbance; therefore, to care for the parent, the child refrains from honest emotional expression. This phenomenon represents a reversal of the caregiving role, in which the child, rather than receiving support, perceives themselves as responsible for maintaining the parent's emotional stability.

Such suppression and concealment not only exacerbate the child's physical condition—because bleeding episodes or symptoms are not reported in a timely manner and treatment is delayed—but also seriously undermine trust in the parent–child relationship. Instead of experiencing emotional safety in freely expressing feelings, the child learns to hide emotions to avoid harming the parents. As a result, emotional communication between parent and child becomes disrupted, and a cycle of misunderstanding, emotional distance, and psychological strain develops. In other words, excessive emotional mirroring places the child in a position where responsibility for managing the parent's emotional experiences is attributed to the child and the illness itself. This imposed sense of responsibility, in addition to increasing the child's psychological burden, may contribute to the development of maladaptive patterns of emotion regulation and social relationships in later life.

From a clinical perspective, these findings highlight the importance of parent education in emotion regulation and the management of emotional mirroring. Psychological interventions can help parents learn how to reflect their child's emotions in a balanced manner without increasing the child's anxiety or sense of guilt. Some studies have even suggested that in sensitive situations such as injections, parents should either maintain a "neutral facial expression" or temporarily leave the room in order to preserve the child's psychological safety. Although this approach may be difficult for both parent and child in the short term, it can contribute to greater emotional independence and reduced anxiety in the child over time.

Just as emotional boundaries between father and child may be disrupted by excessive emotional mirroring, boundaries related to roles and responsibilities in interactions with the healthcare team can also become challenging. Defining this relationship—whether it should be based on "collaboration" or "obedience"—represents another important source of tension for fathers. The findings of this study showed that clarifying parents' position within the treatment pathway is one of the core challenges in the experiences of fathers of children with hemophilia. The distinction between therapeutic collaboration and therapeutic obedience is often unclear in practice, and this ambiguity places the parent–provider relationship in a suspended and uncertain state. Such conditions may lead to negative emotions, including anger, distrust, and a sense of exclusion from the treatment process. This finding is consistent with existing literature indicating that active family participation in treatment decision-making enhances feelings of control and security and improves the quality of the therapeutic relationship [53, 54].

Fathers in this study reported that when they are positioned alongside physicians as part of an "equal team" in the treatment process, they experience greater calm and trust. This experience aligns with the concept of therapeutic collaboration, which emphasizes the preservation of patient and family autonomy and their active participation in decision-making [55]. In contrast, experiences of therapeutic obedience, characterized by authoritative behaviors or lack of transparency, led to parental resistance and, in some cases, independent decisions to modify or discontinue treatment. These findings indicate that training healthcare professionals in communication skills and in clearly differentiating between collaboration and obedience is a

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clinical and cultural necessity that can prevent deterioration of the therapeutic relationship.

All of these complex challenges—from cultural stereotypes and interactions with healthcare professionals to parenting styles and emotional involvement—ultimately converge in one central domain: everyday life. The cumulative pressure of these factors makes the management of fathers' multiple r

results of this study showed that following a child's hemophilia treatment is not merely a medical responsibility for fathers but is deeply intertwined with their social and familial roles. Society expects men to function simultaneously as financial providers, emotional supporters of their spouses, and active caregivers for their children. This multiplicity of roles, combined with ongoing treatment

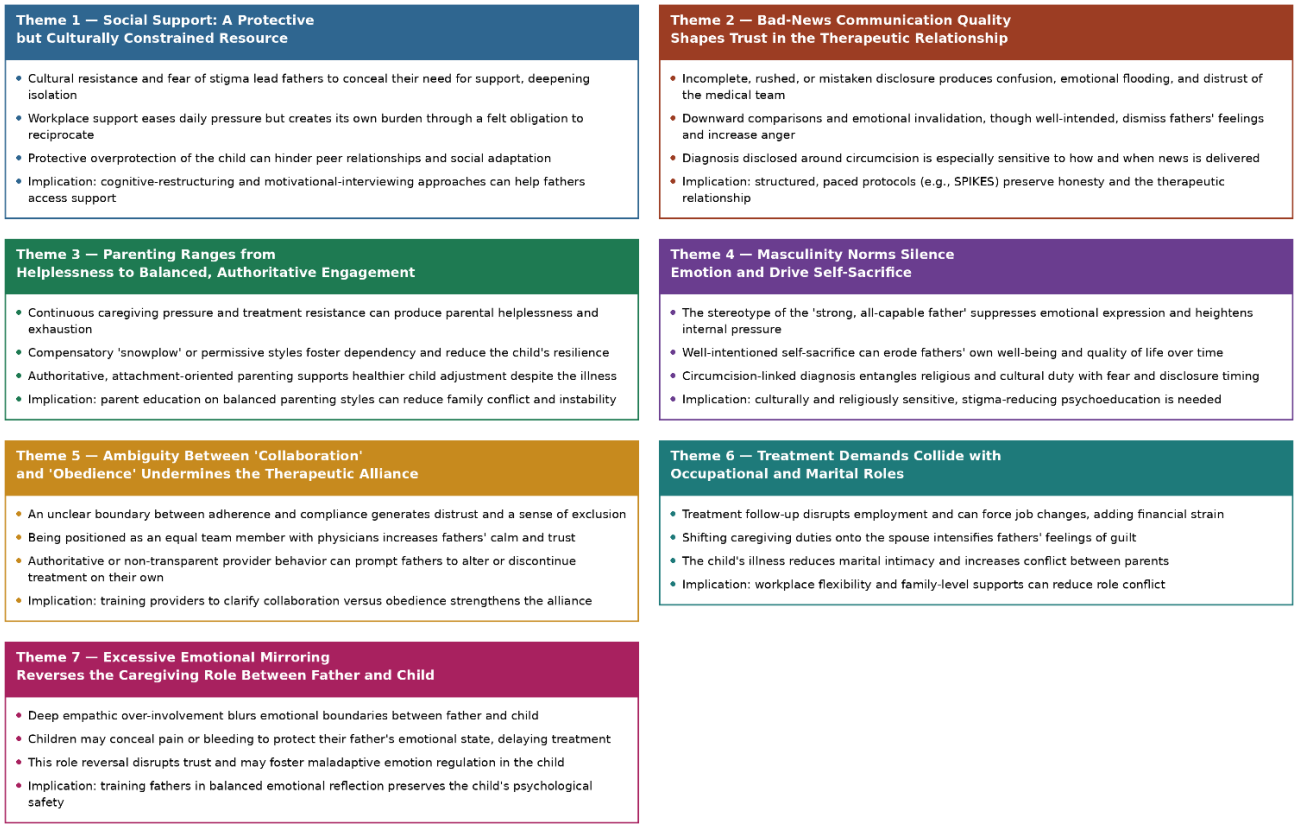

Figure 2. Interpretive Synthesis of the Discussion and Conclusion: Clinical and Cultural Implications Across the Seven Themes. Discussion- and conclusion-level synthesis of the study's seven themes (presented in Theme 1–7 order), summarizing the interpretive meaning, underlying mechanisms, and clinical/cultural implications drawn from the Discussion and Conclusion sections — rather than restating the Results section theme titles.

demands, leads to role conflict and psychosocial strain. This finding is consistent with previous research showing that parents of children with chronic illnesses—particularly fathers—are exposed to multiple pressures arising from conflicting roles [51].

The experiences of fathers showed that following the treatment process can seriously interfere with employment and, in some cases, even force individuals to leave their jobs. In addition to financial pressure, this situation intensifies feelings of guilt related to placing caregiving responsibilities on the spouse. Moreover, the child's illness directly affects marital relationships, leading to reduced intimacy and increased conflict between parents. This finding is consistent with studies showing that a child's chronic illness can weaken marital relationship quality and place parents at higher risk of anxiety and depression [56]. Findings from this and related research help to illuminate the complexity of factors involved in the lived experiences of caregivers of individuals with hemophilia, as well as in their therapeutic, emotional, and social interactions. Examining each of these factors in depth, and considering their interactions can lead to a clearer understanding of this relational matrix—one that, in turn, can inform modifications to interventions and to the guidelines that shape clinical practice. An interpretive synthesis integrating the seven themes with their underlying

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mechanisms and clinical and cultural implications is presented in **Figure 2**.

5. CONCLUSION

This study showed that the lived experience of fathers of children with hemophilia in Iran goes beyond the management of treatment and is shaped by the intersection of sociocultural pressures, occupational roles, and parenting styles. Norms of masculinity and the stigma of vulnerability make the process of seeking and receiving support difficult, and they interact with the way bad news is delivered and with the quality of relationships with healthcare professionals; incomplete or rushed communication of bad news fosters distrust and therapeutic ambiguity. At the family level, consequences include inconsistency in parenting styles, a tendency toward overprotection, and excessive emotional attunement. These issues both complicate treatment adherence and encourage the child to conceal symptoms, thereby weakening mutual trust. Social support—despite its protective function—acts simultaneously as a source of stress and as a source of resilience due to stigma, fear of labeling, and role conflicts. Based on these findings, culturally sensitive interventions that simultaneously address three key domains are necessary: (1) improving the communication skills of healthcare teams in delivering bad news and clarifying the distinction between "therapeutic collaboration" and "therapeutic obedience," (2) empowering parents in emotion regulation and emotional boundary-setting with the child, and (3) facilitating practical family and workplace supports to reduce role conflict. Finally, the findings emphasize the need for policies and training that address structural, cultural, and organizational barriers rather than placing blame on individuals; future research can contribute to the design of indigenous support protocols for fathers and families by following pathways of change over time.

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Conflict of interest

The authors declare no conflict of interest.

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Ethical statement

The study was approved by the Pediatric Congenital Hematologic Disorders Research Center, Research Institute for Children's Health, Shahid Beheshti University of Medical Sciences (ethics code IR.SBMU.RICH.REC.1402.021). Informed consent was obtained from all participants.

AI usage statement

The original manuscript was conceived, conducted, and written by the authors in Persian. Claude (Anthropic) was used to (1) translate the manuscript text from Persian into English and refine the language for clarity, and (2) assist in the graphic design and layout of Figures 1 and 2, which visually represent the authors' own study design and thematic findings. No AI tool was used to generate, alter, or fabricate research data, participant quotations, or study findings; all interview data, coding, and analysis were performed manually by the research team as described in the Methods section. The authors reviewed, verified, and take full responsibility for the accuracy and integrity of all translated and visually presented content.

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