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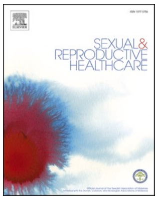

Full Length Article

“Navigating in a maze without a map“. Partners’ experiences of hyperemesis gravidarum- a qualitative study

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ABSTRACT

Objective: A supportive environment for women with Hyperemesis Gravidarum is crucial but not always provided. There is a lack of research regarding Hyperemesis Gravidarum, its impact on the family, and the partner’s perception of supporting their spouse. Thus, this study aims to explore partners’ experiences of Hyperemesis Gravidarum during their spousés pregnancy.
Methods: Data were gathered through 13 individual, semi-structured, in-depth, digital interviews with partners of women who had experienced Hyperemesis Gravidarum and analysed with Qualitative Content Analysis. The partners were recruited through advertisement on a social media platform and were exclusively males, representing 8 of 21 Swedish regions. The mean age was 34, and they had, on average, 1 previous child. The mean time from the experience to the interview was 12 months.
Findings: The main theme, “Navigating in a maze without a map”, explains partners’ situation as stressful and demanding when their spouse suffers from Hyperemesis Gravidarum, with insufficient support and guidance from healthcare providers. The analysis resulted in three themes: “Standing alone with a demanding responsibility”, “Being in a lottery when facing healthcare”, and “Climbing the mountain together.” The themes display challenges within everyday life and healthcare, as well as strained relations within the family.
Conclusion: Partners experience a need to support their spouse in every aspect of daily life and advocate for adequate healthcare. Healthcare professionals must support and acknowledge the partners’ struggles during the demanding situation with Hyperemesis Gravidarum.

Introduction

Hyperemesis Gravidarum (HG) is the most severe form of nausea and vomiting during pregnancy, with a reported prevalence of 0.3 %-3.6 % worldwide [1], and approximately 4,000 pregnant women in Sweden need specialised health care each year due to HG [2]. The HG field of research is considered incomplete and contradictory due to inconsistency in the definition of the HG diagnosis. A commonly used definition of HG is persistent vomiting, measurable signs of starvation, e.g., ketonuria, electrolyte abnormalities, acid-base disturbances, and more than 5 % weight loss [2,3]. However, this definition does not fully comprehend the complexity of the disease. In 2021, an international consensus definition of HG was agreed on and articulated as follows: i) symptoms start in early pregnancy, before a gestational age of 16 weeks, ii) Characterised by severe nausea and/or vomiting, iii) Inability to eat and/or drink normally, and iv) strongly limits daily activities [4].

HG is one of the most frequent reasons for hospital admissions during pregnancy [5] and causes adverse maternal health outcomes, including, but not limited to, nutritional deficiencies, dehydration, and weight loss [6]. Additionally, adverse pregnancy and fetal outcomes such as increased frequencies of infants born small for gestational age (SGA), low birth weight, and premature births have been reported [6,7]. The etiology is unknown but appears to be multifactorial [3]. A strong hereditary pattern for HG has been found between mothers and daughters [8] and between sisters [6], and genetic risk factors for the disease have been identified [9]. Furthermore, elevated levels of the hormone Growth

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Differentiation Factor 15 (GDF15) have been found in maternal circulation in HG pregnancies [10]. Taken together, this suggests GDF15 to be an important factor in the etiology and a possible marker in future diagnostics and in developing a curative treatment for HG.

Psychological factors of impact have also been investigated and debated in discussing HG etiology [3,11]. Mental illness has not been verified as a cause for HG, but it has been shown to have a negative psychological and psychosocial impact on women's lives regarding high levels of distress, depression, anxiety, and post-traumatic stress syndrome [12–14] However, the thought of mental illness as a cause has contributed to the stigma associated with the disease [3].

Since the cause of the disease is unknown and there is no cure, the treatment available is aimed solely at relieving symptoms and restoring electrolyte balance [2]. Women suffering from HG express being unable to care for their families and themselves, manage daily activities, and fulfill work responsibilities [13,14]. The situation for women with HG can become so challenging that they pursue elective termination of wanted pregnancies, and in some cases, they suffer from suicidal ideation [13].

Support from family, friends, and healthcare are positive and considered protective factors improving the woman's coping strategies [13]. However, many women describe a lack of support and understanding from those around them, including healthcare professionals and partners [13,14]. Emotional and physical support by partners during pregnancy is important for pregnant women, as expected by the mother as well as the father-to-be [15] and may decrease the risk of pregnancy-related anxiety and depression for the mother [16].

Partners' experiences of women's health have been investigated, for example, for chronic diseases [17] and in complicated births [18], but not, to our knowledge, from an HG perspective. Thus, this study aimed to explore experiences of Hyperemesis Gravidarum during their spousés pregnancy.

Methods

Design

A qualitative study design with an inductive approach was chosen due to its ability to describe and capture poorly understood lived experiences [19]. The method used in this study was stepwise according to manifest and latent qualitative content analysis [20,21]. Qualitative content analysis is a systematic method that allows the authors to analyse the descriptive, manifest content and interpret the latent underlying meaning of the narratives to broaden and deepen the understanding of the lived experience [22].

Participants and settings

The study was conducted in Sweden, representing 8 out of 21 counties (1–3 participants per county). HG management and guidelines vary greatly across the country, and for available treatments, there is low evidence and a lack of research [2]. The first contact with the healthcare system in Sweden for women with HG symptoms is usually the maternity healthcare services, which, depending on the region, assesses the level of care the woman needs. Depending on the region, the healthcare organisation to which the woman is referred may be primary care, specialist care or inpatient care [2]. The healthcare services do not consistently use existing disease definitions, rendering them unusable for this study's sample.

An advertisement was shared in antenatal care units, childcare-, and gynecology clinics in three different counties in Sweden: Kalmar, Västerbotten, and Västernorrland. Additionally, advertisements were shared on social media. Inclusion criteria were: i) Partners of women in Sweden who had HG in a current pregnancy that had lasted for at least 20 weeks or who had experienced HG in a previous pregnancy, resulting in a birth less than six years ago, ii) the women with HG should have been treated with intravenous fluid therapy during their illness, and iii) the partner should be fluent in Swedish or English. The recruitment aimed to achieve maximum variation in background characteristics within sample [23]. 17 individuals were recruited, living in different areas of Sweden. Four of the participants were excluded. One participant declined to participate, two could not be interviewed due to time constraints on data collection, and one was excluded due to birth more than six years ago. A total of 13 participants were included. The participants were exclusively males, and the majority were recruited through social media. All participants were living together with their pregnant spouse and had an occupation. Close to half of the participants experienced the effects of an ongoing HG pregnancy at the time of the interview. For more information, see Table 1.

Data collection

The data were collected between February and March 2023 through 13 individual, semi-structured, in-depth interviews [23,24], conducted by one of the co-authors, JD, via a digital platform. An interview guide was prepared and piloted among one participant. The pilot interview did not lead to any alteration of the interview guide and is therefore included in the analysis. All the interviews started with the question, "What are your experiences of living with a partner suffering from HG, and how has it affected your life?" Additional questions helped the participants deepen and broaden their narrative. The interviews were recorded using an external dictaphone and transcribed verbatim into text. The mean duration of an interview was 40 min (25–57 min).

Analysis

Data were analysed between March and August 2023 in a stepwise manner according to the method Qualitative Content Analysis [20–22]. Accordingly, the transcribed text was read repeatedly by LL, JD and ML to grasp the essence of the whole dataset. The main author listened to the original recordings and compared them to the transcribed text to ensure a correct understanding. Meaning units were extracted, condensed, and coded. LL and JD started to code the same interview independently and then compared the codes to ensure that the authors coded similarly. Thereafter, the authors divided the dataset in half and individually coded 50/50 of the interviews. Codes that did not comply with the aim were excluded, like codes solely focused on the woman's experiences without the partner's perspective. Once the data were coded, groups of codes with similar meanings were created, and seven sub-themes were formed and discussed with senior author ML until a

Table 1
Background characteristics of participants (n = 13).

Participants	13
Age	
Mean	34
Min-Max	26–44
Highest educational level	
University	9
High school	2
Compulsory school	2
Country of origin	
Sweden	11
Other European country	2
Number of children	
0	1
1	7
>1(2)	5
Time from the experience to the interview (months)*	
<12	6
12–36	6
36–72	1

* Mean time between HG pregnancy and interview: 12 months.

consensus was reached. The sub-themes were analysed on a latent level with a low degree of interpretation and abstraction. The sub-themes were then further analysed, and three themes were formed with a higher degree of interpretation while remaining on a low abstraction level. Finally, the themes were analysed into one overarching main theme, “Navigating in a maze without a map”, which captured the experience on a latent level with a high degree of abstraction and interpretation. The analysis was not linear; the authors, LL and JD, iterated between coding and the original text, refining the approach with ML and the research group to continually strive for consensus.

Ethics

The study has been approved by the Swedish Ethical Review Authority (Dnr: 2020-03675, approved 2021–01-04). The participants were informed orally and in writing about the study. An information letter was sent to the participants who met the inclusion criteria, and a consent form was signed before the start of the interview. Participants were explicitly informed that they retained the right to withdraw from the study at any point without needing to provide a reason. By GDPR, all personal data was anonymised and stored confidentially.

Findings

Navigating in a maze without a map. The main theme, navigating in a maze without a map, illustrates the participants’ situation as being alone in a stressful and demanding situation with insufficient support and guidance from healthcare. They had to find their own way through the maze to cope with this situation at home, at work and in encounters with the healthcare system. Table 2.

Standing alone with a demanding responsibility

This theme describes the participant’s experience of a challenging and demanding time when the woman suffers from HG. The participants need a supportive environment, such as understanding and caring family, friends, and employers, to cope with this life-changing transition of becoming a parent during a pregnancy complicated by HG.

Needing support from family and friends

To manage everyday life, the participants described a need for support from their surroundings as crucial, essential, and relieving. The participants explained that they couldn’t leave the woman alone during specific periods and needed someone to take their place when they needed to leave the house. Sometimes, it was hard to ask for help because they desired to manage the situation by themselves and keep the family situation hidden. However, eventually, everyone knew about it, and when relatives became aware of the problem and offered support, the participants realised how important it was. Simultaneously, for some, it was necessary to tell people around them about their situation as a form of counselling.

Table 2
Overview of the findings with the embracing main theme divided into three themes and seven sub-themes.

Main Theme	Themes	Sub-Themes
Navigating in a maze without a map	Standing alone with a demanding responsibility	Adapting work to the family situation
		Needing support from family and friends
		Putting oneself aside
	Being in a lottery when facing healthcare	Meeting ignorance and lack of knowledge
		Being confirmed and treated with respect
	Climbing the mountain together	Strengthening the relationship through challenges
		Changing the plans for expanding the family

Many had friends and family to talk to and receive support from, but some did not have support due to distance, the COVID-19 pandemic, elderly relatives, or deceased relatives. Some of them asked for counselling from healthcare providers but never received it, as it was not the standard procedure within healthcare. Some of the women’s mothers had also experienced HG and supported the family by providing information about the sickness and sharing their experiences.

“It was the reason for us to move from x. We had no family and friends nearby, and at last, the situation became untenable. We needed the support". (11).

Adapting work to the family situation

It was hard to maintain a good performance at work due to the responsibilities at home.

Therefore, participants needed to be honest with their employers about their situation, and they emphasised the importance of them being understanding.

> *“You become extremely less productive at work. I only focus on what I must get done; everything else must wait. My main priority is my family, always the family”(2)*

Many participants expressed being unable to attend work full-time due to taking care of a sick older child or being needed at the hospital to support their spouse. Taking care of morning routines, leaving older children at daycare, and going home for breaks sometimes led to late arrivals at work. They were also stressed over being at work while their spouses needed them at home, which made them distracted and mentally disconnected at work. Participants explained that they required good support from their employers to cope with everyday life.

The managers were often able to support the participants by allowing them to work from home or having their schedule adjusted to daytime when needed, and for some, the possibility of having flexible working hours. Some participants who were on parental leave when a second pregnancy started found it easier when they were at home full-time, while others thought it was burdensome with an older child at home. There were also examples of participants being on sick leave due to the pressure at home. Some participants also described an economically strained situation. For those who had income insurance, the situation was easier.

Putting oneself aside

During the time of illness, the participants felt that the family relied on them, and they had to shoulder a heavy and demanding responsibility. They were trying to manage a new, challenging situation at home and were forced to adapt their everyday routines to fit a situation where the HG woman sometimes could not be present in the family. They cared for the woman’s basic needs, such as helping her out of bed, dressing, managing nutritional intake, and personal hygiene. If there were older children in the family, the participants bore the full responsibility, and many of the respondents described themselves as a single parent during their spouse’s illness. The situation was difficult, stressful, and demanding, and they always felt needed at home.

However, they were often careful to underline that their amount of struggle could not be compared with the woman’s. They feared being unable to endure this period without becoming sick due to the stress. The possibility for recovery was limited, and they often forgot to take care of themselves, leading to physical and mental symptoms of stress such as sleep disorder, depression, fatigue, and peptic ulcers.

> *" Íve got so stressed with everything. I started to sleep less, and I set the alarm earlier and earlier in the morning to manage everything: the kids and preparing breakfast and everything. I got less and less sleep, and finally, my body broke down."(4)*

It was described as painful to see their spouse sick during pregnancy and constantly fearing that something terrible would happen to the woman and the unborn child. The participants revealed a feeling of powerlessness and inadequacy when they couldn't help or solve the problem. They wished for an early diagnosis so they could be better prepared. Participants with good knowledge about the disease did not experience it as hard and were more equipped to prioritise themselves. In addition, the participants described a subsequent pregnancy as easier to handle, as they were better prepared for the situation. And expressed some level of acceptance.

> *"From the start, I knew that the only thing I could do was to give her as much love as possible. Not trying to affect what and how she eats or getting angry at the healthcare system. I need to be present and realise that things are what they are."(9)*

Being in a lottery when facing healthcare

Most participants expressed a need for assistance when navigating through the healthcare system, and the encounters were often influenced by ignorance and lack of knowledge. There were experiences of healthcare as adequate and supportive, but it depended on which healthcare personnel you were fortunate to meet, therefore the comparison with a lottery.

Meeting ignorance and lack of knowledge

When encountering healthcare professionals, the participants describe their frustration with being met with ignorance in every instance. The woman was confronted with ignorance by the social insurance authority, antenatal care units, gynecological clinics, and the gynecology ward. Even during labour, the illness was not taken into consideration. This situation left the participants feeling bewildered and frustrated. Healthcare professionals attempted to normalise the condition, trying to provide comfort by stating that it was expected and that nausea would soon subside. However, the normalisation process only exacerbated the frustration felt by the participants, who believed this to be far from ordinary.

> *"I felt a great sense of shame because I did not put more pressure on the healthcare system. Oh, I was naive; I did put my trust in them".(7)*

This frustration prompted the woman and the participant to begin navigating through the healthcare system independently, and many participants took the responsibility of gathering information. They searched various websites on the internet and, for those with the means, also in scientific databases. The vast majority had not received any information about HG from healthcare professionals. The participants' main concern was that healthcare professionals did not take them seriously. They felt that healthcare professionals were unfamiliar with HG and how to treat it. This situation instilled fear in the participants concerning potential medical complications for the woman and the unborn child.

> *"There are so many steps to follow all the time. You miss a safe haven in all this, and I don't want to nag all the time. If you don't nag, nothing ever happens"(2)*

The lack of support from healthcare compelled the participants and their spouses with HG to compensate for inadequate healthcare by suggesting treatments and advocating for, e.g., home-based healthcare. They monitored the women's blood test results, kept track of doctors' appointments, and grappled with the ongoing struggle of contacting healthcare. The participants described having lost all trust in healthcare and felt they couldn't rely on it to manage the situation. They outlined a pervasive lack of knowledge among healthcare professionals. Some participants were sure this knowledge gap resulted from gender inequality in research. They did not just point out the lack of knowledge but also an unwillingness and lack of interest in caring for HG patients. The participants described numerous healthcare encounters, constantly interacting and conversing with someone new. They wished for continuity and someone accountable who would adopt a comprehensive approach with a holistic view and would be interested in devising a plan and conducting follow-ups on treatment. They also wished for early recognition of the illness and guidance from healthcare. The participants desired someone other than themselves to ensure the woman received adequate healthcare.

Being confirmed and treated with respect

Despite the healthcare system being described as dysfunctional, the participants highlighted positive aspects. The participants recounted that personal treatment varied from person to person. Even though the healthcare providers couldńt cure the disease, it was always valued when the couple was met with sympathy, respect, and a willingness to help. Feeling heard and taken seriously brought them a sense of security. Furthermore, the participants mentioned that encountering someone knowledgeable usually led to excellent healthcare management.

The healthcare was described as adequate and respectful, particularly during the second pregnancy. Compared with the first pregnancy, healthcare responded more promptly with doctors' appointments, early start with medical treatment, and early identification of personal needs. Furthermore, healthcare professionals did not question the seriousness of the nausea and vomiting to the same extent as in the first pregnancy.

> *"We had a medical record to refer to. So, it was easier to get medication. But also, to be taken seriously"(8)*

Participants knew what to expect from healthcare early on, alleviating the overall experience. Healthcare encounters were generally smoother for those who were also healthcare professionals, as they understood how the healthcare system operates, had more resources to demand and question the system, and, in some cases, a better pre-understanding of the disease.

Gratitude was felt when, for instance, home-based healthcare was provided. It lightened their workload and mental stress, knowing that healthcare professionals would visit their spouse multiple times daily to provide the necessary care.

Climbing the mountain together

This theme illustrates HG's relational strain on the family regarding the relationship between the spouses and the relationship with any previous children. Ultimately, the HG experience leaves the spouses strengthened but reluctant to have more children.

Strengthening the relationship through challenges

The participants described becoming a parent as a highly significant event and simultaneously witnessed their pregnant partner being weak and sick, yet strong. The participants depicted the relationship as challenging, marked by arguments and occasional anger toward each other associated with the strained situation and a lack of energy. During the illness, the participants experienced that the relationship had to be put on hold. They expressed the loss of intimacy, a difficulty they had to come to terms with. The participants also conveyed a sense of loss, as if they had lost their best friend and the person they usually confide in when things get tough.

> *” You get a whole new perspective on your partner because you get to see that she’s very strong and willing to get through all that for us to have a child together”. (10)*

A feeling of isolation during the illness period was also described, as the woman lacked the opportunity or desire to socialise with friends or engage in activities outside the home, while the participants did not want to leave the woman alone. This resulted in the family being isolated from their social life, living in a bubble. The couple attempted to discover moments of positivity in life, with the participants viewing it as their responsibility to encourage and support the woman towards their goal, the birth. The participants noted that the long-term perspective of the relationship had not been affected in any negative way; in fact, they emerged stronger from this situation. They navigated through it together, and it was all worth it.

> *“After she got better, there haven’t been any issues at all. I would say it has only strengthened our relationship”(13)*

The participants also acknowledged a responsibility to nurture the relationship with previous children. They described that the women sometimes expressed concern that their relationship with older children would deteriorate. The participants had to support the woman with that aspect as well. Because of the increased time spent with older children, the participants experienced those relationships becoming stronger, sometimes at the expense of the mother–child relationship.

Changing the plan for expanding the family

One long-term effect of experiencing HG is a reluctance to suffer through more pregnancies, resulting in fewer children than originally planned. Some participants believed that HG did not impact their desire to have more children, while others did not want more children. The participants sometimes feared additional pregnancies due to the significant struggle and could not support another pregnancy with HG, as the risk of recurrence was imminent. The challenge with thoughts of elective termination of pregnancies was also narrated. It was hard for the participants to stand on the side, neither able to nor wanting to influence the woman’s decision. It gave them a sense of powerlessness. They had hoped for someone from the healthcare system to reassure the couple that everything would be fine and that they could manage this.

> *“But we don’t want to go through the same thing again, because it wears out a lot. It wears immensely on, on, not so much the relationship itself, but more on the energy”.(9)*

Discussion

This study aimed to explore partners’ experiences of Hyperemesis Gravidarum during their spousés pregnancy. Overall, the participants experienced overwhelming stress and responsibility when their spouse’s pregnancy was complicated with HG. However, the impact on daily life differed among the participants. Adapting their lives to the new circumstances of having a spouse who could no longer contribute to their daily family life was described. Participants expressed the loss of a partner with whom they shared a common life and who usually was their closest confidant. Participants assumed a significant role in supporting and caring for their spouses. They took full responsibility for the household and their older children while continuing to manage work responsibilities. They sensed that the well-being of the family solely depended on them; they felt lonely and needed a supportive environment. Previous research in an endometriosis context showed similar results regarding the type of support provided by the partners to the women suffering from the disease. The support was divided into three areas: i) support in managing everyday life. ii) providing emotional support. iii) support in relation to healthcare [17].

An aggravating factor in an already challenging situation was the healthcare encounters. Most participants reported being met with ignorance, trivialisation, and a sense of unwillingness from healthcare providers to take responsibility for the spouse’s care. These negative experiences are in accordance with previous research [25,26], which reports trivialisation, normalisation and lack of knowledge as common experiences among women with HG in healthcare encounters. Negative healthcare encounters contributed to feelings of frustration, helplessness, and fear. Frustration mainly concerned the fact that no professional healthcare provider took responsibility for the care, leading to fear for the health of their spouse and unborn child. Partners felt it was their responsibility to advocate for adequate healthcare, and they had no guidance in finding solutions. Partners lacked early initiatives, recognition, and professional support on the part of the healthcare system. Previous studies exploring partners’ experiences of healthcare given to their spouses for chronic conditions [17] or acute obstetric events [18], have found that partners often feel frustrated, helpless, and fearful when they are not adequately informed and included in the care process. This is also valid for the participants in the present study, showing evidence for the need for early intervention, recognition, and professional support in the context of HG.

Furthermore, the participants expressed a demand to be strong for their spouses. Vallin et al. (2019) [18] found that such feelings are often hidden to show strength towards their spouse to protect her from additional concerns; thus, they need emotional support from healthcare providers. Partners in our study requested counselling but did not receive it as it was not part of healthcare routines. Research has shown that emotional support can reduce feelings of helplessness, anxiety, and stress while increasing partners’ sense of empowerment and ability to provide quality support [18]. Partners need to be acknowledged, informed and reassured to feel calm and safe [27].

The present study found that HG strained the couple’s relationship during the sickness but was strengthened in the long-term perspective. However, as shown in earlier research [28], many couples struggle with the relationship. Therefore, our result contributes to new insights but can also be discussed regarding sample selection bias. The recruitment strived for maximum variation in the sampling of participants; however, the final participants ended up being quite homogenous. A possible explanation may be the social media platform within a Swedish HG discussion group where the majority of the participants were recruited. People engaged in such groups may be more involved in their healthcare, resulting in partners being more engaged in their spouse’s care than the average population. In addition, partners who are not supportive, and in those cases where the relationship may have been hurt permanently, could be reluctant to share their experiences in studies. Further, most participants, or their spouses, in the present study were employed within the healthcare system, which could have contributed to higher demands on adequate healthcare. Regarding transferability, the purpose of qualitative research is not to generalise, and it is ultimately up to the reader to determine if the result is transferrable into other settings in terms of the reader’s own experiences [29].

A limitation of the study may be the aspect of recall bias due to the inclusion criteria of having experienced an HG pregnancy within the past six years. However, only one participant had experienced an HG pregnancy six years ago, and it is debatable whether recall bias is the appropriate term in qualitative research. According to Gaydos (2004) [30], life events create stored memories, and with the right stimuli, the memory reveals itself as unchanged, regardless of how the story is told or how long since the experience. The strength of the Qualitative content analysis method with an inductive approach is its ability to systematically analyse texts and capture multifaceted and sensitive phenomena as unconditionally as possible [19]. The research group is represented by medical doctors, midwives, chemists, and medical students with varying experiences caring for HG patients. The multi-professional knowledge and the ongoing discussions within the group contribute to the trustworthiness of the result regarding mitigating the risk of the result being drawn from any preconceptions [21].

Healthcare professionals may use this result to better understand to which degree HG impacts the partners and the importance of including them in the care.

Based upon the findings in this study, involving the partner in the woman's healthcare visits, supporting and providing them with information about the diagnosis and management, and inviting them to ask questions may be a valuable investment in healthcare. Further suggestions include offering counselling to the partner and the woman, individually and jointly. Healthcare professionals should take responsibility for organising the woman's care and work jointly with the woman and her partner to design an individualised careplan that meets their specific needs and preferences. This collaborative approach can help ensure that the woman receives high-quality care tailored to her unique circumstances as well as minimising any additional stress or burden on the partner.

Despite the possible limitations of the sample selection, the results of the strained situation at home with a stressful isolated environment, relational challenges [26,28], insufficient healthcare [25,26] and the thought of elective termination of pregnancies with the hesitation of wanting more children [25,26,28] is confirmed by other studies. More research on partners' experiences is needed, considering diversity in ethnicity and socioeconomic backgrounds.

Conclusion

The partner and their family are going through a demanding time when the woman suffers from HG. Being met with ignorance and normalisation of symptoms by healthcare professionals can be experienced as stressful and can hamper the partner's ability to give adequate support to the woman. Feeling responsible for supporting the woman in all aspects of daily life and advocating for good healthcare put additional strain on the partner. It is essential for healthcare providers to acknowledge the partner's struggle and to support both the woman and her partner towards parenthood.

CRediT authorship contribution statement

Louise Lindgren: Writing – original draft, Formal analysis. **Sophia Holmlund:** Writing – review & editing, Methodology, Conceptualization. **Johanna Dunge:** Writing – review & editing, Investigation, Formal analysis. **Malin L. Nording:** Writing – reviewing and editing, Methodology, Conceptualization. **Marie-Therese Vinnars:** Writing – review & editing, Methodology, Investigation, Conceptualization. **Maria Lindqvist:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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