Exploring Bereaved Fathers’ Experiences of Pregnancy Loss: A Phenomenological Study

by

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Dedication

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Abstract

The purpose of this study was to explore and gain understanding into bereaved fathers’ experiences of pregnancy loss. A qualitative study using phenomenological methodology based on grounded theory was employed for this study. A sample of four male participants who each experienced at least one pregnancy loss were selected for a single in-depth interview. The goal of grounded theory research is to identify an explanatory core category that becomes substantive theory and from this study’s theoretical coding, one core theme emerged from the data: Men who experienced a pregnancy loss responded to their female partner’s needs. This substantive theory was named “responding.” Other core categories resulting from the data included “expecting the pregnancy,” “losing the pregnancy,” “emotions,” “managing,” “following the partner’s lead,” and “medical follow-up.”

In addition to providing a further understanding of paternal pregnancy loss experiences, this study also highlighted considerations for professionals when supporting men, including adopting inclusive language about the pregnancy and loss, broadening understanding of pregnancy loss complications and increasing knowledge on supports and resources that would be available to bereaved fathers and their families. While this study’s findings contribute to a growing body of research on the topic of paternal experiences of pregnancy loss, further research would be useful to examine and understand how men respond to pregnancy loss when they receive appropriate support and resources from health care professionals, families and friends during this critical time.
Chapter 1 – Introduction

The birth of a child is arguably one of the most joyous events a couple can experience together; however, the journey to this momentous day can be fraught with disappointment and challenges. Pregnancy complications or perinatal loss can include miscarriage, stillbirth, or fetal abnormality (Nazaré, 2012). Miscarriage is the most frequent form of perinatal loss, developing in about fifteen percent of all clinically identified pregnancies (Serrano, 2006). However, there is a societal perception that miscarriage is considered something that happens to women, and men are often viewed as merely the caretakers for their partners (Rinehart & Kiselica, 2010). Few studies have evaluated the impact of early miscarriage on expectant fathers (Armstrong, 2002; McCreight, 2004).

Importance of Understanding Bereaved Fathers’ Experiences

Often men’s grief is treated differently from women’s grief. Family, friends, and coworkers tend to react with more concern for the woman's well-being, reinforcing societal expectations that men are to be the “strong” ones (Versalle & McDowell, 2005). North America has long adopted societal expectations for men to be in control, be courageous, be rational and analytical, accomplish tasks and achieve goals, express anger, be able to endure pain, and be a provider (Versalle & McDowell, 2005). It is, therefore, not surprising to find the implications of these expectations are profound when applied to a loss situation. When keeping within these societal expectations, bereaved fathers are more likely to be seen as being uncomfortable with and not encouraged to lose control, or openly cry, feel fear, express anxiety, loneliness, or depression, or be dependent or vulnerable when experiencing a pregnancy loss (Miron & Chapman, 1994; Puddifoot & Johnson, 1997).
The role of fathers in pregnancy, labour and delivery and child-rearing continues to evolve. It was not until the early 1970s that fathers were permitted to even bear witness to the birth of their children (Johnson, 2002). Prior to this, labour was viewed as something to be endured by women under the control of other experienced and knowledgeable women from the family or close friends who assisted as midwives and, consequently, men were mostly excluded from the process (Johnson, 2002).

Today, there is more of an emphasis for fathers to be included in all aspects of the pregnancy starting from sharing the discovery of the pregnancy through home pregnancy tests or joint visits to the family physician, pregnancy announcement, attending ultrasound and maternity appointments and participating in labour and delivery. When fathers are present at the birth of their child, there can be a greater attachment toward their infant compared to non-attending fathers (Miller & Bowen, 1982). Other research has noted that a father’s involvement during pregnancy and delivery can positively influence health outcomes for the man, his partner, and their children (Plantin, Olukoya & Ny, 2011). There has also been an increase in the number of men taking paternity leaves and sharing child-rearing responsibilities with their partners. In Canada, according to Statistics Canada (2015), for all provinces combined, thirty-one percent of recent fathers in 2013 claimed or intended to take parental leave, which is an increase from twenty-five percent in 2012.

Despite fathers commonly becoming more present and playing an active role in their pregnancy experiences, the impact of pregnancy loss on this male population is still not well researched. This paradigm shift in parental roles confirms the need for families dealing with a loss to be supported as a whole rather than each member separately (Centre for Addiction and Mental Health, 2004). A family-centred approach encourages greater collaboration among
policy and practice, services and supports that touch and influence the lives of families (FORCE Society for Kids’ Mental Health, 2012). This approach also complements and expands on a patient-centred approach by considering the needs of all members of the family. When health care professionals apply a family-centred lens when supporting a family through a pregnancy loss, it is more likely that the impact and significance of the loss will be acknowledged and will be extended to grieving fathers.

When pregnancy loss occurs, researchers have noted differing grieving responses exist between genders. Key differences in grief responses between men and women can include women talking more about the loss as a means of coping with the grief and being more likely to seek out social support than their male partners (McCreight, 2004). Often societal and familial misconceptions of how men should grieve lead to the idea that men deal with their grief quickly so they can support their female partners during this time. These differing grieving styles and societal misconceptions may lead to mental health issues (Martin & Doka, 2002) and relationship complications (Corbet-Owen, 2003; Hutti et al., 2015; Hutti, 2005; Lasker & Toedter, 1991). As most of the focus is commonly on women’s physical and emotional responses towards pregnancy loss, many male partners’ grief responses are overshadowed, which may explain why little academic research exploring effective supportive models for grieving male partners has been conducted. It is evident that more research is needed to not only identify how to best support both bereaved parents through a pregnancy loss (Armstrong, 2002; McCreight, 2004; Puddifoot, 1999; Rinehart & Kiselica, 2010) but also to encourage health care professionals to adopt a family-centred approach to ensure the needs of fathers are also considered during this difficult time (FORCE Society for Kids’ Mental Health, 2012).
Recognizing the Significance of Pregnancy Loss

The impact pregnancy loss can have on parents has been recognized through enacted legislation and policy development in many jurisdictions. In December 2015, the Ontario Government enacted Bill 141 Pregnancy and Infant Loss Awareness, Research and Care Act, which proclaimed October 15 as Pregnancy and Infant Loss Awareness Day. As part of this bill, subsection 6 (1) of the Ministry of Health and Long-Term Care Act was amended by adding the following paragraph:

To undertake research and analysis on pregnancy loss and infant death that assists those, including mothers and families, who experience such loss and that informs the establishment or expansion of programs related to such loss. (Bill 141, 2015)

This bill acknowledges pregnancy loss impacts not only mothers but also their families and seeks to fill identified gaps in treatment, testing, research and mental health support. In the United States, the House of Representatives amended House Resolution #222 on September 2006 which supports the goals and ideals of National Pregnancy and Infant Loss Remembrance Day. As part of this concurrent resolution, it specified that people of the United States consider how, as individuals and communities, to meet the needs of bereaved mothers, fathers and family members and work to prevent the causes of these death (H.Con. Res. 222, 2006).

In addition to enacting legislation and developing proclamations that recognize the impact pregnancy loss has on mothers and their families, local regions have been working to create dedicated spaces intended as places where pregnancy and infant loss can be remembered and honoured. For example, in Victoria, B.C., the Little Spirits Garden, located at the Royal Oak Burial Park, is available to all families who have experienced a perinatal loss and is open all year round (Royal Oak Burial Park, 2016). Every year, in recognition of Pregnancy and Infant Loss
Awareness Day, the Gardens host a Remembrance Gathering for families and friends who have experienced the loss of a pregnancy or a baby. It is also an opportunity for the bereaved to share time with other bereaved parents and families.

**Purpose of Study and Research Questions**

The purpose of this research is to attain a better understanding of the lived paternal experience of pregnancy loss. Although it is recognized that health care professionals can increase their awareness and understanding of the paternal experience so that support and care are provided, there is also a need to determine what appropriate interventions can help to promote coping, healing and will allow men to make sense of the meaning of their experiences when such a life event occurs.

This study aims to explore two research questions including:

1. What is the experience of expectant fathers who lose a child in early pregnancy?
2. What sense do they make of these experiences?

The use of phenomenological and grounded theory methods helped to provide in-depth understanding of the phenomenon of interest, illuminating the meaning of the experience of pregnancy loss. Through encouraging fathers to share their experiences, the results of this study not only contribute to the understanding of men’s experience with pregnancy loss, but also contribute to the body of research that will inform counsellors and other professionals who are in positions to support parents. Additionally, the results of this study will help to illuminate men’s actual experience so that their needs can be proactively addressed when they experience a pregnancy loss with their female partner. In the following chapter, a review of the literature is discussed where specific concepts of interest are explored, including relationship quality, role of support, gender grief differences and emotional components of grief.
Chapter 2 – Literature Review

Prevalence

It is estimated that one in four pregnancies end due to miscarriage, stillbirth, and neonatal death, which can all be categorized as perinatal loss (Hutti, Armstrong, Myers, & Hall, 2015). Miscarriage is the most common complication of pregnancy where about three out of four miscarriages occur in the first twelve weeks of pregnancy (Bangal, Shalini, Sachadev & Suryawanshi, 2013). Despite these high statistics of pregnancy loss, most women assume they will be able to conceive; expect to experience a successful pregnancy; and believe that once the pregnancy has started that it will continue until the birth of a healthy baby. Miscarriage is one of the events that challenges this set of assumptions (Abboud & Liamputtong, 2003).

Grief is an essentially unavoidable and normal reaction to loss (Gilewski, 2012). An unexpected or sudden loss, like perinatal loss, can be traumatic (Colon, 2008) and can result in complicated grief (Corbet-Owen, 2003; Lasker & Toedter, 1991). Grief related to a perinatal loss is especially difficult due to the emotional investment in both the unborn child and the anticipation of taking on a new parental role (Armstrong, Hutti, & Myers, 2009). Even with the advanced technology of today, it is not possible to foresee or prevent most perinatal losses (Frache & Mikail, 1999; O'Leary & Thorwick, 2006; Rich, 2000). Bereaved parents can experience the most intense and overwhelming type of grief, which can result in an increased risk of mental and physical health complications and increased mortality (Colon, 2008; Frache & Mikail, 1999; O'Leary & Thorwick, 2006; Rich, 2000).

Quality of the Parental Relationship

The quality of the parental relationship is a key factor in coping with pregnancy loss. It affects whether the grieving process for the couple will proceed within normal limits or whether
grief will become prolonged and complicated (Corbet-Owen, 2003; Lasker & Toedter, 1991). Couples face numerous relationship issues when experiencing perinatal loss (Corbet-Owen, 2003; Hutti et al., 2015; Hutti, 2005; Lasker & Toedter, 1991), such as having divergent expectations about how their partner will or should react to the loss, how they and others around them should behave after the loss, and what is considered an appropriate length of time to grieve (Hutti et al., 2015, p. 43). These divergent expectations can create friction within the couple relationship and can limit the amount of support partners are able to offer each other (Rich, 2000). Couples who cannot negotiate the relationship changes imposed by a perinatal loss, experience greater risk of dissolution of the relationship than couples whose pregnancies end with a live birth (Franche & Mikail, 1999).

There is a misconception that when a miscarriage occurs early in a pregnancy, the intensity of grief from expectant parents will be in proportion to the length of the pregnancy (Bangal et al., 2013). However, it appears that the most intense grief response occurs in parents where an attachment based on expectations, fantasies and hopes for the developing baby has already formed. Parental attachment to the developing baby can occur at differing stages throughout the pregnancy, as well as develop at different rates between each parent (Bangal et al., 2013). In instances where parents feel less of an attachment to the pregnancy, such as if they were ambivalent about the pregnancy or the pregnancy was unplanned or undiscovered, less intense grief is experienced (Hutti, Armstrong & Myers, 2013). The intensity of grief responses by the parents cannot be estimated by the duration of the pregnancy and whenever a planned or desired pregnancy ends for a couple, the loss of the expected child needs to be acknowledged so parents can start their healing processes (Hutti, 1992, 2005; Rich, 2000; Toffol, Koponen, & Partonen, 2013).
Research participants in studies of perinatal loss reported that ideally, they would have preferred to have a supportive partner and a helpful social network to help them through the loss (Frost & Condon, 1996; Hutti et al., 2015; Swanson, Karmali, Powell, & Pulvermakher, 2003). Parents who had poor quality partner relationships were closely associated with reports of intense grief (Frost & Condon, 1996; Hutti et al., 2015; Swanson et al., 2003) and when there is disparity between partners in the grieving process, the risk of relationship breakdown appears greatest (Frost & Condon, 1996; Hutti et al., 2015; Swanson et al., 2003). When this breakdown occurs, irritability, anger and detachment in the parental relationship may lead to an increased sense of isolation for each partner. In addition to varying emotions and feelings of isolation, couples with intense grief also have a greater level of post-traumatic stress, pregnancy-related anxiety, and depression symptoms (Armstrong et al., 2009).

**Importance of Social Support**

Couples can experience little support and understanding for their feelings of grief from their extended families, friends, and communities after an early pregnancy loss (Franche & Mikail, 1999; O'Leary & Thorwick, 2006; Puddifoot & Johnson, 1997). When there are no supportive conventions for miscarriage, couples can feel unable to cope with their feelings (Puddifoot & Johnson, 1997). Couples may deal with this lack of understanding by minimizing their loss and avoiding the topic within their social networks. Before the Internet, a lack of perceived support from one’s family was considered a long-term risk factor for the couple, while support from friends appeared to be an important short-term factor (Lasker & Toedter, 1991; Puddifoot & Johnson, 1997).

Since the Internet, social media appears to have taken on a new type of support network for many people grieving a loss (Morehouse & Crandall, 2014). Social media has changed the
ways people grieve with one another including communal expression and ritual of grief (Morehouse & Crandall, 2014; Taubert & Norris, 2015). For example, when people hear of a loss on Facebook, the news can be shared in waves of postings that can quickly overwhelm a user's newsfeed. Often these online conversations do not stop at the initial disclosure as family, friends, acquaintances, and now strangers can post and respond online for days, weeks, months, and even years afterward (Taubert & Norris, 2015). As an emerging area of study, examining how these virtual communication channels provide support for bereaved parents with pregnancy losses, might assist counsellors to support grieving parents.

**Men Taking on Supportive Roles**

When male partners share experiences of losing a pregnancy with a partner some of them think their role during the time of miscarriage is one of support and encouragement, particularly at the time that their female partners were actually going through the miscarriage (Abboud & Liamputtong, 2003, Armstrong et al., 2009; Puddifott & Johnson, 1997; 1999; Rich, 2000; Rinehart & Kiselica, 2010). For instance, studies in the 1990’s suggested that men’s role was to provide emotional support to their partners during and after miscarriage (Lasker & Toedter, 199; Puddifoot & Johnson, 1997, 1999). This theme has abided, being confirmed in literature from the 1990s until the present (Abboud & Liamputtong, 2003, Bangal et al., 2013; Serrano, 2006; Toffol, et al., 2013). The notion that men can grieve sometime in the future, has also been embraced by men, which unfortunately has only served to delay or suppress men’s grieving process, which might be misinterpreted as not grieving at all (Corbet-Owen, 2003).

In addition to believing they need to be a source of encouragement for their female partner, men may also believe they need to put their partner first, hold back their emotions in order to be in control of the situation and to be the one to help their female partner through this
difficult physical and emotional time (Abboud & Liamputtong, 2003, Armstrong et al., 2009; Puddifott & Johnson, 1997; 1999; Rich, 2000; Rinehart & Kiselica, 2010). It seems the physical pain the woman endures makes women the first priority in the men’s lives during this time (Abboud & Liamputtong, 2003). In addition to the supportive role, men may also feel that their role is to maintain normality and to absorb any practical strain, such as paying the medical bills or taking care of other children, in order to protect their partners (Corbet-Owen, 2003).

Women’s Grief Experiences

Ninety percent of women report initial shock and disbelief followed by feelings such as sadness, guilt, shame, helplessness and hopelessness upon learning of their perinatal loss (Toffol et al., 2013). Grief after miscarriage can differ from grief from other losses due to physiological changes a woman will experience as her body adjusts to the decreasing levels of pregnancy hormones (McCoyd, 2010). This drop in hormone levels may create a propensity towards depressive moods and could, therefore, intensify a women’s grief response. Another difference that can make grieving a perinatal loss unique from other losses involves losing a part of oneself (the pregnancy) which can differ from mourning a relationship separate from self (a spouse) although it could also be argued that some people may feel like a part of them died when their spouse dies (McCoyd, 2010).

As a way to cope with various type of losses, woman may adopt an avoidance strategy for a period of time whether deliberate or not (Van, 2012), delaying telling others about the loss and, therefore, not accessing resources to facilitate coping and promote grief resolution (Lang, Fleiszer, Duhamel, Sword, Gilbert, & Corsini-Munt, 2011). This strategy can become problematic when it is used for an extended period of time or interferes with recovery or daily interactions (Lang et al., 2011). The phenomenon is referred to as prolonged or disenfranchised
grief and the most common outcome is depression (Frost & Condon, 1996; Kersting & Wagner, 2012; Lang et al., 2011; Woerner, 2010). Disenfranchised grief is characterized as “vivid memories of the events surrounding the loss, frequent intrusive thoughts of events on the day of the loss, persistent anniversary effects persistence of dysphoria (possibly over years) and disproportionate response to subsequent crises (Frost & Condon, 1996, p. 59).

As a way to help women avoid suffering from pathological grief after a pregnancy loss, it has been suggested that social supports including friends, family and healthcare professionals provide immediate opportunities for women to discuss their feelings about the loss and immediately convey an understanding about the normal spectrum of grief responses (Bangal et al, 2013). In addition, it is recommended that bereaved mothers should be monitored for depression and/or anxiety over the next year to ensure their grieving processes do not become complicated (Bangal et al., 2013).

There are many reasons why bereaved mother’s grief can be intense. She may have identified the growing baby as being a part of her, and if the pregnancy is lost, she may be left feeling empty, shameful, helpless, and insecure (Hutti, 1992, 2005; Rinehart & Kiselica, 2010). If women feel unable to connect or to create an identity for the lost baby, by naming, holding, burying, or photographing the child as she could perhaps do later in pregnancy, she could develop an intensified grief response should another loss occur (Hutti, 1992, 2005; Rinehart & Kiselica, 2010). Additionally, the sex of the foetus in early pregnancy is often not known, which can add to the difficulty in mourning the pregnancy (Frost & Condon, 1996). For example, if a woman is left without knowing the sex of the baby or knowing how to image the developing baby, it may add to her grief because she may be left with unanswered questions. Sometimes
knowing the gender of the developing baby may contribute to higher levels of attachment and, therefore, lead to intensifying her grief response (Hutti, 1992, 2005; Rinehart & Kiselica, 2010).

When defining complicated grief, some researchers have focused on defining levels of suffering and duration of grief after a miscarriage (Rich, 2000; Serrano, 2006; Shear, Ghesquiere, & Glickman, 2013; Toffol et al., 2013), while others have attempted to identify and describe the qualities of suffering, such as a sense of shock and surprise, a sense of loss, grief (ranging from intense sadness to depression), frustration and anger, and alienation and/or marginalization (Hutti, 1992; 2005; Rinehart & Kiselica, 2010). It could be, however, that the difference in symptoms of the intensity of grief that has been reported may have been affected by the length of time after the loss when women were approached to participate in research studies (Rinehart & Kiselica, 2010; Serrano, 2006). For instance, women who were interviewed immediately after the loss focused on their sense of shock and surprise (Rinehart & Kiselica, 2010) whereas women who were interviewed six months following their loss, reported raised levels of suffering (Serrano, 2006).

**Subsequent pregnancies.**

Perinatal loss may affect subsequent healthy pregnancies (Hutti et al., 2015). Instead of experiencing a subsequent pregnancy as a time of joyful anticipation, it can be a time of hypervigilance and constant pregnancy threat appraisal (Bangal et al., 2013; Hutti et al., 2015). This state of being on constant alert may lead to anxiety, post-traumatic stress and increased health care use for either or both partners (Bangal et al., 2013).

In addition to women being hyper-vigilant with future pregnancies, mothers may be at greater risk for experiencing postpartum depression after the subsequent pregnancy following a perinatal loss (Armstrong et al., 2009; Bicking Kinsey, Baptiste-Roberts, Zhu, & Kjerulff, 2015).
Postpartum depression correlates with posttraumatic stress for women who have experienced previous perinatal losses (Armstrong et al., 2009) and is linked to depression, specifically during the first month postpartum (Bicking Kinsey et al., 2015). This increased risk for postpartum depression in women with subsequent pregnancies supports the need for early identification of risk factors for depression, in order to provide intervention and monitoring (Armstrong et al., 2009; Bicking Kinsey et al., 2015).

It is clear that women’s experience has been well studied and documented (Frost & Condon, 1996; Kersting & Wagner, 2012; Lang et al., 2011, McCoyd, 2010; Toffol et al., 2013; Woerner, 2010). However, similar research on men’s experience is not readily available. While we know what is expected of men (Abboud & Liamputtong, 2003, Bangal et al., 2013; Lasker & Toedter, 1991; Serrano, 2006; Toffol, et al., 2013), it still remains unclear how they would describe their own authentic experience. In order for counsellors to better assist couples, and particularly men, more research is needed to assess whether men experience or show signs of depression after perinatal loss, and further, compare the outcome with the postpartum depression prevalence noted for women who experienced a prior perinatal loss.

**Women’s perceptions of their partner’s grief response.**

Women perceive men’s grief in response to miscarriage as different from their own grief (Abboud & Liamputtong, 2003). As a way to make sense of this perception, some women believe that their male partners want to be strong for them (Abboud & Liamputtong, 2003), while others believe that men just do not know how to talk about feelings (Abboud & Liamputtong, 2003), or assume that their partner is unwilling to talk about their feelings (Abboud & Liamputtong, 2003). Despite a perceived lack of communication and expression of feelings
by their male partners, women experience their partner’s attention and presence during the loss as a source of emotional support (Abboud & Liamputtong, 2003).
Men’s Grieving Experiences

Where research has compared men’s grief response to perinatal loss to women’s responses, it was found that while men initially felt a sense of loss after a miscarriage their focus shifted to other priorities for a variety of reasons (Abboud & Liamputtong, 2003). When male participants made reference to their immediate feelings like anger, sadness, loss, disappointment, and helplessness (Miron & Chapman, 1994; Puddifoot & Johnson, 1997), it was to show how intense their partners were feeling at that stage (Beil, 2002). Men appeared to change their attention on their own experience and rather focused on their wife/partner and her well-being (Beil, 2002), appearing to accept the loss more quickly than their female partner (Beil, 2002). It is now believed that there are widely held societal misconceptions on the way men grieve and this may have contributed to how men were approached in these studies, not taking into account whether their interviews allowed for elaboration on their answers (Abboud & Liamputtong, 2003; Bangal et al., 2013; Hutti et al., 2015; Swanson et al., 2003). This omission may have been clarified, had men been given the opportunity to provide a more fulsome explanation of their experience around loss.

Many support the traditional view that men prefer to intellectualize grief, or that it is just men’s nature not to express feelings (Beutel, Willner, Deckardt, Von Rad, & Weiner, 2006; Gold, Sen, & Hayward, 2010; McCreight, 2004). By mistaking male patterns of behaviour following a loss as being a natural response, rather than a socialized response, this further supports society’s misconception of how men are supposed to grieve, but does not provide any understanding on why some men have differing grieving responses. If male patterns of grief are attributed to a socialized response then these patterns might be attributed to men not having had the chance to express their grief or, alternatively, feeling the need to hide, repress, or internalize
their feelings regarding the loss as a necessary strategy in order to provide support to their wives, thus meeting societal expectations. The most common reason that men give for not expressing feelings is that they want to avoid adding to their spouse’s distress (Puddifoot & Johnson, 1997, 1999; Kersting & Wagner, 2012; Shear et al., 2013), although it has been suggested that they might be uncomfortable displaying their emotions due to societal norms (Abboud & Liamputtong, 2003; Bangal et al., 2013; Hutti et al., 2015; Swanson et al., 2003). Interestingly, when men were interviewed and given time to focus on their own experience of perinatal loss, they expressed emotions consistent with grief rather than intellectualizing or rationalizing their experience (McCreight, 2004). In one particular study for instance, the main theme that emerged from the analysis was “emotion,” supporting the idea that more focus and support for men regarding their feelings may be beneficial in future studies (Rinehart & Kiselica, 2010).

**Differing Gender Grief Responses**

A couple may have differing expectations (Hutti et al., 2015; Frost & Condon, 1996) about how each of them should react and behave after a perinatal loss (Franche & Mikail, 1999; O'Leary & Thorwick, 2006) and about the appropriate length of time for grieving after a loss (Toffol et al., 2013). When couples’ grief or expectations are discordant, they may experience higher levels of conflict in their relationship and may be unable to provide adequate support for each other (Corbet-Owen, 2003; Lasker & Toedter, 1991). In a randomized controlled trial of 341 couples who had miscarried (Swanson, et al., 2003), two-thirds of the women reported their relationships with their partners were the same or improved and that they were either pregnant again or trying to get pregnant. The remaining one-third reported their relationship was more distant at one year after the loss, and referred to a lack of communication, lack of social supports
and feeling isolated from their partner as possible reasons for their distance (Swanson et al., 2003).

The potential consequences of these relationship issues for the couple are significant. In the only national study to examine marriage outcomes after fetal loss, Gold et al. (2010) found relationships have a higher risk of dissolving after miscarriage or stillbirth when compared to live birth. It is clear from the literature that the differences in grieving styles between men and women, jeopardize a couple’s relationship and may result in grieving responses that can vary in number, type, intensity, and duration of visible symptoms between men and women (Corbet-Owen, 2003). This incongruence in the grieving process may result in communication issues and leave partners with feelings of isolation, disappointment, frustration, and anger towards one another (Corbet-Owen, 2003; Franche & Mikail, 1999; Lasker & Toedter, 1991; Nazaré, 2012; O'Leary & Thorwick, 2006), which may lead to dissolving the relationship.

It is possible that parental grieving responses after miscarriage may differ because the baby may be much more real to one parent, often the mother, than to the other (Hutti et al., 2015). As stated above, when attachment to the pregnancy has formed, the baby then becomes more real to the expectant parent and should a loss occur, it is more likely that grief will intensify (Hutti, 1992, 2005; Hutti et al. 1998). Women may have more depressive and suicidal thoughts stemming from the loss of the child and the associated future anticipated roles and images than men (Corbet-Owen, 2003). In contrast, men may feel anxious and helpless and they may attribute those feelings to their inability to relieve their partners’ pain (Corbet-Owen, 2003). Men may not feel able to discuss their feelings openly with their female partner at the time of the loss and feel pressure to meet expected gender-appropriate grief patterns (Corbet-Owen, 2003, p. 25).
Substantial differences occur in how men and women respond to perinatal loss (Nazaré, 2012; Puddifoot & Johnson, 1999). The intensity of women’s display of grief is contrasted with that of men, and this difference has been linked to women’s physical experience of pregnancy, perhaps creating a stronger emotional bond to the child and, hence, a stronger sense of loss (Nazaré, 2012). However, when men have seen the baby during an ultrasound appointment for example, the baby can become more real and the expectant father may experience the loss more intensely (Nazaré, 2012) than a man who has not seen his baby. This indicates that varying levels of attachment to the baby may lead to stronger grief reactions, regardless of the parent’s gender (Puddifoot & Johnson, 1999).

For instance, women appear to have more need to talk about the loss as a means of coping with the grief than their partners (McCreight, 2004). Their partners, appear to have less positive attitudes about communicating their grief experience, making them less willing to discuss the topic (McCreight, 2004). These differences in grieving responses may lead to women more commonly seeking out social support (i.e., sharing their feelings) to deal with their loss more frequently than men. Generally, men may not seek this type of support, as societal preferences expect men to deal quickly with the loss and turn to look after their wives’ needs. Alternatively, some men may use work and physical activities to cope with their grief (McCreight, 2004).

Research has found that men may feel more comfortable expressing their grief when female partners acknowledge that men are grieving too (Beutel et al., 2006; Rinehart & Kiselica, 2010). It is important for both partners to acknowledge the impact of a miscarriage (Beutel et al., 2006, p. 252), but to do so, their different ways of coping with the loss must be recognized and coordinated to promote sharing and understanding (Rinehart & Kiselica, 2010). It seems that
when a woman gains greater insight into the grieving differences between her and her partner, she can let go of her expectations that her partner needs to grieve similarly to her and allow him to grieve in his own way (Rinehart & Kiselica, 2010). These findings (Beutel et al., 2006; Rinehart & Kiselica, 2010) could be extended to health care professionals as an informed practice so they too can acknowledge the loss of the couple jointly and include male partners in their sphere of concern and care.

Gender Grieving Styles

Martin and Doka (2000) set precedence in grief literature when they identified styles of grieving as being “intuitive” and “instrumental,” moving away from Kubler-Ross’s (1969) stages of grief, which had previously prevailed as the norm for grief. Although intuitive or instrumental grieving styles may be used by either gender, it was suggested that more women adopt an intuitive style of grieving, characterized by expressing feelings openly and finding support through sharing the experience of grief with others. In contrast, men tend to take an instrumental style of grieving which in comparison is a more active or cognitive style that involves intellectualization, taking control, and channeling grief into action. A famous example of instrumental grief would be Mothers Against Drunk Drivers (MADD) for instance (Fell & Voas, 2006). Some grief may also be expressed through aggression, hostility, or blaming others. Overall, it may not be reasonable to expect men be able to actively express their grief or talk about their feelings in similar manner as their wives due to opposing societal expectations (Martin & Doka, 2000).

Gender socialization.

The social expectation of being the strong protector and supporter following a perinatal loss (Abboud & Laimputtong, 2003; Colon, 2008), and withholding the emotional turmoil that
they are experiencing, (Abboud & Laimputtong, 2003) has put expectant fathers at increased risk of complicated grief. When grief is socially negated it is known as “disenfranchised grief” (Martin & Doka, 2002). By not having a loss recognized, it becomes a social stigma that inhibits the bereaved individual's ability to express or discuss any feelings or thoughts about the loss. If disenfranchised grief goes unresolved, it may lead to mental, physical, and emotional health complications (Martin & Doka, 2002).

When pregnancy loss occurs, men may not respond to their partner with conventional emotional support, but instead may respond with practical instrumental help in ways that are difficult for their female partners to understand (O'Leary & Thorwick, 2006). This can leave men feeling unappreciative or guilty for their attempts to console or comfort their partner. In turn, men may cope by withdrawing emotionally and/or physically from their anguish as well as their partners’ pain (Rich, 2000). Men appear to be more reluctant than women to get professional emotional support. If they do seek support it is normally to help their partner or to get information, but not to heal themselves (Rich, 2000). Overall, the differences in how each partner grieves is not necessarily the problem, rather it is not understanding and respecting existing discrepancies that can exacerbate the distress for couples after a pregnancy loss (Corbet-Owen, 2003).

**Emotional Components of Grief**

Anger has been recognized as being a major component of grief (Abboud & Laimputtong, 2003; Bangal et al., 2013; Frost & Condon, 1996; Martin & Doka, 2000; Miron & Chapman, 1994; Puddifoot & Johnson, 1997). When a pregnancy loss occurs, anger may remain unexpressed, particularly where feelings of self-blame are high (Miron & Chapman, 1994; Puddifoot & Johnson, 1997). When anger is expressed as a response to the grieving process, it
may be directed towards the partner, friends and oneself (Abboud & Liamputtong, 2003; Bangal et al., 2013; Frost & Condon, 1996). Women’s anger may stem from being concerned that she or others may not have done enough to prevent the loss (Abboud & Liamputtong, 2003; Bangal et al., 2013). Overall, research on the topic of perinatal loss does not indicate whether women or men have a higher prevalence of experiencing anger as a component of grief after a pregnancy loss. Further research on this topic may help both men and women to better understand anger in themselves and their partners and to recognize anger as part of a normal grieving process.

The traditional differentiation of grief from depression rests upon the absence of guilt, self-reproach, and lowered self-esteem in grief and its presence in depression (Kersting & Wagner, 2012). Miscarriage-induced grief is characterized by high levels of guilt and self-reproach, often accompanied, for women, by a sense of loss of identity as a mother with substantial impact upon self-esteem (Frost & Condon, 1996; Kersting & Wagner, 2012). Overall, it can be hard to differentiate chronic grief from depression. Ongoing monitoring by health care professionals is recommended for couples that have experienced a pregnancy loss (Kersting & Wagner, 2012; Woerner, 2010).

Additional Considerations

While some men may experience similar thoughts and emotions as women (Abboud & Liamputtong, 2003; Bangal et al., 2013; Hutti et al., 2015; Swanson et al., 2003) they may have specific needs that are not being discussed and met, due to societal expectations to be the “stronger” partner, thus they may keep their feelings hidden (Abboud & Liamputtong, 2003, p. 45). In addition to societal misconceptions of male grief responses, it has long been recognized that a lack of a legitimate means for fathers to express the loss of a baby may place men “under entirely new and unrecognised pressures” (Puddifoot & Johnson, 1997, p. 840). This may also
lead to further emotional ill health. It is, therefore, acknowledged that support and counselling should extend to the men of partners who miscarry as well (Warland, O'Leary & Mccutcheon, 2010) so men can be supported to express grief. It might be helpful to consider gender when recommending a counsellor as some men might be more comfortable expressing inner feelings with a male (Abboud & Liamputtong, 2003), while others may prefer to see a woman (Strohmer, Leierer, Hotard, & Stuckey, 2009). Recent literature clearly shows the need for bereaved fathers to be provided with care in times of critical life events such as miscarriage (Beutel et al., 2006; Rinehart & Kiselica, 2010) and most importantly, this care and support should be personalized and specific to men’s needs (Warland et al., 2010).

While the needs of men have been identified (Beutel et al., 2006; Rinehart & Kiselica, 2010) much of the understanding of male partners has been based solely on the perspective of their female partners and understood in very simplistic and linear ways (Corbet-Owens, 2003). Narratives capturing the rich perceptions of men also need to be heard on this important topic, in order to hear how they might like their female partners to support them during this loss (Corbet-Owen, 2003).

In summary, the research on the topic of paternal responses to perinatal loss tends to highlight the societal misconceptions about gender grieving processes and is generally based on female partners’ perspectives (Abboud & Liamputtong, 2003; Bangal et al., 2013; Hutti et al., 2015; Swanson et al., 2003). This has led researchers to assume that men recover from perinatal loss more quickly than women (Hutti, 1992, 2005; Rich, 2000; Rinehart & Kiselica, 2010; Serrano, 2006; Toffol et al., 2013). However, on closer examination, when men attend to their grief, it can be similar to women’s grief responses in intensity and duration (Shear et al., 2013). Where men are the focus of in-depth interviews, it was found that men do indeed have deep
feelings (McCreight, 2004). Considering the main focus of major studies (Abboud & Liamputtong, 2003; Bangal et al., 2013; Hutti et al., 2015; Swanson et al., 2003) have been on women’s perception of their husbands, rather than on men’s own perception, more research is needed to understand men’s experiences.

In this chapter, I have examined literature that outlines differing gender responses to grieving a pregnancy loss, as well as how the quality of the parental relationship and supportive social networks can be key factors in helping couples cope with the loss. In the following chapters, I set out to examine the rich description of men’s actual pregnancy loss experiences. I will discuss the meaning men attribute to their experiences and then compare it for similarities and differences to literature on this topic.
Chapter Three – Research Methodology

This chapter describes this phenomenological study’s research design and methods, interview process, selection criteria for participants, human subject considerations and protection, data collection, data management and data analysis. The purpose of this study is to gain a better understanding of the paternal experience of pregnancy loss. By shedding light on the father’s experience of pregnancy loss, this study contributes to the body of knowledge of pregnancy loss, as the father’s experience has not been widely studied. The outcome of this study aids in guiding future care and support of fathers who have endured the loss of a pregnancy, and provides a foundation for future research and consideration.

Research Design

The two research questions for this study include:

1. What is the experience of expectant fathers who lose a child in early pregnancy?

2. What sense do they make of these experiences?

In addressing these questions, a phenomenological methodology based on grounded theory was employed for this study. Phenomenology is essentially the study of lived experience or the life world (van Manen, 1990; 2014). Its emphasis is on the world as lived by a person, not the world or reality as something separate from the person (Valle, King & Halling, 1989). This kind of inquiry asks “what is this experience like?” as it attempts to unfold meanings as they are lived in everyday existence. Further, the context is important to the interpretation of data. This approach requires that the researcher "center on the attempt to achieve a sense of the meaning that others give to their own situations" (Smith, 2005, p. 12).

Edmund Husserl (1859 – 1938), considered the founder of phenomenology, developed the concept as a new foundation for both philosophy and science (Kakkori, 2009). He saw
phenomenology as a practical or scientific philosophy that would allow a method of inquiry into all aspects of lived experience and mental activity (Spinelli, 2005). Fundamentally, the aim of phenomenological inquiry is to gain a deeper understanding of the human experience and its meaning of everyday life through descriptions of experiences that are lived by the participants (van Manen, 1990; 2014). Given there is an apparent lack of understanding concerning the paternal experience of pregnancy loss, phenomenology seems to be an appropriate approach. The intent of using this approach is to gain understanding of what pregnancy loss truly means for bereaved fathers, and in order to do this we must first be able to acknowledge the intensity of perinatal grief while cultivating curiosity around the ability to comprehend, as well as describe it (Bogdan & Biklen, 2003).

Grounded Theory research design (Charmaz, 2006; Corbin & Strauss, 2008; Kenny & Fourie, 2014) was also used to assist in identifying and coding themes as I sought to understand the male partner’s lived experience of pregnancy loss (Strauss & Corbin, 1998). In addition to coding and interpreting the data, I used a constant comparative analysis, relied on literature as data source, and used theory integration to aid in the development of a substantive theory. Strauss and Corbin (1998) suggest that since the essence of grounded theory is “developing a theory,” one must frame the research question in a way that will “provide the flexibility and the freedom to explore a phenomenon in depth” (p. 40). By using this method, the theory that emerges determines inductively from the data (Connelly, 2013) and elucidates the main concerns of the participants, and their ways of resolving those concerns (Scott, 2009).

A substantive theory was chosen for this research study as it can be applicable to a discipline or a situation and it is derived from a narrow sample of a population (Glaser & Strauss, 1967). It has a limited scope because it has not been tested outside the population it has been
generated to represent. A researcher may begin with substantive theory because it is easier to find relevant concepts in a more congruent group (Glaser & Strauss, 1967) then, after establishing a substantive theory, the researcher can attempt to expand it into a formal theory. Overall, the research methodology of phenomenology and grounded theory will be useful in answering the “how and why” type of research questions while generating a substantive theory that describes and explains men’s experience with pregnancy loss.

**Interview Process**

The interview process used in this qualitative study is consistent with grounded theory data collection methods (Charmaz, 2006; Strauss & Corbin, 1998; Wimpenny & Gass, 2000). I conducted in-depth interviews with four male participants who were willing to share their experiences for the purpose of this research project. The researcher’s role when conducting an in-depth interview is designed to elicit a vivid picture of the participant’s perspective on the research topic (Mack, Woodsong, MacQueen, Guest, and Namey, 2005).

To help guide the in-depth interview process, I referred to the *Qualitative Research Methods: A Data Collector’s Field Guide* (Mack et al., 2005). The Guide acknowledges that qualitative methods have become important tools within this applied field of research because they provide valuable insights into the local perspectives of study populations. According to Mack et al. (2005), key principles of in-depth interviewing include the participant being considered the expert, and the interviewer being considered the student. Additionally, the researcher’s interviewing techniques are motivated by the desire to learn everything the participant can share about the research topic. Researchers engage with participants by posing questions in a neutral manner, listening attentively to participants’ responses, and then asking follow-up questions designed to probe the participant based on those responses. They do not
lead participants according to any preconceived notions, nor do they encourage participants to provide particular answers by expressing approval or disapproval of what they say (Mack et al., 2005, p. 29). Overall, the nature of this type of interviewing is seen as being a flexible and informal approach to interviewing, creating opportunities to explore, rather than to interrogate (Charmaz, 2006).

**Criteria for Participant Selection**

The grounded theory methodology requires that participants have experiences with the phenomenon under study (Charmaz, 2006). In this research study, the criteria required that all participants be male and have experienced a pregnancy loss with a female partner, be over the age of 18 years old, speak and understand English well (even if English is not their first language), be willing to be interviewed for up to 60 minutes, and to have this interview audio recorded.

In grounded theory, it is not possible to predict the exact number of participants needed in advance (Charmaz, 2006; Strauss & Corbin, 1998). In looking at other studies that studied the pregnancy loss experiences of fathers (Abboud & Liamputtong, 2003; Bangal et al., 2013; Hutti et al., 2015; Lasker & Toedter, 1991; Serrano, 2006; Toffol et al., 2013), a sample size of five participants was estimated to be ideal for this study. I was able to attract four participants for the study: two through informational notices (See Appendix A) sent to doctor and midwives offices. Two additional participants contacted me through word of mouth. Redundancy or data saturation occurs when there is a repetition of themes during the participant interviews (Crist & Tanner, 2003) and this was achieved with four participants.

**Human subject considerations and protection.**
As part of the IRB requirements for human subject research, I submitted an approved Ethics Review Protocol to the Board prior to recruiting participants and collecting data. I also completed the mandatory online, research ethics, training course and received IRB approval to begin interviews.

Furthermore, I recognized that interviews concerning this potentially stressful life event might be difficult for some to discuss and may elicit negative emotions and feelings. To address and manage emotional distress, I planned to pause the interview when necessary to allow time for individualized comfort measures, and was prepared to discontinue the interview if needed. I prepared a list of resources and services in the event that a participant felt he required any follow-up supports or counselling post interview.

As an ethical requirement of IRB, all participants signed an informed consent form. Consent was obtained willingly and without coercion, and all participants were made aware of their right to withdraw at any point throughout the research process, without negative consequences. The consent form was reviewed with each participant, prior to the interview and included phenomenological research design principles (Groenwald, 2004). These principles included:

- The fact that they are participating in research;
- The purpose of the research;
- The procedures of the research (audio recorded interviews, notes);
- The risk and benefits of the research;
- The voluntary nature of research participation;
- The participant’s right to stop the interview at any time without consequence;
- The procedures in place to protect confidentiality.
Data Collection

After obtaining approval from City University of Seattle’s Institutional Review Board (IRB), I provided research notices to a doctor’s office and a midwife clinic that provide maternity care for couples. The informational notice described the study and its purpose, and I provided my contact information. All participants initially contacted me by University email which was password protected and I arranged a phone call to verify that each of them met the inclusion criteria. I also provided further information about the study, answered any outstanding questions, and arranged a mutually convenient time and location for an interview. I also explained during this initial phone call that each participant would need to sign an informed consent form and would be provided with a $20 Starbucks gift certificate in appreciation for their participation, regardless of whether they chose to withdraw from the study at any time.

To ensure privacy and to promote participant comfort, interviews were held in a private and professional office and times were set that were convenient for and chosen by the participants. Participants noted that they felt comfortable in discussing their experiences with pregnancy loss in the quiet and private location.

Once informed consent was understood and signed, the interviews were conducted. All sessions lasted approximately 60 minutes. Prior to the start of the interview, each participant selected an identifying initial to protect his identity and verbally re-confirmed that the audio-recording was taking place. Each interview began with a general welcoming statement acknowledging my appreciation for the man’s willingness to spend time being interviewed. To encourage the fathers to share their story, I made an open-ended statement such as, “I’m interested in hearing about your experience with pregnancy loss. Where would it feel comfortable for you to begin?”
As the participants began to narrate their experiences, they were encouraged to continue until they felt that their story had been completely told. When needed, prompts were used to elicit further comments such as: “What was that like for you?” or “Tell me more about…” Immediately following each interview, I wrote notes to capture any nonverbal communications, perceived emotional state, physical appearance or anything else that might be useful or pertinent to help clarify the transcribed audio recordings.

Data Management

During the entire research process, privacy and confidentiality was maintained, at all times. When audio-recordings were transcribed each document was simultaneously compared with the audio recording to assure accuracy. Names mentioned were replaced with the initial chosen by the participant. Any identifying information, such as names, clinics, hospitals or primary care providers were not included in the transcripts. All materials were saved to an encrypted external drive, and these files along with signed forms and researcher’s notes, were then locked in a filing cabinet at the researcher’s home office. Upon completion of the project, the audio recordings, forms, interview transcripts, and written notes will be securely stored according to City University of Seattle’s research data collection policies.

Data Analysis

Once the interviews were conducted, the data was reviewed extensively. Recurrent themes were established, categorized, and analyzed guided by phenomenological and grounded theory approaches. Van Manen (1990) states that “phenomenological themes may be understood as the structures of experience. So when we analyze a phenomenon, we are trying to determine what the themes are—the experiential structures that make up that experience” (p. 79). In grounded theory, there is a constant interplay between data collection and analysis as the
researcher becomes more immersed in the data (Corbin & Strauss, 2008). After each interview, I recorded my observations and interpretations of the interview experiences while reflecting on ideas that began to surface as themes. The database for analysis consisted of audio recordings, transcribed interview notes and my post-interview notes.

Analysis began immediately following the first interview, using standard grounded theory coding procedures consisting of labeling portions of the data (Charmaz 2006; Strauss & Corbin, 1998). The intent of this first step of open coding is to divide the data, mostly consisting of the transcribed interviews, into initial concepts so that commonalities emerge into eventual themes or categories (Charmaz 2006; Strauss & Corbin 1998). To aid in identifying the meaning of the data, I also asked questions, made comparisons and looked for similarities and differences between the comments.

Once common themes became apparent, I proceeded by finding links between themes. To do this, I looked for connections between incident to incident, incident to concept, and concept to concept, which allowed for a thorough analysis of the content (Corbin & Strauss, 2008). For instance, when the new category of “role of managing” emerged, I further examined what circumstances gave rise it (learning of the pregnancy loss), and the strategies participants used to manage it (focussing on their partner’s needs). Core categories that emerged and formed an understanding that describes the experience of men who experience a pregnancy loss included “expecting the pregnancy,” “losing the pregnancy,” “emotions,” “role of managing,” “following the partner’s lead,” and “medical follow up.”

A central feature of the grounded theory method is its constant comparative method of analysis (Charmaz, 2006; Corbin & Strauss, 2008; McGhee, Marland & Atkinson, 2007). Becker (1993) states that the constant comparison approach allows the researcher to be more sensitive to
cues and subtle patterns in the data when the researcher is immersed in the data from the beginning of collection. For this study, I was the sole researcher involved in data collection and analysis and was able to be attentive to patterns in the data. In addition, the method requires the researcher test and retest, and compare and contrast existing data with the participant’s understanding and perceptions at each stage of analysis (Corbin & Strauss, 2008). To ensure I was consistent and accurate with my interpretations of the participant’s understanding and perceptions, I continually compared my post interview notes and literature findings with the transcribed data as a measure of constant comparative analysis.

**Summary**

This chapter described the study’s research design and methods, including participant criteria for selection, data collection, data management and analysis. Also included were human subject considerations that described measures taken to protect the participants involved. The following chapter discusses the research findings, including a description of the themes of experience that emerged from the interviews.
Chapter 4 – Research Findings

This chapter outlines the research findings through analyzing transcripts of the interviews and identifying emerging themes of experiences. The research questions addressed in this study were: What is the experience of expectant fathers who lose a child in early pregnancy? and what sense do they make of these experiences?

Although demographics were not collected as part of the interview process, all of the men interviewed were over the age of 18 years old. For the purpose of this study, participating fathers are identified with an initial in order to protect confidentiality when using summary statements or portions of transcripts to illustrate concepts. The participants’ own words are used to exemplify their perceptions and demonstrate identified themes. Nonessential aspects of the descriptions that might be used to identify a particular father have been altered to protect anonymity.

All of the men experienced pregnancy loss as a deeply significant and devastating event and the impact in their lives was obvious as they told their stories. Most made eye contact when telling their story, but some looked down at their feet or across the room. Some men described their experience in a long and uninterrupted narrative while others paused between thoughts. Some became misty-eyed when recounting their story, and mentioned that retelling their experience brought up emotions for them, but none of them cried openly during the interview process. All the men were provided with resources in the event that they decided to follow up with a professional practitioner after the interview.

From the transcripts, it was obvious that the participating fathers confronted multiple challenges as they experienced pregnancy loss. Each father told his unique story, how he dealt with the loss, and what impact the experience has had in his life and family. Major themes
Emerged from the data including “expecting the pregnancy,” “losing the pregnancy,” “emotions,”
“managing,” “following the partner’s lead,” “medical follow up,” and “hope for the future.”
Each of these concepts contributed to the essence of the experience for these men and
encompassed who they are now because of their experiences.

**Expecting the Pregnancy**

All the men spoke of their feelings around expecting the baby to be born. The men
summarized their experience with feelings like “excitement,” “anticipation,” “fear,” and
“uneasiness.” R expressed both excitement and apprehension by saying:

> I was a little scared at the notion that things were going to change for us; I was also
> excited, as we both wanted kids and felt ready where we were at in life. I just graduated
> with my Masters and started a new job so the timing felt right.

When asked to elaborate further on feeling “uneasy,” J spoke of seeing his older sister endure
sleepless nights and postpartum depression. “I wondered what might be in store for us.” Then he
added, “But I knew our experience would be our own, and I also had lots of feelings of
excitement that made my insecurity of being a new father fade.”

Two of the men spoke very fondly of the time they found out about the pregnancies. R
mentioned that his wife had shared the news of the pregnancy by presenting him with a birthday
cake on his thirty-third birthday that read “Happy Birthday, Dad-to-Be.” S shared that both he
and his wife eagerly looked at the pregnancy test together to find out the results.

> Once it was ready, we put it down on the sink and walked away and I set my watch for a
> few minutes. When the time was up, we both walked together over to the sink and stared
> happily at the lines that showed it was positive (S).
Three of the participants shared their news with close family members early on in the pregnancy and this added to their excitement. J disclosed how he and his wife, at 10 weeks’ pregnant, wanted to surprise his family while on vacation, assuming that it was now safe to share. They planned to create fortune cookies that had the news, including the anticipated due date of the baby, printed inside the cookie. “My family would have been suspicious the minute that [my wife] passed up a drink.” J explained further,

We already felt like we were being ‘baby watched,’ given I’m the youngest of three brothers who each has kids. I don’t think there has been a family gathering in the last four years where some relative [hasn’t said] ‘when are you planning on having kids?’

It was disappointing for him when he was unable to play out the surprise.

**Losing the Pregnancy**

The participants were able to share their experiences about when they and their partners received the news of the pregnancy loss. Three of the four participants were at the ultrasound clinic and the fourth miscarried at home. The men who received the news at the clinic shared feelings of shock, sadness, and disbelief. M described it this way:

We were about 11 weeks along and the pregnancy had been going well. By well, I mean my wife was feeling sick and she was really tired [which] were very normal symptoms. We were both excited about the thought of being parents. We didn’t suspect anything was wrong as she didn’t have any bleeding or cramping at all.

M’s midwife ended up sending them in for an ultrasound at 11 weeks and it was at that time, the couple received the news about the loss. “We expected a routine ultrasound. Our midwife thought she should confirm our dates. It was only when the technician asked my wife to cough during the procedure that I knew something was wrong (M).”
According to M, the technician then told them that she needed to get her supervisor and left the room. When she returned, she had a doctor accompanying her who asked permission to step in and continue with the examination. The doctor then searched for the baby’s heartbeat and after a few minutes of silence, he turned to them and informed them that the pregnancy had ended. Responding to the news, M said “[my wife] started to cry and I held her, not wanting to believe what this meant.”

Feeling helpless in the situation was difficult for these fathers. R shared his experience after learning the news:

We went into [the midwife’s] room. I remember the midwife reaching out to hug and hold my wife and she cried. They both sat on the couch together continuing to embrace so I took the chair on the side. The midwife said “I’m sorry for your loss” aloud but I assumed it was mostly for my wife. I do remember [the midwife] looking my way and saying something like ‘[you are] going to need to take good care of her while she heals.’ It was, like, no acknowledgement that I lost a baby with my wife.

R also noted how there was a noticeable change in the language people used after the pregnancy ended. He said when the couple originally found out about the pregnancy, most people referred to the news jointly by saying “your pregnancy” or “your baby”. Upon learning his pregnancy ended, R shared there was a noticeable shift in how people referred to “the pregnancy” or “the loss” which made the pregnancy loss feel less like a part of his own experience.

While most of the men and their wives received the news that their pregnancies had ended at ultrasound clinics, J’s wife started to miscarry at home. J described his experience by explaining his wife was about 10 weeks along and ended up with the flu. She became dehydrated and their midwife suggested they go to the hospital for care which they decided to
do. After a few days spent recovering at home, his wife started to bleed and cramp and their midwife recommended they return to the hospital to monitor her symptoms. Eventually, a doctor at the emergency department ended up confirming that the pregnancy had ended.

Once the couple received the confirmation, J described how he made sense of his wife’s grief response:

The doctor assured us that [the miscarriage] would continue naturally and offered up some pain medications to help her with it all. But she refused to fill the prescription and I remember being confused as to how to help her. It was like, like, she wanted to punish herself with the physical pain and even though I pleaded with her to take the meds, she didn’t. She was in immense pain, cramping and crying, pretty much the whole night after we left emergency. I was left to try to help someone who didn’t, I guess, know how she wanted to be helped. All my attention turned towards waiting for her to ask me to do something… anything, grab food and even, I don’t really want to say this because it’s embarrassing… (long pause) I even wished for her to tell me to go back to work. It’s not that I didn’t want to be there to go through it with her. I just didn’t know how to do it.

Despite how each couple learned of their pregnancy loss, the impact of their experiences evoked a variety of emotions and all the men interviewed provided insight as to how they made sense of the meaning of these responses to the loss.

**Emotions**

In recounting their experiences, each father described initial shock at the news that the pregnancy was lost, using words such as “shocking,” “surreal,” “confusing” and “nightmarish.” The men reported overwhelming emotions including sadness, crying, frustration, devastation,
disappointment and anger. Each man reported that he cried with his wife initially as they faced their loss together. For instance, after finding out the baby did not have a heartbeat at the ultrasound clinic, M said that all he remembered was “being shocked and confused.” J described feeling upset about his pregnancy loss right away and then being later inadvertently reminded of his sadness after learning one of his soccer friends was expecting a baby.

I felt so sad in that moment when [my friend] told me his news. I also knew right away that I couldn’t share this with my wife or anyone really at the time. I actually found it hard to go to the next practice and wondered if I would have to hear him talk more about his excitement for the new baby (J).

S described the availability of social support for him and his wife. He said that he was worried and stressed, and felt he needed to be the one to provide support to his wife as well, as external support was not available to them. When his wife needed to have a follow-up medical procedure, S elaborated further on his feelings by saying:

It also felt like an ongoing nightmare because she then had this medical procedure and it made us feel like we were reliving the grief. She took a few days off after the D&C [dilation and curettage] and so did I so I could be home with her. Coming home from the hospital she wept so hard and I felt alone in my sadness.

R’s wife also went through a D&C, a therapeutic gynecological procedure at a women’s clinic. For them the experience was horrendous. He describes it like this:

It turns out this clinic is also an abortion clinic and they didn’t realize she was just being referred to it because of the [D&C] procedure. They ended up interviewing her like she was aborting the pregnancy – like it was her choice. God. My wife was stunned and so was I. I just couldn’t believe that they would have mixed up that kind of information. I
immediately asked to go see my wife who was now crying and very upset. This made me feel so angry…angry with the nurse who put my wife through it and mad at the midwife for referring us to such an ass backwards clinic.

The central emotions that surfaced for the men when describing their experiences contributed to the meaning of these men’s experiences.

**Managing**

All of the men described taking on a managing role after hearing of the loss of the pregnancy. This managing role consisted of being there for their partner, informing family and friends, protecting and supporting his wife and providing for the household. The grieving fathers seemed to prioritize the needs of their wives and other family members over their own, which sometimes displaced their own grieving response.

One participant explained how he took on the role of protector immediately after finding out about the loss of the pregnancy during an ultrasound appointment: “My wife didn’t want to pass all those expectant mothers in the waiting area so I remember shielding her as best as I could on the way out (S).” R described how he ended up managing two different roles by saying that while on the way to the midwife’s office he attempted to comfort his wife after learning of the pregnancy loss, but she could not be consoled. He then described taking on the role of gatekeeper by explaining how he only allowed friends over to visit when he felt his wife was strong enough to handle the company. Providing a source of comfort and support for their wives was common. As M explains:

I just wanted to comfort her. She still questioned whether she was losing the pregnancy and immediately Googled [her] symptoms. We had a midwife who told us what to look for as in symptoms like cramping and bleeding. But she also said that [some bleeding
and mild cramping] can be normal. I think my wife was holding on to hope that everything would be okay.

When M was asked what he was holding onto he responded, “a part of me hoped things were going to be okay,” but then added “… although something told me things weren’t right and I needed to be strong for her in that moment.” M suspected the pregnancy was ending but instead decided to keep this thought to himself and turn his efforts towards being present and responsive to his wife’s needs.

While some men were able to provide a supportive role for their wives, J shared his unsuccessful attempt to console his wife as they awaited confirmation at the hospital that his wife was miscarrying the baby. He explained:

We waited for hours, and as we waited our hope diminished. My wife actually was talking in definite terms that the pregnancy had ended. I still needed to hear it from the doctor before I believed it. My efforts to reassure her and comfort her were not welcomed. I understand that. You know, she didn’t want me to be hopeful and at the same time she didn’t want me to be negative about it either. I really felt unsure how to express anything but take my cue from her. She kept blaming herself for the loss saying had she not got sick, she would still be pregnant. The doctors assured us this was not true and I in no way believed it either. But there was no way to convince…she was in a state where logic seemed to go out the door and all she felt was loss and sadness and, I guess, needed something to blame it on.

Overall, all the men in this study revealed how they managed the pregnancy loss by taking on a role which commonly was one of comfort and support for their female partners. While some men donned multiple roles to accommodate their partner’s needs, one father’s attempt to be
supportive proved to be unwelcome at the time. Regardless of whether the roles assumed by the fathers were accepted or dismissed, the outcome of each experience of the men contributed towards shared meaning among them.

**Following the Partner’s Lead**

Three of the participants described taking the lead from their partners and then adapting their own behaviour to align with their wives. For example, M said:

She didn’t want to tell anyone that we lost the baby and what we were going through.

I agreed. Luckily it was early enough in the pregnancy that we hadn’t told anyone but I wondered if people would notice us pulling away as we grieved our loss privately.

J discussed how his partner decided not to tell anyone about their second pregnancy “until she reached the 12 weeks and we had an ultrasound under our belt.” Similarly, S said that “right away my wife decided on what to share with the handful of people who knew and [she] told me who to tell first.” All of these men mentioned they followed their partner’s lead when it came to sharing information about the loss or subsequent pregnancies and expressed how it was important to align their behaviour with that of their female partners.

**Medical Follow Up**

All the men described how their respective wives needed to have medical follow-up procedures and for some of them this served as a reminder of the pregnancy loss. J’s experience started after his wife miscarried at home but needed a follow-up procedure because of complications that developed. He described how it was “devastating for us because it seemed to prolong the pain. Or maybe it was more like it reminded us of the pain.” Although J experienced prolonged grief due to the follow-up procedure, he also described how he was able
to finally be a source of comfort for his wife – a role that was previously unwelcomed during the time of the miscarriage.

During this procedure, though, I can say that my wife seemed to be more accepting of my attempts to comfort and console her. She wasn’t in the headspace of wanting to shut me out and this allowed me to feel really connected to her during this time (J).

While three of the men’s wives recovered from the medical procedure relatively quickly, one of the men found out his wife had experienced a molar pregnancy, a rare condition where a tumor develops instead of a fetus. He described how the ongoing medical follow-up appointments prolonged his grief:

I almost forgot I’d lost a pregnancy with my wife and instead felt like she had a procedure that went wrong. It was only about a year of all these blood tests, follow-up ultrasounds and doctor appointments, and the due date that she originally told me, Sept 11th came around, that I felt so sad. I imagined what it would have been like to have had a baby and wondered how our lives would have changed if everything would have happened like it was supposed to the first time.

**Hope for the Future**

Two participants wanted to be hopeful for the future. When asked what he thought he needed, S responded by saying:

Good question. I needed to be okay with thinking about the future. [My wife] kept worrying that we won’t be able to have a family and I didn’t think that way. I thought this miscarriage happened for a reason – something genetic. This pregnancy wasn’t meant to be but I didn’t feel like I had anyone I could say this to, well at least at the time when we were going through it. Even months later,
when we got pregnant again, I didn’t feel like I could be too hopeful it would work out. [My wife] was very cautious and on edge. I didn’t want to lose this pregnancy either but until we had the first ultrasound, then I could finally look to the future and be excited.

While S wanted to hold on to hope for the future, J had a sense that he almost needed permission from his wife in order to shift his thoughts forward. He said:

I just felt very torn about wanting to move on and not just keeping talking all the time about the loss. It was awful when it happened. The D&C reminded us of it and I wanted to get to a place where we could be hopeful for the future.

Summary

The participants described anticipating the pregnancy, experiencing challenges with the loss, managing various roles, sharing their emotions openly during the interview, following the direction of their female partners, and providing glimmers of their own hope for what the future may hold for them as fathers. These men who graciously participated and shared their personal, emotional stories considered their pregnancy loss a deeply significant, influential experience that shaped them into who they are today. The meaning they assigned to their experiences is insightful and points towards the need for further understanding to be shared with health care professionals, families, and friends who want to better support men through pregnancy loss.
Chapter Five - Discussion and Conclusion

In this chapter, I will reflect upon how phenomenological and grounded theory approaches for this study led to an understanding of the experiences of men who lose a pregnancy. Specifically, the study findings will be discussed in relation to the research questions, the substantive theory “responding” and the core categories that emerged from data collection and interpretation. I will also disclose my perceptions and conclusions about how my participation and ways of thinking about the issues may have introduced bias into the interview process and also how these elements may have impacted discussions with the participants. Finally, I will outline the limitations of the study and highlight potential considerations for health care professionals.

Understanding Men’s Experience of Pregnancy Loss

From the grounded theory data collection and analysis methods, core categories emerged and formed an understanding that describes the experience of men who experienced a pregnancy loss. These categories included “expecting the pregnancy,” “losing the pregnancy,” “emotions,” “managing,” “following the partner’s lead,” and “medical follow-up.”

All of the men interviewed, when discussing the core category of expecting the pregnancy, indicated they were excited and happy about the news. They felt a part of the pregnancy and explained how as a couple they did things such as marking the due date on the calendar, discussing how to decorate a nursery, examining whether current space and vehicles would accommodate a growing family and planning for maternal and paternal leaves. J shared:

Once we found out the news, celebrating turned into planning for this baby’s arrival by thinking about our space in our townhouse and even throwing around potential names
although we didn’t know the gender. It was something we both launched into immediately.

This planning and anticipation seemed to be shared equally by both partners at the beginning of the pregnancy. None of the men interviewed for the study indicated they thought that pregnancy loss might be possible, even though some of their healthcare practitioners did mention miscarriage was common and provided a list of symptoms to monitor for as the pregnancy progressed. Research describes women’s assumptions about pregnancy include a belief they will be able to conceive, experience a successful pregnancy, and that once the pregnancy has started it will continue until the birth of a healthy baby (Abboud & Liamputtong, 2003). This study found similar pregnancy assumptions were shared by both female and male partners, which provides further context as to why initial reactions of shock and sadness following the pregnancy loss were shared equally by both partners.

All the men in this study experienced overwhelming emotions upon learning of their pregnancy loss, including sadness, crying, frustration, devastation, disappointment and anger. This aligns with research that indicates the emotions men experience with pregnancy loss range from anger, sadness, loss, disappointment, and helplessness (Beil, 2002; Miron & Chapman, 1994; Puddifoot & Johnson, 1997). The men I interviewed also referenced being “shocked” as the news was contrary to their beliefs that the pregnancies were progressing normally, based on their partners’ common pregnancy symptoms of nausea and fatigue. Only one participant experienced alarming signs such as bleeding and cramping with his partner, who started miscarrying at home.

After the loss was discovered, men in this study turned their attention towards their partner’s needs. This concept of male partners taking on a supportive role when dealing with a
pregnancy loss coincided with previous research findings (Abboud & Liamputtong, 2003, Armstrong et al., 2009; Puddifoot & Johnson, 1997, 1999; Rich, 2000; Rinehart & Kiselica, 2010). When male partners share experiences of losing a pregnancy with a partner some men indicated that they consider their role during the time of miscarriage to be one of support and encouragement, particularly at the time when their female partners were physically going through the miscarriage (Abboud & Liamputtong, 2003). It would seem that the once mutually celebrated pregnancy is soon forgotten and the experience usually changes to the female partner attending to grief while the male partner supports her through it.

Men in this study explained how taking on a supportive role was something they did automatically and that this role changed as different situations arose. For instance, one participant took on a protective role and automatically shielded his wife in the waiting room from expecting mothers at the ultrasound clinic. Another participant took on the role of gatekeeper as he deemed it necessary to handle the influx of visitors that wanted to provide support. While literature documents this role-taking behaviour as societal driven (Abboud & Liamputtong, 2003, Bangal et al., 2013; Lasker & Toedter, 1991; Serrano, 2006; Toffol, et al., 2013), it could be argued that men’s experiences in this study accounted for these behaviours as responses intended to uphold the dignity of their partners (Wade, 1997).

Most of the men in this study also shared the experience of being hopeful for the future but this sentiment was not congruent with their female partner’s desires. This disparity kept the men from sharing their feelings openly. Research pointed out how divergent expectations can create friction within the couple relationship and can limit the amount of support partners are able to offer each other (Rich, 2000). Once the men learned of their pregnancy losses they soon
followed their partner’s lead as to what supports to provide and how to communicate and manage the loss.

**Theory Development – Responding to Female Partner’s Needs**

The goal of grounded theory research is to identify an explanatory core category that would become substantive theory (Glaser, 1978). As theoretical coding for the current study proceeded, one core theme emerged from the data: Men who experienced a pregnancy loss responded to their female partner’s needs. This core theme, or theoretical category, was designated “responding” because soon after the couple processed the pregnancy loss news together, by conveying similar emotions (crying, sadness), male partners then assumed supportive roles as ways to respond their partner’s grief and then tended to follow their female partners’ leads as to how and when to communicate the loss with others as well as how to behave going forward.

While the research does not specifically denote men following their partner’s lead, this theme aligns with men taking on a supportive role after experiencing a pregnancy loss with their female partner, which is well documented in the literature (Abboud & Liamputtong, 2003, Bangal et al., 2013; Lasker & Toedter, 1991; Serrano, 2006; Toffol, et al., 2013). However, when men attend to their partner’s needs instead of their own grief, this may perpetuate society’s perception that men may not be grieving at all (Corbet-Owen, 2003).

The men in this study described how they each experienced their pregnancy loss, albeit at varying tempos, intensities and frequencies. While they assumed supportive roles and followed their partner’s lead on how to manage the pregnancy loss, none of the men’s experiences suggested they did not grieve their losses or that they become detached from their own grieving processes. Instead, these behaviours could be viewed as responses that were purposeful in action
and were intended to not only uphold the dignity of their partner but were also deliberate measures designed to restore their own agency during a time when the focus was on their partner.

**Response based perspective.**

When examining the men’s responses and applying a response based perspective, their experiences could be described as a form of resistance (Wade, 1997). Forms of resistance are vast and can include but are not limited to “mental or behavioural acts through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect), or the conditions that make such acts possible” (Wade, 1997). The loss of a child, whether expecting or living, can arguably be considered a traumatic event for a couple and the social responses the couple endure could be seen as a form of oppression.

One participant described a situation where he was left feeling helpless and alone. R recalls his midwife providing direct comfort to his wife while insinuating his role in this situation was to “…take good care of her while she heals.” He then shared, “It was, like, no acknowledgement that I had lost a baby with my wife.” When healthcare professionals acknowledge pregnancy loss for both partners, men may then experience themselves as stronger, more insightful, and more capable of responding effectively to the difficulties and in essence begin to restore their own agency (Wade, 1997).

**Medical Follow-Up - Unexpected Finding**

The theme of medical follow-up emerged in all participants as a shared experience where the men described how the medical follow-ups prolonged their grief process, increased feelings of anxiety and sadness as well as impacted the couples’ ability to try to get pregnant again.
One participant described his experience with a molar pregnancy which had prolonged medical effects. The prevalence of molar pregnancies has been reported to vary from 1 in 200 to 1 in 2000 pregnancies and can consist of multiple types of complications for women, including surgical procedures, possible management with chemotherapy, loss of a pregnancy and delay in future childbearing (Petersen et al., 2005; Quinlivan et al., 2012). Despite this prevalence, there is limited data that has evaluated the quality of life and emotional and sexual impact of molar pregnancy in women and their male partners (Petersen et al., 2005; Quinlivan et al., 2012; Wenzel, Berkowitz, Robinson, Goldstein & Bernstein, 1994).

In the limited research, however, it was found that male partners who experienced a molar pregnancy with their female partners may suffer as a result of the forced delay in childbearing and may express symptoms of immediate and prolonged stressors belonging to psychological, social and sexual domains (Wenzel et al., 1994). This focus on medical-related stressors that develop in a molar pregnancy tend to shift attention away from the grief experienced from the pregnancy loss and turn attention towards supporting the patient (the female partner) through her treatment schedule.

When a pregnancy loss turns into a medical issue where one partner becomes a recipient of medical treatments, male partners may find themselves largely in a supporting role and may begin to feel a sense of indirect involvement in the management of the molar pregnancy (Petersen et al., 2005; Quinlivan et al., 2012, Wenzel et al., 1994). It has also been noted that when male partners experience a molar pregnancy, feelings of anxiety can be present that stem from a sense of frustration consequent to experiencing loss of control over their fertility,
particularly their anxiety that they may never have a child and their anxiety over their partner’s well-being (Petersen et al., 2005; Quinlivan et al., 2012).

**Limitations of the Research**

Limitations of this study include a lack of generalizability. The data was obtained from a sample size of four male participants and was not representative of the population of men who have experienced a pregnancy loss. All men in the study either had a subsequent successful pregnancy and/or were actively trying to get pregnant with their partner, so their reflection of their pregnancy loss experiences may have been overshadowed given their current circumstances. While the theory of “responding” emerged as a major category in this study, follow-up studies are needed to examine where this theory is supported and applicable to men who experience other types of perinatal losses including stillbirth, and neonatal death.

**Researcher’s Bias and Management Strategy**

Another limitation of the current study is that I am the sole researcher and I have also experienced a pregnancy loss. During the data collection and analysis of the current study, I had to be cognizant of my own personal bias considering I having experienced pregnancy loss with a male partner and I have an understanding of his personal grieving experience.

As a measure to address my personal bias, I adopted the process of “bracketing” as part of a phonological approach. Bracketing is explained as a “method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project” (Tufford and Newman, 2010). Given the sometimes close relationship between the researcher and the research topic that may both precede and develop during the process of qualitative research, bracketing is also a method to “protect the researcher from the cumulative effects of what may be emotionally challenging
“researcher is the instrument for analysis across all phases of a qualitative research project” (Tufford and Newman, 2010, p. 81). “This subjective behaviour entails the inevitable transmission of assumptions, values, interests, emotions and theories within and across the research project. These preconceptions influence how data are gathered, interpreted and presented” (Tufford and Newman, 2010, p. 81). Van Manen (1990) describes bracketing as “the act of suspending one’s various beliefs in the reality of the natural world in order to study the essential structures of the world” (p. 175).

Specific bracketing measures I adopted to address personal bias included activities of reflexivity that examined my consciousness and thoughts. For example, before deciding on a phenomenological approach for this study, I asked myself questions such as “Am I able to openly learn about the pregnancy loss experiences of men?” and “Can I keep a lens of curiosity throughout the data collection and analysis processes and challenge my own assumptions throughout the process?” After ensuring that I answered the above questions in the affirmative, I committed to maintaining curiosity throughout the in-depth interviews with participants and used data collection and analysis processes as opportunities to check in and reflect on potential bias creep. Overall, I confidently took appropriate measures to ensure that the findings reflected in this study were what the male participants intended to share and that I provided an accurate account of their lived experience.

**Implications for Helping Professionals**

As helping professionals, counsellors often face those confronted by unexpected life events and supporting these clients through their grief and loss becomes crucial so that normal grieving responses do not become complicated. Some important findings in this study, such as
using inclusive language when discussing the pregnancy loss, promoting pregnancy loss as a
significant type of perinatal loss, and understanding the impact of medical follow-up procedures
may have on the grieving responses for the couple, may be beneficial to counsellors in practice.

The support bereaved parents need will depend on their individual needs; however,
ensuring that the loss is equally acknowledged for both woman and men is something that can be
universally adopted by health care professionals. One way of achieving this would be to use the
same language as the client, and paying attention to how the pregnancy is referenced (i.e., does
the couple refer to the developing child as a baby or as a fetus). In addition to mirroring the
language used, attention should be paid to ensure the language is inclusive. For instance, when
supporting men who have loss a pregnancy, using phrases like “your loss,” “your pregnancy,” or
“when you were expecting.” Referencing the similar language and ensuring the loss is
acknowledged inclusively may help men feel more supported with their loss and allow them to
attend to and process their grief.

Counsellors may also want to acknowledge pregnancy loss as a significant type of
perinatal loss when working with clients. While research acknowledges that pregnancy loss can
significantly impact a couple and may lead to mental health concerns when grief becomes
complicated (Rich, 2000; Serrano, 2006; Toffol et al., 2013; Shear et al., 2013), a societal
hierarchy of perinatal loss may exist. For example, when one participant mentioned he did not
know of local services and supports where couples could go when dealing with pregnancy loss, I
offered the suggestion of a local garden intended to honour people who have experienced
perinatal loss. The participant commented that he thought that kind of memoriam would be more
appropriate for couples who had actually lost a baby. This exchange highlighted for me how
important it is for counsellors to acknowledge their clients’ loss of hope and expectation of a
child and to be prepared to offer information regarding supports available that honour all types of perinatal loss experiences.

Finally, counsellors may want to increase their awareness of the various types of pregnancy losses a couple may experience in order to better support the couple through anticipated medical follow-ups. For example, in the case of a molar pregnancy follow-up medical care may be needed for up to two years (Quinlivan et al., 2012). When a counsellor is knowledgeable about potential medical complications involved with pregnancy loss, measures to support the couple reliving the loss can be in place throughout the medical treatment schedule. Overall, the findings from this research study have provided insights concerning the paternal experience of pregnancy that will help guide and support counsellors, bereavement supportive care, theory development and future research.

Conclusion

Pregnancy loss is something that is often jointly experienced by both expectant parents; however, how individuals experience grief differs vastly and little is known about the male partner experience of losing a pregnancy (Armstrong, 2002; Beutel et al., 1996; McCreight, 2004; Nazaré, 2012; Puddifoot, 1999; Rinehart & Kiselica, 2010). Through a phenomenological design, this study aimed to provide insight from the perspectives of male participants so that more awareness of their experiences could be shared and their support needs understood. A substantive theory of “responding” emerged from the data to address men responding to their partner’s grief by taking on supportive roles and following their female partner’s leads on managing the pregnancy loss. After reviewing existing research (Armstrong, 2002; Beutel et al., 1996; Nazaré, 2012; Rinehart & Kiselica, 2010) and comparing this study’s findings and considerations as part of the available research involving male partner experiences with
pregnancy loss, it is clear that further information on male partners’ experience around the impact of medical follow-ups can benefit families and health care professionals.

Upon starting this research on the paternal experience of pregnancy loss, I expected to hear stories of men’s grieving experiences being neglected on many levels. While many of the men affirmed my expectations, I was also surprised to hear each participant openly describe how they wished they could have been supported through their experiences. This sheds light on my role as a counsellor to be proactive when working with couples around grief and loss. While each client will grieve individually and require interventions that are tailored to their specific needs, a simple and inclusive question of “is there anything you need during this time” directed at both parties can really open the discussion and allow each person feel included and supported while attending to the own grief.

I was also surprised to find the commonality of each male partner needing to deal with medical follow ups and following their partner’s lead when it came to managing communication and follow up appointments. When medical follow up is needed, there tends to be a specific focus on the women’s physical complications which can take away from health professionals attending to men’s grief responses. This understanding can aid a counsellor to ensure that both parties continue to be monitored and the couple is continually supported throughout the medical process. Finally from my own learning from this study, I came to understand how the couple’s hope for the future may differ and how imperative it is allow male clients to express their personal hope for the future even if their female partners are not ready to entertain possibilities for the future at the time.
Appendix A – Informational Notice

Research Study

A Masters level thesis research project is being conducted by Twila Lavender, a Master of Counselling student at City University. The project is intended to explore the male partner's lived experience of early pregnancy loss (up to 20 weeks gestation).

Criteria:
- You are a male participant who has experienced a pregnancy loss with your current partner.
- You speak and understand English well, even if English is not your first language.
- You would be willing to be interviewed for up to 60 minutes, and to have this interview audio recorded.

Participation in the interview is voluntary and informed consent will be explained and obtained before an interview is conducted. You may withdraw from the study at any time.

Your privacy will be protected and your name will not be disclosed in any written version of the presentation of data from this study. In addition, any unique identifiers will be removed, further ensuring your privacy. All research data will be kept according to the relevant privacy legislation in British Columbia.

If you are interested in being interviewed, please email Twila Lavender:

tlavende@cityuniversity.edu
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FATHERS’ EXPERIENCES OF PREGNANCY LOSS

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