

A grief ignored: narratives of pregnancy loss from a male perspective

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Abstract This paper, utilising a narrative approach, aims to describe the experiences of men whose partner had experienced pregnancy loss, based on data from Northern Ireland. The methodology was based upon observation within pregnancy loss self-help groups and in-depth interviews with 14 men who attended the groups. The study also included interviews with 32 midwives and nurses, with the intention of examining attitudes within the medical context towards bereaved fathers. The impact of pregnancy loss on male partners has been largely overlooked in academic research. When a baby dies before birth the loss can be devastating for fathers yet, very often, the world that surrounds them tends to discount their loss, and emotional support and cultural rituals that are normally available to other bereaved individuals are often absent for this group of men. Previous research has shown that men are expected to be emotionally strong in order to support their partner. The present study will show that the perception that men have only a supportive role in pregnancy loss is unjustified, as it ignores the actual life-world experiences of the men, and the meanings they attach to their loss, in what may be a very personal emotional tragedy for them where they have limited support available. The study uncovered several recurring themes including self-blame; loss of identity; and the need to appear strong and hide feelings of grief and anger. There is consideration of the need for hospital staff and the wider community to acknowledge the male partner's grief as being a valid response to the bereavement suffered.

Keywords: pregnancy loss, male grief, support, narrative, emotion

Introduction

This paper examines the impact of miscarriage and stillbirth on male partners and in particular, the evidence that lasting grief can result from this experience¹. Within the last decade research has focused on the impact of

pregnancy loss on women (see Layne 1997, 1990, Madden 1994, Rajan 1994, Cecil 1994, Cecil and Leslie 1993, Letherby 1993), while the impact on men has largely remained unexamined. Research carried out by Janssen *et al.* (1996) has shown that psychological complaints appear to be fairly common among women following pregnancy loss and they have also demonstrated that a delayed grief reaction can also occur, most often, it seems, among men. In this study the accounts of men who have suffered grief from the loss of a baby through miscarriage or stillbirth are explored in order to understand common or recurring features in their experiences. Puddifoot and Johnson (1997) acknowledge that previous research has tended to consider male partners primarily as providers of emotional support to their partners. Interviews with men in the present study, however, demonstrated that they had suffered lasting grief as a result of the pregnancy loss in a context where they had experienced marginalisation and neglect of their unrecognised emotional needs. The study uncovered several recurring themes including self-blame; loss of identity; and the need to appear strong and hide feelings of grief and anger. Evidence is considered for the need for the medical profession and wider community to acknowledge the male partner's grief.

The impact of miscarriage and stillbirth on male partners has been largely overlooked in academic research (Murphy 1998). Some researchers have asserted that men feel they are expected to be emotionally strong and to conceal emotion despite changing social attitudes towards the traditional male role (McGreal *et al.* 1997, Worth 1997, Kimble 1991). Stinson *et al.* (1992) note that when men do express their grief, they tend to do so in culturally prescribed 'masculine' ways. According to Buetel (1995) men are more reluctant to express their grief openly and may hide it in order not to overburden their partner. Evidence of the impact of pregnancy loss on male partners is, however, emerging as male participation in self-help groups increases and more opportunities become available for male grief to be expressed in contexts where such expression is not judged negatively. Since fathers are not physically involved in the carrying of a child, it is not, perhaps, surprising that male attachment is assumed to develop only after a child's birth. The literature demonstrates, however, that this is not the case (see Murphy and Hunt 1997, Puddifoot and Johnson 1997, Volker and Striegel 1995, Thomas 1995, Kohn and Moffitt 1994). McGreal *et al.* (1997) point out that the expectant father may have formed an intense emotional attachment to the stillborn baby or a baby lost through miscarriage. The present research identifies the need for a theoretical framework for paternal attachment, constructed in the recognition that legislative structures and institutional procedures have tended to marginalise the male role in childhood and child raising. These research findings call for enhanced awareness of men's emotional needs among health professionals and the wider community. Wider acknowledgment that men have suffered may help to create a climate of opinion where men feel more able to express their grief and seek assistance through participation in self-help groups or through consulting professionals.

The men in this study revealed strong emotional reactions following a partner's pregnancy loss, and, also, showed how they had struggled for recognition of their own transition to fatherhood. It is important to note that not all men who have experienced a miscarriage or stillbirth will construct themselves as parents. All the fathers interviewed for the study, however, referred to themselves as a 'parent' or 'father' even when, for a few fathers, they did not have any living children. Furthermore, for all men in the study, whether their pregnancy loss was through miscarriage or stillbirth, they believed that a baby had been lost. Throughout the study, therefore, men will be referred to as fathers and their loss as the loss of a 'baby', eschewing the medical terminology of 'fetus', 'spontaneous abortion', 'product of conception' or 'gestational sac'. It should be noted that the men, without exception, referred to their baby by name, demonstrating the extent to which the baby had come to be acknowledged by them as a separate individual persona.

Themes from the literature

Grief is defined as the emotional response to a loss (Menke and McClead 1990). Prior (1989) notes that historically the study of the grief reaction has been directed towards quantifying the individual's grief as a distinguishing 'abnormal' reaction, one consequence being that bereavement has become 'medicalised' and the phenomenological aspects of the experience largely ignored. This is particularly true with regard to the experience of pregnancy loss and male partners. Recent research on the impact of pregnancy loss on male partners has usually identified fathers within the context of a supporting role for the mothers, while grief is assumed to be a predominantly maternal domain. Research carried out by Cecil (1994) with women in Northern Ireland who had experienced a miscarriage indicated that the partner of the woman was likely to be deeply affected by the event. Cecil notes, however, that 'despite the generally positive reactions of partners to the pregnancy and their concern and distress at the loss of the pregnancy, it appears, not perhaps surprisingly, that the impact of miscarriage was felt more deeply and for longer by the women themselves than by their partners' (1994: 1417). The research, however, included women's perceptions of their partners' coping and supporting strategies within the family unit, but did not include interviews with fathers.

Studies of the psychological impact of miscarriage on fathers have been carried out by Puddifoot and Johnson (1997, 1999) and by Johnson and Puddifoot (1996, 1998). The findings from these studies are important as they highlight the extent to which 'a complex set of thoughts, feelings and considerable confusion about appropriate behaviour is revealed, to the extent that such males might feel it necessary to deny their own feelings of grief' (Puddifoot and Johnson 1997: 837). Furthermore, Puddifoot and

Johnson (1999) found a difference in the way that women and men handled their grief, suggesting that men displayed less immediate 'active grief' but were more prone to subsequent feelings of despair. Moreover, Lasker and Toedter (1994) point out that men are at risk of developing a chronic grief response to pregnancy loss because they are less likely to receive support and understanding at the time of loss itself. Lang *et al.* (1996) claimed, similarly, that men exert more control over their emotional expressiveness and intellectualise their grief, whereas women are more expressive in their grief. Other studies (see Theut *et al.* 1989, 1990, Hughes and Page-Lieberman 1989, Condon 1986, Peppers and Knapp 1980), however, have suggested that men go through the grieving process faster and with less intensity than women, though such findings may, owing to a gendered measurement bias, underestimate the longer-term grief consequences of pre-natal infant loss for men (Cook 1988). Men may undergo suffering which is not apparent to observers attuned to female modes of emotional expression, and they may grieve later. Furthermore, society's cultural expectations that men remain stoical and strong indicate that men have few opportunities to express their emotions cathartically because they respond in a manner they feel that culture demands. It is important to ensure, therefore, that failure to identify paternal grief, or the particular nature of the father's grieving process, does not generate conclusions regarding the intellectualisation of feeling on the basis of stereotypical concepts or gendered templates of emotional expression.

Murphy (1998), describing the experience of early miscarriage from a male perspective and adopting a phenomenological approach, noted how the men in her study felt the need to suppress feelings of sadness, loss and anger in order to support their partner. In addition, the men expressed uncertainty as to how to handle the event. In a grounded theory study of eight Canadian men whose partners experienced a miscarriage, Miron and Chapman (1994) also found that men identified their primary roles as supporters to their partners, while also articulating the need for follow-up and support. Hughes and Page-Lieberman (1989), in their study of fathers experiencing a perinatal loss, found that a few men in their study characterised work as a healing or a diversionary strategy.

Several papers have been written by men on their own experience of pregnancy loss. Dubose (1997: 367), writing from a phenomenological perspective, observed how 'time, space, and expectations of new ways of being with our child were in disarray. In a world of pregnancy, we were parents, if only for eight weeks'. Documenting his experience of stillbirth, O'Neill (1998) noted that although he was a parent, he felt that he could not be recognised as one because he did not have a living child to show for it. Narrating his account of his experience of watching his first child being delivered stillborn, Sakai (1998: 322) stated that 'if there is no greater joy watching the birth of your child, then there is no greater sadness than watching your child delivered, knowing she is already dead'.

Method

The investigation is a qualitative study concerned with the impact of pregnancy loss on male partners in Northern Ireland. The evidence was gained from observations of pregnancy loss self-help groups and semi-structured interviews with 14 male partners who attended the group meetings. Permission to attend their meetings was granted by members and facilitators of the self-help groups, which were being held monthly throughout Northern Ireland. The groups included Stillbirth and Neonatal Death Society (four groups), Remember Our Child (one group), and Miscarriage Support Group (one group). Observation within the groups took place, usually once per month, over a period of three years. Before conducting observation within the groups, I explained the aims and objectives of the research and how participation would be confidential. Observation of group interaction revealed how the group had originated and was currently organised; this involved listening to the experiences of parents, becoming aware of commonalities and differences among their experiences of pregnancy loss, and identifying more particularly the context of each loss (in fact, all were associated with a hospital setting, either during or immediately subsequent to the pregnancy loss). Participants were assured that notes would not be taken during the meetings, and that no comments expressed would be included in the study without individual permission. Field notes were written after the group meetings and ambiguities clarified by the group's facilitator. It was also made clear that I would be interested in interviewing any member of the group who wished to volunteer for this aspect of the study. Semi-structured tape-recorded interviews were carried out with 14 men, who volunteered to take part in the study over a period of three years. It was explained that research interviews would not be carried out during group meetings and that respondents could choose where the interview should take place. Twelve men chose to be interviewed in their own home but two wished to be interviewed where their meetings were held, in a separate room from the meeting venue. In order to gain insight into how health professionals care for bereaved parents; semi-structured interviews were carried out with 32 nurses and midwives.

It should be noted that the research was an investigation designed to gain insights into the social phenomenon of pregnancy loss as experienced by male partners in self-help groups. In relation to the possibility of bias in the sample drawn from the self-help groups, it is important to recognise that entry to the world of fathers who have had these traumatic experiences must be negotiated with care and sensitivity. The fathers' experiences can only be representative of men within the self-help groups and may not be representative of all men who have experienced a pregnancy loss. Given the sensitivity surrounding the issue of pregnancy loss, and the ethical considerations, it was decided that only men from self-help groups would be interviewed. The use of this sampling frame, though it restricted the range and representative

nature of the research, enabled data to be collected from men who would probably be less vulnerable, since they had already agreed to share their experiences within a group context. While this has meant that the sample cannot be taken to represent men who do not participate, it was not considered appropriate to approach men who had not taken steps to articulate their experience of pregnancy loss within a group context. Nevertheless, areas of concern have been identified and highlighted. It is hoped that the results illuminate the particular experience of men in grief, and offer a basis for provision of practical assistance.

Interviews: bereaved fathers

Three men had had experience of miscarriage, six had experienced a stillbirth and five had experienced both miscarriage and stillbirth. The earliest miscarriage occurred at eight weeks, with other losses occurring throughout the pregnancy. Two men in the study had no living children (see Table 1). The age of the men ranged from 21 to 43. At the initial interviews the period

Table 1 *Demographics*

<i>Respondent</i>	<i>Period since death of baby</i>	<i>Weeks gestation</i>	<i>Burial arrangements</i>	<i>Living children</i>
Andrew	20 years	23 weeks	hospital	one
(group facilitator)	16 years	27 weeks	private	
Brian	3 months	16 weeks	hospital	three
Connor	9 months	41 weeks	private	none
Daniel	5 years	25 weeks	private	one
Dave	6 years	33 weeks	private	one
	4 years	27 weeks	private	
	3 months	30 weeks	private	
Eric	2 years	39 weeks	private	two
Gary	1 year	27 weeks	private	none
	2 years	16 weeks	hospital	
James	2 years	24 weeks	private	two
	1 year	14 weeks	hospital	
	5 months	12 weeks	private	
Martin	5 months	38 weeks	private	three
	2 years	8 weeks	none	
Patrick	3 years	37 weeks	private	two
(group facilitator)	2 years	7 weeks	none	
Peter	2 years	24 weeks	private	none
	9 months	11 weeks	none	
Robert	8 weeks	12 weeks	none	one
Thomas	5 years	38 weeks	private	none
William	5 years	40 weeks	private	two
(group facilitator)				

elapsed since the pregnancy loss ranged from two months to 20 years. It is important to note that several men in the study were recalling events which had taken place many years earlier. Nevertheless, men were able to recall the loss in vivid and emotional detail indicating that the loss had deeply affected them, and was an event not to be forgotten. Interviews commenced by asking the men to relate their own personal experience of losing their baby. Observation within the self-help groups had led to the identification of key issues to be further explored through individual interviews. Through the format of a semi-structured interview, questions were also posed concerning burial arrangements and support from nursing and midwifery staff. The men's responses were presented through the medium of a personal narrative, which they adopted naturally as their preferred mode of expression. Indeed, a personal narrative might have been the only method available to them for giving voice to their experiences.

Although the men attended the self-help groups, a few expressed the view that telling their story to a researcher on a one-to-one basis was the first opportunity they had been given to express their emotions on the subject. The interviews, then, assumed a narrative nature, with men taking the opportunity to relate the complete sequence of events which had led to the loss, possibly because they had not been able to do so before. As Chase (1995: 20) has asserted, 'life stories themselves embody. . . the relation between *this instance* of social action. . . and the social world the narrator shares with others; the ways in which *this* narrator makes use of cultural resources and struggles with cultural constraints'. The interviews offered the men the opportunity to reconstruct events to a researcher within a relaxed time frame. The term 'reconstruct' is crucial to an understanding of the process of recounting past experience; experiences are narrated within the teller's current framework of understanding and reflect how the event is now being interpreted rather than, necessarily, interpretations held at the time the event occurred. Since the men existed within a milieu where emotions related to loss were generally ascribed to the woman, and where they were bereft of cultural tools for the analysis of their loss, they were constantly undergoing the traumatic work of sense-making in a semi-vacuum. The interviewer can assist the process of sense-making by inviting the respondent to 'narrativise topics' (Holloway and Jefferson 2000: 35), that is, to offer story-telling invitations rather than to constrain the respondent within circumscribed boundaries. Narration, for men, may be a powerful tool for accessing hidden grief, as the telling offers men a way into discussion of the experience which does not compromise their male roles; in addition, a legitimisation of the narration experience is provided in terms of 'helping' others.

Interviews: nursing staff

Since most pregnancy losses involve admission to hospital either before or immediately after the event, it was important to survey the nursing and midwifery staff involved in the provision of care. Semi-structured in-depth

interviews were carried out with 32 nurses and midwives in ten hospitals throughout Northern Ireland. Thirteen hospitals were initially contacted, of which 10 responded positively. The hospitals were chosen on the basis that they provided both maternity and gynaecology services. Thirteen nurses (two nurses were qualified midwives) and one ward sister working in gynaecology wards took part in the study. Seventeen midwives and one ward sister working in maternity wards were also interviewed. Demographic information obtained from the nursing and midwifery staff included length of time qualified. For the nurses, length of time since qualifying ranged from two to 32 years. For the midwives, the period since qualifying was between three and 28 years. Interviews were tape-recorded and ranged from 30 minutes to two-and-a-half hours in length. Criteria for inclusion in the study were that the nursing and midwifery staff had had experience of dealing with pregnancy loss. Questions were posed concerning attitude and care of nurses and midwives toward male partners, and burial arrangements for the deceased baby.

Transcribing the data

Interviews were transcribed and analysed with the assistance of the NUD*IST Vivo (non-numerical unstructured data, indexing searching and theorising) (NVivo) software package. The data analysis was informed by themes drawn from the literature and from the observations of self-help groups and interviews. This knowledge helped to inform the researcher regarding the possibilities for categorising similar types of responses while leaving open possibilities for a range of other themes to emerge from the data. Through the process of analysis, commonalities were identified from the responses, and the researcher was able to construct further themes and subcategorise the themes where appropriate. NVivo's Index system is a 'nodal' (categories) system whereby data are organised and represented in a visual tree structure. Nodes are containers for storing information and ideas about the data. Nodes are linked in a 'parent' (main category) and 'child' (sub-category) relationship (MacMillan and McLachlan 1999). For example, the largest theme that emerged from the observations of the self-help groups and the interviews was 'emotions'. Therefore, a 'parent node' entitled 'emotions' was created, from this, 20 'child nodes' were created relating to different emotions expressed during the interviews. Nodes were, also, created from other themes which emerged from comparison across the observations and the interviews. For example, 'loss of identity', 'the male supporting role', 'help received', 'burial arrangements' 'communication with hospital staff' and 'breaking the news'. One problem with creating nodes before the commencement of the interviews is that the researcher may create a node for concepts which he or she expects to find in the data, thus imposing prior categorisation on the data. As several researchers (see Coffey *et al.* 1996, Lee and Fielding 1996) point out, 'computer-aided qualitative data analysis' may be fostering an undesirable convergence towards a unitary ideal-type of data

collection, storage and analysis. For this reason the majority of nodes in the study were created as they emerged during interview transcription and from analysis of the data. Furthermore, the content analysis of the narrative data was carried out at the manifest level, that is, an analysis of what the respondents said rather than at the latent level where attempts are made to code the meaning of the response. This process was carried out with great caution in order to avoid creating entities that did not exist in the data or imposing unrepresentative words and meaning on the respondents.

Findings

Visual images

It has become widely accepted within the last decade (see McGreal 1997, Puddifoot and Johnson 1997, Volker and Striegel 1995, Kohn and Moffitt 1994) that attachment to an unborn baby begins before birth. The introduction of ultrasound scanning now enables parents to see and begin a bonding process with the unborn baby. It is as if the visual image provided by ultrasound scanning provides a material link from which a bonding process can develop. All the men in the study who experienced a stillbirth; two who experienced both miscarriage and stillbirth, and two who experienced a miscarriage (10 men), saw an ultrasound scan of their unborn baby. These fathers reported developing an awareness of the baby as a real living person and specifically described physical features, such as fingers and toes, they had observed, or believed they had observed. Sandelowski and Black (1994) suggest that by attending an ultrasound scan, men come to occupy the same position as their partner in terms of 'knowing' the baby. Research carried out by Johnson and Puddifoot (1996, 1997, 1998) found that experience of confirmatory imaging of the baby via routine ultrasound scan was a factor related to raised levels of grief and stress in male partners. This would appear to indicate that the representation of an image of the baby sparks off a strong emotional response from the male who then has a strong visual focus for his feelings. For example, in the present study, one father, Martin, had scanned the image of his baby onto his computer as a screen-saver and three weeks later his baby was stillborn. The presence of the image, continuously accessible, was said by Martin to be at first a strong source of comfort, and subsequently a terrible reminder of tragedy when the news of bereavement was received. This narration showed the capacity of the respondent to construct and express very different kinds of emotion elicited by an image recalled in different circumstances. This evidence suggests the importance of visualisation in understanding how the fathers came to construct their own meanings in relation to the anticipated birth. Research has shown (see Cecil 1994, Letherby 1993) that women who have experienced a pregnancy loss find support for their healing through oral communication with networks of friends. Men, generally, may not be able to avail themselves

of equivalent support, but may make use of other modalities, such as use of visual and other material links or images, which afford opportunities for them to articulate to themselves their sense of loss, and to share their grief with others.

By contrast, four fathers, who had experienced early miscarriage, did not have the opportunity to see an ultrasound scan and did not report that they had visualised the babies. All reported that they had grieved deeply for a baby whose coming they had anticipated, but in view of the small sample of respondents interviewed and the absence of any relevant interview cues, it is not possible to infer more from the evidence. Nevertheless, fathers, in many cases, had generated visions of parenthood either implicitly or explicitly through their imaginings of the future being. These imaginings amounted to personal and social constructions of a lived being with individual characteristics. The fact that these constructions were attached to biological events that might not come under a scientific classification of what might be considered a lived life does not take away from the grief experienced by fathers. This aspect of pregnancy loss merits further research.

Self-blame

Most men in the study blamed themselves for the pregnancy loss. One father, Gary, noted: 'I should have listened when she [partner] said she felt ill, I should have made her go to the hospital sooner'. Another father, Brian, stated: 'if I had taken my wife to hospital instead of listening to our General Practitioner, who told us we were being over anxious, things may have been different'. Two fathers related how their experience with hospital staff had left them blaming themselves for the pregnancy loss. Eric, whose baby son was stillborn, stated: 'they [hospital staff] just ignored us totally, we were a bit like a bad smell in the ward. Yes it's true to a certain extent that men are ignored, you feel you're almost the bastard that caused all this'. Another father, Connor, stated: 'it took me a long time to live with myself, never mind, you know because the hospital really done a hatchet job on me, they ruined me emotionally the hospital, done to me emotionally what nobody else could have done, they really put the hatchet in me, they left me in bits, they left me blaming myself, blaming God, blaming my family'. Connor cited lack of consideration for his partner's acute physical pain and inadequate information regarding his partner's health as the cause of his intense distress. Connor recognised that blaming himself for the loss was irrational, but, as he explained, his anger and feelings of helplessness were so intense that he blamed everyone, including himself, for the loss of his baby.

Identity

The men in the study also questioned their identity as fathers, uncertain as to their right to the term 'father' and equally unclear as to whether the pregnancy outcome was to be understood as a baby. The pregnancy loss has impacted on the future of the men; several perceive their visions of family

life to have disintegrated. When a pregnancy ends there is not only the loss of the baby, but also a loss of future hopes and dreams. Thomas, whose baby had been stillborn five years before the study, stated: 'I feel I have lost my future, no Fathers' Day celebrations, no Christmas presents, no birthday cards'. Thomas did not have any other living children and this may have been a factor in considering the extent of his grief relating to what he perceived as his future role and identity. Men who have gone on to father a child may still, however, have ambivalence in relation to identity; Dave expressed his dilemma when asked how many children he had. He did not know whether to describe himself as a father of four children, or a father of one, since three children had been stillborn. It was not possible from the data to draw any definite conclusions relating to long-term grief since all fathers appeared to have suffered irrespective of the time lapse since the bereavement had occurred. It should, however, be noted that three men who had suffered long-term grief had become group facilitators, suggesting that the grief had profoundly affected their lives. The study also found that several men who had experienced multiple losses attended group meetings over a long period of time. Equally, three fathers who had experienced a single loss still attended group meetings five and two years after the loss. Differences in impact of grief between men who had experienced stillbirth, or both stillbirth and miscarriage, and men who had experienced miscarriage only, could not be adequately investigated, however, owing to the small number of men in the sample.

Social recognition

The results from this research clearly indicate that, where pregnancy loss is approached as a social event, which requires reflection, explanation and the development of an appropriate ritual, there is increased opportunity for parents to articulate their own interpretation of the experience. It is clear that ritual is used to signal life events of key importance, and in particular birth and death. For example, when a baby is stillborn, that is, where a baby dies after 23 weeks gestation, a stillbirth certificate is required, which serves as a ritualistic affirmation that bereavement has taken place. Fathers, however, who are not married to the mother, are excluded from registering the stillbirth. One father in the study expressed how his grief was heightened when he tried to register his stillborn daughter only to find that, since he was not married to the mother he was unable, legally, to register the stillbirth, although the parents and siblings of the mother (as well as the mother) are able to do so. Such men are thereby prevented from having their experience of death validated through customary social procedures and their status as parents acknowledged. A baby born under the age of legal viability does not require any documentation, is classified as non-viable, has no legal status and is termed a miscarriage. Six fathers in the study were not given the opportunity to bury the remains (where remains existed) of their miscarried baby, although, five fathers had expressed a wish to do so. Miscarriage

can, therefore, be considered as an intangible loss with no formal mechanism in Western societies that allows the expression of grief through the formal ritual of burial.

Supporting role

Consistent with previous research (see Murphy 1998, Murphy and Hunt 1997, Worth 1997, Miron and Chapman 1994) the present study found that men put their own grief and emotional needs aside in order to support and comfort their partner. One father Robert stated: 'it took me a while to talk to Jane [partner] about losing the baby because I didn't think I could be seen to be breaking down crying in front of her, I mean I had to be strong for her. I would have Jane crying on one shoulder and in bits and me crying on the inside but not able to show it'. Another father, Connor, stated: 'I had to be strong for Kate [partner], I had to let her cry on me and then I would get into the car and drive up into the hills and cry to myself. I was trying to support her even though I felt like my whole life had just caved in, you know my whole life just ended there and then'. This theme was expressed by all fathers in the study.

Fathers' reports on hospital staff

The study demonstrated that several men tended to be marginalised by hospital staff, despite the fact that the men often had onerous responsibilities at the time of the loss, through, for example, being the first family member to see the remains of the baby. Furthermore, it is usually the role of the father to inform relatives, friends and work colleagues of the loss. The men in the study also had the overwhelming task of arranging a funeral. All the fathers expressed the view that they were not prepared for this practicality. For several men this was their first experience of death and most expressed the feeling of helplessness and despair surrounding the ambiguity of burial arrangements for a stillborn or miscarried baby. The haphazard approach to burial arrangements adopted by some hospital staff may add to the feelings of isolation and distress expressed by the fathers. The following narrative from Connor illustrates this point:

We had a funeral, it was the mortician who helped us arrange it, he said 'don't worry about the coffin I'll get that sorted out' so we didn't have to worry about that. He picked us the most beautiful coffin. He came to me and said 'you know you can get your baby christened, the hospital doesn't have to deal with it, you can deal with it'. Not one of the doctors, nurses or midwives came to us and told us that. You know I have so much respect for that man it's unbelievable. He got out of his bed in the middle of the night and came up to talk to me, showed respect, put on a black tie and shirt, you know I wouldn't of cared if he had come up in his pyjamas, it was just somebody to talk to, because they [hospital staff] were just leaving me sitting there. He came in and talked to me like I was a human being who was hurting, it wouldn't have hurt any of those nurses to do that.

Andrew had lost two babies in 1980 and 1984. The first baby, Grace, had been born at 23 weeks gestation, the second baby, Stephen, at 27 weeks gestation. Grace and Stephen had both been defined as miscarriages as they had been born under the age of viability which was, at that time, 28 weeks. Andrew had asked if he could see his first baby. He stated:

She was a perfectly formed baby girl; however, it wasn't a question of wrapping the baby up and seeing her dressed, she was presented to me lying in a kidney dish covered in a green paper towel, I remember that and that will stick with me more than anything. Grace was probably incinerated, she was just taken away and we thought we'd get an answer for her death, but we didn't and the hospital never brought her back to us. We didn't know to ask if we could have her back, it wasn't the done thing then.

The study found that most hospitals in Northern Ireland now encourage parents to see their deceased baby, take photographs, a lock of hair [usually in the case of a stillborn baby], and to hold a funeral, although not every parent is offered this opportunity. Robert, who had lost his baby at 12 weeks gestation, had not been offered the opportunity to take the remains of his baby home for burial. Another father, James, related how when he had asked hospital staff if he could bring his 14 week gestation baby home to bury it, he was told that they [hospital staff] did not know where the remains were. James stated: 'I think it was up in the lab just like a bit of tissue thrown about, I think they would have thrown it in the bin if I hadn't asked, you know they don't have any compassion'. The study also showed that miscarriage and stillbirth are deeply personal experiences and the way in which the decease of the baby is socially constructed is crucial to enabling the parents to come to terms with their grief. The present research strongly suggests that the procedures adopted within hospitals for handling the remains should be as similar as possible to those used in relation to the death of a lived person, in terms of recognising the sensibilities involved. The following narratives from the men in the study clearly indicate that there are occasions when the procedures would appear to suggest to parents that the event is not accorded the value that would be expected when a bereavement has occurred.

Connor had lost his baby daughter Sinead in 1998 at 41 weeks gestation; she weighed 10lb 2oz. Connor stated:

When I saw Sinead she shocked me, the hospital staff did not inform me that there might be a bit of skin loss. They handed me my baby in a basket and the skin had ripped off her face and from under her arms. The skin ripped off her head with the force of the vacuum and forceps and they didn't warn me about it. I held her and I was afraid, I was actually petrified, my own flesh and blood and I was petrified to see her, she shocked me, they handed me 10lb 2oz of meat, it was freezing cold in a basket with no skin.

Connor went on to relate: 'I haven't grieved yet, I can't because I'm still so angry with the hospital staff. If even one of the hospital staff had said, "Connor, I'm sorry, you know you're a Dad and you feel pain as well", it would have helped, but I was constantly pushed aside'.

Daniel lost his baby son Michael in 1995 at 25 weeks gestation. The hospital put Michael in a moses basket for his parents to take home for burial. On the morning of the funeral, however, the hospital rang Daniel and requested that the moses basket be brought back as they needed it for another baby who had died. Daniel states: 'I had to lift the baby out of the moses basket and put him into a casket. I felt a terrible sense of loss then, at that particular moment'. Another father, James, lost three babies at 12, 14 and 24 weeks gestation. He explained how, when he had lost his baby at 12 weeks gestation, one consultant had commented: 'it didn't have a chance, it wasn't really a baby, it was a product of conception'. James went on to state that 'it had wee arms and wee legs and it's amazing, something so small and they don't class it as a baby'. The devaluation of loss expressed in the doctor's remarks was clearly being resisted in James' recollection of feelings engendered at the time.

William, whose baby daughter had been stillborn, recalled how when he was in a side room waiting for his baby to be born, the consultant had come in and said 'Mum is doing fine, but we've lost baby'. William stated: 'it didn't register with me what he was telling me and I thought well, like I mean, how? That's very careless surely you can look for it, it can't be that big a room and baby can't move, and then the consultant said "I'm so sorry" and it slowly registered with me that he was telling me something more serious than he had just misplaced the child'. This incident demonstrates that the use of a particular form of language can disadvantage men who may not, generally, be familiar with specific modes of expression found in doctor-patient interaction. The narration of his interpretation enabled William to articulate the mechanisms through which his grief was amplified, albeit unintentionally, by the consultant.

Two men in the study felt that they had been treated well by hospital staff. William recalled how the anaesthetist had come after the event to say she was sorry for the loss of his baby; another father, Thomas, related how the midwives had cried along with him and had offered him emotional support. Several of the men, however, expressed anger and dissatisfaction with hospital care. Eric described the time he had spent in hospital with his partner as 'not a good experience'. He notes that, except for one particular ward sister, his experience would have been totally unbearable:

While they addressed my partner's medical needs, to say they didn't address her emotional needs doesn't even start to describe it, they never addressed her as a human being, they never spoke to her, they never came to see her, she was abandoned. I was even less a consideration.

Hospital practices

Hospital practices after pregnancy loss have changed considerably over the past decade, yet they have not been well evaluated (Lasker and Toedter 1994). Interviews were carried out in the present study with nurses and midwives throughout Northern Ireland, in order to determine the attitude of staff towards a male partner and the nature of the care provided. Hospital practices for dealing with the remains of babies were also investigated. The Stillbirth and Neonatal Death Society: guidelines for professionals' (SANDS 1991, 1995) offer guidance for health professionals on the emotional and practical care of parents who have experienced a pregnancy loss. In a study of midwives' perceptions of dealing with miscarriage, stillbirth and neonatal death in Northern Ireland, Devlin (1998) found that while midwives reportedly perceived these guidelines as being an invaluable source of information, nevertheless, a number of midwives in her study had not read the guidelines.

During the 20th century, experiences of death have been mediated through the intervention of professionals, for example, medical staff or undertakers, and the personal care which people of previous generations would have accorded their deceased relatives has been superseded by standardised and externally-provided services. The professionalisation of the protocols surrounding the death process has distanced relatives from an experience which, in the past, would have been handled by the community directly, including the clergy, and would have made use of a range of informal and semi-informal rituals. It has been suggested by James (1989: 20) that 'it is health care professionals in hospitals who are most likely to set the tone immediately after a death, although they appear to be poorly equipped to do so'. From an emotion management perspective, Hochschild (1979: 551) argues that emotion is often subject to acts of management and that 'the individual often works on inducing or inhibiting feelings so as to render them "appropriate" to a situation'. In the context of a strong, sometimes overpowering institutional context, such as a hospital, men who have suffered loss may well submit to forms of emotion management which may operate not through direct manipulation, but through latent, inhibiting qualities of a milieu in which it seems inappropriate to release certain feelings, particularly when the hospital culture does not accord recognition to men's unexpressed emotional needs.

Most of the nursing and midwifery staff in the interviews felt they addressed the needs of the male partner, such as by providing a bed, thus enabling him to spend the night with his partner and deceased baby. Sara, a midwife, however, commented:

I'm sure we don't really focus on men at all; they get explanations, but it's funny you don't even think of them, well I don't. Men come to the labour ward and they sit beside their partner and they participate in the event, but nobody really ever thinks to say, are you all right unless you look at them and they're pale and you think they might fall over and get in the way.

Norma, a staff nurse in a gynaecology ward, had had experience of research for a post-graduate degree in health promotion and she took a reflective approach to the issues under consideration. It was noticeable that she began by focusing on communication and feelings, stating that she would encourage the woman to talk to her partner. Norma also commented that she would explain things fully to the male partner.

Anna, a midwife, stressed that she was very aware of the feelings of the male partner and always asked the male how he was coping. Anna goes on to state:

The men very often try and put on a brave face, for their partners sake obviously; they maybe don't discuss their feeling as much as they should. Most of the time they are putting on a good front and being supportive, outside the room, however, they would be very upset but inside they don't want to show their feelings to their partners.

There is recognition, therefore, among some hospital staff, that men's different approach to the expression of feelings belies the depth of their emotional response and may often conceal the fact that they are grieving.

Hospital burial arrangements

Hospital staff in Northern Ireland now encourage parents to take possession of their stillborn baby and to hold a funeral. In the case of miscarriage, however, arrangements for possession and burial are variable and depend on individual hospital practices, as well as the knowledge and sensitivity of the medical and nursing staff involved. Furthermore, not all hospital staff were aware of the method of burial in their particular unit. The study found that it was no longer acceptable in many hospitals for the remains of miscarried babies to be disposed of in hospital incinerators. Nine hospitals in the study have a ritual procedure for dealing with the remains of miscarried babies. One hospital, however, did not have any common burial plot for the remains of the miscarried babies, although the parents were given the opportunity to bury their baby themselves. According to one staff nurse: 'they [the hospital] were to get a common burial plot for all denominations, but they didn't. A lot of parents think that you do have a burial plot and then when they find out you don't, you know what the next question is going to be, "well what do you do with the baby?"' and it doesn't even bear thinking about, you have to be honest and it's just, you know incinerated'. While hospital staff cannot take away parents' grief, they nevertheless need to create a climate for dialogues that addresses burial arrangements in an informative and sensitive environment.

Acknowledgement of loss by wider community

All fathers indicated that they frequently felt their loss had been devalued by the wider community. Feelings of loss may have been exacerbated by the

modes of language and discourse used in discussions with fathers or in informing them of the bereavement. Opportunities for validating the loss, however, are of particular importance in facilitating a healthy grieving process (e.g. see Robinson *et al.* 1999), and the use of appropriate language is necessary if the men are to be enabled to come to terms with their loss.

All the fathers noted how 'well meaning' remarks from the wider community, for example, 'never mind, you can always have another baby', led to feelings of anger and despair. As Corr *et al.* (1997) point out, no individual child ever is or should be a replacement for another child. One father, Patrick, lost his first baby Sean through stillbirth in 1994 and his second baby was lost through miscarriage in 1995. Patrick, stated how 'communication and understanding are very important, some people did not understand'. He noted how one woman commented, 'I know how you feel, it nearly happened to us'. Another commented, 'I know how you feel, I lost my dog last year'. Patrick also related how 'when the phone rang it was always the same question, "how is Maria [partner], how is she coping?" At one stage I wanted to scream, what about me? No-one ever asked how I was'. He goes on to state:

It was hard because all the time when you're growing up you're told 'you're a big boy now', when you fell in the playground you were told 'big boys don't cry, boys are strong', you're always fighting those emotions really, but when you lose your baby, it sort of confuses you, you want to tell some-one how you feel, but yet you think 'I'm a man, I shouldn't be feeling like this.

This account suggests that the father has profound emotions and that he has not attempted to intellectualise the grief; rather, his concealment of some of the obvious indicators of emotion may have led others to underestimate the impact of his experience.

Another father, Eric, also commented on reactions from the wider community. One individual commented to Eric: 'it could be worse, he could have lived for an hour and died; he could have come home and suffered a cot death; he could have been six years old and run down by a car. Now wouldn't that have been far worse?' His rejection of attempts by others to rationalise his loss demonstrates how Eric has struggled to resist the depersonalisation of his experience.

The men also noted how many people, including family, reacted by avoiding talking about their loss. Patrick recalled how when he tried to talk to his mother about the loss of his baby, she told him 'now don't you think its time you stopped the crying; you've cried long enough'. A study carried out by Cecil (1996) found how pregnancy loss in rural Ireland in the 1940s, 1950s and 1960s was embedded in secrecy. The author notes how the evidence suggests that information about pregnancy loss was not passed from one generation to another. Several men in the present study related how it only

came to light when they lost their own baby that their sisters, aunts and even their parents had lost babies many years before. In Ireland, therefore, families and communities may have failed to develop appropriate rituals for the validation and sustenance of perinatal bereavement so that individuals are bereft of coping strategies. This would be particularly true in the case of the men.

It has been suggested (Miller 2000) that people make sense of what is happening to them in relation to the past and to future expectations and in relation to other actors. If men are not offered opportunities to understand past events and do not have access to appropriate discourses in which to articulate and express their interpretations and feelings, they may be less able to prepare for their future lives. The evidence from the men, therefore, suggests that the discourses of grief are predominantly gendered through a customary and habitual focus on the grief of women, and a need arises for professional carers to attend to the construction of forms of discourse that can assist men to comprehend and reflect on their experiences within an established tradition of knowledge.

Role of pregnancy loss self-help groups

Lang *et al.* (1996) point out that couples who are able to reach out early on and maintain a common social network are better able to progress in their 'grief work'. Three men in the study gave talks to the medical profession and wider community on their experiences. Three men also facilitated a self-help group, along with their partner. The men expressed the view that belonging to a social network, where they were able to share the grief of others, also helped them come to terms with their own grief. The self-help groups also afforded to the men an opportunity to grieve through rituals and remembrance services. For example, many self-help groups organise communal memorial services during which bereaved parents are invited to enter their baby's name in a book of remembrance, lay a flower, light candles, recite poems and sing songs. These developments have shown the need to devise rituals that can serve the purpose of signalling that an important event has taken place, one that sanctions grieving processes and shows to parents that their sorrow has been recognised. Kuller and Katz (1994) note that the social acceptance of grieving through ritual assists in the progression and resolution of the grief. Yet for most men, when a baby dies before birth, the world that surrounds them tends to belittle, or at least discount, their loss and the emotional support and cultural rituals that are normally available to other bereaved individuals are often unavailable for men. Rando (1984) asserts that social support reflects the degree to which the deceased individual is valued by members of society at large. In the case of pregnancy loss, where the status of the baby is not valued, few traditional gestures that accompany a 'social death' will be made. The absence of rituals and rites marking pregnancy loss denies men an opportunity to mourn within a traditional ambience of comfort and support provided by significant others. Men mourning

the loss of a baby suffer the additional burden of disenfranchised grief (Doka 1989); they do not have a socially recognised right to grieve because the loss is not considered a 'social death'.

Participants in self-help groups cannot be taken to represent all individuals who have experienced a pregnancy loss; they have, however, the potential to contribute to change in hospital practices through helping to encourage the provision of rituals such as annual services for bereaved parents. It is important also to consider that many fathers will not have access to a self-help group and may, therefore, be distanced from sources of support available to mothers.

Writing in 1990, Layne noted that in the previous 15 years, organisations had sprung up throughout the United States in protest at the cultural denial of perinatal loss and had sought to define the pregnancy loss as a legitimate source of grief. The author noted that 'SHARE' (source of help in airing and resolving experiences), the largest national directory of support groups for perinatal loss, lists almost five hundred such groups in urban, suburban, and rural settings around the country, as well as groups in Canada, Australia, Israel, Italy, England, West Germany, South Africa and the Virgin Islands. Layne (1997) conducted ethnographic research with pregnancy loss support groups in the New York/New Jersey area of the United States and found that although some women and an occasional man attended group meetings on their own, most support groups were attended by couples. The present study found that where a group was facilitated by both partners, as in the case of three SANDS groups, the group was attended by both partners. It was notable, however, that where a woman alone facilitated the group, as in the case of the Miscarriage Support Group and one SANDS group, men rarely attended the group. All the men expressed the view that having another male present was a source of support. Most fathers stated how they felt relief at sharing their grief and anger, in a context which was viewed as normal and acceptable. One father, Brian, expressed how he attended the group but felt uncomfortable at being the only male there. Brian stated: 'I felt like it was sort of a woman's group'. The results from this study are important as they indicate that the needs of the male partner may remain ignored if they are unable to find an outlet for their grief. Moreover, most of the men in the study noted how they were unable to talk to family or work colleagues about their experience. Further research with male partners who do not attend self-help groups is needed, therefore, in order to locate the determinants of their grief and understand their experiences more fully.

Discussion

Some key themes that emerge from the literature on pregnancy loss from a male perspective are also represented in the findings of the present study.

Men in this study, for example, confirmed the importance of having to be strong for their partner. Similarly, Murphy (1998), Puddifoot and Johnson (1997) and Miron and Chapman (1994) found that the men in their study identified their role as one of giving support to their partners. Five fathers in the study also took the initiative of finding help and support, through self-help groups, for themselves and their partners.

The study confirmed the findings of Middleton and Quirk (1990) and Wilson and Soule (1981) that it is usually the father who has the task of informing family and friends of the bereavement and of making funeral arrangements. In addition, since the partner of the man was often incapacitated after the loss, following a general anaesthetic, the father was likely to be the first family member to see the remains of the baby. Fathers were frequently faced with a situation where a deceased baby was abruptly thrust into their arms by staff, no doubt with the best of intentions. The men, however, had no preparation for such a traumatic event, which was usually unexpected and for which they had no prior knowledge concerning how to handle a deceased baby, nor any cultural guidelines as points of reference. On some occasions, the body of the deceased baby was still warm when given to the father to hold. One father, William, described how the baby's head turned in his direction through gravity, so that he believed there was still life in the child's body. On another occasion, Connor, sleeping in the same room as the deceased baby, woke to hear what he thought was the baby crying only to find that the crying was coming from another room. It should be noted, however, that none of the men expressed regret at holding their deceased baby and all were glad to have had the opportunity to do so.

Researchers (*e.g.* Menke and McClead 1990, Peppers and Knapp 1980) have referred to 'incongruent bonding' and 'incongruent grief' to conceptualise the observation that fathers and mothers bond differently with the child, and work through their grief in different ways or at different times. The fact that men in the present study experienced different patterns of interaction with the deceased baby and had little advance information regarding what was likely to happen, or how they should behave, may suggest a mechanism for subsequent differences in grief patterns. It is important to consider, however, that incongruence needs to be mapped at levels beyond the chronological; that is, differences amount to more than a matter of timing, and may reflect different role expectations and assumptions regarding fathers' experiences, as well as the different ways in which fathers are able to give them expression.

In the study, some men perceived visual recognition of the baby through medical imaging as a key stage in their coming to terms with the reality that the baby really existed, and in the growth of their self-identity as the baby's father (see also, Sandelowski and Black 1994). Johnston and Puddifoot (1996) and Puddifoot and Johnston (1999) found that men who had seen an ultrasound scan had considerably raised levels of grief. The conclusions drawn from their research, which is psychologically oriented, is that men

who have strongly visualised their baby will have a deeper experience of grief. The current study, however, suggests that men acquire a sense of their identity as a father partly through the experience of the visual image and that this leads to a reconstruction of their image of self. The loss itself has a powerful effect in terms of damage to their self-identity and ambivalence concerning their status as a father.

It was not possible to determine differences in impact of grief by length of time of bereavement since the sample was small and no definitive conclusions can be drawn. It may be worth noting, however, that three men who had suffered long-term loss (3, 5 and 20 years respectively) had become facilitators for the self-help groups suggesting that the issue was still central to their lives.

Conclusion

The findings from the study identified implications for improving practice by hospital professionals, pregnancy loss support groups and the wider community. Furthermore, the evidence demonstrates the need for appropriate rituals to validate the feelings and experiences of the men. The range of rituals devised by members of the self-help groups for their remembrance ceremonies could be adapted for use in hospital settings. It is clear, however, that the ability to issue a death certificate would constitute a key ritual act, which would be helpful in lessening grief for parents. Some men held the view that hospital staff, especially nurses and midwives, were sympathetic and supportive towards them. Interviews revealed, however, that several men felt the hospital staff did not address the emotional needs of either partner, and several noted a lack of sensitivity and compassion from the medical profession. There was, also, in some cases, an absence of informed choice concerning burial arrangements for the deceased baby.

The study challenges traditional notions concerning male behaviour in relation to pregnancy loss. Many researchers support the traditional view that male bereavement is experienced through an intellectualisation of the process of grief. The findings from this study, however, suggest that, on the contrary, men deal with the loss at an emotional level. Rather than intellectualising or rationalising their experience it would appear that the men in this study both grieved and reflected on their grief. The main theme that emerged from the analysis was 'emotion', demonstrating that the primary focus for men was their feelings. The treatment of the men, in terms of lack of legal recognition and institutional validation of their rights and feelings, poses problems for male identity. While the identity of the woman as 'mother' is often ambiguous (see Lovell 1983), the status of the male as 'father' is especially problematic, since the social visibility of the male is minimised. In addition, the absence of situations where men can discuss their feelings and the inability of men to relate the events to family members

further marginalises the role of the father in pregnancy loss. Previous research has tended to suggest that men respond differently to women in relation to this experience. The current research, however, points to a model of male grieving which is predicated on emotions similar to those expressed by women in previous studies (see Brier 1999, Letherby 1993). The differences arise from the social, institutional and familial structuring of the male experience, the devaluing of men's experiences by some of the medical profession and wider community, and restrictions on the ways in which men can openly express emotion.

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Note

- 1 A summarised version of this paper was presented at the second joint conference of the BSA Medical Sociology Group and the European Society for Health and Medical Sociology, 14th–17th September, 2000, University of York.

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