THE FATHER'S EXPERIENCE OF GRIEF AFTER A STILLBIRTH

by

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DECLARATION

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ABSTRACT

A stillbirth is regarded as a devastating event for any parent and usually results in deep sorrow for them. This phenomenon is on the increase in South Africa with approximately 20 000 stillbirths reported annually. Statistics on the prevalence of stillbirths in the Western Cape Province indicate that approximately 14.6 percent of stillbirths occurred between 2003 and 2006. While the grief process of mothers after a stillbirth has been widely researched, the experience of fathers has been neglected, and even if it was included in a study, it was still not the primary aim of the study. Therefore, the research question for this study was "How do fathers grief after the experience of a stillbirth? Consequently, the aim of the study was to gain an understanding of the grieving process of fathers after their experience of a stillbirth. To achieve the aim of the study the following four objectives were formulated. To discuss the causes and consequences of stillbirth as medical phenomenon; to discuss the nature and extend of the grieving process of fathers after a stillbirth according to appropriate theoretical viewpoints; to investigate the grieving process of fathers after a stillbirth; and to make recommendations relating to the experience of the father's grief process after a stillbirth based on the findings of the study.

A qualitative research approach was employed combined with an exploratory and descriptive research design to investigate and describe the phenomenon being studied, namely the grief process of the father after a stillbirth. Ten fathers who experienced a stillbirth were involved in the study by means of a purposive sample. Data was gathered by means of a semi-structured interview schedule that was administered during individual interviews.

Key findings of the study were that fathers experienced grief after a stillbirth in isolation, as they do not openly express their emotions. This included the father's experience that culture, gender stereotypes, views of the church and religious community and the attitude of the professional hospital staff towards the father influenced his grief process. The findings also highlight those fathers made their wives or partners and living children their focus, which contributed to the postponement of their own grief and resorted to their destructive coping mechanisms. Fathers in the study expressed a need for support from professional hospital staff and found that counselling from the social worker was of significance in dealing with their grief.

In the light of the findings, it is recommended that their wives or partners, society, cultural beliefs and religious communities, should acknowledge the fathers' grief after the experience of a stillbirth, as it will allow them to openly grief. Professional hospital staff should design and implement support programmes that suit the specific needs of fathers whom grief after a stillbirth.

OPSOMMING

‘n Stilgeboorte word deur enige ouer beskou as ‘n rampspoedige gebeurtenis wat swaar verdriet vir hulle meebirng. Hierdie verskynsel is aan die toeneem in Suid-Afrika met ongeveer 20 000 stilgeboortes wat jaarliks rapporteer word. Stasistiek oor die voorkoms van stilgeboortes in die Wes-Kaap Provinsie dui aan dat ongeveer 14.6 persent van stilgeboortes voorgekom het tussen 2003 en 2006. Terwyl die rouproses van moeders na ‘n stilgeboorte wyd nagevors is, is die ervaring van vaders verwaarloos, en selfs wanneer dit ingesluit is in ‘n studie was dit steeds nie die hoofdoel van die studie nie. Derhalwe was die navorsingsvraag vir die studie: “Hoe rou vaders na die ervaring van ‘n stilgeboorte?” Gevolglik was die doel van die studie om begrip te ontwikkel vir die rouproses van vaders na hulle ervaring van ‘n stilgeboorte. Om die doel van die studie te bereik is die volgende vier doelwitte geformuleer. Om die oorsake en gevolge van’n stilgeboorte as mediese verskynsel te bespreek; om die die aard en omvang van die rouproses van vaders na ‘n stilgeboorte te bespreek ooreenkomstig toepaslike teoretiese uitgangspunte; om die rouproses van vaders na ‘n stilgeboorte te ondersoek, en om, gebaseer op die bevindinge van die studie, aanbevelings te maak oor die ervaring van die vader se rouproses na ‘n stilgeboorte.

‘n Kwalitatiewe navorsingsbenadering is in kombinasie met ‘n verkennende en beskrywende navorsingsontwerp gebruik om die verskynsel wat bestudeer word, naamlik die rouposes van vaders na ‘n stilgeboorte, te ondersoek en te beskryf. Tien vaders wat ‘n stilgeboorte ervaar het, is met behulp van ‘n doelbewuste steekproef by die studie betrek. Data is ingesamel met behulp van ‘n semi-gestruktureerde onderhoudskedule wat geadministreer is tydens individuele onderhoude.

Sleutelbevindinge van die studie was dat vaders na ‘n stilgeboorte in isolasie rou omdat hulle nie hulle emosies openlik uitdruk nie. Dit sluit in dat vaders ervaar dat kultuur, geslag stereotipering, sienings van die kerk, die religieuse gemeenskap en die houding van professionele hospitaalpersoneel teenoor die vader sy rouproses beïnvloed. Die bevindinge beklemtoon ook dat vaders hulle fokus op hulle eggenotes of lewensmaats en lewende kinders geplaas het wat bygedra het tot die uitstel van hulle eie rou en wat neerslag gevind het in destruktiewe hanteringsmeganismes. Vaders in die studie het hulle behoefte aan die ondersteuning van hospitaalpersoneel uitgespreek en hulle het die berading van maatskaplike werkers betekenisvol gevind in die hantering van hulle rou.

In die lig van die bevindinge word aanbeveel dat die eggenotes of lewensmaats, kulturele gebruike en religieuse gemeenskappe die rou van ‘n vader na die ervaring van ‘n stilgeboorte moet erken omdat dit hulle sal toelaat om openlik te rou. Professionele hospitaalpersoneel behoort ondersteuningsprogramme te ontwerp en implimenteer wat gerig is op die spesifieke behoeftes van die vader wat rou na ‘n stilgeboorte.

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CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

The loss of a child through death is regarded as untimely and extremely difficult to overcome (Cleiren, 1993:61). Bateman (2011:365) compares this medical phenomenon to an invisible earthquake because to explain this phenomenon until recently it was difficult to measure the existence and experience thereof by parents. Likewise, the Diagnostical and Statistical Manual of Mental Disorders (DSM-IV) states that the loss of a child can be classified as a catastrophic event where the parent can experience a feeling of captivity (American Psychiatric Association, 1978:11).

To understand the experience of stillbirth, it is important to show insight into the prevalence thereof. The question thus is how the prevalence looks elsewhere in the world compared to South Africa.? According to Goldenberg, McClure, Bhutta, Belizan Reddy, Rubens, Mabeya, Flenady and Darmstadt (2011:1798), annually about 3 million stillbirths occur worldwide with most in the middle and low-income countries. Since South Africa is classified within the aforementioned categories these authors suggest that most stillbirths occur on our own shores. The Unicef Report (Unicef, 2011:8) highlights that approximately 20 000 babies are stillborn in South Africa annually. They furthermore mentioned that 30 per cent of the mortality rate of the South African children population below the age of 5 years can attributed to stillbirths. Also worth noting is that Bateman (2011:364) base his argument on the findings of his own study that 23 000 stillbirths occur annually in South Africa with an estimated 61 per day. Bateman (2011:364) furthermore indicates that South Africa is ranked 148th with regards to the prevalence of stillbirth compared to other countries in the world.

In determining the prevalence of stillbirth in the Western Cape in South Africa, Groenewald, Bradshaw, Daniels, Matzopoulos, Bourne, Blease, Zinyaktira and Naledi (2008:41) emphasise that only 1085 or approximately 14.6 per cent stillbirths occurred between 2003 and 2006 in the province. Data about the current prevalence in the province is currently not available due to the lack of research thereof. Bateman (2011:364) supports this statement by highlighting that only babies who demise five minutes after birth were included until recently (2011) into the data. This confirms that stillbirths and the occurrence thereof are not accurately documented.

Consequently, Bateman (2011) argues that more mothers and fathers experience stillbirths than what is recorded. Furthermore, as a result of the lack of proper recording of stillbirths, it is clear that these parents receive minimal social, professional and emotional support and that they should rely predominantly on their own coping mechanism. Hence, it is important to establish how fathers experience stillbirth and the grief process.

It is worth noting that studies by Groenewald et al. (2008:41) show that the relationship between stillbirths against live births is nine out of 1000 live births during the aforementioned timeframe. In considering this, these authors (Goldenberg et al., 2011:1798; Groenewald et al., 2008:41) suggests that a father in the Western Cape Province would have a nine out of a 1000 chances to experience a stillbirth.

It is of importance to take into account that the experience of stillbirth affects the whole family system. Because most research focuses on the effect of this traumatic event on the mother and the other children within the family, McCreight (2004:326) states that the effect of stillbirths on fathers is being overlooked in academic research. In support hereof, Aho, Tarkka, Astedt-Kurki, Sorvari and Kaunonen (2011:879) mention that the prevalence of stillbirth can be regarded as a psychological traumatic and disastrous event for the mother, as well as the father. Human (2013:07) in a recent South African study about the effect of stillbirth on the family, challenge these authors (McCreight, 2004; Aho et al., 2011) by stating that the effect of fatherly grief is mentioned in research, but it is not the primary focus thereof. In light of this, it is clear that there is a need for a study that primarily focuses on the grief process of fathers after a stillbirth.

Various perceptions that fathers only fulfil a supporting role when their life partner experience a stillbirth often exist within society (McCreight, 2004:326). This perception is according to Haralambos and Heald (1980:5) based on norms that are used as guidelines to determine acceptable behaviour in society in certain situations or, for the purpose of this study, a stillbirth. Burn (1996:88) shows insight into this issue when she mentions that society plays a massive role in the perceptions of masculinity and sex-role identification. With specific reference to society's norms about the management of fatherly grief, Burns (1996:99) highlights a specific norm named "anti-femininity". According to the aforementioned norm, it is expected of fathers to avoid stereotypical female activities and behaviour including expression of emotions and self-disclosure. It seems from the remarks of these authors (Burns, 1996; Haralambos & Heald,

1980; McCreight, 2004) that the environment in which these fathers should grief is rather challenging and also impacting on the manner in which they grief.

If it is the case that norms in society make it clear to fathers that it is not fitting for him to grief, there is a need to explore why mothers only have the right only to grief after the experience of stillbirth. In defence of this, Beauchamp (1995) highlights that mothers are believed to form a strong and intimate bond with the unborn baby that she often can even identify her baby by his or her scent. In debates about why fathers also have a right to grief, Hey dad meet baby (2011:22) mentions that fathers also form an intimate bond with the unborn baby during pregnancy. Compared with the mother, it might be difficult to form a bond with the unborn baby that cannot be seen, felt or heard, but the father can do this on a practical manner by reading, playing music and even talking to the unborn baby. Another method to form a bond with the unborn baby is to do emotional, physical and financial preparations for the arrival of the baby (Hey dad meet baby, 2011:22). It is evident from these sources that the task of the father is also to do preparations for the arrival of the baby and therefore, he also has the right to grief if the baby is stillborn as otherwise all his preparations would be in vain. Furthermore, literature (Habib & Lancaster, 2006:235) supports this argument that the disclosure of pregnancy not only lead to preparations by the father but that it is also the indication of a new era namely fatherhood. Lack of research about the challenging environment in which fathers are grieving specifically in South Africa and the Western Cape can be regarded as the motivation for the study.

1.2 PROBLEM STATEMENT

Research (Bateman, 2011; McCreight, 2004; Aho et al., 2011; Burns, 1996) shows that fathers should be given an opportunity to grief over a stillbirth. McCreight (2004:329) found that fathers expressed the need to suppress their own grief because they have to support the mother in her grief process. Cook and Oltjenbruns (1998:165) however, indicate that fathers do experience feelings of pain and loss, but acknowledge that it is overlooked during the grief process. Likewise, Corr, Nabe and Corr (2000:233) acknowledge that studies about adult grief predominantly focused on women and not on men. The reason for this can be because women are more willing than men to communicate their emotions (Corr et al., 2000:233). According to Neimeyer, Harris, Winokuer and Thornton (2011:69), fathers do have their own unique manner of grieving, while Cook and Oltjenbruns (1998:174) mention that fathers, after the

experience of stillbirth may lose their hope to expand the family and may experience a feeling of emptiness.

Although in literature there is a lot of emphasis on a feministic manner of grief as the conventional method of grief, Corr et al. (2000:234) introduce the manly-grief model. Neimeyer et al. (2011:69) indicate, in defining this model, that it allows the fathers an opportunity where their grief is acknowledged. It seems from these statements that the authors emphasise that the environment in which fathers grief should be conducive as it influences the reaction to grief and the grief process as a whole. Likewise, Cook and Oltjenbruns (1998:175) mention that fathers, in their grief process, experience feelings of anger and guilt combined with an increase in reactions to their work-related activities. Consequently, fathers may be of opinion that they should grief in private.

If fathers experience the need to suppress their own feelings of grief, Rubinstein (2004:211) mentions that fathers become depressed and experience a feeling of loss of control. Aho, Tarkka, Astedt-Kurki and Kaunonen (2009:93) acknowledge that as a result of lack of literature and studies on the grief process of fathers and how they should be supported, a lack of knowledge about this exists. Bonnette and Broom (2011:248) furthermore state that previous studies about stillbirths were predominantly medically oriented and focused on the effect of it on the mother. The researchers, Bonnette and Broom (2011:48), place great emphasis on this as it led to the existence of a so-called grief hierarchy where the grief of fathers is not regarded as a priority. Likewise, Aho et al. (2009:93) state that fathers often are resorting to alcohol to cope with the stillbirth which then brings disruptions within the family systems. This type of coping mechanism does not only bring disruptions in the family system but also create a crisis whereby the mother cannot provide any support to the father as she herself is grieving. Based on the above arguments, the grief process of fathers can no longer be regarded as rare; hence there was a need to conduct this study. Against this background the research question for the study was: “How do fathers grief after the experience of stillbirth?”

1.3 AIM AND OBJECTIVES

The aim of the research was to gain an understanding of the grief of fathers after their experience of stillbirth.

Considering the aim of the research, the following objectives were formulated:

1) To discuss and explain the causes and consequences of stillbirth as a medical phenomenon.
2) To discuss the nature and extent of the grieving process of fathers after a stillbirth according to appropriate theoretical viewpoints.
3) To investigate the grieving process of fathers after a stillbirth.
4) To make recommendations relating to the experience of a father's grief process after a stillbirth based on the results of the study.

1.4 THEORETICAL VIEWPOINTS

Since the focus of the current study was on the grief process of fathers, theoretical viewpoints on grief were explored. In light of this contribution of Elizabeth Kubler-Ross (2001) about grief and her introduction of the so-called Stages Theory of Grief were (Maciejewski, Zhang Block & Prigerson, 2007:716) were used as the starting point for the study. It is of importance to note that other authors (Maciejewski et al., 2007:716) acknowledge that since the introduction of the contributions of Kubler-Ross (2001) about grief it is still regarded today as the most acceptable theory to deal with grief. As a result of this, this theoretical framework was chosen for the current study. Also Cook and Oltjenbruns (1998:93) mention that people who experience grief presents with various reactions. These reactions include shock or denial in the initial disclosure of the news and can progress to a feeling of acceptance (Cook & Oltjenbruns, 1998:93). This means that an individual can move between a continuum of initial shock and complete acceptance.

In the development of the Stages Theory of Grief, various authors (Cook & Oltjenbruns, 1998; Maciejewski et al., 2007) emphasised that the various stages of grief were first identified by Bowley (Kubler-Ross, 2001). It was known as Bowly's theory and included four stages namely shock and numbness, yearning and searching, despair and disorganization and reorganization and recovery. Bolden (2007:235) emphasised that these stages can also be regarded as the reactions of a person to the loss. Kubler-Ross (2001) adjusted these four stages to five stages as it is still known today; namely denial and isolation, anger, bargaining, depression and acceptance. It is worth noting that, Cook and Oltjenbruns (1998:93) mention that these stages of grief do not necessarily present itself in the same order, but that a person, for example, could find themselves in the depression stage before they experience the anger stage. Since the aim

of the study, as mentioned already, was to gain an understanding of the grief process of fathers after a stillbirth in order to understand, the model of Kubler-Ross (2001) was used to guide this study of the grief process of fathers after a stillbirth.

1.5 CLARIFICATION OF TERMS AND CONCEPTS

1.5.1 Heartbroken

According to Buckle and Flemming (2011:4), the term heartbroken is closely related to the term grief. They further mention that the term heartbroken can be defined as the emotional reaction to the death of a loved one. In their study on grief, Buckle and Flemming (2011:4) mention that this term in this context refers to the cognitive, behavioural, physiological, social and spiritual reaction of a parent to the loss of a child.

1.5.2 Grief

According to literature (Buckle & Flemming, 2011:3), this term refers to the feeling that is experienced after loss. These authors emphasise that the terms refer to the interruption of a loving relationship by means of death. In a study by Modiba and Nolte (2007:5) this term is alternatively defined as the overall process that is unleashed by the loss of a child through death.

1.5.3 Stillbirth

According to the World Health Organization (WHO), stillbirth is a global phenomenon and they were necessitated to define it globally. According to the Lancet study of stillbirths, this term is defined as the death of a child of at least a birth weight of 1000 grams or gestation of 28 weeks.

1.5.4 Masculinity

Burns (1996:88) defines masculinity as the common norm that governs manly action and thoughts.

1.5.5 Experience

Experience is defined as the acquisition of knowledge through personal involvement with an event, situation or circumstances (Modibo & Nolte, 2007:5). For the purpose of the study, the research focused on the experience of fatherly grief after a stillbirth.

1.6 RESEARCH METHOD

1.6.1 Literature study

Babbie (2013:82-83) emphasises that there is a strong correlation between research and theory. He further mentions that the theory is presented as a framework for empirical analysis. Also De Vos, Strydom, Fouché and Delport (2011:109) argue that the theoretical framework can be used as indication of whether the proposed research would have any significance if it is compared with similar previous studies. Consequently, for the current study, existing literature and research were used as point of departure.

1.6.2 Research approach

De Vos et al. (2011) make mention of two research approaches namely qualitative and quantitative approaches that can be used for a research study. Supporting literature (Neuman, 2011:163) also identifies these two approaches as mentioned by De Vos et al. (2011), but suggest that it can be used combined or separately. Considering this, the researcher only used a qualitative research approach in the current study. This approach was used as the aim of the study was to gain insight into the phenomenon of grief rather than to explain the grief process of fathers. Furthermore, the research aimed at understanding the natural behaviour and responses of fathers rather than doing a controlled measurement as with a quantitative approach (De Vos et al., 2011:308).

1.6.3 Research design

A research study is normally characterised by many goals, but according to De Vos et al. (2011:95), there is always an overpowering goal that can be regarded as the motivation for the study. Of importance is that Mouton (1996:107) mentions that the research design can be regarded as the framework that guides the researcher in terms of processes that needs to be carried through. Considering that the aim of the study was to investigate the grief process of

fathers, an exploratory research design was used. De Vos et al. (2011:95) mention that exploratory research designed is aimed at developing insight into a phenomenon, situation, community or individual. Similarly, Babbie (2007:88) also states that the aim of the use of an exploratory research design is to answer the who and how questions in research. It is worth noting that Babbie (2007:88) mentions that exploratory research is executed to:

a) Satisfy the researcher's curiosity and desire to develop a better understanding;

b) Test the feasibility of a more comprehensive study;

c) Develop methods that can be applied in subsequent studies.

With reference to the above-mentioned reasons, as indicated by Babbie (2007:88) and the current study, the motivation for the study was to increase knowledge about the grieving process of fathers after a stillbirth. To complement this, a descriptive research design was also used as recommended by De Vos et al. (2011:96), because research designs should be used in addition to one another in order to gain optimal results in a similar study. The choice of research designs corresponds with the views of Peil (1982:11) who emphasises that a descriptive research design would give the results obtained by using an exploratory research design a more descriptive nature. Through the combined use of both research designs, the results of this study will consequently be more useful.

1.6.4 Sampling

Respondent accuracy, data validity and various ethical considerations are regarded as a few of the issues to be considered in research (Russell, 2013:127). In addition, Nachmias and Nachmias (1987:179) emphasise that the researcher should be aware, from the inception of the study, that the result cannot be generalised to the overall population. This will thus guide the researcher when a decision is being made regarding the sample. Russell (2013:127) indicates that a non-probability sample would fit best with the exploratory research design. In line with this, a non-probability sample was utilised for the study. For the purpose of this study, purposive sampling was selected since the sample was selected based on the judgement of the researcher (Bernard, 2000:176). To further justify the use of non-probability sampling for this study it is worth noting that, Gliner and Morgan (2000:154) mention that this type of sampling is aimed specifically at selecting participants who are able to provide information about a chosen topic.

The population for the study consisted of fathers who experienced a stillbirth and resided in the Western Cape and used the services of the three selected hospitals in the Western Cape Province. The following criteria for inclusion were the following:

a) The person must be male.

b) The person must as a father, must have experienced a stillbirth within their lifetime.

c) The person must, as a father, be fluent in either Afrikaans or English.

d) The person must reside within the Western Cape and make use of services at any of the three selected hospitals.

The researcher orientated the social workers at the three selected hospitals about the aim of the study and the selection criteria. The social workers subsequently identified potential participants and provided the researcher with their contact details. The researcher then made telephonic contact with them to find out if they are willing to participate in the study. An appointment was scheduled with those who were willing to participate at the most convenient time and place for them. Interviews were conducted with participants after informed consent was obtained from them prior to the commencement of the interviews.

The sample consisted of ten participants. After the eighth interview, the same themes and subthemes started to emanate indicating that saturation was reached. The researcher however pursued to interview ten participants. In support of this, De Vos et al. (2011:350) asserts that saturation is reached when there is no new information that is learnt by the researcher from participants.

1.7 METHOD OF DATA COLLECTION

1.7.1 Research instrument

A semi-structured interview schedule (**Annexure A1-Afrikaans and Annexure A2-English)** was used during interviews as the research instrument to collect data. According to Forcese and Richer (1973:160), an interview schedule is described as a method to gain information from participants involved in the study. Likewise, Bless and Smith (2000:104) mention that the use of such an instrument does not limit participants to respond to questions, because it allows them the freedom to share their own experiences. In order to ensure that the researcher remained

within the parameters of the ethical considerations, each participant was requested to sign an informed consent form (**Annexure B1-Afrikaans and Annexure B2-English**) to grant permission to participate in the study. The researcher also, through the informed consent form, obtained permission from the participants to record the interviews. The researcher recorded the interviews with a voice recorder and transcribed it afterwards. As De Vos et al. (2011:243) suggest the researcher ensured that the electronic equipment was tested prior to the interviews to prevent problems with validity and reliability.

1.7.2 Pilot Study

Barker (2003:327-328) defines a pilot study as "… a procedure for testing and validating an instrument by administering it to a small group of participants from the intended test population.". Based on the definition provided, the researcher conducted interviews with two participants to test the aforementioned selected data collection tool. The participants were recruited in the same manner as indicated above under the discussion on sampling. This pilot study showed that the questionnaire had to be adjusted as the initial one were too long and as a result, participants lost interest in the questions. In addition, some questions had to be reformulated as the participants did not understand them.

1.7.3 Method of data analysis

According to De Vos et al. (1998:100), the researcher is expected to clearly discuss how the data will be analysed. Therefore, the researcher analysed the transcriptions. Based on the views of Creswell (2003:191-195) the researcher analysed the transcriptions according to the following steps as presented in figure 1.1 below.

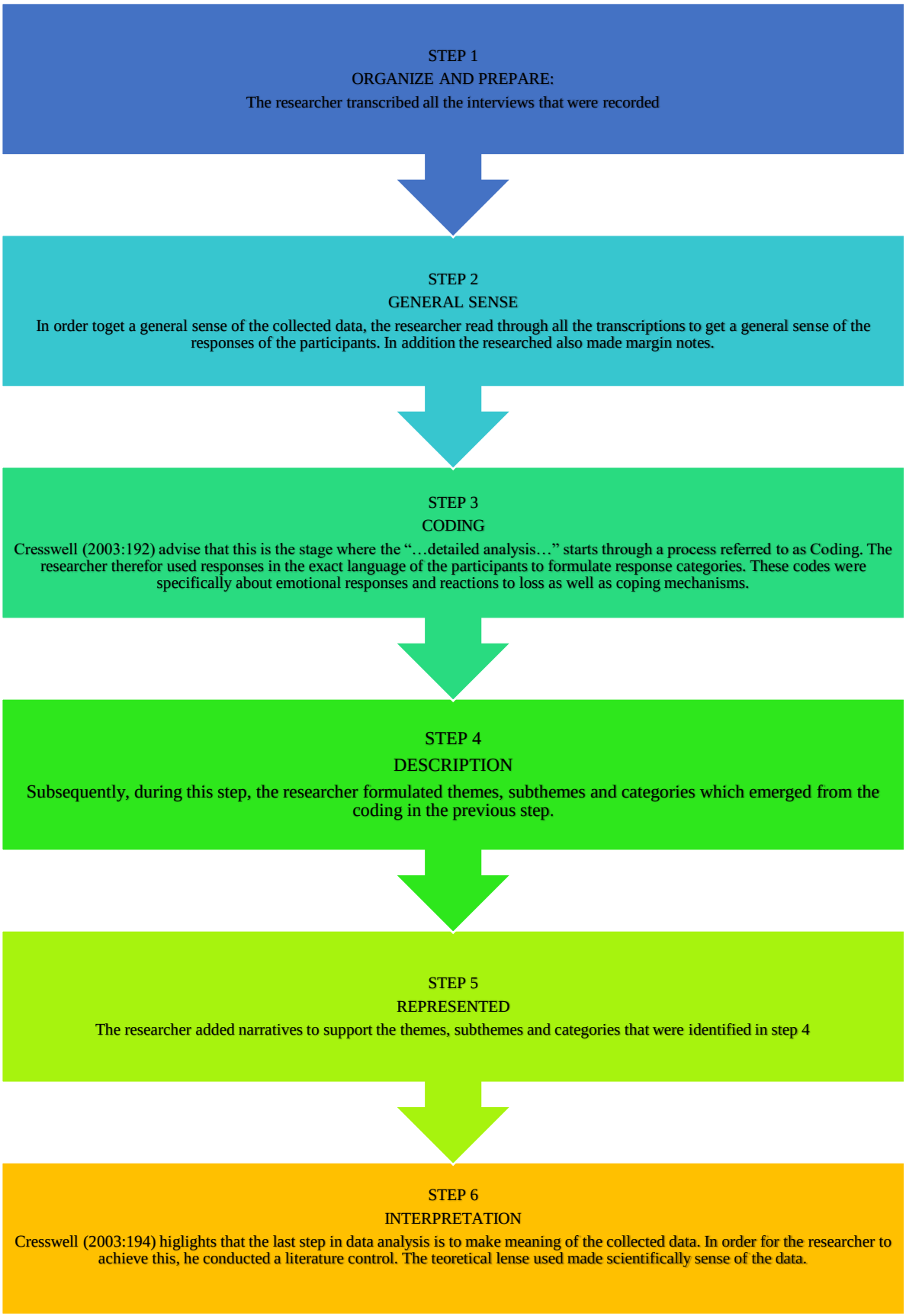

Figure 1.1: Steps in data analysis

Source: Creswell, J.W. (2003:191-195)

Subsequently, themes and subthemes were identified as well as categories that are supported by narratives from participants to give more validity to the collected data. The researcher then presented the findings in tables and figures (De Vos et al., 1998:204).

1.7.4 Method of data confirmation

Lincoln and Guba (Cited in De Vos et al., 2011:420) emphasised that the collected data should be confirmed to ensure the validity thereof. These authors highlight the following aspects that the researcher had to consider during the qualitative study:

1.7.4.1 Credibility

According to De Vos et al. (2011:420) credibility is aimed at demonstrating that the research was executed to ensure that the participants and the topic are described accurately. The researcher thus had to ensure that there is a relationship between the participant's view and the researcher's presentation of the investigation based on the results of the study. To further ensure credibility, the researcher contacted some of the participants after the empirical study for their feedback on the results. This action that is known as participant confirmation is regarded by Lincoln and Guba (Cited in De Vos et al., 2011:420) as one of the methods to confirm the credibility in qualitative research.

1.7.4.2 Transferability

De Vos et al. (2011:421) mention that the results of the study should be transferable. These authors acknowledge that the transferability and generalisation of a qualitative study's results can be challenging. To deal with this challenge, the researcher approached participants to participate in the study until saturation was reached.

1.7.4.3 Dependability

De Vos et al. (2011:421) emphasise that the dependability of the data is confirmed by ensuring that the research process flows logically and is well documented. Therefore, the researcher ensured that the collected data is presented in a logic and well-organised manner. Furthermore, supporting literature, scientific research articles, journals and books were consulted for compiling the literature study in order to further ensure the dependability.

1.8 ETHICAL CONSIDERATION

De Vos et al. (2011:421) argue that research should be based on mutual trust, acceptance, cooperation and promises between all parties involved with the research project. To concur, there is also reference to the ethical code of the South African Council for Social Services profession. Various authors (Hepworth & Larsen, 1982:19-21; Mattaini, Lowery & Meyer, 2002:381) are in agreement with one another when they note that certain ethical standards including dedication, right to self-determination, informed consent, privacy and confidentiality of clients, or specifically participants, must be in line with the ethical requirements as suggested by De Vos et al. (2011:113) during research.

In addition to the above, Mattaini et al. (2002:383) refer to the National Association for Social Workers (NASW) which states that the ethical principles of the organisation where the research will be conducted should also be taken into account. In view of the research that was conducted at three selected hospitals in the Western Cape the researcher was obliged to consult certain policy documents that govern service delivery and protects clients. One of these documents is the White Paper for the Transformation of Public Service. (Republic of South Africa, 1997) in which there is specific reference to the Batho Pele principles. These eight principles namely consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money, as indicated in the literature (Republic of South Africa, 1997:15) aim at guiding research and to protect participants.

In line with the provisions of these aforementioned policy documents, the researcher ensured that the collected data were stored on a password-protected computer, as well as in hard copy in a safe cabinet to ensure that only the researcher and the research supervisor had access to it. To further ensure that the researcher avoids the aforementioned ethical issues, he is registered as a Social Worker with the South African Council for Social Services Professions and as a result is bound by their ethical code. Mattaini et al. (2002:389) argue that registration with a professional board and abiding by an ethical code is not sufficient as an ethical code does not guarantee ethical behaviour. Considering this, the research proposal was first presented to the Departmental Ethics Screening Committee (DESC) of the Department of Social Work (Stellenbosch University) as well as the Research Ethics Committee of the University of Stellenbosch for approval as medium risk research where the only foreseeable risk was that of possible discomfort.

As soon as the researcher obtained ethical clearance from the Departmental Ethics Screening Committee (DESC) of the Department of Social Work (Stellenbosch University) and the Research Ethics Committee of the University of Stellenbosch (**Annexure C1**), he applied for further ethical clearance from the Western Cape Department of Health to execute the research (**Annexure C2**) in the three selected hospitals. In doing so the researcher further ensured the protection of the participants. This approval gave the researcher access to the register of stillbirths where fathers are involved at selected hospitals in the Western Cape. As already mentioned the social workers at the three selected hospitals were informed about the selection criteria and they identified potential participants. Following the identification of interests, the social workers informed them to the researcher who made telephonic contact and upon telephonic confirmation of interest, an appointment was scheduled at a time and place that was convenient for the participant. During the formal meeting, the participants were orientated regarding the nature of the study and their right to withdraw from the study at any given time. When the participant agreed to participate in the study, the participant was requested to sign the informed consent form (**Annexure B1-Afrikaans and Annexure B2-English**). Each participant was requested to sign two copies of which one was issued for them to keep and the other copy was reserved in a cabinet for safekeeping.

1.9 LIMITATIONS OF THE STUDY

This descriptive and exploratory research study was conducted with ten men who experienced a stillbirth in their capacity as fathers at three selected hospitals within the Western Cape Province. Due to the small sample size, the results, therefore, cannot be generalised to the male population who experienced a stillbirth in this province, South Africa and globally.

The results as indicated in chapter 4 would be of specific benefit for social workers and other multidisciplinary team members as it gives insight into an appropriate approach to follow when encountering fathers who have experienced a stillbirth in a clinical setting.

1.10 PRESENTATION

The consolidation of collected data and transferring the research findings can be regarded as the primary goal of research (De Vos et al., 2011:277). Should the researcher fail to present the findings and research plan in a scientific manner, De Vos et al. (2011) assert that there is no record of the research at all. In addition, De Vos et al. (2011) and Neuman (2011:543) explain

that the researcher could also consult other research reports for clues on how to present scientific research. In the presentation of the research in written form, Grinnel and Unrau (2005:432) argue that the researcher should caution against the advice of Nueman (2011:543) as the proposed research report should be compiled with a specific audience in mind. In accordance with the above-mentioned guidance from various authors, the research is presented in the following chapters:

Chapter 1: This chapter is regarded as the introduction to the study as it consists of a synopsis of what the researcher planned and how the research was executed. This chapter is primarily focused on the research method and research approach. The aim and objectives, ethical considerations and the possible limitations related to the study are also clearly discussed in this chapter. The researcher regarded this chapter as his research plan.

Chapter 2: The aim of this chapter is to examine the prevalence of stillbirths as a medical phenomenon. In addition, the chapter also presents a discussion of the causes and consequences of stillbirths.

Chapter 3: The focus of chapter three is on the grief process in general, as well as specifically on the father's experience of the grief process after a stillbirth as explained by relevant theories.

Chapter 4: This chapter presents the collected and analysed data obtained from the empirical study. This is achieved through the presentation of themes, sub-themes as well as categories that are supported by narratives of the participants. In further support of the findings, literature control is provided.

Chapter 5: This chapter presents the conclusions and recommendations based on the findings presented in chapter four.

CHAPTER 2

THE NATURE, RISK FACTORS AND SOCIAL CONSEQUENCES OF STILLBIRTH

2.1 INTRODUCTION

Stillbirth is regarded as the "most devastating adverse outcome associated with pregnancy …" apart from maternal death (Matjila, 2016:17). Furthermore, stillbirth is a catastrophe that affects not only the couple experiencing the loss, but also the extended family. In addition, the experience of stillbirth can have various psychological effects including "… depression, anxiety, post-traumatic stress disorder and a breakdown in personal relationships" (Matjila, 2016:17). It is worth noting that Bateman (2011:364) compares this medical phenomenon to an invisible earthquake as it is challenging to measure the cause due to a lack of accurate data about it. As Chapter 1 indicates, this chapter will focus on achieving the first objective indicated for this study. Hence, it would provide an exploration of the nature, and causes of stillbirth as medical phenomenon with specific identification of the risk factors. The chapter will also investigate the social consequences that this phenomenon has for the family, parents and other siblings.

2.2 THE PREVALENCE OF STILLBIRTHS

Kayode, Grobee, Amoakoh-Coleman, Adeleke, Ansah, De Groot and Klipstein-Grobusch (2016:1) emphasise that stillbirth has a higher prevalence "… in middle to low income countries …". These authors, (Kayode et al., 2016) furthermore, argue that approximately "… 3 million stillbirths occur annually …" "… with 98% in low and middle income countries …". Like Bateman, (2011:364), Kayode et al. (2016:1) also highlight that, due to the lack of accurate data on stillbirths globally, its rate has been underestimated over the years. Therefore, it is thus worth noting that Matjila (2016:17), explains that this is due to the inconsistency in the definition that excludes stillbirth occurring after 22 weeks or before 28 weeks of gestational age in the data thereof.

Furthermore, Bateman (2011:366) draws attention to data from a Lancet study that 42% of deliveries locally happens at district hospitals, 30% at regional hospitals, 17% at community health centres and 11% at tertiary hospitals. Furthermore, research indicates that despite high

levels of antenatal care and deliveries by a skilled birth attendant, there had only been a 0.7% decline in stillbirth since 1995. It is also evident from the Lancet study that the high stillbirth rate in South Africa can be contributed to the lack of early detection of risk factors and access to health facilities (Bateman, 2011:366). It is evident from the aforementioned that research about stillbirth remains a challenging health phenomenon that is underrated.

2.3 DESCRIPTION OF STILLBIRTHS

In order to understand the causes of stillbirth as a medical phenomenon, it is imperative to define it first before exploring the possible causes or risk factors. Matjila (2016:17) mentions that according to the World Health Organization (WHO), stillbirth is defined globally as "… a baby born with no signs of life at or after 28 weeks gestation …", with a "birth weight of more than 1000 grams or less than 35 centimetres in body length".

Despite this definition of stillbirth that could assist with the classification thereof, Eng, Karki and Trivedi (2016:754) draw attention to approximately 17% to 50% of stillbirths that is still unexplained globally. They, furthermore, explain that many stillbirths are classified as unexplained as they have either been poorly investigated or lack pathological explanations. Penn, Oteng-Ntim, Oakley and Doyle (2014:1) share the views of these authors, as they acknowledge that "… identifying the causes of stillbirth can be challenging due to the plurality of the classification system …" which resulted in many "… cases often going unexplained". As a result, some authors (Eng et al., 2016:754) support the notion that research has shifted to investigating the risk factors associated with stillbirth rather than the causes. Hogberg and Cnattingius (2007:699) also maintain that, although stillbirth rates in developed countries are approximately only "… 3.4 per 1000 live births …", when it occurs it is reported to be associated with "… great emotional distress for the parents". As a result of this, similar to the views cited above, Hogberg and Cnattingius (2007) assert that a lot of efforts should be devoted to investigating the risk associated with stillbirth.

These risk factors will be explained in the section below:

2.4 RISK FACTORS ASSOCIATED WITH STILLBIRTHS

In seeking to understand the risk factors associated with stillbirth, various risk factors have been proposed by various authors.

2.4.1 Smoking

Marufu, Ahankar, Coleman and Lewis (2015:1) observed that smoking in pregnancy is regarded as a major public health issue in many developed countries which might soon reach a stage of epidemic proportions in developing countries, according to the predictions of the World Health Organization (WHO) (Marufu et al., 2015:1). It is argued that smoking during pregnancy imposes a significant burden on population health and resources in an already challenging economic climate, and is associated with a range of poor outcomes for the mother and child, including stillbirth.

The first risk factor associated with stillbirth is women who smoke during pregnancy. Odendaal, Steyn, Elliott and Burd (2009:1) explain that preterm labour occurs more frequently in women who smoke cigarettes during their pregnancy. These authors also argue that smoking could result not necessarily in stillbirth, but could lead to medical complications such as placental abruptions and intrauterine growth restriction that would, in any case, lead to stillbirth. Similarly, Eng et al. (2016) maintain that stillbirth is commonly linked to intrauterine growth restriction and placental insufficiency.

Torpy, Lynm and Glass (2005:1286) maintain that smoking during pregnancy is particularly dangerous as the "… developing …" fetus in the "… mother's womb is in contact with the mother's bloodstream …"; this result in the fetus sharing "… any chemicals the mother breathes …" in and ingest, placing the fetus in direct risk of demise. Therefore, these authors (Torpy et al., 2005:1286) also emphasise the inclusive dangers of secondary smoking.

In addressing risk factors, Aliyu, Salihu, Wilson, Alio and Kirby (2008:39) emphasise advanced maternal aged women associated with smoking during pregnancy as an even greater risk of stillbirth, compared to their younger counterparts. These authors (Aliyu et al., 2008:) found in a study which examined the risk of stillbirths in smokers of advanced maternal age, that the risk of stillbirths were three times higher in women older than 35. To support this, Aliyu et al. (2008:43) explain that in older women the utero-placental vasculature fails to adapt sufficiently to the increased demands of pregnancy. In addition, nicotine in tobacco smoke is associated with a reduction in umbilical blood flow to the fetus. Another explanation for this is that older women might have longer cumulative years of exposure than younger counterparts; therefore, there is a greater likelihood of having chronic vascular disease or being more sensitive to vaso-constrictive effects of toxins in cigarette smokes (Aliyu et al., 2008:43). Additionally, Marufu

et al. (2015:12) noted in a systematic review of 29 research papers on the effects of smoking on the risk of stillbirths, that three studies shown the risk of stillbirth being higher in mothers younger than 15, as well as older than 35, respectively. It was also noted that a study from Sweden proved that placental abruption causing stillbirth is likely to be more common in smokers (Marufu et al., 2015:12). It is evident from the outcome of these studies that the effects of smoking on the risk of stillbirth is not necessarily higher in a specific age group, but that it has a probability to have such outcome, despite the age. Likewise, Hogberg and Cnattingius (2007:699) assert that there is no uncertainty regarding the risk of smoking on stillbirth as it "… has repeatedly been associated with stillbirth …".

In contrast, it is argued that the risk of stillbirth generally increase with the amount of cigarettes being smoked (Hogberg & Cnattingius, 2007:699). To demonstrate this, Wisborg, Kesmodel, Brink Heriksen, Frodi Olsen and Secher (2001) found that a risk of stillbirth in mothers who stopped smoking during the first trimester, was comparable to the risk among women who were non-smokers during the entire pregnancy. Equally important is that Hogberg and Cnattingius (2007:700) found that where smoking pregnant women who experienced a stillbirth in a previous pregnancy, the risk to experience another stillbirth in the following pregnancy almost doubled.

In addition, Kitsantas and Christopher (2013:310) maintain that smoking can result in various respiratory conditions in the pregnant female, which include asthma, acute repertory infection and pneumonia, amongst others. Asthma is identified as "… the most common potentially serious chronic respiratory problem to complicate pregnancy …" as it "… affects 6% to 8% of women" (Kinsantas & Christopher, 2013:310). In further support of this view, studies have shown that women with respiratory conditions are "… 1.55 times more likely to experience …" stillbirth, "… and 2.20 times more likely to have …" premature rupture of membranes than non-smokers with no respiratory conditions (Kitsantas & Christopher, 2013:312).

In order to prevent stillbirth, it is recommended that smoking females with associated respiratory conditions are prioritised early in the pregnancy, as it is clear from the results from the aforementioned studies that there is undoubtedly a causal relation between smoking and stillbirth risk.

2.4.2 Advanced maternal age

The second risk associated with stillbirth is the advanced maternal age of pregnant women. According to Mutz-dehbalai, Scheier, Jerabek-Klestil, Branter, Windbichler, Leitner, Egle, Ramoni and Oberaigner (2014:50) "… women older than 40 years carry an increased risk for a stillbirth". They observed that women "… in industrialised countries …" "… delay reproduction …" until they are at an advanced age that makes them prone to adverse pregnancy outcomes like stillbirth. Furthermore, Arnold, Beckmann, Flenady and Gibbons (2012:286) state that "… the number of pregnancies in women older than 35 has increased …" over a number of years with approximately 6%. Research also showed that the "… percentage of first births …" have almost doubled "… in this age group …" as well (Arnold et al., 2012:286).

According to Waldenstrom (2016:235), this risk can be rather problematic for parents as it will decrease their chances of actually becoming parents. It is evident from Waldenstrom's argument that should parents postpone reproduction till an advance maternal age, they may make themselves vulnerable to an increased risk of stillbirth. Consequently Mutz-dehbalai et al. (2014:51) assert that research should be used to advise parents about the risk of reproduction at an advance maternal age and the associated increased risk of stillbirth.

It is worth noting that after conducting a study on the impact of advanced maternal age on stillbirth, Waldenstrom (2016:238) found that it poses less of a risk for parous women who have their following pregnancy in advanced age; possibly due to physiological adaptation during the first pregnancy, compared to women who have their first pregnancy in advanced age. The same study also showed that the risk of stillbirth increased by 25% in ages 25 to 29 and almost doubled at age 35 (Waldenstrom, 2016:238). Furthermore, Arnold et al. (2012:286) explains that despite other modifiable risk factors such as maternal obesity and smoking, "… advanced maternal age …" remains and "… independent risk factor …" for stillbirth follows. Likewise, Huang, Sauve, Birkette, Fergusson and van Walraven (2008:165) assert that when reviewing advanced maternal age in pregnancy, stillbirth is the most "… adverse pregnancy outcome …" of concern. These authors emphasise that women delay reproduction as they do not understand that it could lead to stillbirth. In addition to this, they also explain that research on the risk of advanced maternal age on stillbirth has led to inconsistent results. Similarly Kenny, Lavender, McNamee, O'Neil, Mills and Khashan (2013:1) note that "… there is limited consensus among …" research as to "… the precise maternal age when the increase in the risk of stillbirth would become clinically important". However, after taking into account the various study outcomes,

Kenny et al. (2013:1) state that the association of age with stillbirth generally becomes significant from age 35 and older. According to Mutz-dehbalai et al. (2014:54), this inconsistency in the risk of advanced maternal age on stillbirth can be attributed to, amongst others, the "… differences in study designs …" used, difference in "… perinatal mortality …" definition and "… using different cut-off values for maternal age".

As a result of these different views, Walker, Bradshaw, Bugg and Thornton (2016:86) conducted a study to determine "… whether particular causes of stillbirth are more common in women …" of advanced maternal age or not. These authors found that women of advanced maternal age are more likely to have a stillbirth due to major congenital anomalies (including issues related to central nervous system, respiratory system, urinary tract and cardiovascular system), maternal disorders (including pre-existing hypertension, diabetes, drug misuse) and associated obstetric factors (including birth trauma, premature labour, asphyxia and premature rupture of membranes). In addition to these findings, it was also concluded that of the 2,850 cases of stillbirths examined, the rate of stillbirth in women older than 35 "… was 4.0 in every 1000 births …" compared to the "… 3.5 in every 1000 births in women …" younger than 35 (Walker et al., 2016:87).

Before further discussing advanced maternal risk, Sauer (2015:1136) draws attention to the importance of defining advanced maternal age. This author explains that this term in medicine has evolved over the years as it related to women in the 1980's, who fell pregnant over the age of 35. Sauer (2015:1137), furthermore, explains that despite the use of this term in the 1980's, it was still "… uncommon to deliver a patient …" in this age group. However, as already alluded, due to an increase in the prevalence of women over the age of 35 who are pregnant, the term evolved to also include women in the 40 to 45 years age group, and even older (Sauer, 2015:1137). Consequently, the descriptive term of "… very advanced …" maternal age was added to differentiate between the very old women and the "… less than old …", yet elderly women (Sauer, 2015:1137).

As a result of advanced maternal age, these females would generally present with various medical conditions that places them at a higher risk of stillbirth. This is also clear from the research findings by Waldenstrom (2016:238) that ageing affects the human egg and other vital organs. Further, it was observed that advanced maternal age can also result in a decline in progesterone (Waldenstrom, 2016:238). Similarly, Heffner (2004:1928) explains that females of advanced maternal age experience menopause; and as a result, spontaneous conception is

lower. In summary, it is evident from research presented in this discussion that reproduction in advanced maternal health in itself exacerbates the existence of other associated medical risk factors for stillbirth. As a result, Sauer (2015:1138) strongly advices that delayed child bearing at an advanced age should be promoted with guarded optimism because it holds risks for both the mother and expected child.

2.4.3 Substance use during pregnancy

The third risk associated with stillbirth is substance use during pregnancy. Two specific substances that will be discussed as risk factors below are drugs and alcohol.

2.4.3.1 Drugs

"Drug abuse has major social and medical implications in pregnancy …" (Tangappah, 2000:597). Thangappah (2000:597) explains that a woman is considered "… to be a drug user" for the purpose of this discussion "… if she had used heroin, methadone, cocaine, amphetamine or any other addictive drugs any time during the pregnancy".

In a study conducted to determine the maternal and neonatal outcome in women abusing drugs, it was found that drug abuse is a prevalent issue globally (Tangappah, 2000:597). As a result of this, substance use during pregnancy made obstetricians even more concerned as statistics in the UK showed that "… 90.7% of female drug abusers …" presented to health care facilities are females of reproductive age (Thangappah, 2000:597). Likewise, Mayet, Groshkova, Morgan, MacCormack and Strang (2008:497) also note that "women account for approximately one third of all illicit substance users". Moreover, Mayet et al. (2008:497) state that substance use during pregnancy could result in complications such as "… low birth weight with increased associated neonatal mortality", like stillbirth.

It is worth noting that due to "… the chaotic lifestyle, drug-using women are frequent defaulters …" of antenatal clinic visits (Tangappah, 2000:599); others who do make the effort to attend antenatal clinics, either book late or fail to disclose substance use during the pregnancy (Tangappah, 2000:599). As a result, these women are at an even greater risk of stillbirth as medical staff is unable to treat them with the necessary caution to prevent adverse pregnancy outcomes such as stillbirth.

In further demonstration of the positive outcome of early disclosure and intervention with drug-using females during pregnancy, Mayet et al. (2008) report that a study conducted with 114 pregnant females showed that only two babies were stillborn as a result of prematurity at 31 and 33 weeks of gestation, respectively. Although these authors claim that all drugs are harmful for the mother and baby, Tangappah (2000:599) emphasises that the use of cocaine specifically results in the abruption of the placenta due to "… vascular damage …" caused to it "… following withdrawal …". In addition, it can result in death of the pregnant female due to myocardial infarction, respiratory arrest and intracranial haemorrhage. Thangappah (2000:599) asserts that drug use generally takes priority over the health and wellbeing of the pregnant female and the unborn fetus; and, as a result, they would rather spend money on substance than on food. This result in malnutrition and associated genital infection that are in return possible causes of prematurity.

2.4.3.2 Alcohol

Bailey and Sokol (2011:86) note that, despite great emphasis on "fetal alcohol syndrome and fetal alcohol spectrum disorder, prenatal alcohol exposure …" could be "… associated with many other adverse pregnancy outcomes" such as stillbirth. These authors highlight that vast research exists that suggests the increased risk that alcohol use during pregnancy leads to stillbirth.

Bailey and Sokol (2011:88) emphasise that stillbirth as a pregnancy outcome may occur more frequently in those who consume alcohol during pregnancy. The amount of alcohol consumed and the relational effects on pregnancy outcomes have been inconclusive in studies. In earlier studies Burd, Roberts, Olsen and Odendaal (2007:370) found that consumption of "… 14 or more drinks per week …" was associated with the risk of stillbirth. Other studies found that alcohol intake of more than 5 drinks per week led to a threefold increase in stillbirth (Kesmodel, Wisborg &Olsen, 2002). However, more recent research by Aliyu, Wilson and Zoorob (2008) found a statistically significance of 40% risk of stillbirth in more than 600 000 births for women who consume any amount of alcohol, compared to those who do not consume alcohol. Burd et al. (2007:370), thus, assert that "… fetal distress during labour …" are more prevalent in "… women who abuse alcohol during pregnancy". It is evident that a risk factor for stillbirth is exacerbated by excessive alcohol.

Similar to drug abuse, Bailey and Sokol (2011:86) emphasise that females using alcohol during the pregnancy either deny the use thereof or "… underreport the amount that they drink". According to these authors, this can be attributed to the increased "awareness of the dangers" of alcohol use "… during pregnancy and the consequent social stigma …" (Bailey & Sokol, 2011:86). In an attempt to provide statistics about this, Burd et al. (2007:361) report that "of the 4 million annual pregnancies in the USA, 40% of women drink some …" amount of alcohol. This "… translates to 500 000 …" of the 4 million "… women drinking at least weekly and …" approximately "… 80 000 with …" persistent "… high levels …" of "… exposure throughout pregnancy" (Burd et al., 2007:361).

Bailey and Sokol (2011:89) further illustrate that various studies undoubtedly show that prenatal exposure to alcohol has a strong association "… with placental dysfunction, decreased placental size, impaired blood flow and nutrient transport and endocrine changes", any of which could play a detrimental role in stillbirth. Worth noting is that Burd et al. (2011:371) report that studies did not find one "… alcohol beverage …" to "… be more harmful than another". As a result, it is conclusive that all forms of alcohol are associated with a risk of stillbirth.

2.4.4 Maternal obesity

The fourth risk associated with stillbirth is maternal obesity. Similar to the abovementioned risk factors, obesity is also regarded as a "… public health problem …" that is associated with risk for stillbirth and other adverse pregnancy outcomes (Kristensen, Vestergaard, Wisborg, Kesmodel and Secher, 2005:403). Furthermore, Leung, Leung, Sahota, Chan, Chan, Fung and Lau (2008:1529) state that this public health problem likewise "… extended to the pregnant populatio".

The Word Health Organization (WHO) classify normal body mass as between 18.5 and 25.9, overweight between 25 and 29.9, obese between 30 and 39.9 and morbidly obese a mass of more than 40 (Basu, Jeketera and Basu, 2010:101). Statistics in South Africa shows that 56.6% of the female population were obese in 2010 (Basu et al., 2010:101).

Kristensen et al. (2005:403) acknowledge that obesity in pregnancy is associated with "… a higher frequency of pregnancy complications". In a study conducted in Denmark on the effect of obesity on the risk of stillbirth, it was found that "… 10.5%" of the female participants were found to be overweight and "… 3.9% as obese" (Kristensen et al., 2005:405). The results,

furthermore, prove that "compared with women of normal weight …", the risk of stillbirth in "… children of obese women almost doubled". The results of the study also suggest that apart from being at high risk of experiencing a stillbirth, obesity in pregnant females also pose vulnerability in other aspects of their lives as it was reported that these women had "… no partner, no job, less than 10 years of schooling, smoked more than 10 cigarettes per day and were multiparous" (Kristensen et al., 2005:405).

In a similar study, Yu, Teoh and Robinson (2006:1121) have also learnt that the risk of stillbirth increased three-fold in morbidly obese women. This study attributes the increased risk to the "… rapid fetal growth induced by endogenous hyperinsulinemia in obese women". In addition, obesity also results in a limited functionality "… of the placenta …" in transferring a sufficient amount of oxygen "… to meet the requirements of the fetus …" which "… may lead to hypoxia and death" (Yu et al., 2006:1121). Ditchfield, Desforges, Mills, Glazier, Wareing, Mynett, Sibley and Greenwood (2015:557) refer to this excessive fetal growth as macrosomia. These authors (Ditchfield et al., 2015:557) argue that a successful pregnancy is dependent on appropriate development and function of the placenta to ensure adequate delivery of oxygen and nutrients from the mother to the fetus. However, due to maternal obesity that results in pre-eclampsia (a condition that is marked by high blood pressure in pregnant women who have previously never experienced high blood pressure and high levels of protein in urine). This is directly associated with placental dysfunction, obesity is a risk for stillbirth through placental complications (Ditchfield et al., 2015:558).

Apart from this direct risk associated with the pregnancy, Leung et al. (2008:1532) state that obesity also imposes challenges during the labour that places further increase on the risk of stillbirth compared to women of normal body mass. To demonstrate this, Fitzsimons, Modder and Greer (2009:52), have found in their study on this issue that obesity is associated with increased intrapartum complications. The authors have also noted a poor labour progression in these women. As a result of the associated fetal distress and risk of stillbirth or neonatal death, birth attendants often resort to an emergency caesarean. Due to the rapidly growing rate of obesity, and specifically morbidly obese, pregnant women, and the associated risk of stillbirth as adverse pregnancy outcome in South Africa, researchers have urgently called for more clear guidelines on weight gain and management protocols of obesity during pregnancy (Basu et al., 2010:103).

2.4.5 Maternal hypertensive disorder during pregnancy

The last risk associated with stillbirth is maternal hypertensive disorder during pregnancy. Hypertension in pregnancy has already been touched on in the previous discussion as its risk to adverse pregnancy outcomes overlap with the aforementioned risk factors, as well. However, despite various identifiable maternal medical conditions "… hypertensive disorder …" is "… one of the major causes …" and risk factors "… of maternal and fetal morbidity and mortality …" (Coletta & Simpson, 2010:607). In providing context for this risk factor, Seyom, Abera, Tesfaye and Fentahun (2015:1) indicate that "… hypertensive disorder …" normally "… manifest after 20 weeks of gestation …". With reference to the definition of stillbirth, provided earlier in this discussion, it is clear that this condition surface during the gestation that is linked to the defining gestation of stillbirth, making it of great danger to the pregnancy outcome.

It is worth noting that Seyom et al. (2015:1) describe hypertension as a "… blood pressure …" reading of "… at least 140mm Hg for systolic and /or 90 mm Hg for diastolic on at least two occasions at least four to six hours apart …". This is applicable for pregnant "… women known to be normotensive beforehand". Severe hypertension, on the other hand, is described as the sustained rise in blood pressure to the level of more than 160 mm Hg for systolic and/or 110 mm Hg for diastolic (Allen, Joseph, Murphy, Magee & Ohlsson, 2004:2).

In providing evidence of the risk that hypertensive disorder imposes for stillbirth, Allen et al. (2004) conducted a study on the effect of hypertensive disorder on stillbirth in 135,466 pregnancies in Canada between 1988 and 2000. The results of this study are suggestive of a clear association of hypertensive disorder as a risk for stillbirths. The results, thus, prove that women with any form of hypertensive disorder are 1.4 times more likely to have a stillbirth and women with pre-existing hypertension are 3.2 times more likely to have a stillbirth, compared to normotensive women (Allen et al., 2004:5).

Worth noting is that certain authors (Colletta & Simpson, 2010:608) are rather optimistic about this risk factor as it is mentioned to be much more manageable "… as a result of improvements in medical and obstetric care". However, it is emphasised that the successful management thereof and successful pregnancy outcome is subjected to early detection, proper diagnoses and treatment through the regular attendance of "… antenatal visits …" (Colletta & Simpson, 2010:608). Despite this optimism, Seyom et al. (2015:1) is still of opinion that "following the drama of hypertensive disorder during pregnancy, 12% to 22% of all pregnancies have a tragic

story". In support of this opinion, they note that an occurrence of convulsions in addition to hypertension which result in pre-eclampsia is not only a matter of terror for the mother, but also for the fetus. To worsen this risk of pre-eclampsia for stillbirth, Seyom et al. (2015:2) argue that "… poor antenatal care, illiteracy, lack of awareness and poverty in developing countries continue to favour these nightmares of pregnant …" women even more.

From the discussion above, it can be noted that the identified risk factors undoubtedly can be associated with stillbirth. It is clear from the research that the decline in stillbirth does not only require medical intervention, but also drastic lifestyle changes on the side of the pregnant women.

2.5 SOCIAL CONSEQUENCES OF STILLBIRTH

Evidently, from the discussion above, stillbirth can have devastating effects on the parents and those around them when it occurs as a result of these risk factors. The discussion below would elaborate on the manner in which the various systems are affected.

2.5.1 Consequences for the family system

The first system affected is the entire family. In seeking to understand the severe effect of stillbirth on the family, Callister (2006:227) draws our attention to the meaning of the word pregnancy. The author explains that pregnancy in Spanish means full of life, light and promise for the expectant family. As a result of the occurrence of stillbirth and loss, it may be perceived by families as a failure to provide for the future and an inadequacy in fulfilling the basic role of procreation (Van Dinter & Graves, 2012:901).

De Montigny, Beaudet and Dumas (1999:151) acknowledge that the loss of a child through death is a tragic event that has an effect on the whole family. These authors (De Montigny et al., 1999:151) argue that life would "… never be the same for these families …" as "… death is not the expected outcome of pregnancy", because parents and medical staff expect a normal labour and delivery (Van Dinter & Graves, 2012:900). Following this traumatic experience "… family members …" are advised to recognise their own grief process after the loss, and "… devise new …" methods of functioning (De Montigny et al., 1999:151). Furthermore, Van Dinter and Graves (2012:900) note that adverse pregnancy outcomes such as stillbirth can

trigger anxiety as parents find ways to cope with it. Consequently, this anxiety causes fear as the family adjust (Van Dinter & Graves et al., 2012:900).

Of importance is that it is suggested that traditional models of grief focused more on the notion of letting go while contemporary models place great emphasis on holding on to the emotional relationship with the child that has been lost (Callister, 2006:227). In addition to this, Van Dinter and Graves (2012:901) also place great emphasis on the fact that there is no single correct response to perinatal loss, but that parents and families should be allowed to decide what feels right for them. In further illustration of the consequences of stillbirth on the family, De Montigny et al. (1999:151) cited a study which showed "… that when a family encounter severe difficulty in one dimension of family functioning, it can …" be expected "… to have difficulties in other areas". These authors assert that this is as a result of the "… interrelatedness …" of "… dimensions …" such as "… communication …", "… response, and problem resolution", amongst others. In support of this, Schwab (1992) emphasises that a rupture in communication can result in a rupture of the couple's sexual relationship also.

Moreover, De Frain, Jakub and Mendoza (1992) emphasise that the effect of stillbirth on the grandparents should not be forgotten. Research conducted by them (De Frain et al., 1992) showed that "… grandparents grief for their grandchild …" as well as "… their child". The same study also proves that grandparents experience an immense feeling of failure as parents as they feel that they are "… unable to protect their children from such pain …" following the loss of a child. Likewise, Callister (2006:229) reported that, according to her study, grandparents responded with narratives such as "she cries for her child and I for mine".

Extended family members often do not know "… how to react to parental grieving", and it often results in avoidance of the topic or making comments that "… diminish the intensity of the loss" (De Montigny et al., 1999:153). This, in return, results in parents isolating themselves and consequently the "… disruption of family ties …" (De Montigny et al., 1999:153). Furthermore, Callister (2006:228) argues that when a child dies, perinatal loss represents the loss of the role of motherhood and the symbolic loss of fatherhood since parenthood is regarded as a developmental task. Looking at the effect stillbirth has on the other siblings, Murphy and Cacciatore (2017:130) found in their study on the effect of stillbirth on families that siblings not only mourn the loss of the baby, but also the "… previous relationship with their …" mourning parents who became emotionally unavailable to them.

These authors (Murphy & Cacciatore, 2017:132) indicate that stillbirths also have an economic impact as parents "… return to work out of financial need rather than legitimate readiness to re-join the workforce". This then results in being unproductive which can have a negative ripple effect on the economy (Murphy & Cacciatore, 2017:132).

Based on the discussion above, it is clear that the occurrence of stillbirth affects the whole family. The specific implications for the parents and siblings will be discussed in more detail below.

2.5.2 Consequences for the parents

The second system that is affected is the parents. According to Lindgren, Malm and Rädestad (2014:337) when a baby demises during pregnancy, "… the first encounter between mother and child occurs when the baby is already dead". Leonard, Bower, Petersen and Leonard (2000) emphasise that such a meeting can be characterised with feelings of emptiness and unpreparedness of the sad reality of death and loss.

Vance, Najman, Thearle Embelton, Foster and Boyle (1995:933) point out that any perinatal loss is synonymous with the development of a wide range of mental health issues, "… ill health, altered relationships …" and the "… roles within families". The loss of a child through stillbirth is reported not only to present "… a physical absence, but also a psychological presence …" of the baby lost (Lang, Fleiszer, Duhamel, Sword, Gilbert & Corsini-Munt, 2011:184). This often results in difficulty for couples "… to define the loss and …" make sense of "… the experience" (Lang et al., 2011:190). In addition to this, it also results in questioning "… what did we lose?" "Was it a baby or …" fetus? "Are we parents or not?" (Lang et al., 2011:190).

Before examining the effect that the stillbirth has on the parents or couple, Lang et al. (2011) places great emphasis on the consideration of the environment in which these parents grief. In support of this view, Cooper (1980:66) found in her study on parental reaction to grief, that parents felt, what is being referred to as, a "… 'wall of silence' …" in "… medical, family, social and employment situations …" following a stillbirth. This, evidently, can result in a greater experience of isolation by the couple as they feel that their grief was misunderstood by family, friends, colleagues and the broader society (Cooper, 1980:65). Lang et al. (2011); thus, acknowledging that these parents experience disenfranchised grief as it is not acknowledged by society. Consequently, some authors (Cooper, 1980; Lang et al., 2011) attribute the difficulty

in grieving the loss of a stillborn baby to society's dismissal of an unborn life. Likewise, Lang et al. (2011:184) assert that bereaved parents may find it difficult to reconcile their "… intense feelings with society's lack of validation", but recognise that this will further "… intensify, interrupt …" or confuse the "… healing process".

Studies, furthermore, show that parents expressed difficulty in "… re-establishing social relationships …" after the occurrence of the stillbirth as "… the word 'stillbirth' …" is viewed as "… blocking any real communication with friends who were trying to be sympathetic" (Cooper, 1980:66). It was noted that parents also perceived the "… societal ostracism …" as "… both unexpected and painful …" while the "… emotional distress …" associated with the loss was experienced as acute (Cooper, 1980:67). Lang et al. (2011:192) attribute this to the lack of understanding by family, friends and society in general about "… perinatal loss and …" failure to recognise it as being significant or painful compared to other forms of loss. Friends and colleagues often do not know how to respond to the grief and were reported to be very supportive initially, but expected things "… to get back to 'normal' " soon (De Montigny et al., 1999:153).

Studies showed that these experiences by parents were further worsened by health professionals' perceptions that their loss was insignificant to them through the use of medical terms such as "… spontaneous abortion, miscarriage or fetal tissue …" when describing the parent's loss (Lang et al., 2011:191). Moreover, research conducted by Lang et al. (2011:188) observed that upon the existence of stillbirth, parents experience an overwhelming sense of "… ambiguity …" that stems from "… viability of the pregnancy …", the physical process of losing the pregnancy, arrangements for the remains of the baby and sharing the news of the loss. In cases where the loss were confirmed in utero, couples were informed to return home and await the passing of the demised baby (Lang et al., 2011:188). This evoked fear in these couples as they were not orientated by medical staff regarding what to expect and felt that this insensitivity prolonged "… the grief …" and "… suffering". (Lang et al., 2011:189).

In addition to the challenging environment in which parents' grief after a stillbirth, Cooper (1980) draws attention to another area of parents' functioning being affected. Studies conducted by her indicate that stillbirth is regarded as a crisis for the parents that affect the marriage. Likewise, Meyer and Lewis (1979:361) assert that couples are generally extremely "… vulnerable …" after a stillbirth. In acknowledgement of aforementioned arguments that parents isolate themselves due to the invalidity of society, these authors (Meyer & Lewis, 1979)

emphasise that parents then resort to supporting one another. It is suggested that since parents often blame themselves for the loss, stillbirth would become a result of sexual intercourse for such couples, making it extremely difficult to enjoy and giving rise to more feelings of guilt.

Moreover, Stinson, Lasker, Lohman and Toedter (1992) argue that the gender differences in response to the grief might aggravate the effect on the marriage. These authors emphasise that it should be noted that "gender stereotypes portray women as more emotional and men as stoic and unemotional …" (Stinson et al., 1992:218). According to Stinson et al. (1992:219), this results often in the couple experiencing incongruent grieving which "… may lead to misunderstanding and …" tension between them at a time when they feel "… misunderstood by and isolated from others". In as much as Cacciatore, De Frain, Jones and Jones (2008:363) hold the view that stillbirth imposes a risk for the marriage, they also emphasise that it holds "… great opportunity …" to strengthen the marital dyad. These authors further argue that "some risks are inherent when …" the "… establishment of boundaries around the very personal process of grieving may create conflict" (Cacciatore et al., 2008: 363). Burden, Bradley, Storey, Ellis, Heazell, Down, Cacciatore and Siassakos (2016:4) report that the different grieving patterns furthermore can result in "… disputes, infidelity and at times physical violence".

Similarly, Kelley and Trinidad (2012:1) acknowledge once more the devastating nature of a stillbirth for parents and emphasise the associated psychological implication such as the development of post-traumatic stress and depression. Likewise, Vance et al. (1995:936) found in a study on the "… psychological changes …" in parents "… after the loss of an infant through …" stillbirth, neonatal death and Sudden Infant Death Syndrome (SIDS), that there have been a significant increase in anxiety and depression particularly in mothers. Furthermore, the study indicated that mothers presented with psychological symptoms "… longer than fathers" (Vance et al., 1995:936). These authors argue that this, however, does not suggest that fathers present with less grief than mothers because they often tend to project their feelings inwards which is manifested by other behavioural changes such as increased "… alcohol consumption …" or "… work practices" and not necessarily through psychological symptoms (Vance et al., 936). Moreover, research has shown that a stillbirth as adverse outcome, is regarded as an unexpected event and the subsequent grieving process is described by fathers as uncertain (Kelly and Trinidad, 2012:3; 15).

2.5.3 Consequences for the surviving siblings

Stillbirth also has consequences for surviving siblings. As a result of this, it is the third system affected by stillbirth that will be discussed. According to Callister (2006, 229), there is limited research on children's concept of death. Likewise, Dyregrov and Gjestad (2011) stress that the death of a child always imposes strain on parents and siblings. Equally important is that Avelin, Gyllenswärd, Erlandsson and Rådestad (2014:558) state that recently there is an increased interest in understanding sibling experiences of loss and grief, due to limited knowledge.

It is important to note that Avelin et al. (2014:557) explain that sibling relationships for most might be the longest relationship they experience and that it generally evokes intense emotions, which can add to difficulties or provide some level of support or comfort. As a result, it is then argued that the siblings are often the family member that lives for the longest time with the influence of loss (Avelin et al., 2014:557). Consequently, the arrival of a baby for the sibling sparks excitement and when the loss occurs, it marks also the loss in status as big brother or sister (Avelin, Erlandsson, Hildingsson and Rådestad, 2011:150). In this regard, a study by Avelin et al. (2011:153) about the experience after stillbirth shows that parents reported a reaction of disappointment by siblings when they informed them of the loss of the baby, as they then realised that they lost out on becoming a big brother or sister.

It is further argued that children's understanding of grief is aligned to their intellectual development; and as a result of this, Avelin et al. (2011:150) recommend that parents should involve siblings after the stillbirth to enable them to grasp what has happened. Avelin et al. (2014:557), furthermore, stress that in this way siblings construct what the news of the arrival of a new baby would mean for the family and get to know the baby only through talks about the baby by their parents. However, when the loss occurs, these children become bereaved siblings before they had the chance to act as just siblings (Avelin et al., 2014:557). Kempson and Murdock describe this phenomenon as "the invisible loss of siblings never known".

Moreover, while parents grief the loss of the baby, they are often consumed by their own grief that results in an inability to parent the remaining siblings (Avelin et al., 2011:154). Avelin et al. (2014:557) assert that this would prevent the parents from helping their children understand death which in return would complicate the siblings' grief. Callister (2006:229), furthermore, observe that when siblings experience stillbirth in their family, they might present feelings of neglect, guilt, sadness or that they are left out

Further studies indicated that siblings would experience feelings of sadness and despair, injustice, aggressiveness and anxiety (Avelin et al., 2014:559). In addition to this, siblings might also experience a sense of guilt when the stillbirth would occur due to negative feelings they fostered towards the pregnancy (Avelin et al., 2014:559). It is evident from the studies conducted by Avelin et al. (2014) and Avelin et al. (2011) that siblings expressed a need generally to suppress their own grief in support of the parents. This might give rise to the need for professional help from a child psychologist to guide them through this difficult time later (Avelin et al., 2011:155). As a result, Erlandsson, Säflund, Wredling and Rädestad (2011) inform grieving parents that the recognition of the siblings' grief has been regarded as the most important part of sibling support. Due to the unexpected nature of the loss, it is emphasised that the siblings expressed a great level of concern for the uncertain future (Avelin et al., 2014:559). In conclusion of this discussion, Avelin et al. (2014:558) draw attention to the fact that after a stillbirth, siblings are undoubtedly forgotten by parents who focus more on the lost child and grieving thereof.

It is evident from the discussion above that stillbirths have adverse effects on the whole family. The occurrence of a stillbirth gives rise to a variety of emotional, physical and societal challenges for the grieving family and those in close proximity of them.

2.6 CONCLUSION

This chapter starts with a presentation of the prevalence of stillbirth. This provided context for the rest of the chapter. Following this was a description of stillbirth for the purpose of this study. The chapter continued to give a detailed discussion on the various medical and social lifestyle factors that may be a risk for the occurrence of a stillbirth. In addition to this, the chapter concluded with a discussion on how a stillbirth can affect the family, the parents and the surviving siblings when it occurs. This is aimed at providing further insight into the fact that stillbirth affects everyone within the family.

CHAPTER 3

THEORETICAL PERSPECTIVES RELATED TO GRIEF EXPERIENCES OF FATHERS AFTER A STILLBIRTH

3.1 INTRODUCTION

As discussed in the previous chapter, stillbirth can have a devastating effect on the family as a whole when grieving the loss of an infant. Research emphasises that the grief process of fathers is often undermined and not recognised by society (Van Ditter & Graves, 2012:900). As a result, it implied that the environment in which fathers grief, are often not favourable as to how they are experiencing the grief. In addition, they are also often expected to provide support to the grieving mother, postponing their own grief process. Callister (2006:228) acknowledges that, although there is little existing research on the differences in the responses of mothers' and fathers' to perinatal loss, there is a "growing investigation of the paternal experience of perinatal loss". This shows that there is a need to investigate not only grieving of mothers', but also that of fathers' after a stillbirth. Hence, this chapter cover the second objective of the study, which is to describe theoretical perspectives related to grief experiences of fathers after a stillbirth.

In achieving this, the chapter will depict the description of bereavement, loss and grief and also the type of grieving parents may present with. Furthermore the chapter aims to give insight into the various factors that influence this grieving process to describe the challenging circumstances under which the father grief. The chapter then continues to give explain the role of the multi-disciplinary team when a family experience a stillbirth. The theoretical framework suitable for this study is then discussed, followed by the various critiques on it. This critique includes a discussion of the suitability of the selected theoretical framework for this study as well.

3.2 DESCRIPTION OF BEREAVEMENT, LOSS, ANXIETY AND GRIEF

To understand the experiences of a grieving father, there is a need to describe the following relevant terms.

3.2.1 Bereavement

Becvar (2002:37) defines bereavement as the process of coping with a loss while Thompson (2012:19) describes being bereaved as a feeling of being robbed. According to these authors, these feelings literally describe the feeling one experience at the time of loss. Additionally, Cleiren (1993:6) points out that bereavement is the state in which a person is after the loss of another person. In addition to this, the author continues to explain the bereavement process which refers to the "… cognitive, affective and behavioural changes in the bereaved individual after the loss" (Cleiren, 1993:6). Corr, Nabe and Corr (1997:220) likewise define bereavement as a "… state of being bereaved or robbed of something". To illustrate the meaning of bereavement, these authors explain that both words 'bereavement' and 'bereaved' derive from a less familiar root verb, 'reave', which mean to despoil, rob or forcibly deprive".

It is clear from the aforementioned descriptions of bereavement that fathers could experience a deep sense of being robbed of their unborn baby before they have even met the baby. Moreover, for first-time fathers are exceptionally vulnerable in their experience of the state of being deprived of becoming a father and of having to cope with this loss.

3.2.2 Loss

Of importance to this study is that Thompson (2012:18) states that loss is the "… everyday term used to refer to something a person had and no longer have". With reference to grief, the author asserts that loss refers to "… situations where someone does not feature in our lives anymore". In relation to loss as a result of a stillbirth, it refers to an event where the family loses a new person they were anticipating to arrive in their family circle. Equally important is that Arnold and Gemma (1983:1) note that people cannot escape loss as it is constantly part of their lives; and due to its mostly unexpected nature, it results in a sense of emptiness.

3.2.3 Anxiety

Another feeling that is closely associated with grief is anxiety. It is described as "… a fear, a dread, and an apprehension, that the structure of values which sustained life, will be destroyed" (Jackson, 1957:19).

3.2.4 Grief

In addressing an understanding of grief, Jackson (1957:17) explains that grief is a complex experience that is challenging to define and explains that the term originated from the biblical context where the writers of the Old Testament attempted to give a presentation of the "… deep sorrows which their people felt". Equally important is that in World War II grief was regarded as the emotional response of distressed soldiers, losing their friends in the war (Jackson, 1957:17). Consequently, Jackson (1957:17) asserts that one needs to resort to twentieth century theorists, such as Freud and Karl Abrahams for a more "… definitive expression of grief", because of their attempt to describe what occurs during grief and bereavement. Taking into account various efforts to explain grief, Jackson (1957:18) concludes with the following final definition of grief:

> *"Grief is the emotion that is involved in the work of mourning; whereby a person seeks to disengage himself from the demanding relationship that has existed and to reinvent his emotional capital in new and productive directions for the health and welfare of his future life in society."*

In addressing a description of grief, it is worth noting that Kastenbaum (1986) emphasises that grief is an individual's "… response to the experience of bereavement …" and can "… often refer to our emotional response to loss" (Thompson, 2012:19). To understand these responses, Kauffman and Jordan (2013:75) observed that grief "… does not have an end date or sell-by-date"; while Thompson (2012:19) explains that grief is a complex experience and must be understood holistically, taking the various components of the experience into account.

The following figure (figure 3.1) provides Thomson's (2012) conceptualisation of the components of grief.

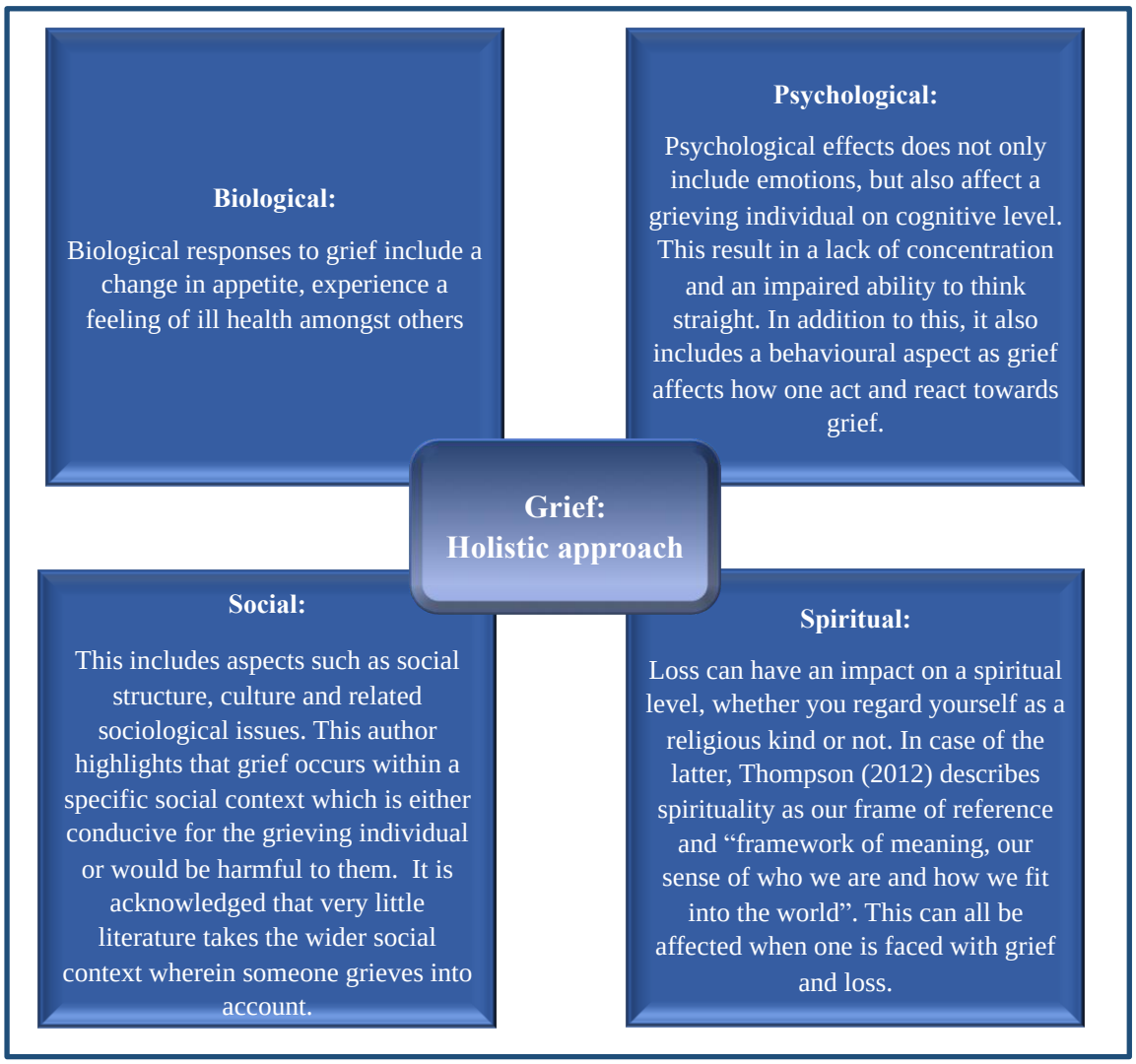

Figure 3.1: Holistic components to grief

Source: Thompson, N. (2012:19)

As can be seen from the figure, it is evident that as soon as grief occurs, it affects the biological, psychological, social and spiritual functioning of a person. Hence, Thompson (2012) suggests that a holistic approach should be applied when dealing with grief.

3.3 VARIATIONS OF GRIEF

To understand grief, an explanation of variations of grief is needed (Corr et al., 1997:244). The authors identified three kinds of grief, namely disenfranchised grief, anticipatory grief and complicated grief which will be described in the section below.

3.3.1 Disenfranchised grief

Disenfranchised grief is defined as "the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported" (Doka, 1989). This definition implies that the social context in which people grief is a determining factor for the manner in which they grieve. As a matter of fact, death and loss is common experiences of people in society, but an acceptable manner as to how people grieve, and when it is appropriate to grieve, is determined by societal views on loss and grief (Corr et al., 1992:244).

Of importance for this study is that Lang et al. (2011) acknowledges society's dismissal of grieving for a life that was unborn. Moreover, Corr et al. (1997:244) state that while this type of grief may not be overlooked by society, it is often "… socially unsupported …". Furthermore, it is worth noting that disenfranchised grieving creates even more problems within the grief process as it is regarded as a hindrance that would result in failure to progress through the stages of grief.

Doka (1989), for example, formulated the following three ways in which disenfranchised grief can occur:

1) The relationship between father and the unborn baby is not recognised.
2) The loss is not recognised.
3) The griever is not recognised.

Based on the views of Doka (1989), fathers will grieve in isolation because their right to grieve as men may remain unsupported by society and the loss of an unborn baby may not be recognised either. Consequently, fathers may present with disenfranchised grief.

3.3.2 Anticipatory grief

According to Corr et al. (1997:246), anticipatory grief refers to a process of withdrawal from the dying person before the actual event of death. These authors, thus, caution that it does not mean that anticipatory grief will minimise grief after the occurrence of the loss. It is worth noting that anticipatory grief is also not a "… strategy for achieving progress in or completing ones grieving prior to, instead of after, a death" (Corr et al., 1997:246). Moreover, Corr et al. (1997:247) assert that loss occurs throughout the process of anticipating death. As a result,

those who would be left behind could experiences loss of, for example, support and assistance with household tasks, even before the loved one dies. Due to the abruptness of stillbirth, this variation of grief would rarely be projected by parents. However, when they are informed of the stillbirth when the baby is still in utero, then they might have a short while before the delivery of the stillborn baby to withdraw from the idea of having a living new baby arriving.

3.3.3 Complicated grief

Corr et al. (1997:247) state that complicated grief was previously known as "… pathological grief reactions …", but recently it is described as a grief process or response that is regarded as unhealthy. Moreover, grief is regarded as a normal process and response to loss, but when it results in constructive behaviour, it becomes complicated. Similar to the views of Corr et al. (1997), Kauffman and Jordan (2013:76) maintain that various factors can complicate grief. Furthermore, Worden (1991) identifies the following complicated grief reactions:

1) Chronic grief reaction: Fathers would experience the existence of grief for a prolonged period which does not lead to an appropriate outcome;
2) Delayed grief reaction: This reaction would occur when fathers would inhibit, suppress or postpone their own grief in order to support the mother;
3) Exaggerated grief reaction: This reaction takes place when grief becomes excessive and disabling that may lead to fathers developing phobia or irrational fear;
4) Masked grief reactions: This reaction takes place when fathers experience symptoms or behaviour that indicates the absence of grief.

Additionally, ambiguous loss can accompany disenfranchised, anticipatory and complicated grief. Cook and Oltjenbruns (1998:119) define ambiguous loss as a response to loss when the loss does not "… make sense …" to the griever. In many ways, parents who experience stillbirth can have such a response as the cause of death might not be clear to them at the time when the loss occurs. These authors, furthermore, assert that death and loss is part of human nature and as a result of this, humans are able to generally cope with the event of loss if they grasp it. However, if they do not grasp it, individuals could present with either a response of being physically present; or emotionally absent or physically absent, but emotionally present (Cook and Oljenbruns, 1998:119)

In view of the aforementioned descriptions of grief, for the purpose of this study, grief would refer to the experiences of fathers after they have suffered loss through stillbirth of their expected alive baby.

3.4 FACTORS INFLUENCING GRIEVING OF FATHERS

A significant argument in some literature (Becvar, 2002:109) is that the loss of a child "is experienced by parents as pushing them almost beyond endurance". Evidently, this author wants to emphasise that it is equally difficult for both the mother and the father to deal with this loss. Similarly, Cook and Oltjenbruns (1998:107) state that despite the limited research into gender specific responses to loss, it is still evident that males and females do not have similar responses to grief. In addition, Mc Creight (2004:326) acknowledges that the impact of pregnancy loss on men has been neglected over centuries as they have been regarded only as sources of support.

Because the diagnosis of a stillbirth is regarded as an unexpected loss, the grief process intensifies as there is no opportunity to prepare for the loss and "all of the grief work must be done after the death" (Cook and Oltjenbruns, 1998:111). This experience furthermore, changes the perception of life for these parents (Becvar, 2002:121). With this in mind the following sections examine factors that can influence how fathers grief after a stillbirth.

3.4.1 Culture

In a study on grieving after a sudden infant death, specifically under Maori men, conducted by Edwards, Mc Creanor, Ormsby, Tuwhangai and Tipene-Leach (2009:131), it was discovered that the services rendered by care workers did not cater for the needs of grieving fathers, because it focused more on the needs of the mother. Worth noting is that, mothers participating in the same study reported that the fathers were incapable of coping and accepting the loss of the infant as they were unable to grieve properly. Consequently, these authors found that the cultural contexts in which fathers grieve are an influential factor as it determines how the father responds to the sudden loss.

3.4.2 Gender

Moreover, Clayton (2015:96) explains that the manner in which boys are socialised into becoming men also impose further challenges to men when they grieve. This author asserts that it can be regarded as unacceptable within society for males to openly demonstrate any emotions that is associated with emotions that are normally acceptable for females. However, in a study conducted with grieving women after a perinatal loss, Hazen (2003:149) found that the grief of these women went unrecognised by society and resulted in what they refer to as "silent grief".

Hence, since men are usually not allowed to openly show emotions, it may be a greater challenge for them if the grief of women is not recognised while they are allowed to show emotional reactions. Similarly, to the views cited above, Wood and Milo (2001:637) assert that societal expectations of how men should deal with emotions can obstruct the father's grieving process.

Wood and Milo (2001:635) point out that just as circumstances surrounding the death and the age of the deceased determine the response to the loss, the gender of the grieving individual should also be seen as such variable. Similar to the views of the aforementioned authors, Mc Creight, (2004: 327) acknowledges that the fathers' grief process is unique and cannot be compared with that of women. A lack of understanding this perception could stem from poor awareness that fathers also have an attachment with the unborn baby despite not carrying the infant during pregnancy. It is worth noting that the establishment of an attachment starts with a visual image of the baby through an ultrasound (Mc Creight, 2004:334). Sandelowski and Black (1994) suggest that men therefore experience the attachment to the baby at the same level as the women by attending the ultrasound. Mc Creight (2004:334), furthermore, has found that for one father a print-out of this image means that he has regular access to the baby that further strengthens the attachment. For others who do not have the opportunity to attend an ultrasound, they still construct visions of parenthood and anticipate the arrival of a alive baby (Mc Creight, 2004:335).

3.4.3 Societal expectations of men

Mc Creight (2015:326) describes the grief of men after a pregnancy loss as one that is ignored in addition to the loss being unrecognised by society. She, furthermore, explains society does not only dictate to men to demonstrate male orientated emotions such as anger, but also asserts

that they are expected to support their female partners in their grief process. In this regard, men who participated in a study by Edwards et al. (2009:142) reported that they modelled what they had observed from their own fathers. This means that their grieving process came second to that of their female counterparts as their fathers had not responded any different to the experience of loss. In addition, these men expressed a need to be "strong" for their partners instead of dealing with their own grief in an attempt to not present any weakness. What's more, Wood and Milo (2001:648) found that men in their study reported that they were isolated due to the inability of their surroundings to respond appropriately to their loss. However, some men have found this isolation as an opportunity to grief without being subjected to judgement from the broader society.

3.4.4 Destructive coping mechanisms

Evidently, this kind of experience poses an even greater risk for these fathers as they suppress and postpone their own grief process. This can result in an inability to deal with the loss effectively as fathers can resort to over-involvement in work and physical activities, as well as the consumption of substances as coping mechanisms (Edwards et al., 2009:131; 141). In doing so, the fathers often express anger and shift the blame to external circumstances (Wood & Milo, 2001:636). Despite these men acknowledging the destructive nature of their coping mechanism, they did not see any other coping strategy as helpful in the grieving process. This was also seen as an escape for many of them from the reality and from partners who wanted to speak about the loss constantly (Edwards et al., 2009). Consequently, the lack of proper coping mechanisms can impose a further risk for the marriage or romantic relationship as men became irritated with the women's grief while the women became upset with the men's inability to show any emotions (Schwab, 1992). Furthermore, Lang and Gottlieb (1993) found that men who reported a lower level of intimacy with their wives, presented with more extreme grief.

What can worsen this for grieving men is the absence of support services (Edwards et al., 2009:147). It was found that this lack of support strengthened their resolution to the aforementioned destructive coping mechanisms instead of finding better and more positive manners to cope with the loss. It is worth noting, however, that this lack of support allowed the men to experience awareness of what they thought worked for them at the time they participated in the aforementioned activities (Edwards et al., 2009:147).

3.4.5 Chronic grief

It is worth noting that as a result of poor social support and insight into their grief process, men have always been at risk of presenting with chronic grief (Lasker & Toedter, 1994). In this regard Cook (1988) states that views of men grieving faster than women, make them vulnerable to the longevity of their grief being underrated by society and in scientific research for example.

According to Murphy (1998), men who have participated in a study on their experiences after a stillbirth, have an inability to deal with the sudden traumatic event. This could provide validity for these men resorting to the aforementioned destructive coping mechanisms in particular. Dubose (1997:367) emphasises that men who experience grief after a stillbirth are challenged with whether they are regarded as fathers or not, as they did not have a living child to prove their status of fatherhood. Similarly, Sakai (1998:321) asserts that any parent experiences joy when a child is born alive, but the sadness when knowing the baby would be born dead even before the delivery, overrides any sad experience in life in general.

3.4.6 Guilt

Mc. Creight (2004) introduces another influential factor of fathers grieving, namely guilt. This can occur when men are unable to make sense of the grief themselves. One of the fathers participating in their study explained that he blamed everyone for the loss of the baby, including himself, and these feelings were coupled with anger and helplessness (Mc Creight, 2004:335). For others the guilt stems from not being present at the time of delivery, resulting in questioning whether the pregnancy outcome would have been different should he have been present (Wood & Milo, 2001:647). After all, Spaten, Byrialsen and Langdridge (2011:2) assert that the onus is on oneself to find meaning in life as the absence thereof would result in an inability to find meaning in death and ultimately loss.

In summary of the above discussion, men and fathers grapple with grief which can have a long lasting effect on their functioning after the experience of loss. Consequently, instead of moving towards regaining some level of stability within their life, fathers can cause more harm to themselves and those around them in doing so.

3.5 ROLE OF THE MULTI-DISCIPLINARY TEAM

As the hospital is usually the place where a stillbirth occurs, Pauw (1991) explains that a multi-disciplinary approach is necessary to support the grieving parents. According to Pauw (1991), the social worker is often more closely involved with the family than the rest of the staff as social workers provide expert support and guidance during this crisis period in the life of the grieving family. Similarly, Cacciatore and Bushfield (2008:61) explain that the responses of the social worker to stillbirth and that of the other multi-disciplinary team members may sometimes differ immensely. It is worth noting that social workers in hospitals can also play a key role in linking parents to community resources for ongoing support beyond their discharge from the hospital (Cacciatore & Bushfield, 2008:74). Social workers may be in the best position to do referrals to community resources as they may be most knowledgeable about such resources available within the community.

Of importance for this study is that Pauw (1991) warns that the absence of consulting a theoretical framework to understand the grief process may cause harm to the grieving family as it would result in incompetence of the social worker to intervene successfully. She suggests that social workers should use Kubler-Ross's (1989) stages of grief and dying to achieve an increased insight into the grief process and intervention.

In a study conducted in India on the impact of stillbirth on women and their families, participants reported that the unmindful attitude of the health care providers deepen the sense of loss they experienced after the occurrence of a stillbirth (Gopichandran, Subramaniam, Kalsingh, 2018:3). It is of importance to note that these authors use Kubler-Ross's stages of grief as the theoretical framework for their study, as it is evident from their findings (Gopichandran et al., 2018:6). Similarly, participants in a study on death notification for stillbirth reported that the manner in which the news of the stillbirth is conveyed to the parents and the family by the health care staff; is also a determining factor in the grief process (Pullen, Golden and Cacciatore, 2012:339).

Ahrens and Hart (1997), however, explain that health care providers acknowledged that sharing the news of stillbirth with the parents and family could be even more difficult than communicating the death of an adult to his/her family. Furthermore, these authors assert that the lack of proper training and education of healthcare providers to play this role contributes towards the difficulty of sharing news of death in a more sensitive manner (Ahrens & Hart,

1997). Consequently, these health care providers feel ill-prepared for the communication of death news to families.

It is also debated by various international authors that to identify that the following aspects of communication by health care providers about the death, would negatively affect the response of parents:

- Getting inadequately or poorly communicated information about the death (Levetown, 2008);
- Receiving conflicting opinions from health care providers (Levetown, 2008);
- Experiencing a delay of death notification (Leash, 1996);
- Receiving indirect or jargon-laden information (Prasad, 2010).

Additionally, two South-African social work scholars assert that the inability of health care providers to respond sensitively to parents who experienced a stillbirth, greatly contributed to failure of the broader society to recognise this type of loss (Conry & Prinsloo, 2008:17). Conry and Prinsloo (2008), furthermore, explain that hospitals within the South African context, should devise the manner in which their health care staff responds to families who have lost their babies. They suggest that hospitals may consider placing mothers who have suffered a stillbirth away from those who experience joy of having a living baby.

3.6 STAGES THEORY

Based on the recommendation of Pauw (1991), the stages theory of Kubler-Ross (1989) is chosen as the theoretical framework for the purpose of the study. This theory was developed by Kubler-Ross (1989) within a clinical setting which is similar to the environment in which a stillbirth is diagnosed. Similar to the clinical setting in which the theory was developed, the treatment and approach to stillbirths requires a multi-disciplinary approach to both parents. In view of aforementioned arguments that services are often exclusive of fathers after the experience of a stillbirth (Edwards et al., 2009), the use of this theory can lead to increased insight into how fathers experience stillbirth. Consequently, the multi-disciplinary team could progress from a one dimensional mother-focused approach to stillbirth to an improved inclusive and more sensitive consideration for the grieving father.

It is worth noting that the conceptualisation of the five stages of grief by Kubler-Ross (1989) is regarded as the most well-known theory relating to loss and grief (Cummings, 2015:1). These phases include denial and isolation, anger, bargaining, depression and acceptance. Cook and Oltjenbruns (1998:93) observe that despite the different terminologies used for these stages by Bowlby (1980), their "basic structures are quite similar".

Kubler-Ross (1989) points out that these stages stem from the idea that death is part of everyday living and emphasises that one could seldom escape the experience of it. Likewise, Johnson (1987:7) asserts that an individual in adulthood should also have an understanding that death is "universal, irreversible and permanent". Similar to these views, Cook and Oltjenbruns (1998:91) explain that when people grieve after death, one should take into account that the specific grief response could follow after many other losses such as "divorce," "loss of bodily function", "imprisonment" and "loss of job".

Although these stages are primarily conceptualised by Kubler-Ross (1989) for terminally ill patients, it is said to be also significant to loss in general. For the purpose of this study, this theory will be used as a theoretical framework to understand the grief process of the grieving father. Figure 3.2 below is presented to highlight the phases of the five stages theory.

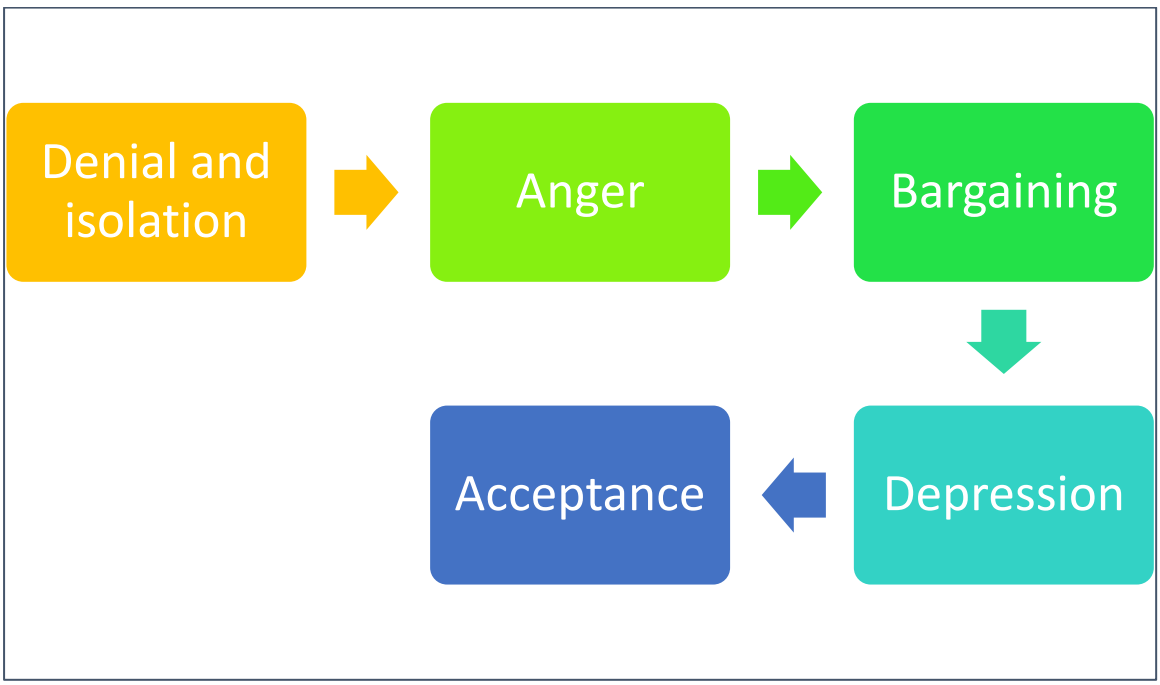

Figure 3.2: Stages of grief

Source: Pauw, N. (1991)

These stages will be discussed in the section below.

3.6.1 Denial and isolation

The first stage identified by Kubler-Ross (1989:34) is denial and isolation. Kubler- Ross (1989) explains that this is the initial stage when the news of death is shared with those who will be left behind to deal with the loss. The first response to such news could be one of denial and isolation. As a result, an inner emotional struggle would exist to question whether the death is unreal or not. This response would often be aimed at obtaining affirmation that the denial of the truth is an appropriate response. In addition, specifically in the case of a stillbirth, denial could manifest through parents requesting a second opinion following their disbelief. In doing so, they might cling to the hope that the initial assessment might be one of error. Kubler-Ross (1989:34) describes this as an attempt to "… get a better explanation for their troubles". Worth noting is that many people would resort to their religious beliefs to further affirm their denial.

Further, it is important to note that for this study the readiness of those receiving the diagnosis of death should be considered by the multi-disciplinary team in the hospital. Kubler-Ross (1989:35) furthermore, observed that people will usually find themselves in this stage when the news are presented to them prematurely or by someone who conveys the news "… to get it over with …". Evidently, she wants to assert that the attitude of the multi-disciplinary team when they present the news will be a determining factor in the response of the family. As a result, Kubler-Ross (1989:36) maintains that these families should be approached with the necessary sensitivity. Moreover, it should be understood that a person may present with denial and isolation as a shield to the unexpected nature of the loss. In doing so, they later will have to rearrange themselves to "mobilise less radical responses". As a result, denial is regarded as of a "… temporary …" nature which is soon "… replaced by partial acceptance" (Kubler- Ross, 1989:36). With reference to this, the time frame associated with denial and isolation is dependent on the ability of the family or individual to face the reality of the diagnosis and realism of death.

Kubler- Ross (1989:36) continues to explain that isolation occurs when a person dwells within denial throughout the grief process. In achieving this, they will isolate themselves from external factors that may break down their state of denial. She emphasises that the multi-disciplinary team should not attempt to break down the denial, but rather advise a person to communicate the acceptance of their loss through "… words, sometimes with little gestures or non-verbal

communication" (Kubler-Ross, 1989:40). The creation of a conducive and caring environment by healthcare providers is paramount to the achievement of this, because denial is reported to be a coping mechanism to guard an individual's sanity (Kubler-Ross, 1989:41). Due to the uneasy nature of death, the multi-disciplinary team members could further worsen the state of isolation, by withdrawing themselves from the grieving family and literally "closing the door on them" (Kubler-Ross, 1989:43). This highlights the reality of a person's experience of not just withdrawal from the rest of society and the world, but also isolation from the sad reality of death.

3.6.1.1 Conspiracy of silence

The multi- disciplinary team needs to know that Johnson (1987:19) introduced the term "conspiracy of silence" which can exist when the individual or family speaks about a specific subject. This author explains that this can be due to the awkward nature of death and it being regarded as a "… culturally taboo subject …". This is then regarded as the "… it …" subject that have an element of "… silence …" surrounding it (Johnson, 1987:19). Of importance is that the existence of such silence after the experience of loss further can promote denial and isolation. Like cultural views surrounding loss, socialisation can also impose a risk for the existence of a conspiracy of silence. Moreover, Johnson (1987) asserts that this could result in not just a grieving individual's isolation from the rest of the world, but also isolation of others from the grieving individual. Resorting to a conspiracy of silence is regarded as a strategy that is used to avoid the show of normal emotional grief responses such as crying or anger. Johnson (1987:20), however, states that a conspiracy of silence "… may last a short period of time …", but warns that the continued existence thereof could hamper the progression in the grief process.

In summary, Kubler-Ross (1989:37) observed that "depending very much on how a …" person "… is told, how much time he has to gradually acknowledge the inevitable happening, and how he has been prepared throughout life to cope with stressful situations, he will gradually drop his denial and use less radical defence mechanisms".

3.6.2 Anger

The second stage identified by Kubler-Ross (1989:44) is anger. Kubler-Ross (1989:36) emphasises that anger manifests itself once a person moves away from denial and finds himself/herself in the above mentioned state of "… partial acceptance". Normally an individual

would progress to this stage once a state of denial is no longer maintained. This stage is then characterised by experiencing "feelings of anger, rage, envy and resentment" (Kubler-Ross, 1989:44). The question frequently asked in this stage becomes: "… why me? …" as opposed to "… no, it's not true, no, it cannot involve me …" in the first stage. The author, acknowledges that this stage, above all, can affect the family dynamics more than the others as it often more projected towards the external environment with outbursts at random times. With reference to a grieving father, as already alluded in Chapter Two, this can affect his marriage, work life and social life negatively which could lead to isolation and withdrawal of social support and networks. The isolation then is also regarded as a buffer for friends, family and colleagues to avoid the issue of loss (Kubler-Ross, 1989:47).

Moreover, Kubler- Ross (1989:44) states that the feelings experienced in this stage is as a result of anger towards those who get to enjoy the very thing or aspect you have lost. Also, the premature disruption of what we perceive to be the order of life, as well as the interruption of future planning, is regarded to worsen the anger (Kubler-Ross, 1989:45).

Furthermore, anger is regarded as merely an attempt to be heard. In doing so, the person wants to draw attention to their situation and seek sympathy (Kubler-Ross, 1989:46). Kubler-Ross (1989:46) asserts that family, colleagues, society, and healthcare providers should not take the anger personally if directed at them, but should rather make an effort to determine the root of its existence. In allowing the existence of anger, the individual can transition towards a better acceptance of the finality of death (Kubler-Ross, 1989:48).

3.6.2.1 Scapegoating

It is worth noting that anger can also manifest through, what Johnson (1987) refers to as, scapegoating. He explains that a scapegoat can take on the form of a "… race, person, institution or sex that bears the blame, prejudice, displaced aggression, irrational hostility, or projected feelings of others" (Johnson, 1987:16). Further, it is a form of anger whereby the blame is shifted towards one of the aforementioned. Johnson (1987:16) asserts that a scapegoating situation only exists when a group or individual are in a threatening situation. With reference to grief, an individual or family such as the father in this study is threatened by the reality of death or loss. The figure below (figure 3.3) shows a demonstration of the scapegoat triangle, as presented by Johnson (1987:17).

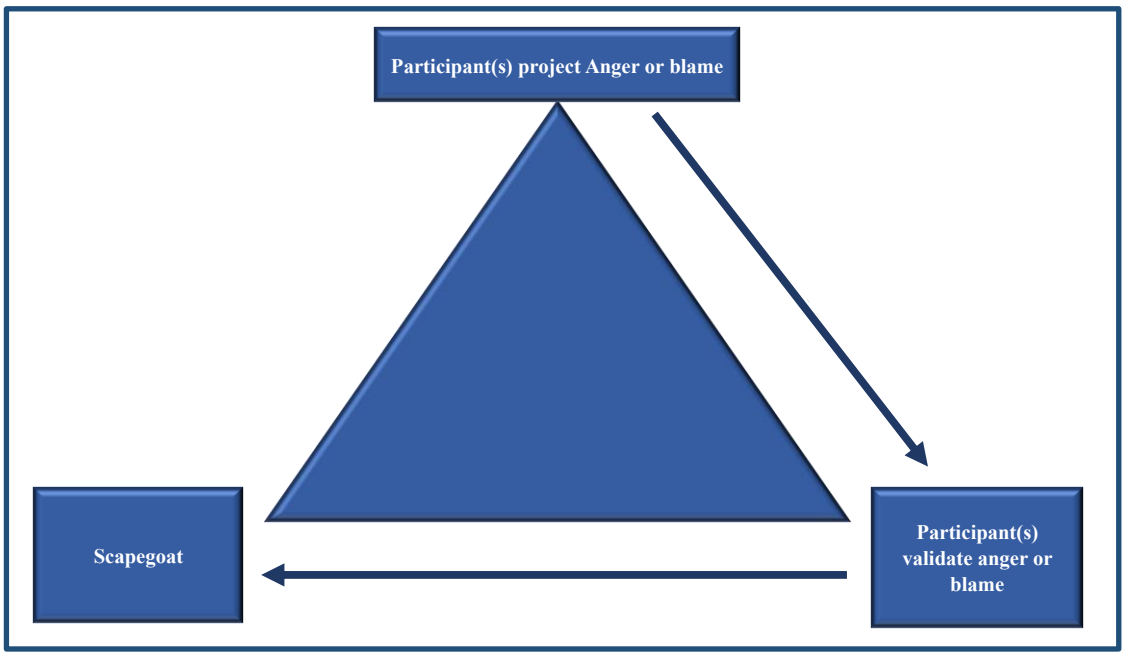

Figure 3.3: Scapegoating Triangle

Source: Johnson, S.E. (1987:17)

To successfully achieve scapegoating, Johnson (1987:16) identifies two mechanisms to do so, namely "… Projection …" and "… displacement …". Projection is described as a process whereby emotions experienced or attitude projected is deemed "… unacceptable in oneself and …" diverted to another source (Johnson, 1987:17). Displacement refers to the transferral of "… emotions or reactions to be transferred from the original subject to a more acceptable substitute" (Johnson, 1987:17). Moreover, the scapegoat is normally on the receiving end of both these mechanisms. In addition to scapegoating posing as a risk for relationships with other individuals, society and institutions, it also imposes a risk for oneself as a result of its destructive nature (Johnson, 1987:19). Similarly, when other systems are also recipients, the surviving siblings can also be victims of scapegoating. Johnson (1987) offers a scenario where children can be blamed by parents for the death of another sibling. This can also affect the surviving siblings into their adulthood. Anger is, thus, directed towards them, being alive and the other being deceased (Johnson, 1987:18). With reference to this study, it is of importance to note that fathers could find themselves in a scapegoating situation as they may blame the multi-disciplinary team for the death of the stillborn baby. In addition to this, he may also project feelings of anger towards the mother as she might be seen as disabling to bring life into the world.

3.6.3 Bargaining

The third stage identified by Kubler-Ross (1989:72) is bargaining. This stage is reported to be less familiar, but is still regarded as equally important in the grief process (Kubler-Ross, 1989:72). If a person refuses to accept (stage 1), or presented with feelings of anger (stage 2), then they progress to this stage of bargaining. Bargaining requires a change of view towards the event of loss and entails that a person will try and bargain with God to try and "… postpone the inevitable …" (Kubler-Ross, 1989:72). Therefore, this requires an individual to acknowledge a higher power such as God to bargain with. Kubler- Ross (1989) compares this bargaining process with a child's request that is initially denied by parents. After this, the child would show anger towards the parents and even isolate himself/herself in their room. However, the approach can then change to one of bargaining with the parents in which the child would agree to do household chores in return for granting the initial request. In addition, Kubler- Ross (1989) states that when experiencing loss, one could often resort to negotiate with God in an attempt to delay the reality of loss. Of importance for this study is that bargaining may surface when the family are informed about the diagnosis of stillbirth. Despite the inevitability of the death of the baby, parents may bargain with God for a positive birth outcome.

Kubler- Ross (1989:72), furthermore, asserts that in order to bargain, such person will request something in return for "… good behaviour". It would also involve a "… self-imposed deadline …" whereby it is bargained for instance for one last moment to see someone, do something or relive a memory before facing the reality of loss (Kubler-Ross, 1989:73). Most of the bargaining is kept in secret and often only disclosed to the chaplain or spiritual leader. As a result, an interdisciplinary approach, involving people from more disciplines, is suggested when aiding an individual during this stage (Kubler- Ross, 1989). Moreover, bargaining is regarded as an indication of what Kubler-Ross (1989:74) refers to as "… quiet guilt …" as a result of promises made for whatever bargained for with God.

3.6.4 Depression

The fourth stage identified by Kubler-Ross (1989:75) is depression. This stage is described to be prevalent when a feeling of acute loss is experienced. Kubler-Ross (1989:75) explains, that during this stage one's feelings of anger and failed bargaining would be replaced by a deep sense of loss, not only for the loved one, but for more than that. With reference to stillbirth, this can be the loss of promotion from being solely female and male to the father and mother.

Furthermore, depression can also have an effect on relationships with those around the person as it is associated with impairment in human functioning. This could further result in the loss of employment, due to poor performance and absenteeism which may further aggravate feelings of depression (Kubler-Ross, 1989:75).

To further illustrate this phase, Kubler-Ross (1989:76) asserts two different types of depression, namely preparatory and reactive depression. Preparatory depression is described as the process of preparation that especially "… terminally ill patients have to undergo in order to prepare themselves for the final separation from this world" (Kubler-Ross, 1989:76). In contrast, reactive depression is regarded as a response to a sudden loss as described in the aforementioned circumstances (Kubler-Ross, 1989:76). Due to the sudden nature of stillbirths, the parents involved do not have time to prepare for the loss and could display with more reactive depression. In addition, reactive depression is also referred to as "… silent …" depression and "… requires many verbal interactions and often active intervention on the part of people in many disciplines" (Kubler-Ross, 1989:76). Therefore, Kubler- Ross (1989:76) emphasises, the role of the social worker and chaplain in the process of addressing depression. The social worker can play a vital role in aiding a family to reorganise the roles that would exist within the household after the experience of loss and the existence of depression as a result.

Moreover, it is acknowledged that allowing an individual to express feelings of depression will ensure that they move towards accepting the loss much quicker (Kuber-Ross, 1989:77). However, due to the uncomfortable nature of loss, those surrounding the grieving person would often instinctively respond by an attempt to cheer them up (Kubler- Ross, 1989:76). However, Kubler- Ross (1989:96) asserts that this is an inappropriate response and "… often an expression of our own needs, our own inability to tolerate a long face over any extended period of time". Although this stage is characterised by the knock-on effect of many losses after the existence of one loss such as a stillbirth, the loss of hope experienced in this stage is emphasised to be the one that describes this stage best (Kubler-Ross, 1989:96).

3.6.5 Acceptance

The final stage identified by Kubler-Ross (1989:99), is acceptance. She emphasises that once a person has been allowed enough time to deny the loss, been angry, bargained with God and experienced a sense of depression, they would transition to the final stage with ease. It is therefore, acknowledged that it is imperative to allow someone the necessary time to go through

the stages of grief in order to achieve final acceptance (Kubler-Ross, 1989:99). Similar to the views of Kubler-Ross (1989) Kauffman and Jordan (2013:144) assert that grief is an "… ongoing process …". Furthermore, they also argue that the progression to this stage is dependent on allowing the expression of feelings such as denial, anger, bargaining and depression which would become the 'new normal' for the grieving individual (Kauffman & Jordan, 2013:144).

Acceptance of the loss is closely associated with the notion of moving on. Kauffman and Jordan (2013:144) emphasise that moving on requires one to be adaptable. They, furthermore, assert that adaptability after losing a loved one refers to adjusting "… to a life without their presence …" (Kauffman and Jordan, 2013:144). The circumstances surrounding the loss, is a determining factor during this stage. If it occurs unexpectedly, then Kauffman and Jordan (2013:147) suggest, "… end of life will also have a major impact on the person's ability to move on". However, they acknowledge that it should "… not ultimately prevent a form of closure" (Kauffman & Jordan, 2013:147).

It is also important to note that having ceremonies like funerals also assist in accepting and obtaining closure (Kauffman & Jordan, 2013:148). Corr et al. (1997:287) maintain that a funeral grants the opportunity to the bereaved person for "… psychological separation …" from the deceased. This promotes acceptance of the loss as it emphasises the reality of loss, making "… the death real …" for the bereaved person (Corr et al., 1997:287). A funeral also contributes to disintegrating the death from the living that can be experienced on an individual, social and familial level (Corr et al., 1997:289).

It is worth noting that the above mentioned stages is not successive as an individual may experience emotions characterised by different stages at once (Cook & Oltjenbruns, 1998:93). These authors observe that there is no beginning and end stage necessarily and emphasised that this should only be used as a framework as an individual might not present with the emotions discussed here. This emphasises once more the complexity of grief and how the griever experiences it, as may also be the case of a father grieving a stillbirth.

3.7 KUBLER-ROSS's THEORY: A CRITIQUE

It is important to note as much as Elizabeth Kubler-Ross was showered with accolades for her conceptualisation of the aforementioned theory, that she also received various critiques about

it. In a review of her book on grief and grieving, Bolden (2007:273) asserts that criticism stemmed from questioning her "… research and process …" followed in conceptualising these stages. He, furthermore, explains that, in the past, these stages became famous in the area of grief, and as a result it was assumed that everyone would be going through these stages towards the end of life. However, Kubler-Ross and Kessler (2005) assert that these stages are not meant to be following rigidly on each other, nor may it be experienced by everyone.

However, despite these criticism against Kubler-Ross' theory, the use thereof in a study about intimate partner violence and women's experiences thereof proves its relevance, not only to the near stages of death, but also to experiences of other complex social issues. The researchers of the aforementioned study assert that the theoretical framework of Kubler-Ross' stages of grief aided them to "… explain the emotional reactions and decision making of …" intimate partner violence victims "… in regard to staying, leaving and returning to their partners" (Messing, Mohr & Durfee, 2015:30). Furthermore, Messing et al. (2015:30) note that social workers and other helping professionals can use this theory to understand other complex social issues such as intimate partner violence. Many other scholars (Pauw, 1991; Gopichandran et al., 2018; Conry & Prinsloo, 2008;) recently used the same five stages theory when researching grief and loss. This proves that this theory is most suited for researching grief and loss, even when it occurs through stillbirth.

In view of the above discussion on the critiques of the suggested theoretical framework for this study, it is important to note that these stages are still relevant in recent times in order to aid helping professionals to understand complex everyday life challenges that people face. One of these complex everyday life challenges is stillbirth; and how fathers experience it. Hence, this theory is used as the study is aimed at increasing insight into the experiences of fathers and also aiding the social worker and the rest of the multi-disciplinary team members to be more sensitive towards fathers' in their grief process after a stillbirth.

Additionally, Carroll-Johnson (2005:11) has acknowledged that this theoretical framework helps the nursing fraternity to a point of realisation that death does not mean the presence of failure. It is clear that this author wants to assert that the five stage theory could also assist these fathers to reach a point of revelation that a stillbirth does not indicate failure on the part of them as fathers. Equally important is that the work of Kubler-Ross provides an opportunity to better understand grief and "creates an avenue" for people when facing the loss of someone close to them (Bolden, 2007:237).

3.8 CONCLUSION

This chapter provided a description of grief and the various responses a person could present with when experiencing grief. These concepts provided a context for understanding the complexity of grief and how to respond to it. Moreover, a description of the variations of grief to further increase insight is provided. Furthermore, the manner in which fathers grieve is discussed. In doing so, the challenges associated with a father grieving are highlighted. In addition, the roles of the social worker and the rest of the multi-disciplinary team in responding to the occurrence of a stillbirth are explained. Furthermore, a discussion of Kubler-Ross's stages theory as the theoretical framework for this study is included as well as reviewing some criticism of the framework. In conclusion, a discussion on the relevance of this theoretical framework for this study is provided above.

CHAPTER 4

SITUATION ANALYSIS OF THE FATHER'S EXPERIENCES OF GRIEF AFTER A STILLBIRTH

4.1 INTRODUCTION

Fathers' experience of grief after a stillbirth is often overlooked. Kader (2006:188) draws attention to the lack of research to supports the impact a stillbirth can have on a father, because of the focus on the mother. Badenhorst, Riches, Turton and Hughes (2006:245) furthermore alert that most studies on the effect of stillbirths, only made mention of the fathers while the focus was not on the psychological effect on the father, but rather on the gender differences between the father and mother.

Within this context, this chapter aims to achieve the third objective of this study by providing the findings of the empirical investigation into the experience of fathers after a stillbirth. Where relevant, the data will be presented in a tabular or narrative format. Furthermore the findings will be analysed, interpreted and verified with literature.

4.2 RESEARCH METHOD

4.2.1 Research approach and design

The study conducted was qualitative of nature. Hennink, Hutter and Bailey (2011:8) indicate that this type of research approach "… allows you to examine people's experiences in detail …" Babbie and Mouton (2001:53) furthermore assert that a qualitative researcher is "… concerned with describing and understanding rather than explaining or prediction human behaviour". Based on these assertions an exploratory research design was utilised as the study is aimed at developing a phenomenological understanding of the grieving process of fathers after the experience of stillbirth. De Vos et al. (2011:95) describe an exploratory design as a design that would achieve the purpose of the study as it achieves to "… gain insight into a…phenomenon …" such as a fathers' experience of grief after a stillbirth. In order to give the findings obtained in an exploratory study, a more descriptive nature, the researcher also used a descriptive design on advice of De Vos et al. (2011:96) who assert that the use of both descriptive and exploratory research designs will yield more optimal results.

4.2.2 Instruments for data collection

De Vos et al. (2011:341) assert that the purpose of the study should guide the researcher to select the most suitable tool to collect data. These authors furthermore highlight that interviewing and focus group are methods used to collect data in qualitative research such as this one (De Vos et al., 2011:341). Based on the assertions of De Vos et al. (2011) interviewing was used as method of data collection as it is best suited for the purpose of the study. De Vos et al. (2011:347) furthermore identify unstructured, structured and semi-structured types of interviewing that can be employed in qualitative research. Based on the definitions provided by Bernard (2013:181) of these types of interviewing, the researcher employed a semi-structured interview schedule. Bernard (2013:181) highlights that during this type of interviewing the researcher "… covers a list of topics …" but also allows the questioning to be open-ended. De Vos et al. (2011:351) assert that this type of interviewing allows for more flexibility for both the researcher and the participant.

It is worth noting that De Vos et al. (2011:352) place great emphasis on the review of the literature to assist in identifying the topics covered in the semi-structured interview schedule. As a result, the researcher consulted the literature in chapters two and three respectively to design a semi-structured interview schedule **(Annexure A1-Afrikaans and Annexure A2-English)**. Subsequently open-ended questions were used that allowed for elaboration on the experience of the participants. The interview schedule includes identifying details of the participants to obtain profiles of them. Before commencing with the interviews, the researcher obtained informed consent from the participants by using an informed consent form **(Annexure B1 and Annexure B2)** that they were required to sign. The informed consent forms were available in either Afrikaans (**Annexure B1**) or in English (**Annexure B2**) depending on the language preference of the participant. Consequently, interviews were conducted in Afrikaans or English according to the preference of the participant. Narratives in Afrikaans were translated by the researcher into English.

4.2.3 Sampling

For the purpose of this study, purposive sampling was used. Bernard (2013:164) defines this type of sampling as when one would "… decide the purpose you want to informants to serve and you go out to finds some." This author furthermore acknowledges that it can be challenging to find participants through the use of this type of sampling because "you take what you get"

(Bernard, 2013:165). As a result of this, a sample of ten participants was interviewed. After the eighth interview the same themes and subthemes started to emanate indicating that saturation was reached, but the researcher pursued to interview ten participants. In view of this, De Vos et al. (2011:350) assert that saturation is reached in a study when the researcher does not learn new information during the data collection phase of the study because of the repetition of information.

To further assist the researcher with the selection of the sample, the researcher took advise from De Vos et al. (2011:392) who asserts that the researcher should be guided by the "… formulation of pre-selected criteria …". The researcher thus ensured that all of the participants in the study adhered to the criteria for inclusion as indicated in chapter one.

4.2.4 Pilot Study

According to Barker (2003:327-328), a pilot study can be defined as "… a procedure for testing and validating an instrument by administering it to a small group of participants from the intended test population." Because of this, the researcher conducted interviews with two participants in order to test the abovementioned data collection tool. These participants were recruited in the same manner and interviewed in the same manner as explained under the discussion of sampling. It is worth noting that the researcher was forced to make minor changes to the data collection tool as it was found that the initial questionnaire was too long and as a result the participants in the pilot study lost interest in the questions. In addition, it was also observed that the questions had to be reformulated because the participants did not understand the meaning of some questions. The transcriptions of the two participants who participated in the pilot study were included in the sample for the study.

4.2.5 Ethical considerations

De Vos et al. (2011:113) maintain that the foundation on which research is based is "… mutual trust, acceptance, cooperation, promises and well-accepted conventions and expectations between all parties involved." Hennink et al. (2001:64) thus emphasise that there are specific ethical aspects that the researcher had to consider in especially qualitative research approach as in the case of this study. These authors (Hennink et al., 2001:64) maintain that due to the sensitive nature of such studies including this one, the foundation of gathering data from participants rests often on the establishment of a professional relationship with the participants.

Such a relationship between the participant and researcher requires "… closeness and sometimes intimacy …" (Hennink et al., 2011: 46) hence it requires consideration of "… the ethical principle of doing-no-harm …" (Hennink et al., 2011:46). De Vos et al. (2011:115) support this by emphasising that participants in social research are often at risk of emotional harm, therefore, the researcher had to include in the ethical clearance applications specific measures to minimise the emotional harm that might have surfaced during the empirical study. In addition to this, these authors (De Vos et al., 2011; Hennink et al., 2011) draw attention to the principle of confidentially and anonymity and assert that it should be maintained throughout the research process to protect the identity of the participants who shared sensitive information in the study.

After thorough considerations of the aforementioned ethical principles, it is worth noting that some authors (Tracy, 2013:243; Hennink et al., 2011:62) advise that the researcher should then submit an ethics application for "… assessment by an institutional review board to assess whether the research will be conducted ethically." (Hennink et al., 2011:62). Based on these assertions, the researcher had to obtain ethical clearance from the Departmental Ethics Screening committee (DESC) of the Social Work Department at Stellenbosch University (**Annexure C1**). After the research study was identified by this committee as medium risk, the application was subsequently forwarded to the Research Ethics Committee (REC) of the University of Stellenbosch. After ethical clearance was granted by this committee the researcher had to embark on an application process to the Western Cape Government Health Department through the National Health Research Database. Approval was subsequently granted to the researcher (**Annexure C2**), which allowed access to participant information and access to confidential records.

4.2.6 Data collection and analysis

As already explained, interviews were conducted with 10 participants at a place that was most convenient for the participants. Predominantly, the interviews took place either at three selected hospitals or at the participants' home.

Babbie (2007:378) asserts that the analysis of qualitative data is the "… nonnumerical examination and interpretation of observations, for the purpose of discovering underlying meanings and paters of relationship" (Babbie, 2007:378). Bernard (2013:394) furthermore asserts that qualitative analysis is aimed at the identification of patterns and searching for ideas

that explain the existence of the patterns in the first place. Because of this, the researcher analysed the data using the following steps as identified by Creswell (2003:191-195) and presented in figure 4.1.

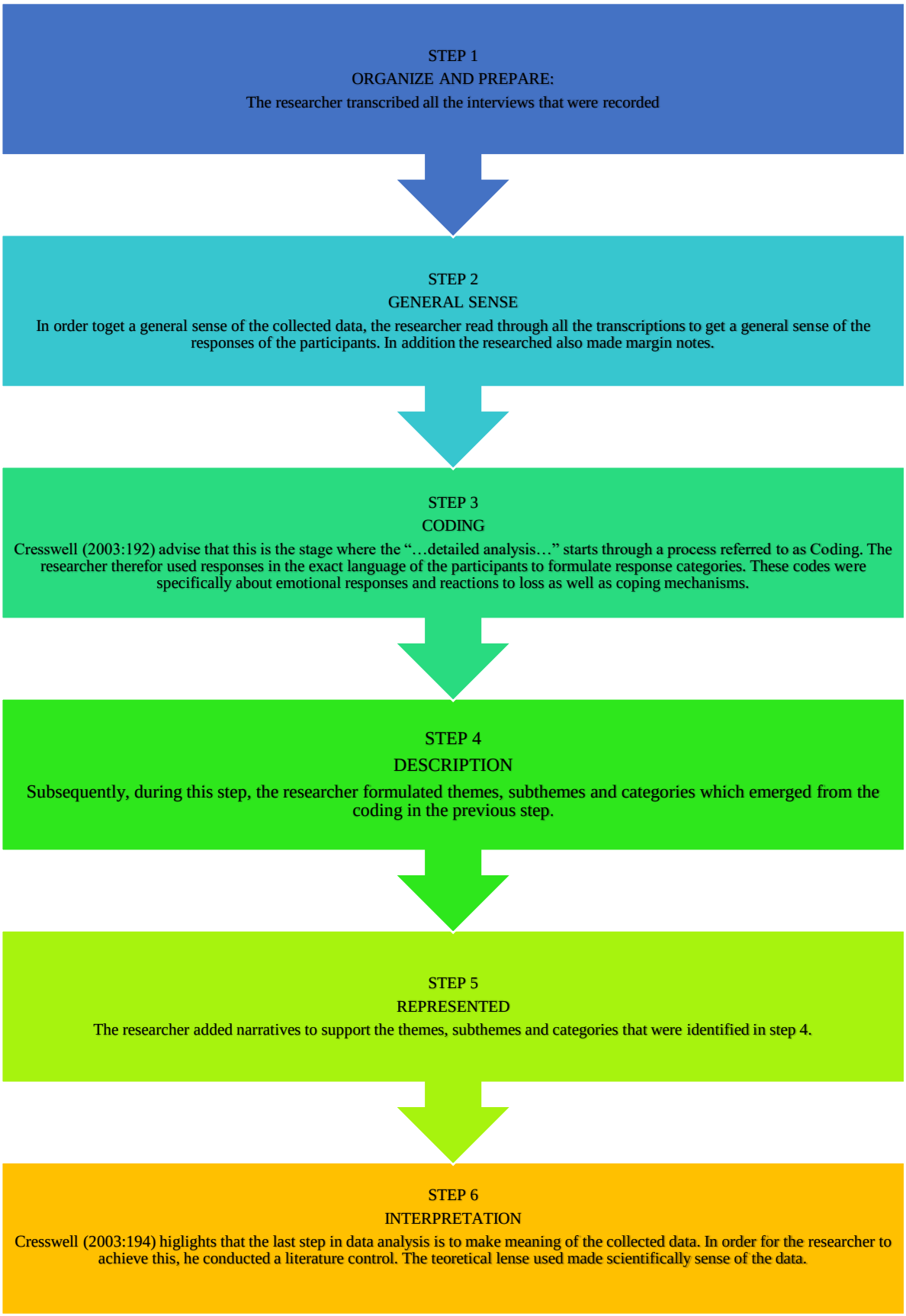

Figure 4.1: Steps in data analysis

Source: Creswell, J.W. (2003:191-195)

4.3 RESULTS OF THE INVESTIGATION

The findings of the study will be presented below. Section A provides a profile of the participants interviewed during the study. In section B the empirical results will be presented in the form of themes, subthemes and categories that emerged from the findings of the study. Narratives of the participants will be presented to justify the themes, subthemes and categories.

SECTION A: OVERVIEW OF THE PARTICIPANTS

4.3.1 Profile of participants

Table 4.1 illustrates the profiles of the fathers who participated in the study. Participants were asked to disclose certain identifying details such as age, home language, marital status, current occupation or work and the number of living children they have. The findings are as follows:

Table 4.1: Profile of fathers

Participant number	Age categories			Home Language	Marital Status	Period of current relationship or marriage	Current occupation or work	Number of living children
	18 - 28	29 - 39	40 - 50					
1		X		English	Partner relationship	3 years	Warehouse clerk	2
2		X		Afrikaans	Partner relationship	2 years	Salesman	0
3		X		Afrikaans	Partner relationship	2 years	Assistant driver	9
4		X		English	Partner relationship	4 years	IT assistant	1
5	X			English	Partner relationship	2 years	Unemployed	1
6		X		English	Married	13 years	Self-employed	1
7	X			Afrikaans	Partner relationship	More than a year	Barber	0
8		X		English	Married	3 years	Cashier	1
9		X		Afrikaans	Married	3 years	Small plant operator	3
10			X	Afrikaans	Married	25 years	Correctional officer	3

n=10

It is evident from the title of the study that all the participants in the study were **male** with almost all (seven participants) in the 29 to 39 age category. Louw (1991:455) asserts that individuals within the aforementioned category to be in early adulthood as it ranges from 20 to 40. It is worth noting that one of the developmental tasks associated with early adulthood is forming romantic relationships and becoming a parent (Louw, 1991:455). Kail and Cavanaugh (2000:387) similarly, highlight that couples today have their first child later in life than before with males normally wanting to become a parent in their late thirties. The assertion of Kail and Cavanaught (2000:387) thus support the findings that most participants are within the age range which includes the late thirties.

The **language** abilities of the participants were evenly distributed with half of the participants reporting English and half of them reporting Afrikaans to be their home language. Furthermore, it is worth noting that almost all (six) of the participants reported that they were in a **partnership relationship** whereas less (four) participants were **married** at the time of the stillbirth. In addition to this, the aforementioned results indicate that most of the fathers were in a partnership relationship or marriage for more than two years and one was not certain of the specific period of the relationship. However, the participant was able to indicate that the partnership relationship was active for more than one year. The findings are corresponding with Makhanya (2018:12211) who asserts that a high number of unmarried fathers exist within South Africa. It is worth noting that Berger (2000:514) indicates that despite the existence of sexual exploration in early adolescence already, the need for forming intimate romantic relationships arise from early adulthood. This author (Berger, 2000:513) furthermore highlights that the difference in marital status and duration, as indicated by the findings, may be determined by social expectation and culture.

Almost all of the participants (nine) were **employed**. Findings also indicate that most (eight) participants had other living children whereas fewer participants (two) had no living children after the experience of the stillbirth. In addition to being asked the aforementioned identifying details, participants were also requested to indicate whether the pregnancy **was planned or unplanned**. Three of the participants indicated that the pregnancy was unplanned compared to seven who reported a planned pregnancy. This data shows that almost all of the pregnancies were planned according to the participants. The findings are supported by Rosenfeld and Everett (1996) who maintain that pregnancies are generally planned, but also observed that there are many pregnancies that are unplanned. These authors furthermore assert that although

unplanned pregnancies are generally common amongst teenagers, it is on the rise amongst married and single adult woman too (Rosenfeld & Everett, 1996). Badenhorst et al. (2006: 245) however, maintain that … "perinatal loss is … an unanticipated tragedy." These authors (Badenhorst et al., 2006:245) therefore emphasise that an expectation for a living baby exists with any pregnancy, whether planned or unplanned and the prevalence of stillbirth, therefore, may result in severe psychological issues for both parents.

SECTION B: THEMES RELATING TO EXPERIENCES OF FATHERS AFTER STILLBIRTH

This section will provide the themes, sub-themes and categories that emerged from the analysis of the findings. The analysis of data was guided by Creswell's (2003:191-195) steps, as previously discussed, to allow the researcher to arrive at the themes, subthemes and categories that arose from the data collection process. In addition, the literature review done in chapters two and three assisted to explore possible themes, subthemes and categories. Various aspects including the experience leading up to the stillbirth, the stillbirth itself as well as the experience of grief afterwards were investigated. As a result of this, this section will firstly provide findings related to themes and subthemes that emerged from the pregnancy. Secondly, the themes and subthemes that emanated from the stillbirth will be provided following the ones from the role of the multi-disciplinary team. Subsequently, the section will present the themes and subthemes that developed from the experience of the fathers coping with grief as well as the consequences of the stillbirth for the father. Table 4.2 below indicates the themes, subthemes and categories that emerged from the findings:

Table 4.2: Themes, subthemes and categories

Theme	Subtheme	Category
1. The pregnancy	1.1 Feelings towards the pregnancy	
	1.2 Involvement during the pregnancy	1.2.1 Ensuring the comfort of the wife or partner
		1.2.2 Accompany the wife or partner to antenatal visits
	1.3 Preparations for the arrival of the baby	1.3.1 Financial preparations
		1.3.2 Purchasing of necessities for the baby
		1.3.3 Making arrangements for more conducive living conditions
2. The stillbirth	2.1 Occurrence of stillbirth	
	2.2 Place of stillbirth	
	2.3 Paternal presence at stillbirth	
	2.4 An informant of the news	
3. The Multi-disciplinary team	3.1 The attitude of the hospital staff	
	3.2 Explanation of the cause of the stillbirth by professional hospital staff	
	3.3 Help or assistance offered by hospital staff	
	3.4 The manner in which help offered assisted in coping with the loss	3.4.1 Unhelpful assistance
		3.4.2 Helpfull assistance
4. Coping with grief	4.1 Source of paternal support	4.1.1 Family
		4.1.2 Religious community
		4.1.3 Partner
	4.2 Personal coping mechanism	

Theme	Subtheme	Category
	4.3 Gender differences in grieving	
	4.4 The reaction of community towards the father	4.4.1 Lack of support from the community
		4.4.2 Support from the community
	4.5 Gender differences in community's response towards grief	4.5.1 Presence of gender differences
		4.5.2 Absence of gender differences
5. Consequences of stillbirth	5.1 Initial emotions or reactions	5.1.1 Anger and blame
		5.1.2 Focus on the mother
	5.2 Mechanisms to cope with emotions or reactions	
	5.3 Role of religion in coping with the loss	
	5.4 Degree of depression experienced	
	5.5 Impact of stillbirth on the relationship with wife or partner	
	5.6 Impact of stillbirth on the relationship with other living children	
	5.7 Impact on stillbirth on work	
	5.8 Factors contributing to accepting the loss	

4.3.2 Theme 1: The pregnancy

The following two subthemes emerged under this theme about the experiences of participants of the pregnancy. Firstly this section will provide findings related to the feelings towards the pregnancy followed by subthemes indicating the involvement of the father in the pregnancy. Lastly, subthemes identified in the exploration of the manner in which the father prepared for the arrival of the baby will be presented.

4.3.2.1 Subtheme 1.1: Feelings towards the pregnancy

For both parents, the news of the pregnancy would evoke a positive response in most circumstances. In a study conducted by O'Leary and Thorwick (2005) on the fathers' feelings during pregnancy and post-perinatal loss, they found that fathers' responses to the news of the pregnancy were related to their first ultrasound experience which confirmed the pregnancy. For these fathers, this event brought them closer to an experience of "… knowing the baby …" (O'Leary & Thorwick, 2005:78).

In order to explore how the fathers felt about the news of the pregnancy participants were asked to explain how they felt when they "were first informed of the pregnancy". The participants were asked about their specific emotions experienced at the time when they discovered that they are expecting a baby. All of the participants responded positively to the news of the pregnancy. This is evident in the following narratives from the respondents:

"I was very excited." (Participant 1)

*"I was **happy**."* ("Ek was happy gewees") (Participant 3)

*"**Happy**."* ("Gelukkig") (Participant 9)

*"Look because it was a planned pregnancy, I mean we were **happy** … I was happy … I was happy …"* ("Kykie omdat dit 'n beplande swangerskap was, ek mean ons was bly … ek was bly … ek was bly …") (Participant 10)

The findings show that all of the fathers were happy about the pregnancy. For some it was more than just being happy about the news of the pregnancy because it meant more than that as can be seen from the following narrative of participants:

*"… to me it was sort of like an **achievement** …"* (Participant 5)

"Actually I was excited that she was pregnant just because I was ***looking forward to receiving another baby****."* (Participant 6)

"I was over the moon because of all these years it was my first child and uhmm, it was always a ***wish to be a father****."* (Participant 8)

The finding concurs with the assertion made by Asenhed, Kilstam, Alehagen and Baggen (2013:1313) that in addition to feeling happy towards the news of the pregnancy, this marks the arrival of a new era for the father and a sense of achievement.

4.3.2.2 Subtheme 1.2: Involvement during the pregnancy

Table 4.2 below indicates the accounts of the participants to the question of how they were involved during the pregnancy. It is worth noting that all the participants confirmed that they were involved in the pregnancy. Their involvement was to ensure the comfort of their pregnant wife or partner and to accompanying their wife or partner to antenatal visits. The findings are presented in the table below.

Table 4.3: Involvement in the pregnancy

Theme 1: The pregnancy		
Subtheme	**Category**	**Narrative**
1.2 Involvement in the pregnancy	1.2.1 Ensuring the comfort of the wife or partner	*Brought her* ***food****,* ***prepared food*** *for her, I was with her* ("… vir haar kos gebring, vir haar kos gemaak, ek was saam met haar …") (Participant 3) *"Even if she says no today I'm tired I don't want ... I don't feel like cooking,* ***I would just gonna buy food for us*** *..."* (Participant 6) *"Like every evening I would* ***give her a foot rub****, when she complained about her back I would also* ***give her a massage,*** *you know. Every time when she complains like I'm tired my*

Theme 1: The pregnancy		
Subtheme	**Category**	**Narrative**
		*feet are getting sore I would jump in and **I would cook** … we'd go for, she **was craving for ice cream we would walk along and go to Mac Donalds to do the ice cream**."* (Participant 8)
	Accompany the wife or partner to antenatal visits	*"… obviously I had to now become involved because I **needed to ensure** that she **gets to the doctor regularly** …"* ("… obviously moet ek mos nou betrokke wees want ek moes nou sorg dat sy by die dokter kom gereeld …") (Participant 2) *"I **went with her to the hospital every time** if she did not feel well or so, then I go with her."* ("Ek het saam met haar gegaan hospital toe elke keer as sy nie lekker voel of so nie gaan ek saam met haar.") (Participant 7) *"So when she perhaps **when she needed to go and see the doctor** uhmm … if she had to go for … how do you say … how do they say for it … appointments you had to make … **I was there, I take off from work**."* ("Soos as sy miskien by dokters gaan sien het is sy moet uhmm … as sy moet gaan vir … 'n hoe sê jy … hoe sê hulle vir daai … afsprake gat maak … ek was daar, ek vat af by die werk.") (Participant 9)

a) Category 1.2.1: Ensuring the comfort of the wife or partner

Participants' account in the table above of their involvement in ensuring the comfort of their wives or partners by providing food for them confirm a study by Nowak and Stevens (2004:124) that the environment of the pregnant woman is crucial in ensuring a healthy pregnancy.

For one father, in ensuring that the mother experience maximum comfort during the pregnancy, his involvement was different as is illustrated by the following narrative:

"Like every evening I would ***give her a footrub****, when she complain about her back I would also* ***give her a massage,*** *you know. Every time when she complain like I'm tired my feet are getting sore I would jump in and* ***I would cook*** *… we'd go for, she* ***was craving for ice cream we would walk along and go to Mac Donalds to do the ice cream****."*

Farland, Rifas-Shiman and Gillman (2015:159) concur that pregnant women would often have cravings that would surface during pregnancy. They found in a study on the relationship between cravings and the development of gestational diabetes that satisfying cravings for sweet things such as ice cream results in an increased intake of sucrose, fat and saturated fat. They furthermore assert that there is clear correlation between the intake of sweet things to quench cravings and the development of gestational diabetes. Despite these alerts asserted by these authors (Farland et al., 2015) the need to create comfort as perceived by these fathers for their partners at the time took precedence over the risk of jeopardising the pregnancy outcome.

b) Category 1.2.2: Accompany wife or partner to antenatal visits

When it comes to accompanying his wife or partner to antenatal visits O'Leary and Thorwic (2005:78) explain that it is often assumed that fathers can play a supportive role to their pregnant wife or partner during this time. In ensuring that the pregnancy goes well, Weaver-Hightower (2012:464) asserts that accompanying the wife or partner to antenatal visit allow an opportunity for the father to not just ensure the health of the mother and baby during pregnancy, but it creates an opportunity for the father to develop an attachment with the unborn. This can be achieved through the experience of ultrasound (Weaver-Hightower, 2012:464). Almost half of the participants saw the need to accompany the mother for antenatal and doctors' visits as is evident from the findings in table 4.1.

It is of importance that one participant had to take time off from work in order to accompany the mother to hospital visits. This was done to ensure that the father does not miss out on the

opportunity to form and sustain an attachment with the unborn baby as is suggested by Weaver-Hightower (2012). In addition to this, McCreight (2004:334) asserts that findings in their study indicate that attending the antenatal visits with the mother creates an opportunity for "… knowing the baby."

Equally important is that Maluka and Peneza (2018:5) draw attention to findings in their study which highlighted that pregnant women preferred to be accompanied by their partners or husbands especially on the first visit to the doctor or hospital.

Important observations that emerged from the findings is that one father indicated that his involvement in the pregnancy can be characterised by the lack of emotional attachment to the pregnancy and mother because he provided financial support to the mother to meet her needs, as well as that of the unborn baby:

*"… **emotionally I wasn't there** for her but like financially and physically I was there for her."* (Participant 5)

Another father acknowledged that for him his partner's weight and overall health was of utmost importance in the pregnancy and he saw his involvement as to ensure that the mother eats healthy and participates in healthy activities fitting for a pregnant woman. This is evident from the following spoken text of the participant:

*"I was like babe we have to **change our diet** … we actually go to the gym but I had to actually keep an eye that you actually not do things that we are used to …"* (Participant 4)

This participant evidently acknowledged obesity during pregnancy which is a risk factor as identified by Carmichael, Blumenfeld, Mayo, Wei, Gold, Stevenson and Shaw (2015). They found in a study on this that there is a clear correlation between stillbirths and obesity. As a result, the participant deemed it important to ensure that the mother is healthy as he was hoping for positive birth outcome.

4.3.2.3 Subtheme 1.3: Preparations for the arrival of the baby

Preparation for the arrival of the baby can be seen not only to be the task of the mother, but also of the father. Samuelsson, Radestad and Segesten (2001:125) made the observation that fathers felt a great sense of disappointment when the loss of the baby occurred. While Samuelsson et

al. (2001:125) explain that feelings of loss stemmed from an awakening that due to the loss, their preparations for and expectations of an alive baby is now "… thwarted …".

In exploring the manner in which the fathers prepared for the arrival of the baby, the sub-theme emerged that overall; fathers were all involved with the preparations. However some indicated that their involvement were of a financial nature while others mentioned purchasing of items necessary for the baby, as well as making arrangements for more conducive conditions. Table 4.3 below indicate the responses per category identified based on the aforementioned question.

Table 4.4: Preparation for the arrival of the baby

Theme: The pregnancy		
Subtheme	**Category**	**Narrative**
Preparation for the arrival of the baby	Financial preparations	*"I started **saving** to be honest without the mother knowing …"* (Participant 4) *"… **financially** I was well prepared because when I got married 2016, 2017 we had our first pregnancy so everything was just planned, got our preparation financially wise we were sorted …"* (Participant 8) *"Then I explained to her whether we can't make a **small loan** at the bank in order to make preparations …"* ("Toe het ek vir haar verduidelik of ons nie 'n klein leningtjie kan maak by die bank lat ons voorbereidings vir ons kan kry …") (Participant 9)
	Purchasing of necessities for the baby	*"… from the time she fell pregnant, I started **buying baby clothes** uhmm … **nappies, basins** you name it so if the child … if the child is born then I don't want to sit with a shortage …"* ("… vanat sy beginne swanger raak het begin baba klere koop uhmm … kimbies, baddens you name it so assie kind … assie kind gebore is wil ek nie met 'n tekort sit …") (Participant 2)

Theme: The pregnancy		
Subtheme	**Category**	**Narrative**
		*"Yes I bought stuff. The **pram**, the **cotton** and the **clothes** and the **bottles** and his **facecloth** and his **towel**."* ("Ja ek het goeters gekoop. Die pram, die cotton en die klere en die borrels en sy waslap en sy handdoek.") (Participant 7)
	Making arrangements for more conducive living conditions	*"... we already have flat paid in Parklands that we supposed to move into because we gonna **have a new baby and we need a bigger space** ..."* (Participant 1) *"... at that stage I thought already, infact at that stage I ... in the time that she was pregnant I already initiated a transfer so I was ... I knew that we will move ... away from the stressful environment because that was very stressful circumstance I worked in at that time then I felt it shouldn't still affect my wife ... that we also get away from that environment there."* ("… op daai stadium het ek al gedink, infact ek het dai stad … in daai tyd toe sy swanger was het ek al 'n oorplasing ingesit so ek was … ek het nou geweet ons gaan verhuis … om nou van die stresvolle omstandighede af te kom want dis 'n baie stresvolle omgewing waarin ek gewerk het daai tyd toet ek gevoel dit moen nie nog op my vrou ook … vir haar affekteer nie dat sy ook ma … dat ons ook ma uit daai omgewing uitkom da.") (Participant 10)

a) Category 1.3.1: Financial preparations

For many parents, the thought of expecting a baby evokes concerns regarding finances. Even in the case where the pregnancy is planned, the concerns of whether their finances would suffice to meet the needs of the baby still exist. In this regard Binks (2011:13) mentions that because the initial stages of the infants life is normally regarded the most expensive for the parent, financial preparedness is crucial. This explains why most participants' preparation is characterised by some form of financial preparedness. This is illustrated in the following narratives:

*"I started **saving** to be honest without the mother knowing …"* (Participant 4)

*"Then I explained to her if we cannot take out a **small loan** at the bank so that we can make preparations for us …"* ("Toe het ek vir haar verduidelik of ons nie 'n klein leningtjie kan maak by die bank lat ons voorbereidings vir ons kan kry …") (Participant 9)

The following narrative is an example of a father that was prepared financially before he discovered the pregnancy. It furthermore shows that he planned his life according to a certain order whereby he would first get married followed by having children:

*"… **financially** I was well **prepared** because when I got married 2016, 2017 we had our first pregnancy so everything was just planned, got our preparation financially wise we were sorted …"*

The findings of a South-African study conducted by Evens, Tolley, Headley, McCarraher, Hartman, Mtimkulu, Manenzhe, Hamela and Zulu (2015:382) concur that the financial position of the father was identified as a factor of importance. These authors found that a mother's decision whether she will conceive is determined by whether the father is able to contribute financially to the pregnancy. Moreover they assert that participants in their study defined "financial preparations to pregnancy … as having money or a husband with a good job …" and being "… highly desired."

b) Category 1.3.2: Purchasing of necessities for the baby

As can be seen from table 4.3 where purchasing necessities for the baby were concerned a few of the participants explained that they were involved in the pregnancy by purchasing clothing and other items such as is evident from the narratives below:

*"Yes, I bought stuff. The **pram**, the **cotton** and the **clothes** and the **bottles** and his **facecloth** and his **towel**."* ("Ja ek het goeters gekoop. Die pram, die cotton en die klere en die borrels en sy waslap en sy handdoek.") (Participant 7)

One participants' narrative clearly indicates that he started purchasing items from the moment he was informed of the pregnancy. This is illustrated in the following narrative:

*"... from the time she fell pregnant, I started **buying baby clothes** uhmm ... **nappies, basins** you name it so if the child... if the child is born then I don't want to sit with a shortage ..."* ("… vanat sy beginne swanger raak het begin baba klere koop uhmm … kimbies, baddens you name it so assie kind … assie kind gebore is wil ek nie met 'n tekort sit …") (Participant 2)

The findings is in line with Asenhed et al. (2013:1313) who found that purchasing items to meet the needs of the baby is a necessity.

c) Category 1.3.3: Making arrangements for more conducive living conditions

The environment in which the mother resides or finds herself in during the pregnancy is of importance for her general well-being (Nowak & Stevens, 2011:124). In ensuring that this is achieved for the pregnant wife or partner, the following narratives of participants reflect how they went about to achieve this:

*"... we already have flat paid in Parklands that we supposed to move into because we gonna **have a new baby and we need a bigger space** ..."* (Participant 1)

*"At that stage I thought already, infact at that stage ... during that time she was pregnant I **already put in a transfer** so I was ... I knew that **we would move** ... to get **away from the stressful circumstances** because it was a very stressful environment in which I worked at that time so I felt that it shouldn't still on my wife ... affect her ... that she ... that we should get away from the environment there."* ("… op daai stadium het ek al gedink, infact ek het dai stadium … in daai tyd toe sy swanger was het ek al 'n oorplasing ingesit so ek was … ek het nou geweet ons gaan verhuis … om nou van die stresvolle omstandighede af te kom want dis 'n baie stresvolle omgewing waarin ek gewerk het daai tyd toet ek gevoel dit moen nie nog op my vrou ook … vir haar affekteer nie dat sy ook ma … dat ons ook ma uit daai omgewing uitkom da.") (Participant 10)

The findings are confirmed by a study conducted by Nowak and Stevens (2011:124) where mothers indicated that the environmental factors including living conditions were having an effect on their pregnancy. Consequently fathers in that study became aware of these environmental stressors and the imposed risk to the pregnancy. Therefore the fathers put measures in place such as moving to less stressful environment (Nowak & Stevens, 2011:125).

4.3.3 Theme 2: The stillbirth

Sutan, Amin, Ariffin, Teng, Kamal and Rusli (2010:209) assert that the experience of a stillbirth can results in some level of psycho-social issues for the family and they emphasise that perinatal loss in itself "… is a psychological trauma" (Sutan el al., 2010:210). Furthermore, they confirm that the father will also experience the same trauma as the mother when a stillbirth occurs (Sutan et al., 2010). Of importance is that Flenda, Middleton, Smith, Duke, Erwich, Khong, Neilson, Ezzati, Koopmans, Ellwood, Fretts and Froen (2011:1703) assert that the death of a baby who died before living, is no less of a death than to lose any other child. Within this context the fathers were asked to describe their experience when the stillbirth occurred. Analysis of the transcripts revealed the following sub-themes:

4.3.3.1 Subtheme 2.1: Occurrence of stillbirth

Findings revealed that most of the stillbirths occurred between one to three years ago. The findings correlate with the views of Flenedy et al. (2011:1703) that a stillbirth has devastating effects on the parents as is evident from the narratives below which indicate that most participants could remember the month and year of the occurrence of the stillbirth:

The experience of one participant who indicates that although the stillbirth occurred so many years ago he kept count of the specific number of years:

"December 2018" (Participant 6)

"March 2019" (Participant 4)

4.3.3.2 Subtheme 2.2: Place of stillbirth

The fathers were asked, "Where did the stillbirth happen?" All the fathers responded that the stillbirth occurred in a hospital as this is evident from the following narratives:

*"At the **hospital**"* ("By die hospital.") (Participant 9)

*"... here in the **hospital** ..."* (Participant 4)

These findings are in line with Bateman (2011:366) who found through the Lancet study that "… 42% of deliveries in South Africa happen at District hospitals, 30% at Regional hospitals, 17% at Community health centres and 11% at Tertiary hospitals" (Bateman, 2011:366). As a result of this, it is evident that a stillbirth would also occur mostly in a hospital or any other health facility as it indicates in the results found in this study. Bateman (2011:366) furthermore asserts that despite being attended to by a trained staff member during delivery at a South African health facility, the likelihood of a stillbirth to occur remains high.

4.3.3.3 Subtheme 2.3: Paternal presence at the stillbirth

To gain an understanding of whether the fathers were present when the stillbirth occurred they were asked about it. Nearly more than half of the participants were present when the stillbirth occurred. Two categories emerged because some fathers were present and others were absent.

a) Category 2.3.1: Present

Most of the fathers were present at the stillbirth as can be seen from the excerpts below:

*"Yeah, I was **present**."* (Participant 8)

*"**Hereby S** (name of hospital) **yes** ..."* ("Hier by S (Naam van die hospitaal) ja …") (Participant 3)

b) Category 2.3.2: Absent

Some fathers were not present when the stillbirth occurred. This is illustrated in the following response:

*"I wasn't ... **I wasn't with** when the child ... when the child ..."* ("… ek wassie … ek wassie by toe die kind … toe die kind …") (Participant 10)

It is evident from the narrative that this father is unable to find the correct description to explain the event where he was absent. Therefore it is almost as if there is a "conspiracy of silence" for him around the death of his baby as a result of the stillbirth as identified by Johnson (1987:19).

For some participant, their absence from the stillbirth is due to unforeseen circumstances and does not appear to be out of an unwillingness to be with the mother. This is evident from the following narratives:

*"No I was **at home** and because she was in the hospital (hospitalised as an inpatient) it happened in the early hours of the morning …"* (Participant 4)

*"I was **not present**; I was out of the country …"* (Participant 6)

These findings are supported by authors such as Wood and Milo (2001:647) who found that fathers might not be present when the stillbirth of their baby occurs. They found that absence at the time of the stillbirth can result in a great sense of guilt experienced by the father. However, these authors explain that this might raise questions on the part of the father of whether the outcome would have been different should they have been present. The following narrative supports this:

*"… y**ou question** what … what went wrong, could the nurses … or doctors did not do anything regarding the situation …"* ("… vir jou vrae maar wat … wat het … wat het fout gegaan, kon die nurse-ste … offie Dokters nieiets omtrent die situasie doen nie …") (Participant 2)

4.3.3.4 Subtheme 2.4: Informant of the news of the stillbirth

Sharing the news of stillbirth is not an easy task, whether for professional staff to the family, one partner to another, parents to other surviving children or for the parents to the rest of the family and social networks. It is worth noting that Stringham, Riley and Ross (1982:322) explains this situation as a baby born "… into an atmosphere of silence …". They also discovered that some mothers learnt about the death of their baby "… a few days prior to the onset of labour", others were informed over a week, and some knew for approximately seven weeks already, while others were informed during the labour. The results of this study by Stringham et al. (1982:82) show that the mother was informed first and therefore acted as the informant to the father. Likewise in this study nearly half of the participants mentioned that their wife or partner was the informant of the news of the stillbirth. This is demonstrated in the following participants' narratives:

*"**She** called me and said …"* (Participant 4)

*"**She** … **(the partner)**"* ("Sy … (die metgesel)") (Participant 7)

*"**My wife**"* ("My vrou") (Participant 9)

In addition the source of information of the stillbirth as indicated by half of the participants were either the doctor or nurses who informed them of the stillbirth:

*"Yeah the d**octors** first at V (name of hospital) hospital and then at S (name of hospital) hospital."* (Participant 8)

*"... the **hospital** phoned to tell us ... to tell me that she gave birth but the child did not live."* ("… die hospitaal het mos gebel om vir ons te sê … om vir my te sê sy het geboorte gegee maar die kind het nie gelewe nie.) (Participant 2)

"*One of the ... **nursing staff** phoned me that night to say I must come in. They did not say it is a still, they just said I must make sure I come into hospital ... I can't remember now whether the doctor told me that day or ... it was such a confusing matter ... I think the doctor was there with her when I came into the ward when the doctor now for us ... sat her down and me too and told us what happened"* ("Een van die … verpleegpersoneel het my gebel daai nag om te sê ek moet inkom. Hulle het nou nie gesê dis 'n stilgeboorte nie, hullet net gesê ek moet inkom en maak laat ek nou by die hospitaal kom … ek kan nie onhou of die Dokters my gesê het daai dag of … dit was so deurmekaar besigheid gewies … ek dink die Dokter daa by haar toe ek in die saal aankom toet die Dokter nou vir ons … vir haar laat stilsit en vir my nou gesê wat gebeur het.") (Participant 10)

The findings are supported by Kelley and Trinidad (2012:4) who confirmed that professional hospital staff and specifically doctors and nursing staff are often a source who informs the parents of the stillbirth. These authors observed that doctors are often only interested in investigating the cause of the stillbirth while avoiding acknowledging the emotional and psychological effect of such news shared as was experienced by one participant:

*"Uhmm ... I would say not necessarily someone informed me because I **kinda saw the way they were acting**... and then I thought probably **something wrong is happening** ... I was like ohkay something is probably **wrong with the baby** and **after a while** I was called by the Doctor ... and he told me what happened ..."* (Participant 5)

In contrast to the findings by Stringham et al. (1982) one participant became the source who had to inform the mother. The narrative below demonstrate that it was rather difficult for the father to disclose this as it was in conflict with the normal practice where the mother is more

often the parent who receives the news first and as in the narratives provided above, has to share it with the father.

"Uhmmm … it was the doctor … the man called me and told me what is going to happen and what then it was hard for ***me to transfer the message to her*** *because I could see how you know, how important it … it was the first and she didn't want to accept …"* (Participant 1)

4.3.4 Theme 3: The Multi-disciplinary team

In the event of a stillbirth, the parents should be informed by the multi-disciplinary team of the stillbirth. Sousou and Smart (2015:242) explain that such a team comprises of "… physicians, midwives, social workers, chaplains, genetics, genetic counsellors, lactation specialists, funeral directors, volunteers and psychologists." Against this background, participants were asked to talk about the role of the Multi-disciplinary team. Four sub-themes emerged from the findings namely, attitude of the hospital staff, explanation of the cause of the stillbirth by professional hospital staff, help or assistance offered by the hospital staff as well as the manner in which the help or assistance offered assisted the father in coping with the loss. In support of these subthemes, the findings will be supported by narratives from the participants as well as a supporting literature control.

4.3.4.1 Subtheme 3.1: Attitude of the hospital staff

The experience of stillbirth is regarded as one that would result in a "… deep sense of sorrow." (Callister, 2006:227). Because almost all of stillbirths occur within a hospital or any other health facility the attitude of the professional hospital staff is crucial in how the families will experience life afterwards. The following narratives indicate the experience of almost all the participants with regards to the professional hospital staff:

"The ladies that helped us at S(name of hospital) hospital were … they could ***sympathise*** *with us …"*(Participant 1)

"All of them … I can't say there was … they were all on their best behaviour like they were paying ***sympathy*** *with me, just telling me to be strong, pray you know …"*(Participant 8).

"No, they were very ***supportive*** *…"* ("Nee hulle was baie supportive …") (Participant 2)

It is evident that the participants experienced the attitude of the staff as sympathetic and supportive. For one participant, his positive experience is so embedded in his memory that he is able to recall specific staff members who acted in a professional way towards him. The following narrative demonstrate this:

*"To say the truth there was **one sister** who helped us a lot … **Sr. O** (surname of nursing sister) and **Sister B** (Surname of the hospital Social Worker) was one of them who came to calm us … and **the doctor** who helped us… the hospital personnel **was very good**"* ("Om die waarheid te sê daar was een suster wat ons baie gehelp het … Sr. O en suster B was een van it wat ons kom kalmeer het … en die dokter wat ons gehelp het … die hospital personeel was baie goed …") (Participant 8).

In line with these findings, James (1989:20) refers to such assistance by the hospital staff as "… setting the tone …" directly after the loss occurred and Cacciatore and Bushfield (2008:76) concur that "… supportive responses are beneficial." in coping with the loss.

Only one participant expressed that he did not have a pleasant experience with the professional hospital staff. This is demonstrated by the following narrative:

*"… when I came here it **wasn't a warm reception** like one would actually expect in a situation like this … I **wouldn't even use the word professional** …"* (Participant 4)

It seems as if this participant had a certain expectation of the professional hospital staff when he arrived at the hospital. This finding relates to participants who had the same experience in a study conducted by Stringham, Rilley and Ross (1982:323). These authors report that their participant at the time of delivering the stillborn baby, experienced a disregard by the hospital staff for their loss. Van Dinter (2012:901) furthermore asserts that this negative attitude by staff can result in a "… increased emotional distress and resentment in parents and other family members."

4.3.4.2 Subtheme 3.2: Explanation of the cause of the stillbirth by professional hospital staff

Participant were requested to explain how the cause of the stillbirth was explained to them by the professional hospital staff. Despite Matjila's (2016:17) indication that most stillbirths are unexplained globally, all of the fathers were able to indicate that there was some form of

explanation provided either to them or to their partners regarding the cause of the stillbirth. This is evident in the following narratives:

"First thing ***he (doctor) said to me*** *blood pressure … **her blood pressure was too high**."* ("Eerste ding het hy vir my gesê die bloeddruk … haar bloeddruk was te hoog gewies.") (Participant 10)

*"**They explained it to my wife** …"* ("Hulle het dit aan my vrou verduidelik …") (Participant 9)

*"Actually they didn't explain to me because it takes me some time to arrive here so actually they didn't talk to me they were **talking to the relative**."*(Participant 6)

The findings indicate that the professional hospital staff explained the cause of the stillbirth to either the father, mother or a relative. The findings concur with a study conducted by Van Dinter (2012:903) on the management of adverse birth outcome which identifies hypertension as a cause of stillbirths amongst 9.2 per cent of the participants. Allen et al. (2004:1) also assert hypertension is the leading causes of "… fetal … mortality worldwide".

Another explanation of the cause provided to some of the other participants was that the stillbirth occurred as a result of an infection. The following narrative demonstrates this:

*"They explained to me that it was a … **it was an infection** if I may say … like the baby … uhmmm … fed some dirty stuff … because the water broke already yah … the doctor at S (name of the hospital), she's the one who explained …"*(Participant 8)

*"… the water broke on Tuesday when she felt that she wanted to go to the toilet and if they (the clinic) could, the following day when she went to the clinic, they could've stopped the water, it couldn't but now the **water was already infected** and the baby couldn't stand that infection so the baby had to come knowing that six-month-old baby couldn't survive."* (Participant 1)

These findings illustrate that participants understood the causes of stillbirths explained to them. The findings also relate to Flendady et al. (2011:1706) who assert that 12 per cent of stillbirths can be attributed to infections and they state that infection could normally be attributed as a cause in early gestation.

In addition to infection as a cause identified by Flenady et al. (2011), they also report that umbilical cord complications can be regarded as both a contributing factor, as well as a sole cause of stillbirth. The following narrative is an example of this cause of stillbirth:

"The umbilical cord that was around … was around her neck and it … and it caused death." ("… die naelstring wat om … om haar nek gewees het en dit … en dit het die dood veroorsaak.") (Participant 2)

4.3.4.3 Subtheme 3.3: Help or assistance offered by hospital staff

It is of significance to note that Conry and Prinsloo (2008:17) assert that the memory of stillbirth is dictated by the support received from the professional hospital staff at the time when it occurred. Van Dinter (2012:900) furthermore confirm that the multi-disciplinary team should be flexible when loss through stillbirth occur and they should also acknowledge the effect of the loss on the entire family. In doing so, the support offered would not only be for the mother, but should also include the father and the entire family involved (Van Dinter, 2012:900). From participants' account of the exploration of help or assistance offered by hospital staff it is evident that hospital staff offered assistance that included **help from professional hospital staff** to the entire family:

*"**They said there are social workers, you can speak with them**. They asked us whether we have support from family and all that."* ("Hulle het gesê daar is Social Workers, jy kan praat met hulle. Hulle het ons gevra of ons ondersteuning het van familie af en almal daai.") (Participant 3)

*"**I need to come to sister B (Social Worker surname)** or if I perhaps can use my own medical aid for other … how do they say … psychologist … but I need to get help"* ("Ek moet na suster B toe kom en of as ek nou miskien my eie medies kan gebruik vir ander … hoe se hulle … sielkundige … maar hulp moet ek kry.") (Participant 9)

*"They offered the **counselling** at the S (name of hospital) hospital … Mr S (hospital Social Worker) did the counselling. He helped us a lot."*(Participant 8)

Findings from the study indicate that more than half of the participants were offered help and had a choice of whether they would like to utilise it or not. The findings are confirmed by Van Dinter (2012:901) who asserts that parents should be given the right to "… decide what feels right for them …" at that moment and their wishes should be respected. It is worth noting the assistance that was offered was predominantly in the form of counselling with the hospital social worker after the occurrence of the stillbirth. Pauw (1991) supports these findings when she asserts that due to the severe psychological and social impact stillbirth has on the parents,

the role of the social worker is crucial in assisting with counselling. The findings further demonstrate that the counselling assisted the fathers a great deal in coping with the loss.

It is worth noting that Cacciatore and Bushfield (2008:62) found that although social work counselling intervention in the hospital is important, it might not be sufficient, they suggest that as a result of this, community-based counselling services may be employed to further provide assistance to the family after the discharge from the hospital. Likewise Sousou and Smart (2015:244) emphasise that the care of a family who has suffered a stillbirth continues after the discharge from the hospital. In this regard one participant said:

"Uhmm … at V(name of the hospital) hospital there were no follow up or any help offered but when we came here(reference to being transferred to another hospital) ***two social workers came to us*** *… they were asking if we want to come back again for counselling sessions and then I told them uhmm …* ***I have my own psychologist of which I go each and every Thursday at the Local Clinic*** *…* ***and then my partner goes*** *…* ***goes to student wellness to see a psychologist*** *… so it won't be necessary."*(Participant 5)

However, for some other fathers, **no help or assistance was offered by the professional hospital staff**. This is demonstrated in the following narrative:

"They only gave the news and ***no help was offered*** *…"* ("Hulle het mos net die nuus oorgedra en geen hulp aangebied nie …") (Participant 2)

*"****No support*** *… from an emotional side* ***there was nothing*** *…"*(Participant 4)

These findings concur with the assertion made by Conry and Prinsloo (2008:17) that supportive services and other programmes with the same aim is at times non-existent within South African health facilities. Van Dinter (2012) however asserts that this may be as a result of physicians shifting the parents to the nursing staff who are also not skilled to offer any emotional assistance or help since findings indicate that emotional support was the need of most fathers at that particular point when the stillbirth occurred. In addition Aho et al. (2009:100) assert that professional hospital staff fail to provide any assistance to fathers who experienced the death of a child because they may minimise the effect of the loss on the fathers.

4.3.4.4 Subtheme 3.4: Manner in which help offered assisted in coping with the loss

Participants were asked to explain how the help of the hospital staff assisted them to cope with the news of the stillbirth.

a) Category 3.4.1: Unhelpful assistance

Findings of the study indicate that almost all the fathers experienced that the assistance offered did not help them to cope with the stillbirth at the time due to their own **state of confusion**. This is demonstrated in the following participant's statement:

"I was in a different state, you know nothing… they spoke with me but I ***did not really take note of what happened*** *there."* ("Ek was in 'n ander toestand, weet kan niks … hulle het gepraat met my maar nie regtig note gevat van wat daar aangaan nie.") (Participant 3)

The finding demonstrates that despite being offered assistance and utilising it at the time when the stillbirth occurred, it was still not helpful at the time because the participants was in a state of confusion. Similarly participants who experienced a stillbirth in a study conducted by Corny and Prinsloo (2008:20) also reported that the timing when the assistance were offered was the cause of its uselessness to the receiver. The following narratives state that it was not the actual counselling that was useless, but rather that the fathers' **focus at the time was on the mother** rather than on himself:

"She's breaking down someone must be strong, so ***I just had to be*** *there so it was just me and my partner no one else … no assistance …"* (Participant 4)

"On the one side I saw here my wife is laying almost dead, I had to stay with her … ***stay with her for support*** *… in a case like this word doesn't count. They don't experience what you go through at that time …"* ("Aan die een kant het ek gesien hier le my vrou amper dood, ek moes vir haar bly … ek moes by haar bly vir ondersteuning … in so geval tel woorde mossie. Hulle ervaar nie wat jy deurgaan nie daai tydtie …") (Participant 10)

These findings are supported by an assertion by Van Dinter (2012:903) that fathers often feel the need to supress their own emotional state at the time of the stillbirth, therefore they focus on the mother.

Some participants experience the assistance offered by the professional hospital staff not helpful dude to their **emotional state at the time**. These participants were experiencing denial and anger respectively which is regarded as natural responses to grief according to Kubler-Ross (1989). The following statements illustrate the state the fathers were in at the time when they utilised the assistance offered through counselling:

*"Not much because I wasn't very talkative with them, I just told them what I told them and then I just sat there and **I was kinda angry** so it didn't help much …"*(Participant 5)

*"**How do you deal with a case if they tell you your child is dead**? **You cannot deal with it** I mean it is … it is … it is just a difficult … it is just a difficult case."* ("Hoe hanteer jy nou 'n saak as hulle jou se jou kind is dood? Jy kan dit nie hanteer nie want ek bedoel dit is 'n … dit is 'n … dis maar net 'n moeilike … dis ma net 'n moeilike saak.") (Participant 2)

b) Category 3.4.2: Helpful assistance

In contrast, some participants felt that the help offered were of great assistance to them. It is evident in the following narratives:

*"**They (nurse) helped me** … helped me in like they were telling me as you know in life these things they do happen and like **from their own experience** they would tell us … they were telling me that you know these stuff we see it every day …"*(Participant 8)

*"It's just Sr. O (surname of nursing sister) … **I think she also lost one** … lost a small one … she also to both of us … I was in the room … **she spoke with both of us** …"* ("… is net Sr. O … ek dink syt oek ene verloor … 'n kleintjie verloor … syt oek aan ons altwee … ek was mos in die kamer … syt saam ons altwee gepraat …") (Participant 9)

These findings illustrate that the source of assistance lied within the hospital staff sharing their personal experience of loss with the fathers. Evidently, this was of great value to the fathers and they could be comforted in the fact that those who offered assistance experienced the same things as they did at the time. Learning about the experiences of others who were in a similar situation is affirmed by Cacciatore and Bushfield (2008:67) as a validation of hope from a situation that seems impossible to get through at that particular moment. However, the source of assistance mentioned by these participants specifically refers to the nurses. Although scholars (Pauw, 1991; Cacciatore & Bushfield, 2008) recognise the social worker as a source of assistance, Kelley and Trinidad (2012) support these findings with findings in their own study

where participants identified the nurses to be very helpful in the event where the physician would desert them.

4.3.5 Theme 4: Coping with grief

In experiencing loss through stillbirth, Forhan (2010:148) introduces transitional phases that a family experience during the loss. These include "… (1) beginning the journey, (2) realising the loss, (3) moving forward, and (4) resumption. In line with these transitional phases, this section will cover phase two when the loss became a reality as well as phase three whereby the fathers were expected to move on with life despite the experience of grief. In exploring this, fathers were asked to talk about their experience of coping with grief. The following subthemes emerged from the findings of the study.

4.3.5.1 Subtheme 4.1: Source of paternal support

Fathers who participated in a study conducted by Samuelson et al. (2001:127) expressed a great need for support after they returned home following the stillbirth. Similarly, participants in this study were also requested to identify the source of their support.

a) Category 4.1.1.Family

Almost all fathers indicated that they have received support from one or other family member. This is illustrated by the following statements:

"From my parents … closest ***family*** *… from my, from my brothers and susters …"* ("Van my ouers af … naaste familie … van my van my broers en susters …") (Participant 2)

"From my ***family*** *… my mother, my sister's children, her mother and her family, her grandfather, her aunty and everyone".* ("Van my familie … my ma, my sister se kinders, haar ma en haar familie, haar oupa, haar aunty en almal.") (Participant 3)

"From the other ***family members*** *… they have been there, they are older than me …"* (Participant 6)

"My ***mother supported me*** *yes … just my mother yes"* ("My ma het my support ja … net my ma ja.") (Participant 7)

Research conducted by Erlandsson et al. (2011) supports these findings as they also found in a study on parental grief after a stillbirth, that fathers identified their family as one of their sources of support. It is worth noting that families can provide a platform for fathers to be able to "… express their emotions" (De Montigny et al., 1998:153).

b) Category 4.1.2.: Religious community

In addition to receiving support from the family, some participants also acknowledged the role that their religious community played in supporting them. This is in line with assertions by scholars (Aho et al., 2009; Erlandsson et al., 2011; Samuelsson et al., 2001) who also recognize the role that the church's intervention and spiritual leaders play in supporting the grieving father. It is evident from the following narratives that due to the feeling of helplessness that the experience of a stillbirth evokes within a person, that resorting to religious community assisted the fathers to gain a new perspective on their experience.

"I get most of the support from my family … Even ***at church*** *… I received a lot of support from the church …"* (Participant 8)

"Firstly my minister. ***My minister was very involved****"* ("Eerstens my predikant. My predikant was baie betrokke.") (Participant 10)

c) Category 4.1.3: Partner

In contrast to the aforementioned findings, it is worth noting that only one participant went to their partners for support.

"I would say my ***partner*** *because yah my partner cause after like going to church and going to counselling sessions I started to become one with her so we would discuss that we should go for grief counselling together as a couple but then due to financial barriers we couldn't …"*(Participant 5)

In line with this finding, a number of studies (Aho et al., 2009; Erlandsson et al., 2011; Samuelsson et al., 2001) on the support after the experience of a stillbirth also identified the partner or wife as a source of support. It is significant to observe from findings in this study that none of the other participants identified their wife or partner as a source of support. The researcher could assume that this might be the case as fathers often regard themselves as a

source of support to the mother or other family members instead of being on the receiving side of the support.

4.3.5.2 Subtheme 4.2: Personal coping mechanism strategies

Participant all responded differently when questioned about their personal coping mechanisms. The findings emphasise the uniqueness of humans and therefore the uniqueness of each father who participated in this study. Wood and Milo (2010:635) support these unique responses from the participants when they acknowledge that the experiences of fathers after the loss of a child are unique. A study by Edwards et al. (2009:141) also supports the findings of the current study when they identified the **consumption of alcohol** as a coping mechanism. The following are narratives from fathers who indicate the various coping mechanisms they individually applied.

For one a coping strategy can be to participate in sport:

*"... sometimes when I'm free I would go and **play soccer** just to relax a bit."* (Participant 8)

A second participant indicated that he coped by consuming alcohol:

*"**Just alcohol** ..."* ("Net alcohol …") (Participant 2)

Fathers often also cope with the loss after a stillbirth by **communicating about it with their partners** (Edwards et al., 2009:141). This was the experience of one of the participants where it evident from the narrative that he communicated about the stillbirth event with his partner and with others about his feelings.

*"**I communicated with my** ... **partner** ... **With my partner I communicated about my stillbirth**, **with other people** I mentioned, I communicated feelings that I felt at that particular moment ..."* (Participant 5)

For another participant supporting his wife was a way in which he was coping as he describes her to express her feelings of grief in a destructive manner and he had to support her.

*"It was difficult ... **my wife was very, very emotional** for the, for the whole period. I had to watch my sit and my stand there. Anything irritated her ... I had to just **support her**."*("Dit was moeilik … My vrou was baie, baie emosioneel virrie, virrie hele tydperk. Ek moes maar my sit en my staan ook ken daar. Enigeiets het vir haar iriteer ha … ek moes maar net vir haar support) (Participant 10)

Positively, one father **used skills acquired from substance rehabilitation** in order to cope with the loss of the baby in his current situation. In line with the assertions from Edwards et al. (2009:142) that fathers often resort to the use of a substance to cope with the loss, one would have assumed, being a former substance user, this participant was at risk of relapse. Instead, he was able to critically assess the circumstances of loss he was experiencing and replaced the grief with the substances and used rehabilitation skills acquired as coping mechanism.

"To say the truth, I … I was a druggie to say so in recovery. I come from rehab from 30 days I was there. I learnt a lot, I took in a lot on ***how to deal with certain situations*** *and it helped me even until today. The 12 steps programme I used and I just put the drugs aside and* ***moved the grief into the drugs' place****. And those 12 steps helped me until today."* ("Om die waarheid te sê, ek … ek was 'n druggie om so te sê in recovery. Ek kom uit rehab uit van 30 dae was ek daa. Ek het baie geleer, ek het baie baie ingevat daa hoe om sekere situasies te hanteer en dit het vir my gehelp tot op vandag toe. Die 12 Stap program het ek gebruik, ek het net die drugs eenkant gesit en toe skyf ek die rou in, in die drugs se plek. En daai 12 stappe het vir my gehelp tot vandag toe.") (Participant 9)

In contrast to the above findings, one participant indicated that he **was not able to cope at all with the loss**. The findings from the narrative below illustrate that the cause for his inability to employ coping mechanisms after the loss lies within constant flashbacks of the delivery of the stillborn baby.

"There was nothing for me … everyday then ***I still see it in front of me*** *how she came out …"* ("Daar het niks vir my … elke dag dan sien ek dit nog altyd voor my want ek het gesien hoe kom sy uit …") (Participant 3)

This finding is in line with assertions made by Lindemann (1944) that characteristics of grief are a preoccupation with the image of the deceased.

4.3.5.3 Subtheme 4.3: Gender differences in grieving

Fathers were requested to indicate how the manner in which they grieved was different from that of their partner or wife. Findings show that almost all the participants indicated that they did not display their emotional response to grief publicly. This finding is in accordance with observations by Edwards et al. (2009:142) that fathers often feel the need to suppress their feelings and portray a façade of being strong for his family. They, therefore, observed that their

wife or partner was able to publicly display emotions such as crying mostly. The following statements demonstrate this:

*"I think I was **stronger than her** ... with her, you **could see she is very stressed** ..."*(Participant 1)

*"... **so I'd be alone and cry myself** to sleep and then **in the company of people I would just pull myself together** but with her **she would just weep anywhere** like we would be walking in town and she would see a couple with a baby and she would just weep but then I hold myself together for her but she just weep in front of everyone."*(Participant 5)

*"**Yah the woman she would be always crying** if you want to talk about that, she's always crying but as for me **as the father I must be there for her to calm her down** ... because we **can't be both of us crying** in the house."* (Participant 6)

These findings are supported by scholars (Spaten, Byrialsen & Langdridge, 2011), who acknowledge that the manner in which these participants grieved compared to their partners or wives could be ascribed to the cultural expectations of men. Wood and Milo (2001:637) also assert that the manner and period of grief are different between mother and father. This difference in grieving is evident from the abovementioned narratives of participants. It was observed by Wood and Milo (2001:646) that fathers may also be less public about their response compared to mothers, as mother are generally more talkative about their emotions.

For another father, likewise, the difference in the manner in which his wife grieved compared to him was also by private expression of emotions. However, in this case, he expressed that his wife compared to those in the aforementioned narratives were not public in her display of grief, but was isolated. This led to the grieving father taking responsibility for the household chores whereas the mother through her grieving process disengaged from her attachment with her living child. He said:

"*She was normally in the room a lot, she kept herself in the room, there one side in the room and **I had to keep the fort with my girl** child during that time ... I also silently ... slipped into the room and cried because I didn't want my child to see I was crying, but it was a sore process"* ("Syt gewoonlik baie in die kamer gewees ne, syt mos maar net in die kamer vir haar gehou, daa eenkant in die kamer en ek moes maar hier met my meisiekind die fort probeer hou maar

in haai tyd … het ek ook maar ge … stilletjies in die kamer geglip en gehuil want ek wil nie he my kind moenie sien ek huil-lie, maar dit was 'n seer proses …") (Participant 10)

This finding shows that grieving was difficult for this father, but despite this, the mere presence of his daughter in the absence of the one he was grieving for was a source of strength for him. Similarly a father in a study conducted by Spaten et al. (2011:15) supports this finding further by asserting that the presence of a surviving child does not allow disintegration from life.

4.3.5.4 Subtheme 4.4: Reaction of the community towards the father's grief

Wood and Milo (2001:637) places great emphasis on the impact of societal expectation of men while they experience grief. They presented results in support of this statement that indicates that fathers are forced to grief differently due to the response of the community towards them while grieving (Wood & Milo, 2001:637). Within this context, the fathers were asked to indicate how the community responded to their grief.

a) Category 4.4.1: Lack of support from the community

All the participants were able to indicate some sort of reaction from the community towards them as grieving fathers; however, it was observed in the findings that some of the participants' responses had some element of not informing anyone in their community. This is evident in the following responses:

"Firstly we ***didn't want everyone to know*** *about it …"* (Participant 1)

*"****Few people knew*** *…"* ("Min mense het geweet …") (Participant 3)

"It was ***not something we shared*** *it was just me and her …"* (Participant 4)

These findings demonstrate what McCreight (2004) refer to as grief ignored. This kind of grief may be related to the decision to remain quiet about the loss or only inform a select few which may be in line with what is asserted by Dubose (1997:367). This author emphasises that men's fatherhood is brought into question through a stillbirth as they grapple with whether they can be regarded as fathers or not since they do not have a child as proof for this. Furthermore, the result that emerges from this finding in the current study indicates that the decision of not disclosing the news of the stillbirth may be as a result of not wanting to appear vulnerable and weak as a male due to societal prescripts of men (Stinton et al., 1992:219).

b) Category 4.4.2.: Support from the community

For a few respondents, the community reacted to their grief with **concrete assistance** and support:

*"The **community** itself … **were very involved** with the funeral …"* ("Die gemeenskap homself … was baie betrokke by die begrafnis …") (Participant 2)

*"They **helped me**, they **stood by me**. If I perhaps needed a lift to the hospital, they drove me."* ("Hulle het my gehelp, hulle het saamgestaan. As ek miskien 'n lift kry of so hospitaal toe dan ry hulle vir my.") (Participant 7)

The results are supported by findings in other studies. Stinton et al. (1992:219) assert that fathers are often perceived by the community members to be the stronger one and suppressing their emotions. Therefore, findings indicate that the concrete assistance with the funeral and offering various lifts to the hospital to the father was perceived by the community to be the responsibility of the father at that time. Consequently, concrete assistance instead of emotional assistance was offered by them to these fathers (Stinton et al., 1992:219).

Some fathers received an **attitude of sympathy** from the community they reside in. This is illustrated by the following statements:

*"People who know they **feel sorry** for me, yeah, if they would see me they will just feel sorry for me."* (Participant 6)

*"… I can say they reacted very well … they respected me, they **were all like in sympathy** for me you know … the way they would speak to me was different now … even some of them who were not on speaking terms … some would just come and give me their sympathy …"*(Participant 9)

*"I was the one that were well known so they came there, the colleagues around us to, to **sympathise** with me … they were supportive towards me."* ("Ek was mos nou die bekende so hul het maar ingekom da, die kollegas daar rondom ons en my my kom simpatiseer … hulle was supportive teenoor my.") (Participant 10)

In contrast with the former results indicated under this theme, the results, as derived from the aforementioned narratives, indicate the community demonstrating an emotionally supportive reaction towards the father after the stillbirth. In contrast with assertions by Wood and Milo

(2001:648) that men who grief normally does so in isolation, it can be assumed that these fathers were open about their emotional responses following the stillbirth and therefore received this kind of emotional response noted by the community. In view of the fact that various authors (Wood & Milo, 2001:648; Edwards et al., 2009:142; McCreight, 2004:326) stress that men are prescribed by society to be inexpressive about the emotions following the stillbirth, Balswick and Peek (1971) assert that males can unlearn the inexpressiveness. Therefore it seems that the sympathetic and supportive response from the community towards these fathers may have stemmed from a state of expressiveness on the part of the grieving father.

4.3.5.5 Subtheme 4.5: Gender differences in community's response towards grief

The participants were asked to indicate how the community treated their grief differently compared to that of their wife or partner.

a) Category 4.5.1: Presence of differences

Worth noting is that it was found that most fathers experienced that the community was more focused on the grief of their wife or partner. The following narratives demonstrate this:

*"The **focus** was much **to the mother** …"* (Participant 1)

*"… most of them they would always say you would **have to be strong for your wife**. For the wife, they would come and take her like … when they see her some of them would take her home, some they started even visited her. For me it was two-three minutes talk but for my wife they would come and sit, share like visit, but for me it was like you just you greet, but for my wife it was nothing like that … a routine like every day they visit her, when they see her they start to talk and some they even **become more close with her**."*(Participant 8)

*"The community were **more focused on her** and obviously **more concerned about her** and so on …"* ("Die gemeenskap was baie meer gefokus op haar en obviously meer bekommerd oor haar en so aan …") (Participant 10)

These findings are supported by assertions made by various authors (Wood & Milo, 2001:648; Stinton et al., 1992) who points out that the grief of fathers is often forgotten. Similarly, McCreight (2015:326) views that paternal grief is often ignored may be a validation for such responses these participants experienced from the community.

b) Category 4.5.2. Absence of gender differences

For other participants, there were no gender differences in the response of the community towards their grief:

*"No there **were no difference**, they treated us the same."* ("Nee daar was nie verskille nie, hulle het ons dieselfde behandel.") (Participant 2)

*"… her **family** were here a lot and **they spoke with her a lot** and with me, sat us down and communicated with us, just the family … but with me many hugs always even the people I don't know asked me…my mother, my father, my grandfather gave me hugs and kisses and said it will be fine …"* ("… haar familie was baie hier en hulle het baie met haar gepraat en met myself, vir ons laat sit en met ons gekommunikeer, net die familie … maar met my baie drukkies altyd tot op mense wat ek nie ken nie het vir my kom vra … my ma, my pa my oupa en my ouma my drukkies kom gee en soentjie gegee en gese dit gaan ohkay wees …") (Participant 9)

Stinton et al. (1992:218) acknowledge that men and woman grief differently. These authors assert that because the mother has the ability to express her feelings following the stillbirth more, compared to the father is no indication that men grief less (Stinton et al., 1992:218). It would, therefore, be unfair to compare the male and female responses to grief (Stinton et al., 1992:218). The fact that these participants did not experience a difference in the community's response to their grief compared to that of their wife or partner can be attributed to insight into these assertions made by Stinton et al. (1992:218).

4.3.6 Theme 5: Consequences of stillbirth

Eight sub-themes emerged under the theme consequences of stillbirth. These sub-themes will be discussed below.

4.3.6.1 Subtheme 5.1.: Initial emotions or reactions

In a study on male perspectives on grief McCreight (2004:328) found that males expressed "… strong emotional reactions following a partner's pregnancy loss …". The initial responses of participants when they were first informed of the stillbirth were explored.

a) Category 5.1.1: Anger and blame

Findings indicate that some of the participants indicated that their reactions and emotions can be characterised by the expression of anger and blame directed at the professional hospital staff and themselves. This finding is confirmed by Cooper (1980:65) who asserts that anger is one of the normal responses to loss. The narratives below show that the anger expressed by the fathers towards themselves and the professional hospital staff stemmed from an observation that they or the staff is to blame for the loss. In support of this finding, Cooper (1980:65) stresses that anger is expressed as parents feel that they have been cheated on and robbed from an opportunity to bring forth this baby into life as well as what they perceived to be their "… marital right …". In addition to blaming the professional staff, Van Dinter (2012:903) supports findings of the current study when she explains that fathers in a study conducted by her also expressed a sense of self-blame. The following statement demonstrates the anger and blame experienced by participants when informed of the stillbirth:

*"Asked yourself what … what did … what went wrong, could the nurses or doctors not do anything regarding the situation … **some anger** …"* ("vir jou vrae maar wat … wat het … wat het fout gegaan, kon die nurste offie dokters nie iets omtrent die situasie doen nie … bietjie woede …") (Participant 2)

*"I was **angry** and somehow … **blaming the nurses** …"* (Participant 5)

*"I was **angry** at myself …"* ("ek was kwaad vir myself …") (Participant 7)

b) Category 5.1.2: Focus on the mother

Other fathers, experienced an immediate need to support and focus on the mother. This is illustrated by the following narratives:

*"**I held her** and asked is our child really dead … I did not know what to do …"* ("Ek het haar vasgehou toe vra ek is onse kind regtig dood… ek het nie geweet wat om te doen nie …") (Participant 3)

*"Ohkay at that point I couldn't much react … it was just a matter of me being strong getting that news and having to **support my partner** …"* (Participant 4)

*"… and when they informed me I had to sit … **I had to hold her** hand and try to cool her down … I put her first and remember it's about her being happy and her being comfortable … I didn't want to show how broken I was."* (Participant 1)

The findings relating to the participants' experience that their initial response was to focus on their partners show that they also did not know how to respond after being informed of the stillbirth. Therefore, as a result, they did what was prescribed to them by societal standards in these circumstances and supported the mother (Spaten et al., 2011). Findings also indicate that the fathers were shocked at the notification of the stillbirth as Samuelsson et al. (2001:125) indicated that due to the magnitude of the loss, their reactions were motivated by an inability to comprehend what was happening to them.

4.3.6.2 Subtheme 5.2: Mechanisms to cope with emotions or reactions

The participants were requested to explain the mechanisms that helped them to cope with the emotions and reactions to the loss to arrive at the aforementioned theme.

Findings indicate that some of the fathers experienced that they did not cope initially, but then resorted to focusing on their wife or partner's pain and grief and this was a coping mechanism for them. This is demonstrated in the following narratives:

*"… there were nothing that really helped me … It was focussing **mostly on her** because she dealt with it differently than what I did"* ("…daar was niks wat vi my regtig kon gehelp het nie … Dis meestal op haar gefokus want syt dit heel different hanteer as wat ek dit hanteer het.") (Participant 3)

*"I had to for the first two weeks **stay at home with her** … I mean her pain was my pain."* ("… ek moes mos maar nou vir die eerste twee weke moes ek mos ma nou by die huis bly saam met ha … ek mean ha pyn was my pyn.") (Participant 10)

In addition to not being able to cope, another father resorted to the use of alcohol. He applied this mechanism while he was waiting for his scheduled counselling session with a psychologist he was seeing even prior to the stillbirth.

*"… **I wouldn't say I was coping** because on the very same day my partner was discharged later the day and it was a Friday and we went home, got home took a bath and I just went out with friends and I just **binged myself you know the whole weekend on alcohol** and tried to*

forget what happened like cause of uhmm … I wanted to talk to someone but then I couldn't but then the ***only person I could talk to them Thursday the following week*** *so the whole weekend I just binged on alcohol yah …"* (Participant 5)

Another participant's coping could be characterised by keeping busy.

"Those ***odd jobs*** *at home that I did"* ("Daai los werkies wat ek by die huis gedoen het, dis al") (Participant 2)

For some participants, they coped with the emotions or reaction by resorting to their religious beliefs and practices.

"I think we were just focused on ***prayer****."* (Participant 1)

The only thing, me as a Christian, I would just say everything ***I put into the Lord****. Lord has got the plan, that's what I can say.* (Participant 6)

The finding confirms with the views of Mendell, McAnulty and Reece (1980) that the manner in which fathers cope with the sudden loss of a child is different than the mother would. These findings indicate that coping mechanisms used by the participants in the current study may be regarded as peculiar by others given the context of the experience of loss (Mendell et al., 1980:221). Therefore, the manner in which the father copes with emotions and his response to the loss and grief are often misinterpreted and understood that he may be less affected (McCreight, 2004:329). The findings are confirmed by McCreight (2004) who asserts that fathers cope with the loss by keeping busy with anything else but coping with the loss. Mendell et al. (1980:222) indicate that these fathers thus postpone the "… grief work." Callister (2006:228) however again reminds that the father's coping mechanisms for their emotional responses to the loss is determined by societal expectation and asserts that the expectation to be the source of strength for the mother and the rest of the family is "… in conflict with his own sense of loss".

4.3.6.3 Subtheme 5.3: Role of religion in coping with the loss

Kubler-Ross (1989:72) emphasised that during the stages of grief, the grieving person, in this case the father, has to acknowledge the existence in God or a higher spiritual power. In view of this, participants were asked about how religion helped them to cope with their loss.

Findings indicate that almost all of the participants acknowledged the importance of a higher power in coping with the loss. Participants specifically stressed how the act of praying that they performed during this time of bereavement helped them. This is demonstrated in the following narratives:

"The church, we were very involved with the church … then we phoned the pastor, she says lets us ***pray****"* (Participant 1)

"You just need ***to pray*** *that's all you can do. It helped because today we can talk about it …"* ("Jy moet mos maar net bid dis al wat jy kan doen. Dit het gehelp want vandag ons kan praat daarvan …") (Participant 3)

"Actually by ***prayers****, even though by the time she was saying she did have some pains, just* ***pray.*** *That was only what we could do."* (Participant 6)

For some other participants it was not necessarily individual religious practices such as prayers that contributed to their coping, but rather their affiliation to a church community and the support offered here that acted as a source of coping for them:

"It helped me well because they told me I have to bury the child, so they gave me a date. The ***church helped me****."* ("Dit het my goed gehelp want hulle het my gese ek moet nou die kind begrawe, toe gee hulle vir my 'n datum. Die kerk het my gehelp.") (Participant 7)

"… when they heard about the news that this is what happened, one of the ***senior leaders at church*** *… uhhhh … some of the people that I would not expect them to help me they just* ***came to me*** *and said wherever you wanna go, whenever your wife is discharged, whenever she wants to go for a check-up or for anything, just call us we will help you."* (Participant 8)

The findings show that the practice of prayer is indicative of a sense of helplessness by the father and motivation to rely on a higher power for endurance. A study by Armstrong (2001:152) confirms the role of religious faith as a coping mechanism during grief and that the loss of a child results in the development of a perception by the father of a lack of control over life events. Furthermore, these findings also indicate that accepting assistance from the church community by the fathers confirms a need for support from outside the family dynamics (Armstrong, 2001:150).

One participant, who is not a spiritual being said:

*"I'm **not a religious** person and also not a traditional intense individual, so for me it was just it had to happen, so that was the belief that was instilled in me."* (Participant 4)

The findings show that religious beliefs did not play a role for this participant. In view of assertions from Kubler-Ross (1989:99), it may be as a result of the fact that the father has accepted the loss already. In this regard, Kauffman and Jordan (2013:144) also assert that to reach such a point the father had to be ready to move on with his life.

4.3.6.4 Subtheme 5.4.: Degree of depression experienced

Participants were asked whether they experienced depression. Findings indicate that more than half of the participants **presented with depression**. These narratives are some of their experiences:

*"**Yes** … **I felt so depressed** yoh, If I could've helped her with all these things she is going through and yoh, then I would've done everything for her and so, but it appears as if I … I can do nothing and I just see …"* ("Ja ek het so depressed gevoel … Ek het so gevoel yoh, as ek ha nog kan gehelp het met almal die goete wat sy deurgaan en yoh,dan sal ek alles gedoen het vir haar en haai, maar dit lyk ek is … ek kan niks doen nie ek sien net hie …") (Participant 3)

*"As a person who was diagnosed with depression last year, I was prescribed an antidepressant so I would say that I think once I was like just, I was like it's too much, let me just commit suicide, but then I was like nah its very cowardly. So I thought to myself let me just not … so I would say uhmm the **degree of depression was very much high**"* (Participant 5)

*"Whenever I go to … I go to work or anytime when I'm not talking to anyone even when I'm travelling in a bus it will always come … you know … these questions they always come … what really happened? … Was it because of my ex … you know you think of a lot of stuff … Yeah cause I would be like sitting here but if I start thinking of that and I start asking those questions I would be like all alone **and feel very depressed**."* (Participant 8)

*"I, I felt that day when I received the news, **I fell into a depression** … you almost don't want to be amongst people … Your mind is just why, you ask yourself the why, why you, why your wife, why not someone else …"* ("Ek, ek voel van daai dag toe ek die nuus gekry het, toet ek in 'n depressive verval … jy wil amper nie tussen mens wees ookie … jou gedagtes is net hoekom, jy vrae vir jouself af hoekom ennie waaroms , hoekom jy, hoekom jou vrou, hoekom nie iemand anders nie …") (Participant 10)

It is evident from the findings that the depression of these participants originated from asking questions about the stillbirth. Kubler-Ross (1989:75) explains that a grieving person, such as these fathers in the current study, experience depression after they have *denied* the loss, been *angry* enough and have failed in *bargaining* with a higher power. In this regard it is worth noting that Clayton (2015:96) explains that men are socialised to be non-expressive of their emotions, it may contribute further to the depression experienced by these fathers as they had to internalise all their emotions which further gave rise to questioning and making sense of the loss. As a result of this, Kubler-Ross (1989:76) refers to this experience as reactive or silent grief.

In contrast, some of the participants indicated that **they were not depressed**. This, however, does not necessarily imply that it was easier for these fathers, but it rather supports views of Kubler-Ross and Kessler (2005) that the stages of grief, including depression is not experienced by everyone, nor followed rigidly in one particular order. The following narratives demonstrate this:

*"I was **not that depressed**."* (Participant 1)

*"I **didn't have any form of depression** … so I accepted it from then, I was like okay it happened it's okay …"* (Participant 4)

*"I **wasn't depressed**"* ("Ek wassie depressed nie.") (Participant 7)

4.3.6.5 Subtheme 5.5: Impact of stillbirth on the relationship with wife or partner

Murphy (1998) observed that the impact of stillbirth or loss of an infant on the romantic relationship and marriage has been largely overlooked in scientific research. Therefore, in view of this assertion made by this author, it was worth examining this phenomenon in the current study. To gain insight into the impact of the stillbirth on the relationship with his wife or partner, participants were asked to describe how the relationship with their wife or partner were affected by the stillbirth.

Findings indicate that almost all of the fathers indicated that their **romantic relationship or marriage was positively** impacted. This is evident from the following statements:

*"I think for me it **strengthened** our relationship …"* (Participant 1)

*"It **is stronger now** because we can talk about her …"* ("Dit is sterkere nou want ons kan praat oor haar …") (Participant 3)

*"Ohkay so I would say in a **positive** way in the sense that ohkay now we are more cautious … we joke about everything. So I think it has actually just put **another level of learning in our relationship** yeah and having to actually do things with a purpose."* (Participant 4)

*"I think what happened it brought us … it made **very strong**, it made us to bond too much. Even the … if I can put it … the **level of love it increased** too much …"* (Participant 8)

Although Cacciatore et al. (2008:363) acknowledged that the experience of stillbirth for parents holds a great amount of risk for the marriage or romantic relationship they explain that stillbirth can also be an opportunity for the marriage and the romantic relationship to be strengthened.

For another participant, the stillbirth, however, had a **negative effect on the romantic relationship**:

*"Let me say so, a month after the … after the stillbirth we did not worry (be in a romantic relationship anymore) … **then we decided that we are not going to worry, she is going back home and that's it**."* (Kom ek se so, se 'n maand na die … na die stilgeboorte toe worry … toe het ons maar besluit ons gaan nie meer worry nie sy gaan trug huistoe en dis dit.) (Participant 2)

It is evident from this finding that the relationship became vulnerable and therefore the couple decided to terminate their relationship (Meyer & Lewis, 1979:361). In addition to this, the finding demonstrates that the decision of the couple was final and that there was no hope to rekindle the relationship after the stillbirth. The findings furthermore support views that society's disregard for grieving stillbirth results in isolation of the parents. Therefore the findings are related to assertions made by Meyer and Lewis (1979) that the marriage or relationship can strengthen after the experience of stillbirth as parents are relying on each other for support.

For another participant, his experience of the effect of the stillbirth on his marriage relates to the assertion made by various authors (Wood & Milo, 2001:648; Edwards et al., 2009:142; McCreight, 2004:326) about a **difference in the manner in which men and women grief**.

"Oehhh ... no it was difficult, it was difficult. My wife was very ... okay as the time went by ***my wife, she was very moody*** *after everything ... moody I would almost use the word ...* ***she appeared very aggressive at home*** *... Anytime, she threw a plate against the wall, threw it broken and* ***so I had to just accept it*** *you see, it was difficult, it was difficult"* (Oehhh … nee dit was moeilik, dit was moeilik, my vrou was baie … ohkay soos die tyd nou aangegaan het was my vrou, sy was baie moody na, na alles … moody ek sal amper die woord … syt baie agressief innie huis voorgekom. Enigetyd het sy sommer 'n bord teen die muur gegooi, stukken gegooi en so maar ek moes dit aanvaar het sien, dit dit was moeilik, dit was moeilik.) (Participant 10)

This narrative demonstrates that there was a divide in the manner in which grief was expressed by the mother who was more expressive and the father being more submissive and on the receiving end of the mothers' grieving. This finding is in line with views of Stinson, Lasker et al. (1992) that woman are portrayed as more expressive compared with fathers because of gender stereotypes. It is worth noting that Stinson et al. (1992:219) maintains that parents who experience incongruent grieving often misunderstood each other which creates a further divide in an already vulnerable marriage.

The findings are further supported by results from other studies. Vance et al. (1995:936) found in their study of parents who experience a stillbirth, mothers presented with a higher degree of behavioural changes as is evident in the aforementioned narrative.

4.3.6.6 Subtheme 5.6: Impact of stillbirth on the relationship with other living children

The loss of a baby through stillbirth is seen to be affecting the whole family system and not just the parents (De Montigny et al., 1999:151). In as much as the parents had an expectation of an alive baby, the surviving siblings are also affected by the stillbirth as it means a loss of a lifelong relationship they could have formed with their expecting sibling. In line with findings made earlier in this chapter regarding the challenges experienced by parents who grieve the loss of a baby through stillbirth, it can be assumed that the surviving siblings are often forgotten while the parents are consumed with their grieving process (Avelin et al., 2011:154). Against this background the participants were requested to indicate how the stillbirth affected their relationship with their remaining or surviving children.

The findings under this sub-theme demonstrate that for almost all the participants who had other living children, their relationship with the surviving children was affected. In view of assertions made by Mandell et al. (2018:222) this is not odd as results from their study indicated that despite fathers expressing a need for a subsequent pregnancy following the loss, the mothers were still fearful. In addition to the aforementioned, half of the participants explained that the relationship with surviving children was positively affected as is evident from the following narrative:

*"… Is **more stronger** … so now I watch them even more infront of me."* ("… is nog sterkere … so nou hou ek hulle nog meer dop voor my.") (Participant 3)

*"… my son is not here in Cape Town so he's in PE … like I said I think we just, **just feel more love** for him uhmm … that's what I actually have, I mean after what happened."* (Participant 4)

*"You see with my living child now it has brought t so **much happiness** in my life because when I look at her every time it just … whenever I look at her even if she is just playing or wash I just have … I just feel happy in my life to say oh today I thank God she's alive, she's walking, she's crying, she's smiling, she's doing … because I remember 2017 I didn't do that so I praise the Lord that I have her now and she's alive yah and the Love is **too much** for her."* (Participant 8)

These findings indicate an increase in affection for and protection over participants' remaining and surviving children as the word "… *more …"* or *"… much …"* were common in their description of a positive impacted relationship. It is further evidence that the fathers are more overprotective of their children after the death of the child. Armstrong (2001:150) supports these findings when she assert that while mothers are often consumed with their loss, the responsibility to care for the remaining and other children fell on the father. In doing so, the relationship with these children are bound to strengthen as in the case of the fathers in the current study (Armstrong, 2001:150).

In contrast, for some participants, the relationship with their children was affected negatively. One participant said:

*"… say we are a **bit distant** cause like as I was saying after the stillbirth **I quite distant myself from my partner and my child** and I became close with my friends like binge (referring to alcohol) … I would say we were quite distant, it affected us in a negative way."* (Participant 5)

This finding shows that the negative impact on the relationship with the surviving children stemmed from resorting to other destructive coping mechanisms. Edwards et al. (2009:131; 14) confirm that fathers often resort to other coping mechanism, including the use of substances like alcohol, as a method to cope with the loss due to their suppressed emotions. In view of this, Avelin et al. (2011:154) assert that parents then often forget to resume their responsibility to parent the surviving children which seemed to be the case with this father.

4.3.6.7 Subtheme 5.7: Impact of stillbirth on work

Findings of a study conducted by Hughes and Page-Lieberman (1998) indicated that fathers who experienced loss identified not only identified an over-involvement in work as a coping mechanism but regarded it also as an activity that distracted them from having to deal with the reality of the loss. The findings indicate that more than half of the participants indicated that their work was not impacted by the loss. The following narratives demonstrate this:

*"**Not exactly on my work** because the driving is also … is dangerous if you perhaps that … vision infront of you … you can anything … I take my mind off of it …"* ("Nie eintlik op my werk nie want die ryery is ook nog … is dangerous as jy miskien met dai … vision voor jou … dingese jy kan enigeiets … ek haal net my mind weg vannit af …") (Participant 3)

*"Nope, **Workwise** it's not, **nothing at all has been affected**."* (Participant 4)

*"The work was very supportive … they were very supportive and **it didn't so affect my work**."* ("Die werk was baie supportive … hulle was baie supportive en dit hettie so seer my werk geaffekteer nie.") (Participant 10)

These findings indicate that the participant's work was not affected, but in contrast, it stresses that the participants regarded the work as a source of support instead. It is worth noting that Mandell et al. (1980:222) acknowledged that compared to mothers, fathers are not very talkative about their experience of grief. In view of this, Edwards et al. (2009:131; 141) observed that fathers often resorted to an over-involvement in work as coping mechanism. It is of importance that these authors' (Edwards et al., 2009:131; 141; Mandell et al., 2018:222) state that they found that fathers instead of experiencing challenges in their work after a stillbirth, they rather found this environment as a source of support and coping. In addition Edwards et al. (2009) report that the fathers' work often acts as an escape from the reality of loss. However despite this, the fathers did not recognise that the experience of grief was still easy for them.

A few participants, however, reported that their work was affected by the stillbirth:

*"It **affected me all the time**. Every time I worked I could not concentrate … Sometimes then I make mistakes and so, then I rectify it again."* ("Dit het my heeltyd ge-affect. Aanmekaar as ek werk dan kan ek nie concentrate nie … Somtyds dan maak ek foute en soe, dan maak ek dit weer reg.") (Participant 7)

*"My work **was affected** to a point that I … I … **I wasn't like feeling again like just to, to, to, to go to work**. It really affected me that the following year **then I resigned** at that work."* (Participant 8)

These findings demonstrate that the experience of the stillbirth was difficult for some participants and that it affected their functioning at work. Invalidation of this, Cooper (1980:65) asserts that while the father allows the mother to grief properly, he needs to resume responsibility for household tasks and other activities alone. This suggests that when the father would return to work, as much as it would be an escape from the loss as asserted by Edwards et al. (2009), he is still concerned with the other tasks given to him because of the stillbirth. In providing another theoretical validation for the negative impact on the work of the grieving father, McCreight (2004:329) highlighted that results from their study demonstrated that fathers who are grieving because of stillbirth may experience impaired functioning in some aspects of their life as they do not know how to deal with the loss.

It is also worth noting that the findings showed that one father was unemployed at the time of the grief. Consequently, he was not able to respond appropriately to the question.

4.3.6.8 Subtheme 5.8: Factors contributing to accepting the loss

The last theme that emerged from the findings of the study is *factors contributing to accepting the loss.* In line with the theoretical framework of Kubler-Ross (1989:99) used in the current study, acceptance is regarded as the final stage of grief. It is therefore assumed that throughout the stages of grief, any grieving person should ultimately aim to achieve acceptance of the loss after the experience of loss (Kubler-Ross, 1989:99). In pursuing what helped participants to accept the loss and feel better about it, almost all participants reported that they have reached a stage of acceptance. Due to the unique experience of grief, the participants provided various responses about what contributed to accept the loss and feel better about it.

The following narratives demonstrate how some participants accepted the loss and felt better about it after there were **prospects of a subsequent pregnancy**:

*"I think when she **announced the second pregnancy**. I was like at least we may forget about what happened …"* (Participant 1)

*"I think after that two years when my wife came to tell me one morning that she feels nauseous, then there was an excitement in me then I said no man, the life, life does not sit in the hands of the doctor and then obviously **my wife were pregnant again** and thereafter I started to have a positive outlook on life again"* ("… ek dink na daai twee jaar toe my vrou een oggend vir my kom se sy voel naar toes daar so oplewing in my toe se ek nee man, die lewe, lewe sit nie in die dokter se hande nie en toe obviously is my vrou toe weer swanger en daarna toe begin ek weer positief uitkyk na die lewe.") (Participant 10)

These findings are supported by the results of another study. Mandell et al. (1980:222) asserts that results in their study on the paternal response to loss demonstrate that in comparison to grieving mothers, fathers more often wanted a subsequent pregnancy. The findings of the study correspond with this view as narratives demonstrate that accepting the loss was on condition of a subsequent pregnancy. In addition, Erlandsson et al. (2011:147) noted that the forecast of a subsequent pregnancy provides grieving parents with a sense of getting back control over their lives.

For other participants, the assistance and **counselling offered by the professional hospital staff** contributed to their acceptance of the loss. The following narratives demonstrate how the counselling offered by hospital staff amongst others was crucial as it is offered at the forefront of the stillbirth experience (Erlandsson et al., 2011:147). Although the support from family is crucial in accepting the loss, it only surfaces later (Erlandsson et al. (2011:147). Furthermore in support of the results in the current study, it is of importance to note that results from a study conducted by Erlandsson et al. (2011:148) indicate that fathers identified the counsellor as a primary source of support compared to the mothers who reported the midwives were the primary source of support (Erlandsson et al., 2011:148). They said:

*"I would say **the counselling** yah … but then somehow she made me see that not everything is up to me, some things I just have to let it be its part of life. I would say counselling helped …"* (Participant 5)

"Uhhh ... it was ... uhhh ... what made me feel better it was the help from the ... hospital staff, ***the counselling*** *from the counsellor ..."* (Participant 8)

For some of the other participants, their acceptance is rooted in their **religious beliefs** and **support received from the church community**. The following statements from participants demonstrate this:

"What I'm saying the ***religion*** *..."* (Participant 6)

"I ***went to church every day*** *... then they come to us then we pray and so ... The priest was also by me and so and* ***then they pray for me****."* ("Ek het kerk toe gegaan elke dag … dan kom hulle na ons toe dan bid ons en soe … Priester was ook by my en soe en dan bid hulle vir my.") (Participant 7)

The findings are supported by Armstrong (2001:150) who observed from fathers who participated in her study that the loss of a baby was validated through their religious beliefs and influences. Likewise, the fathers in the current study identified religious influences as contributing to their acceptance of their loss as it allows them to make sense of the loss.

4.4 CONCLUSION

In conclusion, it is worth noting that men grief under tremendous challenging circumstances that are influenced by many factors. This chapter aimed to achieve the third objective of the study which was to investigate the experiences of the fathers after a stillbirth. By using a semi-structured interview schedule that was developed by consulting literature in chapters two and three, the researcher was able to collect and analyse data. In doing so, themes, subthemes and categories were identified. In this chapter, the researcher presented the findings related to these themes, subthemes and categories and was able to also draw on existing theory for a literature control. The analysed data presented in this chapter will be used to arrive at conclusions and recommendations that will be presented in the following chapter.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

As stated in chapter one the research question of the study was “How do fathers grief after the experience of a stillbirth?” Consequently, the aim of the study was to gain an understanding of the grief of fathers after their experience of a stillbirth. This chapter will set out the conclusions and recommendations based on the findings of the empirical study as presented in chapter four. This chapter aims to achieve the fourth objective of the study which is to draw conclusions and recommendations relating to the experience of fathers’ grief after a stillbirth based on the results of the study.

In order to answer the research question and to achieve the aim of the study the following four objectives that have been fulfilled were identified:

Chapter two addressed objective one which was to discuss and explain the causes and consequences of a stillbirth as medical phenomenon while chapter three fulfils objective two that was to discuss the nature and extend of the grieving process of fathers after a stillbirth according to appropriate theoretical viewpoints. Chapter four, which offered the research results addressed objective three that was to investigate grieving of fathers after a stillbirth.

Finally, this chapter five fulfils objective four that is to draw conclusions and make recommendations relating to the experience of fathers’ grief after a stillbirth based on the results of the study.

5.2 CONCLUSION AND RECOMMENDATIONS

This section will depict the conclusions and recommendations of the study based on the findings of the study offered in chapter four. The section will firstly provide conclusions and recommendations related to the profile of the participants followed by conclusions and recommendations based on findings related to the themes, subthemes and categories that emerged from the empirical findings. The themes included the pregnancy, the stillbirth, the multi-disciplinary team, coping with grief and the consequences of stillbirth.

5.2.1 Profile of participants

In view of the criteria for inclusion indicated in chapter one, all the participants were males. Findings furthermore indicated that the participants were almost all in the early adulthood life stage and were equally conversant in English and Afrikaans. In addition, participants were almost all in partnered relationships compared to only a few that were married. The duration of most of the partnered relationships or marriages were more than two year. Almost all of the participants were employed with other living children. Findings also indicated that almost all the pregnancies were planned.

It can be concluded from findings that early adulthood is the life phase during which most males become parents. Hence most of them are in either a partnered relationship or marriage already for more than two years, planned the pregnancy and already have other children.

Recommendation:

- Social workers and professional hospital staff should alert fathers who are the early adulthood life stage about the risk of experiencing a stillbirth.

5.2.2 Theme: The pregnancy

Three sub-themes and five categories emerged under this theme. The relevant conclusions and recommendations will be presented below.

5.2.2.1 Subtheme: Feelings towards the pregnancy

Findings indicated that all of the fathers were happy about the pregnancy. It can be concluded from the findings that the fathers were overjoyed about the pregnancy as it did not just mean the arrival of the new baby, but it meant that they would progress their status from being an adult male to also being a father. It can therefore concluded that the happy feelings expressed towards the news of the pregnancy have deeper roots than being just an expression of a specific emotion after being informed of the pregnancy.

Recommendation:

- Medical staff should encourage wives and partners to acknowledge fathers' feelings of joy about the news of the pregnancy and that they should not only be consumed with their own feelings about the pleasant news of the pregnancy.

5.2.2.2 Subtheme: Involvement in the pregnancy

Regarding the involvement of the father in the pregnancy, two categories became evident from the findings namely ensuring the comfort of the wife or partner and accompanying the wife or partner to antenatal visits. The conclusions and recommendations of these categories are discussed below.

a) Category: Ensuring the comfort of the wife or partner

In ensuring the comfort of the wife or partner, findings indicated that some of the participants deemed it their task to ensure that their wives or partners are physically comfortable by providing them with food that she craved for, cooking for her and pampering her with massages and foot rubs amongst others. It can therefore be concluded that the fathers acknowledged the importance of creating a comfortable environment for their wife or partner in order to achieve a positive pregnancy outcome. It also emphasises the excitement and deeper meaning that the pregnancy and ultimately the arrival of the baby holds for the fathers.

Recommendation:

- Professional hospital staff should inform wives and partners that they should allow fathers to create a comfortable environment for them during the pregnancy, as this could be an expression of their excitement towards the pregnancy.

b) Category: Accompany wife or partner to antenatal visits

Findings indicated that the fathers' involvement in the pregnancy is characterised by fathers accompanying their wives or partners to the antenatal visits. It can be concluded that accompanying the wife or partner to the antenatal visits is evident of the father's concern about the overall health and wellbeing of the mother and the unborn baby.

Recommendations:

- Professional hospital staff should inform mothers that antenatal visits should not be seen as the responsibility of the mothers alone, but that the fathers should be encouraged to attend the visits too.
- Professional hospital staff offering antenatal clinics programmes should accommodate the involvement of the fathers too and not solely focus on the readiness of the mother to give birth, but also on the role of the father during the pregnancy.

5.2.2.3 Subtheme: Preparations for the arrival of the baby

Findings that emanated from the preparation of the father for the arrival of the baby, yielded three categories namely financial preparations, purchasing of necessities for the baby and making arrangements for more conducive living conditions. Findings under this sub-theme indicated that all the fathers found it crucial to prepare in some way or the other for the arrival of the baby.

a) Category: Financial preparations

It is evident from the findings that fathers saw the need to prepare financially for the arrival of the baby. It can be concluded from the findings that despite whether the pregnancy is planned or unplanned, fathers still regard it necessary to be financially prepared for the arrival of the baby. This action is motivated by the insight shown by fathers that in order to meet most of the needs of the baby, additional financial resources are required as the baby is a new addition to the family. Therefore, most fathers acknowledged that their current financial resources will not be sufficient to provide optimal care for the baby.

Recommendation:

- Professional hospital staff should inform mothers that they should allow fathers to prepare financially for the arrival of the baby. This will enable them to focus on the health of their wives or partners and the unborn baby' health as it will eliminate stress.

b) Category: Purchasing of necessities for the baby

Findings under this category indicate that the fathers regarded it as their task to prepare for the arrival of the baby by purchasing items that are deemed a necessity when the baby arrive. These

items can include a pram, clothes, bottles, facecloths, towel amongst others. From the findings, it can be concluded that while the fathers perceived the mother to be responsible for ensuring that the baby is healthy during the pregnancy, the father deemed it of importance to prepare for the baby. Since purchasing items of necessities for the baby is often an act displayed publicly, it can be concluded from the findings that in doing so the fathers are able to boast and express their pride for the arrival of a new role of becoming a father to the broader society.

Recommendations:

- Society should acknowledge the act of fathers purchasing items for babies and move away from gender stereotypical ideas that it is only done by expectant mothers.
- Mothers should allow fathers freedom to purchase items or necessities for the baby as it has a significant meaning for the father.

c) Category: Making arrangements for more conducive living conditions

Findings indicate that the father prepared for the arrival of the baby by ensuring that they move towards more conducive living conditions. It can be concluded from the findings that the fathers acknowledged that the environment that the mother resides in has an effect on her health and ultimately the health of the baby. These actions of fathers of preparing for the arrival of the baby can be seen as a proactive manner of preparation which required a lot of logistical arrangements to move from one location to another. Furthermore, it can be concluded that in doing so, the fathers expected a positive pregnancy outcome by moving the mother to a less stressful environment where she could continue with the pregnancy.

Recommendation:

- Social workers should inform mothers to cooperate with the father in his plans to move her to a more conducive environment, when needed.

5.2.3 Theme: The stillbirth

Findings under this theme yielded four subthemes namely occurrence of stillbirth, place of stillbirth, paternal presence at the stillbirth and informant of the news. The conclusions and recommendations under each of these subthemes will be discussed below.

5.2.3.1 Subtheme: Occurrence of stillbirth

Findings indicated that most stillbirths occurred between one and three years ago. It can be concluded that the occurrence of a stillbirth is an experience that is embedded in the memory of the fathers. It furthermore speaks to the traumatic and even life-disturbing event in the life of a father. It can be concluded from the findings that in comparison with the mother, the stillbirth has just as devastating effect on the father as on the mother when they were able to recall specifications regarding the number of years past when the stillbirth occurred.

Recommendation:

- The professional hospital staff should acknowledge and deal with the effect that the occurrence of the stillbirth has on the father.

5.2.3.2 Subtheme: Place of stillbirth

Findings indicated that all the stillbirths occurred in the hospital. It can be concluded that the hospital is the place where the father would most likely experience a stillbirth.

Recommendation:

- Hospital staff in general should take note of the fact that stillbirths occur in a hospital, as they should ensure that they create a conducive environment in the event of a stillbirth.

5.2.3.3 Subtheme: Paternal presence at the stillbirth

Findings demonstrated that most of the fathers were present at the stillbirth while some were absent. Conclusions and recommendations related to these categories will be discussed below.

a) Category: Present

Findings indicated that most fathers were present at the stillbirth. It can be concluded from the finding that after being aware of the stillbirth, the reason for paternal presence wanting to share in the joy of the arrival of the baby were replaced by being present for the support of the mother who has to deliver the stillborn baby. Therefore, the joy was replaced with an unexpected situation overwhelmed with sorrow.

Recommendation:

- Hospital staff should take the reason for fathers' presence at a stillbirth into consideration and allow fathers to be present during the delivery of the stillbirth as their presence serve a deeper emotional purpose for them.

b) Category: Absent

Some fathers were absent at the time of the stillbirth. Findings indicated that the purpose of their absence was due to unforeseen circumstances or due to being informed after the stillbirth occurred. It can be concluded that the absence of the fathers from the event of the stillbirth, make them more vulnerable to express denial as they did not experience the stillbirth. Coping with the loss after the stillbirth is also bound to be challenging for these fathers as a result of their absence.

Recommendations:

- Professional hospital staff should encourage mothers as far as possible to plan their delivery as to allow the father to be present and alert the father regarding any health concerns as to allow him to prepare and avail himself to be present in the event of the stillbirth.
- Professional hospital staff should inform fathers that they should accompany their wives or partners to as many hospital or doctors visit as to be informed throughout the process of pregnancy and therefore avail themselves for any eventuality.

5.2.3.4 Subtheme: Informant of the news

Findings indicated that some fathers were informed of the stillbirth by their wives or partners and others indicated they were informed by either the doctor or the nurse. For another father, he acted as the informant of the news to the mother. Findings furthermore highlighted that the manner in which the news are being shared is crucial in determining how the recipient, in this case mostly the father, copes with the loss. It can be concluded from the findings that the informant of the news of the stillbirth, whether it be the wife or partner to the father or, the father to the partner or wife, or the doctor or the nurse, they should be mindful of the sensitive nature of such news. It can be concluded that sharing the news of the stillbirth is not a task that

should be taken lightly, but one that is not always easy to perform especially for the partner or wife to inform the father and vice versa as they are within the centre of the experience.

Recommendation:

- The informant of the news of the stillbirth should take cognisance of the manner in which they share such sensitive news.

5.2.4 The multi-disciplinary team

Four sub-themes were evident from findings related to this theme namely attitude of the hospital staff, explanation of the cause of the stillbirth by professional hospital staff, help or assistance offered by hospital staff and the manner in which help offered assisted in coping with the loss. The conclusions and recommendations related to these subthemes are presented below.

5.2.4.1 Subtheme: Attitude of the hospital staff

Almost all the fathers experienced the attitude of the hospital staff sympathetic and supportive towards them. In view of previous recommendations under the subtheme place of stillbirth, it can be concluded from this finding that since most stillbirths occur in a hospital, the attitude of the hospital staff towards the father is important in determining how he will experience the loss at the time it occurs. Furthermore, the attitude of the hospital staff also determines how the father and his wife or partner will experience the loss of the baby after they leave the hospital. Findings also indicate that one father experienced the hospital staff's attitude as the complete opposite. In this case, the findings supports the aforementioned conclusion as this unpleasant experience is still embedded in the memory of the father today.

Recommendation:

- Social workers should make hospital staff aware that their attitude displayed towards the fathers has an impact on how they will experience the loss of a baby after the discharge of the mother from the hospital.

5.2.4.2 Subtheme: Explanation of the cause of the stillbirth by professional hospital staff

Findings indicated that an explanation into the causes of the stillbirth were provided to all the fathers. Theses explanations included causes related to hypertension, infection and umbilical

cord complications. It is worth noting that findings indicated that the explanations were either given to them directly or to their wives or partners. It can be concluded from the findings that the explanations about the cause of the stillbirth is important as it eliminates questions that may stem from the occurrence of the stillbirth. This furthermore can create the use of an impaired coping mechanism by the fathers after the experience thereof. In addition, it can be concluded that the explanations provided to the fathers also allow them to make better sense of the loss they have experienced through the stillbirth. In view of the findings, that the fathers were able to relay their understanding of the cause of the stillbirth, it can be concluded that the explanations of the stillbirth were done in simple understandable terms.

Recommendation:

- Professional hospital staff should ensure that they take time to explain the cause of the stillbirth in simple terminology to allow the fathers to get answers to questions they might have regarding the stillbirth.

5.2.4.3 Subtheme: Help or assistance offered by hospital staff

Findings indicated that the help or assistance offered by the hospital staff is a crucial element in the experience of the father after a stillbirth. Moreover, findings highlighted that some fathers were offered help or assistance by the professional hospital staff whereas other fathers did not get it. It can be concluded from the findings that the offering or help or assistance is an illustration of the sensitivity and attitude of the staff towards the father. In the event where help or assistance were offered, a conclusion may be drawn that the hospital staff acknowledged the impact that the stillbirth has on the father. In the case of a lack of help or assistance offered a further conclusion can be drawn that the professional hospital staff did not have any programme or assistance that caters specifically for the needs of the father after the experience of a stillbirth.

Recommendations:

- Hospital staff should take note of the need of fathers for assistance after a stillbirth and allow the father to exercise his right to self-determination in relation to the use of the help or assistance offered.
- Hospital staff should initiate programmes to offer help or assistance to fathers who experienced a stillbirth to cater specifically for the need of fathers.

5.2.4.4 Subtheme: Manner in which help offered by hospital staff assisted in coping with the loss

Under this subtheme two categories namely unhelpful and helpful assistance emerged. The conclusions and recommendations will be discussed below.

a) Category: Unhelpful assistance

Findings showed that almost all of the fathers found that the help or assistance offered by hospital staff at the time when they experienced the stillbirth were unhelpful. In view of assertions made by various authors in chapter four about the role of the father that is perceived by himself to offer support to the mother, it can be concluded that the father saw himself as a source of help or assistance to the mother. Therefor as a result of this, it can be concluded that the help or assistance offered to some fathers were experienced as unhelpful. In addition, it can be concluded that the fathers, after the experience of the stillbirth, were overwhelmed with emotions, taking responsibility for many other tasks in an attempt to take care of their wives or partners and therefore also postpone their grief. It can be concluded from this that the father consequently will not deem the assistance offered as important or helpful as his focus is shifted elsewhere.

Recommendation:

- Hospital staff should take note of the fact that the focus of the father after a stillbirth is often on his wife or partner and they should encourage fathers to utilise the support they are offering.

b) Category: Helpful assistance

Findings indicated that the help or assistance offered by the professional hospital staff was experienced by some fathers as helpful. The specific benefit of helpfulness lied within the hospital staff sharing their own experience of loss and grief through a stillbirth with the parents. It can be concluded that the offering of assistance or help offered by the hospital staff were often of a personal nature and therefore the fathers could relate more easily to the hospital staff. Due to this experience, a conclusion can be drawn that the fathers felt understood and the hospital staff members became a beacon of hope after a similar experience compared to a place of despair that they found themselves in at that time.

Recommendation:

- The hospital staff should be encouraged to share their personal or professional experience of grief in a professional manner with the father in an attempt to portray the value of utilising the assistance or help offered by them.

5.2.5 Coping with grief

Under this theme of coping with grief, five subthemes emerged namely source of paternal support, personal coping mechanism, gender differences in grieving, reaction of the community towards the father and gender differences in the community's response towards grief. The conclusions and recommendation under each subtheme will be presented below.

5.2.5.1 Subtheme: Source of paternal support

With regards to the sub-theme exploring the source of paternal support, two categories were identified. The conclusions and recommendations related to each category are discussed below.

a) Category: Family

Findings indicated that almost all of the fathers received support from their family. It can be concluded from this finding that the family provides a safety net for the father, and also a space where he could express his true emotions regarding the experience of the stillbirth.

Recommendation:

- Social workers should convey to families that they can be the system where the father is able to obtain support from after a stillbirth.

b) Category: Religious community

It was found for some fathers, the religious community was a source of support to them. It can be concluded from this finding that support from the religious community is also evident in the reliance on a higher power as coping mechanism. The support from the religious community cannot be utilised in isolation of the belief in a higher power. Furthermore, a conclusion can be drawn from this finding that the religious community's involvement and influence allowed fathers for placing the experience of their grief after the stillbirth into perspective.

Recommendation:

- Religious communities should be praised by their congregations for support offered to fathers after a stillbirth and encouraged to acknowledge the vulnerability of the father after a stillbirth in order to offer support to him.

5.2.5.2 Subtheme: Personal coping mechanism

Findings indicated that almost all the fathers identified coping mechanisms that they applied. Amongst others, these coping mechanisms included the consumption of alcohol, communicating with their partners and others about their feelings as well as applying skills acquired in rehabilitation to the loss. It can be concluded that the fathers' coping did not primarily involve their expression of any emotions, but that it includes the participation in activities that are acceptable by society and deemed appropriate for males when coping with loss. Based on the supporting role that some grieving fathers played towards the mother and his family, it is concluded that these father acknowledged that they had to managed and employ mechanisms to cope during the grief period as to prevent that the grief affects their functioning in such a manner that it may compromising their ability to fulfil this supportive role. In contrast it was found that one father was unable to cope and the conclusion may be drawn that this finding demonstrates once more the devastating effect the experience of a stillbirth has for the father. It may also be concluded that in such an event, the father might not have reached a stage of accepting the stillbirth.

Recommendations:

- The professional hospital staff should take note of their role to enable grieving fathers to explore positive coping mechanisms and to encourage the fathers to utilise these mechanism for coping with the loss.
- The professional hospital staff should encourage fathers to consider all types of coping mechanism and their impact on their functioning thoroughly before applying them.

5.2.5.3 Subtheme: Gender differences in grieving

It is of importance to note that findings indicated that all the fathers acknowledged that there was a difference between the manners in which they grieved compared to the way in which their wives or partners grieved. Findings indicated that the fathers expressed their emotions less

in public, compared to their wives or partners. It can be concluded from the findings that this is often the reason why there are mistaken assumptions that fathers grief less than their wives or partners. However the findings indicated that the father indeed expressed their emotions in isolation from their wives, family, friends and the rest of society. It can be concluded then that the father gives expression to his emotions in isolation in order to prevent portraying himself as weak, vulnerable and non-masculine.

Recommendation:

- The professional hospital staff should inform mothers that they should ignite an expression of feelings about the stillbirth and loss in the father as to allow him to give expression to these feelings openly.

5.2.5.4 Subtheme: Reaction of community towards the father

Two categories emerged from the findings related to this sub-theme namely lack of support from the community and support from the community. The conclusions and recommendations under each of these categories will be discussed below.

a) Category: Lack of support from the community

Findings indicated that some of the fathers experienced lack of a supportive response from the community towards their grief. Findings demonstrated that some did not share the news of the stillbirth with the rest of the community or with anyone. It can be concluded from this findings that the fathers were aware of the disregard of the community towards their grief; hence they decided not to make the news of the stillbirth public.

Recommendation:

- Community members should take note of the need of fathers to inform them of their experience of a stillbirth and start to acknowledge the grief of the father after the experience of a stillbirth.

b) Support from the community

Findings demonstrated that some fathers experienced a supportive response from members in the community towards their grief. This was in the form of concrete assistance and a

demonstration of a sympathetic attitude towards the father. It can be concluded from the findings that due to the community's perception that the father takes up responsibility for the household while the mother is consumed with grief, they responded with concrete support. In addition, it can be concluded from findings that the display of community members of sympathetic gestures towards the father may be an indication that some community members observed and acknowledged the grief experienced by father, despite their attempt to try and hide it from them.

Recommendations:

- Social workers in hospitals should inform fathers that the community members do have the ability to respond in a supportive manner towards their grief after a stillbirth.
- Social workers should encourage community members to respond with a sympathetic manner and offer concrete support as to allow that this becomes the norm within the community when fathers experience grief after a stillbirth.

5.2.5.5 Subtheme: Gender differences in community's response towards grief

The following two categories emerged from this subtheme which explored the gender differences in the community's response towards grief of fathers after a stillbirth. The conclusions and recommendations under each category will be discussed below.

a) Category: Presence of gender differences

Findings demonstrated that most fathers experienced that there was a presence of gender differences in the community's response towards their grief. The findings showed that there was more focus on the mother than on the father. It can be concluded from the findings that, despite findings related to the previous sub-theme about the presence of support from the community, the focus of the community remains on the mother. This gender difference also encourages the father indirectly to also make the mother his focus.

Recommendation:

- Social workers should encourage members of communities to divide their focus with regards both parent's grief equally.

b) Category: Absence of gender differences

Some fathers, as shown by the findings, experienced an absence of gender differences in the community's response to their grief. It can be concluded from this finding that some members of the community were able to acknowledge that the experience of grief after a stillbirth is affecting both parents equally. Therefore, there is no difference in the community's response to the grief experienced by the mother compared to that of the father.

Recommendation:

- Social workers should encourage members in communities to treat the grieving father and mother equally in their response to them.

5.2.6 Consequences of stillbirth

Under this theme, eight sub-themes emerged namely initial emotions or reactions, mechanisms to cope with the emotions or reactions, role of religion in coping with the loss, degree of depression experienced, impact of stillbirth on relationship with wife or partner, impact of stillbirth on relationship with other living children, impact of stillbirth on work and factors contributing to accepting the loss. Two categories emerged also from the first subtheme namely anger and blame and focus on the mother. Conclusions and recommendations related to findings under each sub-theme and category will be discussed below.

5.2.6.1 Subtheme: Initial emotions or reactions

The findings related to the initial emotions or reactions of the father to the stillbirth showed that two categories emerged from this subtheme namely anger and blame and focus on the mother. The conclusions and recommendations related to these categories is discussed below.

a) Category: Anger and blame

Findings under this category indicated that some of the fathers expressed anger towards themselves and blame towards the professional hospital staff initially. The anger towards themselves was rooted in their views that they could have done something to prevent the stillbirth. The findings also showed that the fathers shifted the blame externally to the professional hospital staff for not doing enough to preserve the life of their babies. This response is in line with the stages of grief conceptualised by Kubler-Ross (1989) namely anger

and blame. It can be concluded from the findings that the experience of grief is overwhelming and the uncertainty surrounding the cause of death evoked anger experienced by the father towards himself and blame towards the professional hospital staff. The conclusions can be made that the expression of anger and blame by the father give him an opportunity to rather express emotions such as anger and blame in response to the stillbirth compared to crying which is regarded as gender stereotypical female emotional response.

Recommendation:

- The professional hospital staff should take note of the different emotions of fathers after a stillbirth as it will allow them to show better insight when they have to deal with these emotional reactions.

b) Category: Focus on the mother

Some fathers focused on the mother in their response to the experience of a stillbirth. Findings showed that the fathers regarded it as their responsibility to respond to the stillbirth by making the mother their focus of attention. Findings furthermore showed that this was done through gestures such as holding her, enquiry into her wellbeing and being the source of strength to their wives or partners. It can be concluded from these findings that the father regarded the mother's experience of grief greater than his own at the time when the stillbirth occurred. It can be concluded further that this action is once more in line with expectations from society where the focus is on the mother and not the father.

Recommendation:

- Social workers should encourage wives or partners that they should make the father their focus of attention after a stillbirth. This will validate that the father being the focus too, is also of importance in the context of loss through a stillbirth.

5.2.6.2 Subtheme: Mechanisms to cope with emotions or reactions.

Findings under this theme indicated that the fathers employed various coping mechanisms to deal with their initial emotions or reactions. Findings highlighted that these coping mechanisms included the use of alcohol, staying busy, focusing on their wives or partners, as well as resorting to their religious beliefs. Except for resorting to religious beliefs, it can be concluded from the findings that the coping mechanisms used, can be viewed as the fathers evading the

reality of loss, as none of the mechanisms dealt with facing the reality of loss. Furthermore, it can be concluded from resorting to their religious beliefs, that the use of this coping mechanism indicate that fathers acknowledged that the experience of grief is beyond what they can cope with and therefore they rely on the intervention of a higher power.

Recommendation:

- Social workers should encourage fathers to ensure that the mechanisms applied to cope with the initial emotions or reactions should not be used for the entire grieving period as it will not give them the opportunity to face the reality of loss and grief.

5.2.6.3 Subtheme: Role of religion in coping with the loss

Finding indicated that most fathers acknowledged the role of religion in coping with the loss. Fathers participated in acts of praying and also received other forms of support from the church community. It can be concluded from this finding that in order to tap into this method of coping; the fathers had to be affiliated to one or other church community because in the absence thereof, religion would not play a role in coping with the loss. Findings however indicated that one father did not find value in religion as coping mechanism of the loss because he does not regard himself as a religious person.

Recommendation:

- Church leaders should be encouraged to offer their support to fathers' after the experience of a stillbirth.

5.2.6.4 Subtheme: Degree of depression experienced

Findings indicated that more than half of the participants presented with depression after the experience of a stillbirth. In view of the fathers experiencing grief in isolation from the mother, the rest of the family and society, as indicated in previous findings, it can be concluded that the fathers are vulnerable to develop depression due to this experience. Furthermore some fathers did not experience depression. It can be concluded from this, that they have perhaps accepted the loss and were not prone to developing depression.

Recommendations:

- Social workers in hospitals should make fathers aware of the risk that grieving in isolation has on the development of depression.
- Social workers should inform the wives or partners, the community and the rest of the family to be observant and identify depression in the grieving father in order to provide support to him.

5.2.6.5 Subtheme: Impact of stillbirth on relationship with wife or partner

Findings showed that almost all of the fathers indicated that the relationship with their wives or partners was positively impacted after the stillbirth. It can be concluded from this finding that the event of the stillbirth tested the depth of the relationship with their wives or partners. From the findings that the relationship was positively impacted, it can be concluded therefore that the strength of the bond shared in the relationship survived the test of the stillbirth. For some father, findings indicated that the relationship with their wives or partners was impacted negatively as the father was either on the receiving side of the anger or the termination of the relationship as there was not more purpose in remaining in the partnered relationship. It can be concluded from this finding that the relationship with the wives or partners will be negatively affected if they are blaming one another or if remaining in a partnered relationship will be a constant reminder of the stillbirth and loss.

Recommendation:

- Social workers in hospitals should make both wives or partners and fathers aware of the impact that the stillbirth can have on their relationship with each other.

5.2.6.6 Subtheme: Impact of stillbirth on relationship with other living children

Findings indicated that more than half of the participants expressed that their relationship with their living children were positively affected. In view of the father having to take responsibility for the other living children while the mother is consumed with grief, it can be concluded that this placed the father in an advantage to strengthen his relationship with his children. In contrast, findings also indicated that for some fathers their relationship with their remaining children was impacted negatively due to their excessive use of alcohol as coping mechanism. It can therefore be concluded from this finding that participation in destructive coping mechanisms can impact

the relationship with surviving children negatively. It can furthermore be concluded that resorting to destructive coping mechanisms can result in fathers neglecting their parenting responsibility and also missing out on the opportunity to spend more time with the surviving children which forms the foundation of strengthening the relationship with them.

Recommendation:

- Social workers in hospitals should introduce fathers to the opportunity the stillbirth creates for either strengthening or neglecting the relationship with the other living children.

5.2.6.7 Subtheme: Impact of stillbirth on work

Findings indicated that more than half of the fathers' work was not impacted by the stillbirth. The work was regarded as a source of support rather than an aspect of the fathers' life that was affected by the stillbirth. It can be concluded that the work acted as an escape for the father from his home environment where he was overwhelmed with constant reminders of what he has lost and of his immense sorrow. For other fathers, as findings also indicated, their work was affected as they were unable to function optimally at work. It can be concluded from this findings that for these fathers, upon returning to work, they experienced that they were unable to function at work because of still being concerned about their wives or partners at home. This conclusion is made in view of previous findings that father take on the responsibility for household tasks and a supporting role to the mother.

Recommendation:

- Employers should be made aware by social workers of the role that the workplaces can play to offer support to a grieving father after the experience of a stillbirth.

5.2.6.8 Subtheme: Factors contributing to accepting the loss

Findings indicated that almost all the fathers reached a stage of acceptance. This finding is in line with findings of Kubler-Ross (1989) who identified acceptance as the final stage in the grieving process. Factors that contributed towards this included announcement of a subsequent pregnancy, counselling by professional hospital staff, support from the church community and religious beliefs. It can be concluded from these findings that the arrival at an acceptance of the

stillbirth was rooted in the value the fathers' found in professional counselling, support from the religious community and the announcement of subsequent pregnancy. Furthermore, it can be concluded that utilising support from the religious community and counselling by professional hospital staff assisted the fathers to accept the loss as it may have placed the loss into perspective for the father and directed him to choose appropriate coping mechanisms. It can be concluded that, in announcing a subsequent pregnancy the father accepted the loss as this posed a possibility of becoming a father again and making up for what he has lost in this pregnancy related to the stillbirth.

Recommendations:

- Social workers and other professional counsellors should take note of the value their support services hold for the father to accept the loss after a stillbirth and adjust their services to meet the needs that fathers experience at this stage of their grieving.
- Churches should provide support to grieving fathers as they can influence the father towards accepting the loss.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

The study was executed with a small sample of ten participants. It was therefore a small scale study that was of an exploratory and descriptive nature and still leaves much to be explored in future research studies. Literature indicates that the impact and experience of the mother was explored more intensely in research and with this study there was a focus on the experiences of the father after a stillbirth. Based on the results of this study it is recommended that the following aspects be considered for future research:

- The experience of the surviving siblings after a stillbirth.
- The nature of the services offered by professional hospital staff to fathers who experienced grief after a stillbirth.
- The perception of the parents about a consequent pregnancy after the experience of a stillbirth.

5.4 CONCLUSION

The chapter provided conclusions and recommendations based on the findings of the study as presented in chapter four. Therefore the chapter achieved the last objective of the study. The chapter also presented recommendations for future research.

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ANNEXURE A1
SEMISTRUCTURED INTERVIEW SCHEDULE - AFRIKAANS

Stellenbosch Universiteit
Departement Maatskaplike werk
Semi-gestruktureerde Onderhoudskedule
Die vader se ervaring van rou na ‘n stilgeboorte

Navorser: *Ashwill Swart*

Neem Kennis*:*

- *Al die inligting wat ingesamel word tydens die onderhoud sal as vertroulik beskou word*
- *Die name van die deelnemers sal vertroulik gehou word.*

Instruksies:

- *Antwoord asseblief die volgende vrae;*
- *Wees asseblief so eerlik as moontlik;*
- *U het die keuse om enige van die vrae nie te antwoord nie*

Datum van onderhoud: _____ *Deelnemer nommer:* _____

1. Profiel van deelnemer

1.1. Hoe oud is u?

18-28	29-39	40-50

1.2. Wat is u huistaal?

Afrikaans	Engels

1.3. Wat was u huwelikstatus toe u baba wat nie gelewe het nie gebore was?

Verhouding	Getroud

1.4. Hoeveel jaar is u getroud of hoe lank is u in u huidige verhouding?

_____

1.5. Wat is u hoogste opvoedkundige kwalifikasie?

_____

1.6. Wat is u huidige beroep of werk?

_____

1.7. Hoeveel lewende kinders het u?

_____

1.8. Was die swangerskap beplan of onbepland?

Beplan	Onbeplan

2. Die swangerskap

2.1. Hoe het u gevoel toe u ingelig is van die swangerskap?
2.2. Wat was u betrokkenheid gedurende die swangerskap?
2.3. Hoe het u te werk gegaan om voorbereidings te tref vir die aankoms van die baba?

3. Die stilgeboorte

3.1. Wanneer het die geboorte van die baba wat nie gelewe het nie plaasgevind?
3.2. Waar het die stilgeboorte plaasgevind?
3.3. Was u teenwoordig toe die stilgeboorte plaasgevind het?
3.4. Wie het u in kennis gestel van die stillgeboorte?

4. Die multi-disiplinêre span:

4.1. Hoe sal u die houding van die hospitaal personeel beskryf toe die stilgeboorte voorgekom het?
4.2. Hoe is die oorsaak van die stilgeboorte aan u verduidelik deur die profesionele hospitaal personeel?
4.3. Watter tipe hulp of ondersteuning is aan u gebied deur die persone van die multi-disiplinêre span wat u in kennis gestel het van die stilgeboorte?
4.4. Hoe het die ondesteuning van die hospitaal personeel u gehelp om die nuus van die stilgeboorte te hanteer?

5. Hantering van rou

5.1. Van wie het u as vader ondersteuning ontvang na die geboorte van die baba wat nie gelewe het nie?
5.2. Wat het jou gehelp om die verlies te hanteer en te verwerk?
5.3. Hoe was die manier waarop jy gerou het anders as jou vrou of metgesel se manier van rou?
5.4. Hoe het u gemeenskap teenoor u reageer as die bedroefde vader?
5.5. Hoe het die gemeenskap u en vrou of metgesel se rou verskillend behandel?

6. Gevolge van stilgeboorte

6.1. Wat was u eerste gevoelens of reaksie toe u aanvanklik in kennis gestel is van die stilgeboorte?
6.2. Wat het jou gehelp om jou reaksies en emosies te hanteer?
6.3. Hoe het jou geloof jou gehelp?
6.4. Watter mate van depressive het u ervaar?
6.5. Hoe is die verhouding tussen jou en jou metgesel of vrou affekteer?
6.6. Hoe is die verhouding met jou oorlewende kinders affekteer deur die stilgeboorte?
6.7. Hoe is jou werk affekteer deur die stilgeboorte?

6.8. Wat het u gehelp om die stilgeboorte te aanvaar of beter te voel daaroor?

7. Afsluiting

Dankie vir u deelname aan die studie.

ANNEXURE A2
SEMI-STRUCTURED INTERVIEW SCHEDULE - ENGLISH

Stellenbosch University
Department of Social Work
Semi-structured interview schedule
The father's experience of grief after a stillbirth

Interviewer: *Ashwill Swart*

Please Note*:*

- *All the information recorded in this interview schedule will be regarded as confidential*
- *The names of the interview participants will be kept confidential*

Instructions:

- *Please answer the following questions;*
- *Please be as honest as possible;*
- *You may choose not to answer any of the questions.*

Date of interview: _____ *Participant number:* _____

1. Profile of participant

1.1. How old are you?

18-28	29-39	40-50

1.2. What is your home language?

Afrikaans	English

1.3. What was your marital status when your baby who did not live were born?

Partnered relationship	Married

1.4. How many years are you married or in your current relationship?

_____

1.5. What is your highest educational qualification?

_____

1.6. What is your current occupation or work?

_____

1.7. How many living children do you have?

_____

1.8. Was the pregnancy planned or unplanned?

planned	unplanned

2. The pregnancy

2.1. How did you feel when you were informed of the pregnancy?
2.2. What was you involvement during the pregnancy?
2.3. How did you go about to prepare for the arrival of the baby?

3. The stillbirth

3.1. When did the birth of the baby who did not live happen?
3.2. Where did the stillbirth happen?
3.3. Were you present at the time of the stillbirth?
3.4. Who informed of the stillbirth?

4. The multi-disciplinary team:

4.1. How would you describe the attitude of the hospital staff when the stillbirth occurred?
4.2. How was the cause of the stillbirth explained to you by the professional hospital staff?
4.3. What kind of help or assistance was offered to you by the person of the multi-disciplinary team who informed you about the stillbirth?
4.4. How did the assistance of the hospital staff member help you to cope with the news of the stillbirth?

5. Coping of grief:

5.1. From who did you as father get support after the birth of the baby who did not live?
5.2. What helped you to cope and process the loss?
5.3. How was the manner in which you grieved different from the manner in which your wife or partner grieved?
5.4. How did the community react towards you as the grieving father?
5.5. How did the community treat you and your wife or partners' grief different?

6. Consequences of stillbirth :

6.1. What were your initial emotions or reactions when you were first informed of the stillbirth?
6.2. What helped you to cope with your emotions and reactions?
6.3. How did your religion help?
6.4. What degree of depression did you experience?
6.5. How is the relationship between you and your wife or partner affected?
6.6. How is the relationship with your living children affected by the stillbirth?
6.7. How is your work affected by the stillbirth?
6.8. What helped you to accept the stillbirth and feel better about it?

7. Conclusion

Thank you for your participation in the study.

ANNEXURE B1
CONSENT TO PARTICIPATE IN RESEARCH- AFRIKAANS

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UNIVERSITEIT STELLENBOSCH
INWILLIGING OM DEEL TE NEEM AAN NAVORSING

TITEL VAN NAVORSINGSPROJEK: DIE VADER SE ERVARING VAN ROU NA ‘N STILGEBOORTE

U word gevra om deel te neem aan ‘n navorsingstudie wat uitgevoer gaan word deur **Ashwill Denzill Swart (geregistreerde MSW student)** , van die **Departement Maatskaplike Werk** aan die Universiteit Stellenbosch. Die resultate van die studie sal bydra tot ‘n navorsingstesis. U is as moontlike deelnemer aan die studie gekies omdat u ‘n baba voor of tydens geboorte verloor het.

1. DOEL VAN DIE STUDIE

Die doel van die navorsingstudie is om ‘n begrip te ontwikkel van die rouproses van vaders na die ervaring van ‘n stilgeboorte, soos blyk uit die onderliggende strukturele dinamika van die rou proses.

2. PROSEDURES

a) Indien u inwillig om aan die studie deel te neem, vra ons dat u die volgende moet doen:

1) U sal telefonies gekontak word en genooi word om aan die studie deel te neem en ‘n onderhoud sal geskeduleer word wat u pas sou u inwillig om deel te neem.
2) Gedurende die studie, sal u deelneem aan een onderhoud van ongeveer een uur.
3) Tydens die onderhoud sal eenvoudige vrae aan u gestel word oor basiese inligting oor uself soos, u ouderdom, huwelikstatus, ens.
4) U sal gevrae word oor hoe die verlies van u baba u eie lewe affekteer het, u huweliksverhouding, u kinders en diegene wat u onderteun gedurende hierdie periode.
5) ‘n Bandopname van die onderhoud, waartoe u inwillig voordat die onderhoud begin, sal gedurende die onderhoud opegeneem word. U sal die reg hê om transkripsies na te gaan van die onderhoud om te bevestig dat u stellings regverdig en akkuraat gereflekteer is.

b) Hoekom word ek gevra om aan die studie deel te neem?
U word gevra om deel te neem aan die studie omdat u u baba binne die afgelope 12 maande voor of tydens geboorte verloor het.

c) Hoeveel persone gaan aan studie deelneem en waar gaan studie plaasvind?
Die studie sal plaasvind by Nuwe Somerset Hospitaal in die gerief van die maatskaplike werker se kantoor. Ongeveer twintig deelnemers wat as vaders ‘n stilgeboorte ervaar het binne die afgelope 12 maande sal aan die studie deelneem.

3. MOONTLIKE RISIKO’S EN ONGEMAKLIKHEID

Die aard van die vrae vrae wat gevra gaan word tydens die onderhoud is van ‘n sentitiewe aard as gevolg van die aard van die navorsingsonderwerp. Indien u ongemak hiertydens ondervind, moet u die navorser in kennis stel hiervan om u te verwys vir ondersteuning en ontlonting na die volgende dienste/persone:

a) Me. Carmen Titus
   Maatskaplike werker
   Nuwe Somerset Hospitaal
   Noord blok, Kusweg, Groenpunt, Kaapstad
   Kantoor Nommer: 0214026380
b) Life Line- 24 uur beradingsdiens
   (021) 461 1113

4. MOONTLIKE VOORDELE VIR PROEFPERSONE EN/OF VIR DIE SAMELEWING

Deur deel te neem aan die studie mag u baat daarby vind om te reflekteer oor u verlies en u emosies en gevoelens te deel met iemand anders as u familie en vriende. Die ingesamelde data sal toekomstige vaders help om die verlies van ‘n baba te hanteer

5. VERGOEDING VIR DEELNAME

Nee, u sal nie betaal word om aan die studie deel te neem nie. Vervoerkoste tot en vanaf die geselekteerde hospitaal sal wel vergoed word deur die navorser en na afloop van u onderhoud sal tee/koffie en biskuit aan i verskaf word. Die studie word befonds deur die navorser self.

6. VERTROULIKHEID

Enige inligting wat deur middel van die navorsing verkry word en wat met u in verband gebring kan word, sal vertroulik bly en slegs met u toestemming bekend gemaak word of soos deur die wet vereis word. Vertroulikheid sal gehandhaaf word deur middel van die beveiliging van inligting wat slegs bekend gemaak sal word aan die navorser sowel as die Navorsingsupervisor, Prof. S. Green, vir kundige leiding deur die proses. Enige bandopnames en onderhoudskedules sal in hardekopie in aparte navorsingsleêr gestoor in ‘n geslote kabinet in die navorser se kantoor by die geselekteerde hospitaal en sal nie deel vorm van jou mediese rekords by die

hospitaal nie. Die navorser sal enige elektronies gestoorde inligting beveilig op ‘n wagwoord-beheerde rekenaar waartoe die navorser alleen toegang het. Vertroulikheid sal verder handhaaf word as die bevindings gepubliseer gaan word in ‘n tesis sonder die verwysing na enige identifiserende besonderhede van die deelnemers.

7. DEELNAME EN ONTTREKKING

U kan self besluit of u aan die studie wil deelneem of nie. Indien u inwillig om aan die studie deel te neem, kan u enigetyd onttrek sonder enige nadelige gevolge. U kan ook weier om op bepaalde vrae te antwoord en steeds aan die studie deelneem. Die ondersoeker kan u van die studie onttrek indien omstandighede opduik wat dit regverdig. Die navorser kan u deelname termineer in gevalle waar u onder die invloed van enige substans of alkohol is of aan enige geestesversteuring lei wat die insameling van inligting sal beïnvloed.
Indien u enige tyd wil ontrek van die studie kan u Mnr. AD Swart kontak by 021 402 6394 of adswart123@gmail.com

8. IDENTIFIKASIE VAN ONDERSOEKERS

Indien u enige vrae of besorgdheid omtrent die navorsing het, staan dit u vry om in verbinding te tree met die volgende persone:

1. Ondersoeker : Ashwill Denzill Swart
   Adress : Nuwe Somerset Hospitaal, Kusweg, Groenpunt, Kaapstad.
   Maatskaplike Werk Departement.
   Kontak besonderhede : Tel- 021 402 6394(Kantoor ure)/ 021 402 6911(na ure)
   E-Pos Adres- adswart123@gmail.com

2. Navorsing supervisor : Prof: Sulina Green
   Adres : Privaatsak X1
   Matieland
   Stellenbosch
   7602
   Kontak besonderhede : 021 808 2070
   E-pos adres: sgreen@sun.ac.za

9. REGTE VAN PROEFPERSONE

U kan enigetyd u inwilliging terugtrek en u deelname beëindig, sonder enige nadelige gevolge. Deur u deelname aan die navorsing doen u geensins afstand van enige wetlike regte, eise of regsmiddel nie. Indien u vrae het oor u regte as proefpersoon by navorsing, skakel met Me Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] van die Afdeling Navorsingsontwikkeling, Universiteit Stellenbosch.

VERKLARING DEUR PROEFPERSOON OF SY/HAAR REGSVERTEENWOORDIGER

Die bostaande inligting is aan my, _____ [*naam van deelnemer*], gegee en verduidelik deur **Ashwill Denzill Swart** in Afrikaans en ek is dié taal magtig of dit is bevredigend vir my vertaal. Ek is die geleentheid gebied om vrae te stel en my vrae is tot my bevrediging beantwoord.

Ek willig hiermee vrywillig in om deel te neem aan die studie. ‘n Afskrif van hierdie vorm is aan my gegee.

_____

Naam van proefpersoon/deelnemer

_____

Naam van regsverteenwoordiger (indien van toepassing)

_____ _____

Handtekening van proefpersoon/deelnemer of regsverteenwoordiger Datum

VERKLARING DEUR ONDERSOEKER

Ek verklaar dat ek die inligting in hierdie dokument vervat verduidelik het aan_____ [*naam van die deelnemer*]. Hy is aangemoedig en oorgenoeg tyd gegee om vrae aan my te stel. Dié gesprek is in Afrikaans gevoer en geen vertaler is gebruik nie.

_____ _____

Handtekening van ondersoeker **Datum**

Goedgekeur Subkomitee A 25 Oktober 2004

ANNEXURE B2
CONSENT TO PARTICIPATE IN RESEARCH

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STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

TITLE: FATHER'S EXPERIENCE OF GRIEF AFTER A STILLBIRTH *(Afrikaans translation: Die vader se ervaring van rou na 'n stilgeboorte)*

You are asked to participate in a research study conducted by **Ashwill Denzill Swart** (Registered MSW student), from the **Department of Social Work at Stellenbosch University**. The results of the research will be to contribute to a research thesis. You are selected as a possible participant in this study because you have lost a baby through stillbirth.

1. PURPOSE OF THE STUDY

The purpose of this study is to develop an understanding of the grieving process of fathers after the experience of a stillbirth, based on the underpinning structural dynamics of the grieving process.

2. PROCEDURES

a) If you volunteer to participate in this study, we would ask you to do the following things:

1) You will be contacted telephonically to invite you to participate in the study and an interview will be scheduled to your convenience should you consent to participate.
2) During the study, you will take part in one interview that will last approximately one hour.
3) During the interview you will be asked simple questions about basic information for example your age, marital status, etc.
4) You will be asked questions about how the loss of your baby have affected your own life, your marital relationship, your children and those who are supporting you through this period
5) An audio recording of the interview, to which you consent before interview commence will be made during interview. You will have the right to read transcripts of the interview to confirm that your statements have been reflected fairly and accurately.

b) Why am I being asked to take part in the study?

You have been asked to take part in this study because you have lost a baby through stillbirth

c) How many people will participate in the study and where will the study take place?

The study will take place at three selected hospitals in the comfort of the Social Worker's office. Approximately 20 participants who have experienced a stillbirth, will be part of this study.

3. POTENTIAL RISKS AND DISCOMFORTS

The nature of the questions that you will be asked during the interview is of a sensitive nature due to the nature of the research topic. If you are experiencing any discomfort you should inform the researcher to refer you for support and debriefing to the following services/persons:

a) Ms. Carmen Titus
Social Worker
New Somerset Hospital
North Block
Beach Road, Greenpoint, Cape Town
Office Number: 021 402 6380

b) Lifeline-24 hours counselling service
(021) 461 1113

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

By participating in this study, you may benefit from being able to reflect on your loss and share your emotions and feelings with someone aside from your family and friends. Information collected during this research may help future fathers deal with the loss of a baby.

5. PAYMENT FOR PARTICIPATION

No, you will not be paid to take part in this study. Transportation cost to and from the selected hospital will be reimbursed by the researcher and after the interview tea/coffee and biscuit will be provided. The study will be funded by the researcher himself.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of safeguarding information that will only be disclosed to the researcher and the research supervisor, Prof. S. Green for expert guidance through the process. Any recordings and interview schedules will be kept in hardcopy in a separate research file by the researcher, locked cabinet in the researcher's office at the selected hospital and will not form part of your medical record at the hospital. The researcher will safeguard electronic information on a password protected computer to which the researcher has sole access. Confidentiality would furthermore be maintained when the results will be published in a thesis by refraining to use any identifying details of any participants.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. The researcher can terminate participation without your consent if you present with substance or alcohol intoxication or any mental health illness that might impact the results of the study negatively.

In case you want to withdraw from the study, please contact Mr. AD Swart on 021 402 6394 or on e-mail at adswart123@gmail.com

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

1. Researcher : Ashwill Denzill Swart
   Address : New Somerset Hospital, Beach Road, Greenpoint, Cape
   Cape Town
   Social Work Department.
   Contact details : Tel- 021 402 6394(Office hours)/ 021 402 6911(After Hours)
   E-mail Address- adswart123@gmail.com

2. Research Supervisor : Prof. Sulina Green
   Address :Private Bag X1
   Matieland
   Stellenbosch
   7602
   Contact details : 021 808 2070
   E-mail : sgreen@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me, _____ [name of participant], by Ashwill Denzill Swart in English and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____ _____

Signature of Subject/Participant or Legal Representative **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]*. He was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

_____ _____

Signature of Investigator **Date**

ANNEXURE C1
REC ETHICAL CLEARANCE

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

APPROVAL NOTICE
Progress Report

28 August 2017

Project number: SU-HSD-001764

Project title: VADERS SE ERVARING VAN ROU NA 'N STILGEBOORTE

Dear Ashwill Swart

Your progress report received on 23 June 2017 was reviewed and approved by the REC: Humanities.

Ethics approval period: 28 August 2017 – 27 August 2018

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (SU-HSD-001764) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrolment. You may not recruit or enrol participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents/process, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrolment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9.Final reports. When you have completed (no further participant enrolment, interactions or interventions) or stopped work on your research, you must submit a Final Report to the REC.

10.On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

ANNEXURE C2
WESTERN CAPE DEPARTMENT OF HEALTH ETHICAL CLEARANCE

Health Impact Assessment
Sub-Directorate: Health Research
Health.Research@westerncape.gov.za
Tel: +27 21 483 0866 fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201801_006
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Social Work Department

Francie Van Zijl Drive

Tygerberg Hospital

Cape Town

7505

For attention: Mr Ashwill Swart, Prof Sulina Green

Re: Fathers experience of grief after a stillbirth

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact following people to assist you with any further enquiries in accessing the following sites:

New Somerset Hospital	**Dr Gregory Petro**	**021 402 6324**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AS Hawkridge.

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 15/2/2018