AN EXPLORATION OF THE EXPERIENCES OF BLACK BRITISH CARIBBEAN BEREAVED FATHERS FOLLOWING BABY LOSS: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

by

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Thesis overview

The first chapter involves a meta-ethnography, including 11 papers synthesising religio-cultural perspectives of perinatal loss across several cultures. A comprehensive search was implemented across Scopus, Web of Science, Proquest and PsychINFO, followed by a hand search to collate relevant literature. Through a rigorous screening method, quality assessment and adherence to the inclusion and exclusion criterion, three themes were formed: (1) The discourse and manifestation of religio-cultural scripts, (2) parental responses to loss and (3) the role of a Higher being in the sense-making of loss. The results showed that there are gendered differences in the experience of baby loss among some communities due to the local cultural scripts and customs. Those who understood their loss through the lens of their religion and/or relationship with God found a more effortless adjustment to the loss, a sense of understanding and a transcendent comfort.

The second chapter details an interpretative phenomenological analysis of Black British Caribbean fathers lived experiences of baby loss. Semi-structured interviews were carried out with five participants, producing four themes: 1) Silenced by the positioning by others, 2) God knows, 3) The shifted experience and appreciation of fatherhood, and 4) Navigating support whilst invisible. The findings demonstrate how the intersectionality of race, gender, culture, and religion complicate bereaved fathers' experiences following baby loss. This experience was intensified by multi-directional forms of positioning from others. Changes in their romantic relationships, relationships with their living children and the understanding of their spiritual and religious beliefs further compounded this experience.

Dedication

First and foremost, I dedicate this thesis to God, Christ Jesus who mercifully carried me to and through this process. As the word says, I can do all things through Christ who strengthens me: Philippians 4:13; Romans 5:1-5; by His grace, I have completed this project and hope it leads to positive changes for people from my community.

To my parents, thank you for supporting my dreams, encouraging me to remain determined and to put my trust in the Lord to carry me through. The sacrifices that have been made have not gone unnoticed, and I am forever grateful. To my brother, Jermaine and my sister, Shana, thank you for gassing me up and picking me up when I was discouraged. The continued support and giggles kept me going; thank you. My sweet nephews Taj, Zaine and Ezra, I hope I made you proud.

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Chapter 1: Literature Review

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"Child killer", witchcraft or a test of faith? Perinatal loss through the lens of religio-cultural perspectives: a meta-ethnography

Introduction

Definitions and frequency of perinatal loss

The definition of perinatal loss varies globally; DiMarcoet al. (2001); Fenstermacher and Hupcey (2013); Robinson et al. (1999) define perinatal loss as involuntary pregnancy loss through early or late miscarriage, stillbirth, or neonatal death. This differs from the definition within the UK, which considers perinatal loss as the death of a baby between 24 weeks gestation and seven days following birth (NHS, 2022).

The World Health Organisation (WHO) advises that miscarriages can occur up until 28 weeks of pregnancy (WHO, 2024a), whereas the NHS (NHS Inform, 2022) report that this can happen until 24 weeks. There is an overall 15% risk of miscarriage, indicating approximately 23 million miscarriages yearly, or 44 per minute (Quenby et al., 2021). WHO (2024a) advises that loss occurring at/or after 28 weeks is considered a stillbirth; by this definition, over two million babies are stillborn each year. However, this contradictory definition of perinatal loss would suggest that this figure is inaccurate and holds the potential to be much higher, especially when accounting for those who do not seek medical attention during the loss and the inconsistent recording protocols of loss globally. It is also important to note that parents are unlikely to subscribe to the medical definitions of loss, may experience grief across the early to late stages of gestation (Smith et al., 2020), and consider their embryo, foetus, or baby to be a *"person"* despite any complications that may occur during pregnancy and/or birth (Côté-Arsenault & Denney-Koelsch, 2011).

Neonatal death is commonly regarded as the loss of a live infant which has been born, irrespective of gestational age at birth, within the 28 days following birth (Pathirana et al., 2016; World Health Organisation, 2006). Neonatal deaths can also be subcategorised into 'early neonatal deaths' (0-7 days post birth) and 'late neonatal deaths' (8-28 days post birth; Pathirana et al., 2016; Oza et al., 2014). Approximately 75% of neonatal deaths occur during the first week of life, with around one million newborn babies dying within the first 24 hours of life (WHO, 2024b). Infections, congenital disabilities, prebirth and birth complications such as birth asphyxia were the leading causes of death in 2022 (WHO, 2024b). WHO (2024b) also found that neonatal deaths have declined by 44% since 2000.

Perinatal and neonatal deaths do not occur equally across all countries – three in four stillbirths occur in sub-Saharan Africa or Southern Asia. The most affected countries are India, China, Pakistan, Nigeria, Ethiopia, and The Democratic Republic of Congo. These six countries accounted for half the estimated global stillbirths and 44 per cent of global live births. The risk of stillbirth is up to 23 per cent higher in the most affected countries (Unicef, 2020). Unicef (2020) reported that in 2019, the stillbirth rate in sub-Saharan Africa was 21.7 per 1,000 total births, seven times higher than in Northern America, Europe, Australia, and New Zealand, with the lowest regional rate of 3.1 per 1,000 total births.

Such data demonstrates a higher prevalence of perinatal loss in the global majority ethnic groups[1] (GMEG), which is mirrored in Western countries with an overrepresentation of perinatal loss within these ethnic groups (National Child Mortality Database, 2023; Office for

[1] This term is defined as "people who are Black, Asian, Brown, dual-heritage, indigenous to the global south and/or who have been racialised as 'ethnic minorities'. Globally, these groups currently represent approximately eighty per cent (80%) of the world's population" (Campbell-Stephens, 2020; Lear & Gasevic, 2019; Tucker, 2023). This term will be used interchangeably with non-white populations throughout this paper.

National Statistics, 2021). In 2021, Black babies had the highest levels of recorded deaths, followed by babies from an Asian background (Office for National Statistics, 2021). The National Child Mortality Database (2023) demonstrates similar links between poverty/ social and economic deprivation and perinatal loss in the UK, with the mortality rates of infants residing in the most deprived areas in England exceeding the national average of infant death between 2020-2023. The rates of infant loss from deprived areas within England were more than twice that of the mortality rates residing in the least deprived areas in England (5.9 per 1,000 compared to 2.2 per 1,000 infant population).

Global breakdown of religions

Pew Research Center (2012) found that 5.8 billion out of 6.9 billion children and adults identified with a religious group – equating to 84% of the population in 2010. At this time, 31.5% (2.2 billion) identified as Christian, 23.2% (1.6 billion) identified as Muslim, 15% (1 billion) identified as Hindu, around 7.1% (500 million) identified as Buddhists, and 0.2% (14 million) identified as Jewish. Folk religions accounted for 5.9% (400 million) of the global population; this includes Chinese traditional, African traditional, Australian aboriginal, and Native American religions. The remaining 1% (58 million) of individuals followed religions including but not limited to Sikhism, Jainism, Shintoism, Taoism, Wicca, Tenrikyo and Zoroastrianism. When considering intersectionality, those within the GMEGs may also identify with a religious group, with culture and religion influencing their sense-making of the loss.

The role of culture and religion

Psychological models are typically based on Western and mostly White populations with socioeconomic privilege. Consequently, such models have the potential to hold biases due to the lack of inclusion of GMEGs and religious influence. Further consideration of culture and religion is necessary for developing a holistic and expansive understanding of how this impacts individuals across cultures. The definition of culture is subjective and malleable, dependent upon many factors. A well-known definition of culture within the literature derives from Opler et al. (1953, p.181):

> Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artefacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other as conditioning elements of further action.

Hofstede (1984, p.21) additionally noted it to be *"... the collective programming of the mind"* which separates humans from each other. An alternative definition of culture is expressed by Parsons (1977, p. 168):

> Culture is understood as an ordered symbolic system that is a symbolically mediated pattern of values or standards of appropriateness that permits the construction of a set of action-guiding, normative, conventional rules through which significant cultural objects are generated and used.

Boyer (2001) advises that religion cannot be understood purely as a cultural expression; religion and culture, indubitably, should be considered close in relation (Beyers, 2017; Durkheim & Zemskova, 2018). The impression that religion is a consequence of the materialisation and continuance of social bonds – rather than principally a matter of belief or culture – is typically closely concomitant in sociological tradition with the work of Durkheim (2001). Durkheim's (2001; 2018) definition suggests that religion portrays the practices and beliefs that are comparative to what is sacred, uniting a 'single community' of those who follow such beliefs. Considering such definitions, it could be argued that the role of religion in culture changes from one context to the other.

Aims of review

This review aimed to consider the phenomena of perinatal loss conjoined with religion and culture to enrich the overlooked experiences of many. The review will prioritise the religio-cultural perspectives and responses to loss across cultures. Further attention to how these perspectives and responses may influence the experiences of bereaved parents following perinatal death across cultures. It was anticipated that the findings may be transferrable to the overrepresented GMEGs in the frequency of perinatal loss within the UK. This was deemed essential to inform clinical practice.

Method

A meta-ethnography was carried out to review the current literature. Atkins et al. (2008) reported that meta-ethnographies are beneficial for synthesising qualitative research. This process is regarded as an inductive and interpretive synthesis method, allowing the gathering

of a collective sense of the data across several interpretative qualitative research encompassing a specific phenomenon (Atkins et al., 2008; France et al., 2019). Soundy and Heneghan (2022) and Sattar et al. (2021) state that meta-ethnographies permit further development of theories and/or augmented meanings, leading to an instigation in understanding, thus informing healthcare policies.

Recent research has shown the health inequalities for GMEGs in maternal care and outcomes, with Black women and babies having the highest mortality rate during pregnancy, birth or the neonatal period compared to all other ethnic groups in the UK (Knight et al., 2023). Little is known about the religio-cultural perspectives of these marginalised groups, particularly in the UK. Consequently, this meta-ethnography was conducted to accumulate and analyse the existing literature, which involves religious and/or cultural perspectives of perinatal loss during pregnancy, stillbirth, and the neonatal period to improve understanding of this phenomenon from various perspectives, differing from the popular Western perspectives which tend to neglect these constructs within established models of grief.

Type of review

This study followed the seven phases of Noblit and Hare (1988), informed by the theories of Iversen and Norpoth (1976), outlined below (see Table 1). The process is considered a rigorous practice to review and understand interpretative literature to develop an innovative understanding of a particular phenomenon. It is also regarded as a form of 'systematic comparison' involving translating several qualitative studies into one another.

Table 1

A table outlining the stages of the meta-ethnography as outlined by Noblit and Hare (1988)

	Phase	Description of process
1.	Getting Started	Identify an area of interest whilst considering if a synthesis of the topic is required.
2.	Deciding what is relevant	Selection of studies for inclusion followed by decisions regarding inclusion, exclusion, and quality assessment.
3.	Reading the studies	Periodic reading of the studies whilst extracting key concepts.
4.	Determining how the studies are related	An exploration of the relationship between the extracted key concepts leading to an understanding of the interrelation between the studies.
5.	Translating the studies into one another	An exploration of the key concepts outlined within all the studies followed by an assessment of presence or absence of key concepts.
6.	Synthesising translations	Formulation of concepts across all included studies. Consideration of the interrelationship between the studies and determining whether the synthesis may be considered reciprocal, disproved or a line of argument.
7.	Expressing the synthesis	Compiling the synthesis and presenting it to the desired population.

Phase one: Overview

The initial stages of the review *"involves identifying an intellectual interest that qualitative research might inform"* (Noblit & Hare, 1988, p.26). Intellectual interests are often noted through the process of reading many interpretative accounts. During this phase, consideration is given to the necessity and readiness to explore the intellectual interest (partly assessed by reviewing the number of relevant literature available). This project considers the overrepresentation of GMEGs in perinatal loss prevalence globally.

Systematic literature search

Phase two was implemented by executing a systematic search of the literature to reveal literature to answer the research question: What are the religio-cultural perspectives and responses to perinatal loss; how may these perspectives and responses to perinatal loss influence the experiences of bereaved parents?

Search strategy

A search was carried out across several databases: Scopus, Web of Science, Proquest, and PsychINFO due to their relevance to the research topic. An additional hand search was carried out to widen the scope provided. The search strategy followed the approach taken by Sattar et al. (2021), Soundy and Heneghan (2022), and Noblit and Hare (1988). The terminology was determined by scoping the literature with various synonyms and observing the number of relevant articles found. It was identified that the terms ‘religion’ and ‘culture’ are used interchangeably within the literature as there is a close intersection between both across ethnic groups, generally. This was reflected in key terms found across many studies within this area. Accounting for the varied definitions of perinatal death, it was felt appropriate to include papers with the inclusion of experiences of miscarriages as it would offer additional insight into the religio-cultural perspectives and responses to loss within those cultures (see Table 2).

Table 2

Database search terms

Construct	Search Order	Search Terms
Perinatal loss	1	"perinatal loss" OR "neonatal death" OR "stillbirth" OR "perinatal death" OR "neonatal loss"
Religion	2	AND "religio*"
Culture	3	OR "cultur*"

Note: * Denotes a truncation

Limits were applied during the search strategy: English only, article only, open access, and dated between 1st Jan 2013 - 3rd – 7th May 2023. All searches were conducted from the 3rd to the 7th of May, 2023. All responses were uploaded to EndNote 20 (a reference management software), where the screening process continued (see Figure 1). Once all the papers from these databases were screened, a hand search was completed to screen for any potential papers missed, and the documents were exported to EndNote 20. All the limits mentioned above were applied to the papers obtained. No limits to the country of origin of these papers were applied, given the invitation of international perspectives.

Phase two: Deciding what is relevant

This stage involved making a conclusive decision on the relevance of the area of interest. A considerable level of thoughtfulness and effort was given to gather a list of studies included in the review. It is noted that there are limitations in the ability to be exhaustive in the literature search as not all relevant studies have been published or were available for full access.

Inclusion and exclusion criterion

Several inclusion and exclusion criteria were applied to the literature screened during the systematic literature search (see Table 3). Studies within the last decade were included due to recency and relevance to the modern climates across cultures.

Table 3

Inclusion and exclusion criterion for the systematic search for literature

Inclusion Criteria	Exclusion Criteria
1 Qualitative studies	**1** Non-human population
2 Referenced cultural or religious understanding of perinatal loss	**2** focused on baby loss beyond pregnancy loss (miscarriage, stillbirth or neonatal death)
3 operationalised pregnancy loss as miscarriage, stillbirth and/or neonatal death	**3** Mixed methods study
4 Parent's, cultural/ religious leaders and health workers perspectives	**4** Quantitative methods
5 Studies conducted and published within 2013-present (2023 at time of data search)	**5** Literature reviews including systematic reviews, meta syntheses and meta ethnographies
6 Full access to article	**6** Case studies or case reviews
	7 Books/ e-books
	8 non-English or not translated into English
	9 Studies published before 2013

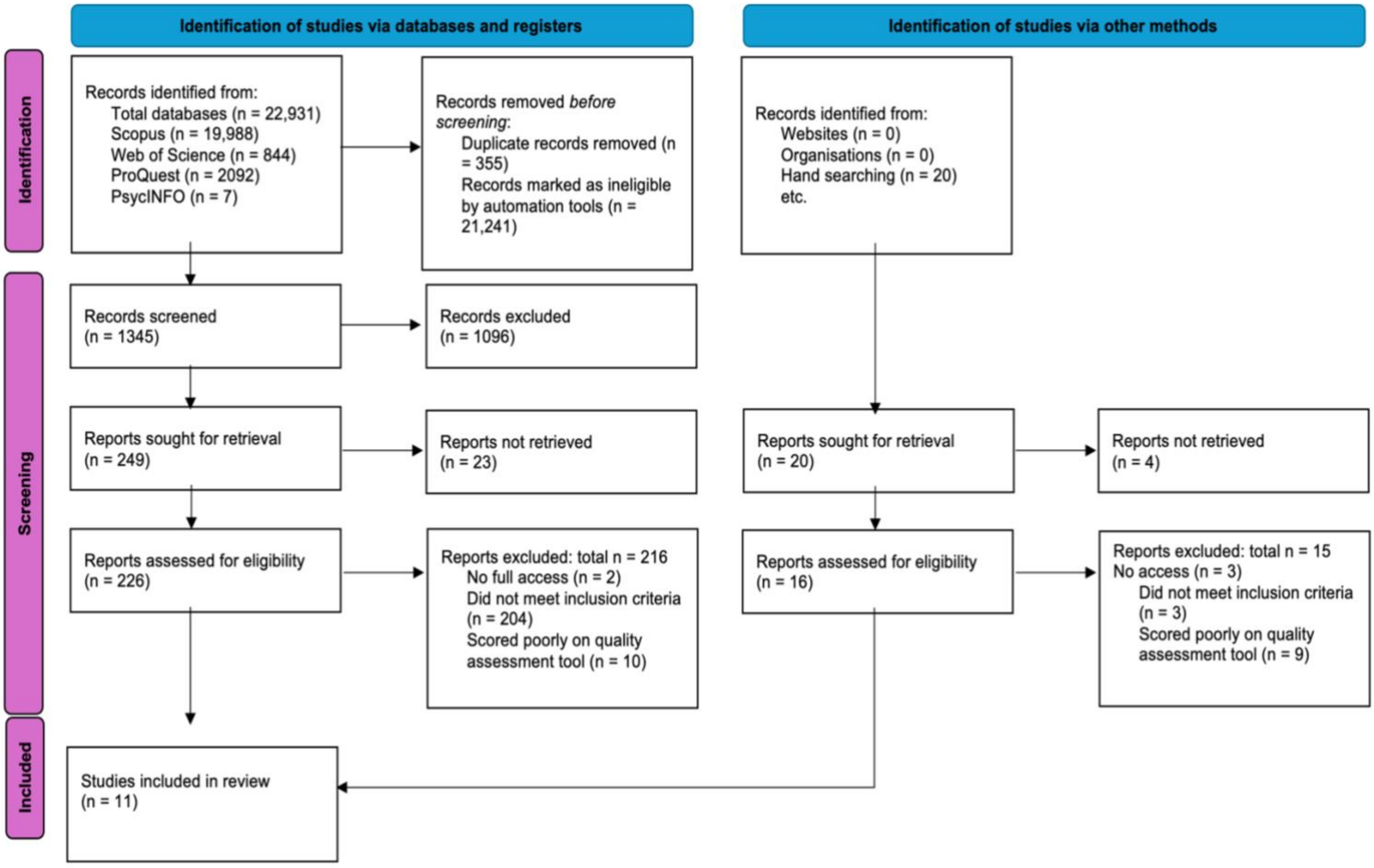
Systematic screening process

A thorough systematic screening process was conducted, following the initial searches across the databases. Several steps were taken during the funnelling stage to arrive at the final number of papers for analysis. Initially, the exclusion criterion was implemented with automation tools, reducing the number of papers significantly. Following this, duplicate papers were deleted through EndNote 20.

The following steps involved screening the titles of the papers per the inclusion and exclusion criteria. This resulted in a further substantial reduction in the papers remaining for a thorough screening process involving reading the abstracts and screening out through to reference of the inclusion and exclusion criteria. The remaining papers were read in their entirety and quality assessed; an additional 11 papers were screened out as they scored the lowest in quality, as determined by the quality assessment tool. This was determined by the questions noted in Table 6 and was determined by the scoring 'no', 'can't tell' or 'partially' on the standard ten questions of the CASP Tool. The quality of papers was additionally assessed through the additional questions of whether the translation process was detailed where applicable, whether 'baby loss' was operationalised, reference to local cultural context and reference to religion. The same scoring was applied across the assessment tool, and those scoring the poorest were excluded accordingly. The remaining 11 papers were included in this study for further analysis (see Figure 1). An overview of the included articles within the study is found below in Tables 4 and 5.

Figure 1

A PRISMA diagram outlining the screening process



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj n71.

Table 4

Paper characteristics

Author(s) and year of publication	Study Title	Religious demographic	Type of loss referenced	Key research question / aim(s)	Sample size
Arach et al., (2023)	Cultural beliefs and practices on perinatal death: a qualitative study among the Lango community in Northern Uganda	Demographic breakdown not specified but Christianity is referenced	Stillbirth	Aimed to describe and interpret the cultural beliefs, practices and behaviours of the Lango community in Northern Uganda on perinatal death.	48
Pearson et al., (2023)	Culturally and Linguistically Diverse Men's Grief Experiences Following Perinatal Death in Australia.	Christian and Islam	Stillbirth and neonatal death	To explore the grief experiences of men from culturally and linguistically diverse backgrounds following perinatal death in Australia.	16
Arach et al., (2022)	"Your heart keeps bleeding": lived experiences of parents with a perinatal death in Northern Uganda.	Not specified	Stillbirth and early neonatal death	To understand the experiences of parents following perinatal death in Lira, Northern Uganda.	32
Asim et al., (2022)	The unspoken grief of multiple stillbirths in rural Pakistan: an interpretative phenomenological study.	Not specified	Stillbirth and early neonatal death	To understand the lived experiences of women who experienced multiple stillbirths in Thatta, Pakistan	8
Popoola et al., (2022).	Beliefs and strategies for coping with stillbirth: A qualitative study in Nigeria	Christianity and Islam	Stillbirth (after 28th week of pregnancy)	The aim of this study was to describe the beliefs and strategies for coping with stillbirth.	20
Punaglom et al., (2022)	Grief Journey: Perception and Response Based on Cultural Beliefs in Thai Women Experiencing Perinatal Death.	Buddhism	28 weeks gestations onwards and before 7 days of life	To understand culturally sensitive knowledge about women's perceptions, responses, and cultural beliefs valid to optimise the quality of care for women who experienced perinatal death. to explore the grief journey set among cultural beliefs of Thai women experiencing perinatal death.	25
Ayebare et al., (2021)	The impact of cultural beliefs and practices on parents' experiences of bereavement following stillbirth: a qualitative study in Uganda and Kenya.	Christianity and Islam	Stillbirth	To describe the influence of cultural beliefs and practices on the experiences of bereaved parents and health workers after stillbirth in urban and rural settings in Kenya and Uganda	195
Adebayo et al., (2019)	Sociocultural Understanding of Miscarriages, Stillbirths, and Infant Loss: A Study of Nigerian Women.	Christianity and Islam	Miscarriage, stillbirth and/or 'infant loss'	To understand the sociocultural dynamics of perinatal loss (miscarriages, stillbirths, and infant loss) from the unique experiences of Nigerian women	35
Tseng et al., (2018)	The meaning of rituals after a stillbirth: A qualitative study of mothers with a stillborn baby. (Taiwan)	Taiwanese folk beliefs, Buddhism, Taoism, I-Kauan Tao, and Christianity	Stillbirth	To explore the meaning of rituals that women and their families perform after a stillbirth	16
Hamma-Raz et al., (2014)	Coping With Stillbirth Among Ultraorthodox Jewish Women. (Israel)	Jewish	Stillbirth	Aimed to describe and analyse the meaning ascribed to coping with stillbirth among ultraorthodox Jewish women	10
Sun et al., (2014)	Seeing or not seeing: Taiwan's parents' experiences during stillbirth.	Buddhist, Tao, Christianity	Stillbirth	To understand the experiences and decision-making that parents go through during stillbirth of their child within the Taiwanese culture	24
					Total: 429

Table 5

Demographic information for included papers

Author(s) and year of publication	Study Title	Participant age	Gender	Analysis
Arach et al., (2023)	Cultural beliefs and practices on perinatal death: a qualitative study among the Lango community in Northern Uganda	50- >70	25 Women; 23 Men	Thematic analysis
Pearson et al., (2023)	Culturally and Linguistically Diverse Men's Grief Experiences Following Perinatal Death in Australia.	27-62	8 Women; 8 Men	Thematic analysis
Arach et al., (2022)	"Your heart keeps bleeding": lived experiences of parents with a perinatal death in Northern Uganda.	17-68	18 Women; 14 Men	Thematic analysis
Asim et al., (2022)	The unspoken grief of multiple stillbirths in rural Pakistan: an interpretative phenomenological study.	15-39	8 Women	IPA
Popoola et al., (2022).	Beliefs and strategies for coping with stillbirth: A qualitative study in Nigeria	22-44	20 Women	Phenomenography analysis
Punaglom et al., (2022)	Grief Journey: Perception and Response Based on Cultural Beliefs in Thai Women Experiencing Perinatal Death.	18-42	25 Women	Content analysis
Ayebare et al., (2021)	The impact of cultural beliefs and practices on parents' experiences of bereavement following stillbirth: a qualitative study in Uganda and Kenya.	19-63	121 Women; 74 Men	Thematic analysis
Adebayo et al., (2019)	Sociocultural Understanding of Miscarriages, Stillbirths, and Infant Loss: A Study of Nigerian Women.	25-65	35 Women	Thematic analysis
Tseng et al., (2018)	The meaning of rituals after a stillbirth: A qualitative study of mothers with a stillborn baby. (Taiwan)	24-41	16 Women	Content analysis
Hamma-Raz et al., (2014)	Coping With Stillbirth Among Ultraorthodox Jewish Women. (Israel)	26-55	10 Women	Thematic content analysis
Sun et al., (2014)	Seeing or not seeing: Taiwan's parents' experiences during stillbirth.	23-42	12 Women; 12 Men	Giorgi's phenomenological method

The geographical locations of the studies included Uganda, Kenya, Nigeria, Ghana, Taiwan, Pakistan, Israel, and Australia. Populations included within the Australian study involved individuals identifying with the following cultural identities: Anglo-Saxon, Colombian, Peruvian, Indian, Bangladesh, Chinese, South Sudanese, Rwandan, Singaporean, Brazilian and French. A total of 429 participants are included in this review. One leading author has produced two articles within a short time frame of one another, exploring the phenomena in the same community and presenting and exploring different research aims and themes (Arach et al., 2022, 2023). Arach et al. (2023) included a focus group and 1-1 interviews. All participants across the studies had either directly experienced perinatal loss or had supported members of their community following a loss.

The age range of the participants was 15- 70+, with an inclusion of more female participants across the studies, with 69 % female and 31% male. Notably, the heavier weighting towards female participants raises challenges in generalising the findings to male partners within these cultures. A further breakdown of the participants' demographics can be found in Table 5. The most frequent analytical approach was thematic analysis, with others leaning on IPA and content analysis.

Quality appraisal

The quality of the final papers included in the study was appraised using the ‘Critical Appraisal Skills Programme’ (CASP) Qualitative Studies Checklist (2018). The CASP tool is commonly utilised as a quality appraisal measure in qualitative studies and syntheses

regarding health-related enquiries (Long et al., 2020). The measure was modified by incorporating four additional questions to critique these studies further and more effectively, considering the relevance to this review's aims and research questions (see Table 6). This involved assessing whether the articles defined pregnancy or perinatal loss, included a description of the translation process (if applicable) and referenced religious or cultural contexts. This allowed for a more rigorous filtering process for the remaining papers.

Table 6

Quality appraisal checklist: modified CASP checklist for qualitative studies

Section	Checklist Question
Are the results valid?	1. Was there a clear statement of the aims of the research? 2. Is a qualitative methodology appropriate?
Is it worth continuing?	3. Was 'baby loss' defined/ operationalised? 4. Does the paper reference the local cultural context? 5. Does the paper reference religion? 6. Does the paper outline a procedure for translation?
	7. Was the research design appropriate to address the aims of the research? 8. Was the recruitment strategy appropriate to the aims of the research? 9. Was the data collected in a way that addressed the research issue? 10. Has the relationship between researcher and participants been adequately considered?
What are the results?	11. Have ethical issues been taken into consideration? 12. Was the data analysis sufficiently rigorous? 13. Is there a clear statement of findings?
Will the results help locally?	14. How valuable are the results?
Assessment coding	○ Yes = Y (all or mostly fulfilled) ○ Partially = P (some fulfilled) ○ Cannot Tell = C (ambiguous from text) ○ No = N (no reporting found within text) ○ N/A= N/A (not applicable with methodology and data collection)

The quality appraisal checklist was applied to the 22 papers; however, only the appraisals of the 11 included papers will be referenced below. The abovementioned coding was applied to each checklist question (see Appendix B). The initial CASP coding does not include a

‘partially’ or ‘not applicable’ rating. ‘Partially’ was added to capture the papers with indicators of some fulfilment of the criteria but not at the level required to fulfil the requirements entirely (or mostly). The scoring of ‘not applicable’ was included for the question: ‘Does the paper outline a procedure for translation?’ as not all papers included a translation process. Most papers were deemed high quality, with each scoring at least ‘yes’ on at least 10 of the checklist questions. Only two papers scored ‘partially’, ‘cannot tell’ or ‘no’ on four checklist questions (Asim et al., 2022; Pearson et al., 2023). Typically, the papers scored lower in the sections relating to the relationship between the researcher and participants, ethical considerations, and data analysis. However, this may be due to the difference in academic standards and methodology across countries. This appeared more in the papers offering a detailed translation process and recruitment strategy. Whether this was prioritised for the restriction applied during publication to academic journals was questioned. Although, this is based on conjecture.

Phase three: Data extraction

This stage involved reading the studies on numerous occasions to increase familiarity with key themes, metaphors, and context of the studies (Noblit & Hare, 1988; Sattar et al., 2021). The first-order (direct participant quotes from each included paper) and second-order constructs (author interpretation and quotes from each included paper) are extracted from the raw data using a spreadsheet to collate all the results. All extracted data was collated verbatim, with direct quotes from the participants and the authors. This is done to preserve the original terminology from the primary authors and enrich the accuracy of determining how the studies are similar or dissimilar to each other.

Phases four and five: Data analysis and synthesis

The remaining phases involved determining how the studies were related, translating the studies into one another, synthesising translations, and expressing the synthesis (Noblit & Hare, 1988; Sattar et al., 2021; see Appendix D). Further steps were taken to ensure high levels of transferability, validity, reliability, trustworthiness, neutrality, and applicability, as outlined by Cope (2014), Noble and Smith (2015), and Yardley (2000). The abovementioned stages were discussed and reflected upon during peer and research supervision across six months. Within these spaces, frequent discussions were had to improve reflexivity, understanding of decision-making and encouragement of neutrality. Additionally, the lead author used a reflective journal to process their stance and potential biases that may influence the analytical process as per recommendations of Doyle (2003).

Phase five was achieved by arranging each of the included studies in chronological order from highest to lowest scoring (Campbell et al., 2011), determined by the quality appraisal (Appendix C). Following this, a summary of each study was completed, noting the key themes and concepts from each paper. Within this process, the cultural contexts were considered, which influenced the interpretations of the datasets. During this process for each paper, similarities and differences were noted (Atkins et al., 2008; Cahill et al., 2018; Sattar et al., 2021). This process continued until all papers had been through this process. During this process, first and second-order constructs were extracted and placed in Microsoft Excel for later consideration in the development of third-order constructs (the researchers' interpretations of the first-order and second-order constructs and interpretations).

Phase six: Synthesising the translations

This process was predominately in line with a reciprocal synthesis (Sattar et al., 2021). The concepts within phase five were refined and solidified. Many papers noted similarities, but attention was given to where differences in understanding varied per culture. This was felt to be essential to avoid previous mistakes within the literature where large generalisations were made, grouping similar concepts within GMEGs and discarding significant differences in nuance and sensemaking. This led to the formation of new third-order concepts through synthesising both the first-order and second-order constructs, leading to a new understanding of the phenomena.

Results

The review produced three themes: (1) The discourse and manifestation of religio-cultural scripts, (2) parental responses to loss, and (3) the role of a Higher being in the sense-making of loss (see Table 7). The results showed that the community responses significantly impacted how bereaved parents understood their loss. It was found that the religio-cultural perspectives surrounding perinatal loss were reinforced through many channels, such as family, friends, community/ spiritual leaders, and professionals. This created challenges for bereaved parents being able to escape these notions, which further influenced their responses to loss. The parental responses to loss involved differing processes for bereaved mothers and fathers across some cultures, which mostly appeared to be attributed to the religio-cultural perspectives and customs of that culture. The relationship with a Higher being was a crucial factor in the sense-making of the perinatal loss as well as the grieving process across many cultures.

Table 7

Third-order constructs: synthesised themes and contributing themes for each theme

Main Theme	Subthemes	Contributing papers to Main Theme
The discourse and manifestation of religio-cultural scripts	Witchcraft, sin, and curses Cultural scripts as minimisation of loss The influence of spirituality in cultural beliefs and customs	Adebayo et al. (2019) Arach et al. (2023) Arach et al. (2022) Asim et al. (2022) Ayebare et al. (2021) Popoola et al. (2022) Punaglom et al. (2022) Tseng et al. (2018)
Parental responses to loss	Womanhood and identity Manhood and perceived role of the father/ male partner The impact of cultural customs on the individual experience of loss	Adebayo et al. (2019) Arach et al. (2022) Asim et al. (2022) Ayebare et al. (2021) Pearson et al. (2023) Punaglom et al. (2022) Sun et al. (2014)
The role of a Higher being in the sense-making of loss	God's 'will' transcend human desires It's a test of my faithfulness God provides a way to cope and hope for the future	Asim et al. (2022) Ayebare et al. (2021) Hamma-Raz et al. (2014) Pearson et al. (2023) Popoola et al. (2022) Punaglom et al. (2022) Tseng et al. (2018)

The discourse and manifestation of religio-cultural scripts

The first theme details the discourse and manifestation of cultural scripts cross-culturally. Cultural scripts appeared to be a dominant influence in the perspectives of perinatal death across cultures. These scripts were shared through many channels, including with family members, local community figures, and professionals. Most scripts pertained to the role of witchcraft, sin and curses. Other scripts involved showing gratitude following the loss as the mothers survived, therefore having the chance to reproduce, the role of luck in a live birth or how bereaved parents should view the loss. These scripts manifested in different ways, primarily through experiences of isolation and exclusion but, in other instances, through support and this varied across cultures.

Witchcraft, sin, and curses

The role of witchcraft, sin, and curses was a fundamental part of the sense-making process of the reasons perinatal loss occurred across many cultures. Some described it as being put on "public trial" with members of the community trying to figure out what the bereaved mother or others close to her had done previously to result in the death (Adebayo et al., 2019). Cultural attitudes denote a sense that the perinatal loss is a direct consequence of previous wrongdoings, which are often derogatory: "… assumed to be the punishment for her wayward lifestyle before marriage such as having committed abortions; hence, she might be referred to as 'Akuna/ashawo', which simply translates to prostitutes" (Adebayo et al., 2019). Such

beliefs may overshadow the mourning process and intensify feelings of shame, guilt, blame and helplessness.

Ayebare et al. (2021) noted that stillbirths were often associated with witchcraft within Uganda and Kenya, resulting in gossip from the wider community and suspicion of parents. It was felt that stillbirths could be a direct result of a 'bad omen', a woman's involvement with/ and/or her possession by demons/evil spirits. This could be a consequence of a curse, witchcraft and/or failure to take herbal medicines. This view was echoed in other cultures, with participants reporting the belief that those experiencing perinatal loss were a direct result of socially inappropriate behaviours of at least one of the bereaved parents, often concomitant with infidelity:

> The reported behaviours are adultery, unnecessary oath (kir), incest and violation of taboos. For instance, to have a successful childbirth, a woman who committed adultery made a public confession in the presence of the birth attendant and close elderly female family members who are allowed in the labour room. Other bad behaviours, such as theft and lack of respect for elders by the pregnant women, attracted curses and lamentations (Lamere), such as 'you will never hold a baby' resulting in perinatal deaths (Arach et al., 2023).

> This man went to see his wife and from there he went to see his 'side chick' [girlfriend] and she prepared tea for him and he took it to his pregnant wife in hospital and according to customs, it is not right. And when you mix that way death must occur (Ayebare et al., 2021; Eric, father, peri-urban Kenya).

Curses are believed to hold power and can be done subtly, with the victims of curses often being unaware, “he wouldn’t curse openly, but in his heart, he had already made a curse as he was terribly angered … wasn’t that not a curse already?” (Arach et al., 2023). Similar notions were present in other cultures, with beliefs that forms of witchcraft have many forms, including dreams, speech, and physical acts of witchcraft:

> ... about three days before I went into labour, I had a dream that a doctor administered an injection into my upper arm, despite my refusal... My husband and I prayed about the dream, but three days later, I woke up to a massive bleeding. By the time we arrived at the hospital, it was too late to save the baby ... one of the nurses at the clinic told me to intensify my prayers because it might be a spiritual attack (Popoola et al., 2022; SK11).

> You know this is not a common thing, when it happens everyone is questioning in their mind what would have happened and they are not comfortable talking about it... and you believe that maybe your wife is a bad omen or you have been bewitched (Ayebare et al., 2021; Ian, father peri urban Kenya).

> Sometimes, anything that belongs to a baby could be removed for evil purposes. When this happened, it would cause the death of the child. Death occurring this way is blamed on an older woman suspected of practising witchcraft. Therefore, the death of only one child is considered bad luck, but when two or three children die in a series, the danger is suspected (Arach et al., 2023; female, KI_12).

Asim et al. (2022) reported that mothers' who experienced stillbirths had a robust belief that supernatural powers 'killed' their babies. Consequently, such women often pursue treatment from spiritual and religious leaders to deliver live babies:

> The reason for delivering dead babies [stillborn] is that I am possessed by an evil spirit (Jin) when I had gone to the holy shrine, a religious man said the same thing and then I believed that because of evil spirit (Jin) my babies are born dead (Asim et al., 2022; Participant, 7).

> After the ultrasound in the seventh month, the doctor said everything was fine. Then I stopped visiting the shrine and also stopped drinking the holy water. Due to which the evil spirit came back and my child was born dead again before the due date (Asim et al., 2022; Participant, 8).

Although, across several cultures, there were cultural scripts surrounding the importance of community and offering support to the parents impacted by the loss. This involved attending and organising ceremonies and rituals for the participants (Arach et al., 2023; Ayebare et al., 2021; Pungalom et al., 2022; Tseng et al., 2018). Other support involved providing practical and emotional support to bereaved parents to prevent mothers from feeling overwhelmed and allowing fathers to return to work.

Cultural scripts as minimisation of loss

Many cultural scripts were shared in response to perinatal loss; within Nigerian culture, women recalled being told the success of pregnancy is determined by luck (Popoola et al., 2022). Some scripts could be deemed as minimising the experience of loss:

> One's child does not die; a child that is yours will not die while the parents are still alive. Neither would such a child die during the pregnancy phase, at birth, nor prematurely. Irrespective of the condition, the child will survive and live to an old age (Adebayo et al., 2019; NW 21)

Within some West African populations, there was a great emphasis on having gratitude following the loss. This mainly pertained to the fact that because the woman was alive, they had the prospect of reproducing in the future, "…people told me to count myself fortunate because some women have died with their babies" (Popoola et al., 2022; SK18). These sayings were common and often had powerful imagery, "…though the water is spilled, the clay pot is not broken and is still capable of holding water again." (Adebayo et al., 2019) - suggesting there is hope for future pregnancies despite the loss on this occasion. However, these sayings are often unwelcomed by the mothers following the loss and can be interpreted as dismissive of the experience:

> You take heart and stay, even when the child has died, there is no cause of alarm as long as the mother stone is left because when the mother stone is alive, you can get another daughter stone and still be able to continue grinding (Arach et al., 2023; female KI_10).

Some community responses appeared to be brusque by Western standards. It could be interpreted as motivational to discourage individuals from being stuck in a state of sadness and focusing on the future: “The child is gone; you need to pull yourself together” (Adebayo et al., 2019); “It is well” / “move on” / “everything that happens for a reason”. (Adebayo et al., 2019). Others were advised that this experience is common and that they should not remain stuck reliving the past:

> Many people told me that it was a past event. I could not go back to fix anything. I had to let it go and live in the present. It’s not only me who lost my child. There are many people who have lost children like me… (Punaglom et al., 2022; Woman 23).

> Oo the nurse—what they told me was that this thing has already happened. Now that your baby has passed on, you take it home and bury it. There is nothing much that we are going to tell you (Arach et al., 2022; P 2002, a father of 9).

As per cultural scripts surrounding not displaying emotional displays of grief following perinatal loss within some West African communities, women often internalised feelings of isolation and/or deep sadness. Some participants shared their experience of suicidal thoughts, “at first, I had suicidal ideas after my child died…” (Punaglom et al., 2022; Woman 16). Others shared the cultural expectation of suppressing one’s emotions following a loss, “you are asked to bottle up your pain. It was almost a taboo to talk about your loss or even speak of mourning. Don’t even go there; it is impossible” (Adebayo et al., 2019). In some individuals, this resulted in intense somatic feelings, “it burned my heart to the extent that I started feeling deep pains in my chest” (Adebayo et al., 2019; NM 1). Others sequestered from their

community, “I sat there quietly, without talking to anyone almost all day” (Pungalom et al., 2022; Woman 18). Each of these experiences led to psychosocial distress:

> They tried all they could so that I would not cry. “Do not cry” was what I was told. This kept ringing in my head: “If I cry, the other one will die.” I was dying; for three nights, I could not sleep, water could not go through my throat, and tears could not drop from my eyes. My head was terribly aching, and I could not express anything (Adebayo et al., 2019; NW 7).

> I was numb and shocked after I heard the devastating news about the death of my child… and I felt like my heart had disintegrated into dust… thinking about my deceased child usually happened repeatedly in my mind all the time in a way that I could not control (Pungalom et al., 2022; Woman 17).

Some studies reported experiencing blame and criticism from in-laws, predominantly from their mothers-in-law. One participant noted that “... it is more painful if you are accused by in-laws” (Arach et al., 2022). This overt blaming culture appeared dominant in Pakistani culture as a bereaved mother shared that they were called a “child-killer” by their relative. (Asim et al., 2022; Participant, 7). Similarly, another participant from the same culture shared that following each infant loss, both her in-laws and husband referred to her as “careless”, and her husband refrained from speaking to her for days (Asim et al., 2022; Participant 5).

The influence of spirituality on cultural beliefs and customs

The role of spirituality underpinned some cultural beliefs across many cultural groups. This was interpreted in many ways and sometimes involved advice on navigating the loss to prevent further tragedy. Some examples are as follows:

> There is a concept in the Yoruba culture which directly speaks to my situation. The children I have lost to stillbirth are referred to as "Abiku". These are children who come and go in repeating cycles before they can be celebrated by their parents (Popoola et al., 2022; SK2).

> Her spirit is still around; if you cry, her spirit would come and carry this one (the other twin boy). I was told not to allow the tears I shed to touch the living child. They said I should not even carry her (the deceased child) or say goodbye that it might cause the other twin to pass on too (Adebayo et al., 2019; NW 7).

Adebayo et al. (2019) shared that "there is a cultural belief that when a child dies, there is the possibility for 'the spirit to hover around' lingering around the living for a while before departing to the 'land of the dead' or before 'finally going to rest'." The lingering spirit of the baby is understood to hold powers to do either good or evil, but participants often referred to them as engaging with the latter. Expressions of grief by the mother are believed to instigate the hovering of the spirit. Interestingly, this notion does not seem to be extended to the fathers from the texts available.

There was the view in some cultures that the loss occurred as cultural customs were violated. This gave entry to evil forces to cause the death, "whole day I work in fields and in

the afternoon we sleep under trees due to which most women get possessed by an evil spirit (Jin) because of which dead children are born." (Asim et al., 2022; Participant, 4). One mother shared that her baby died because of "a goat that was tied up within the compound' (SK6) when labour began. She explained that 'it is forbidden for an animal to be tied up within the close vicinity of a pregnant woman" (Popoola et al., 2022; SK6).

Parental responses to loss

The second theme details the individual experiences and responses to loss showed gender differences, with women showing heightened internalised shame due to the inability to produce a live baby. In some cases, women were excluded from events they usually engage in as a woman within that culture. This further intensified a sense of distress and isolation. Men showed heightened pressure to act as supporters and fulfil cultural customs. There was a shared experience of internalised sadness due to the religio-cultural perspectives of perinatal loss across several cultures.

Womanhood and Identity

Some bereaved mothers shared that their perinatal loss "hurt" them, leaving them with the "feeling of guilt stuck in my heart that destroyed the self-worth in my life as a mother." (Punaglom et al., 2022; Woman 19). Other women expressed feelings of failure, disappointment for the physical changes and reminders on the body with no baby to show for it, thus the experience being in vain. Others shared that perinatal loss symbolised failure to adhere to cultural beliefs surrounding the role of the wife:

> It dawned on me that I had a nine-month journey and I have nothing to show for it. . .I said I would rather die than have a physical scar in addition to the emotional one I was already anticipating. Have a scar with no child? Never! I would not advise anybody to do it, it would be a constant reminder all your life of the failed nine-month journey (Adebayo et al., 2019; NW 16).

Adebayo (et al., 2019) found that women were often called a "yeye fowl" (a useless chicken that does not hatch its eggs) or a "basket" (failing to hold water as compared to a pot). Some women engaged in avoidance due to an overwhelming sense of shame as they were not regarded as women in the absence of a successful live birth:

> I was told by my in-laws that they would have preferred to have a hen (woman) that would lay its eggs (pregnancy) and hatch them (birth) rather than a "yeye fowl" like me; I was asked countless times if I was a woman because they think I was responsible for the death of my children (Adebayo et al., 2019; NW 13).

Adebayo et al. (2019) additionally noted that within the Nigerian culture, it is expected to reproduce children following marriage. In this culture, perinatal death violated the social norms by failing "to fulfil their wifely or motherly role". The authors felt this experience translated to "the double stigma of failing to produce and keeping a man", undoubtedly reducing their sense of womanhood. It was interpreted that childbirth adds a sense of respect and meaning to a woman's life, whilst unintended and habitual perinatal loss/ childlessness "rips a woman of her identity"; this experience is intensified by the absence of living

offspring before the loss. This experience was echoed in other Nigerian cultures: “I used to feel very sad, but I consoled myself with the children that I already have ... by having these children, I am able to prove that I am a woman” (Popoola et al., 2022; SK4). Participants reported that immediate family members and close friends would coerce their husbands to raise an additional family surreptitiously so they could be a “man” as living offspring maintain the lineage (Adebayo et al., 2019).

This cultural importance of being able to produce live offspring and the negative impact of the inability to do this on womanhood and their identity was also found within Pakistani culture, “I felt valueless that I am not even able to deliver a live child. I think my husband will leave me because I will not be able to become a mother” (Asim et al., 2022; Participant, 7). This has an impact on their value within their local communities. However, also on how they view themselves, suggesting poor self-worth, “in our society, only women who have children get respect in family and society. I feel incomplete when I think that I am not able to become a mother of any child.” (Asim et al., 2022; Participant, 5).

These scripts often resulted in Pakistani women being excluded from their communities; women who experienced stillbirths were “marked as a disgrace to the society” (Asim et al., 2022). Bereaved mothers from these cultures were deemed “untouchable”, with members of the community ‘forbidding’ their children from visiting them or disallowing the women to attend events about childbirth or marriage out of fear that they would bring bad luck or negative impact on their ability to conceive and deliver a healthy baby:

> It is very painful for me that I cannot go to any parties. Especially when a new child is born in some house, women there, during pregnancy and in post-partum don't meet me due to fear of losing their child (Participant, 7).

Interestingly, one participant regards the perinatal loss as a "disability". Such a term portrays a sense of limitation in functioning, a difference to the 'norm' and potential hardship. One may speculate that it may hold similarities to the isolation, exclusion and being overlooked that those with disabilities may typically face. It additionally appears to seem that the experience of loss feels defeatist.

Manhood and perceived role of the father/male partner

Some men noted prioritising their partner's well-being and experience over their own, adhering to societal scripts regarding gender roles (men as supporters and leaders). In other cases, great concern for their partner was shown. The motivation for this varied across cultures. For instance, within the Lango culture, Arach et al. (2022) expressed partners' concern surrounding the recovery of their partners, but in some cases, appeared to be linked with the prospect of having other children: "It's better to lose the children when their mother is alive" (P2014, a 44-year-old father of deceased twins).

Arach et al. (2022) noted that fathers are expected to fulfil many competing roles within this culture whilst also mourning for the loss. There is the expectation that they will arrange the transportation of their baby home if the loss occurs at the hospital. Additionally, sourcing the finances for the funeral arrangements whilst supporting their wives. In cases where the

couple are unmarried, the female partner's family members may mandate marriage or compensation for their deceased baby before burial. Given that many losses were unexpected, this put a tremendous financial strain on men and was interpreted as a "double loss" – loss of the baby and financial resources:

> …you know it's not easy to be a man. You have all the burden on your shoulders. Firstly, you need to comfort the wife so that she doesn't have many thoughts then on the other side, you are also mourning. I also worried a lot about how the deceased and the mother would get back home (Arach et al., 2022; P 2001).

This slightly differed for fathers of African and Southeast Asian descent living in Australia. Some participants expressed uncertainty about whether the mothers would be able to cope with the loss without them being "strong". Comparably to Arach et al. (2022), they noted the challenges of playing the roles they believed they had to fulfil due to cultural scripts whilst experiencing the grief themselves:

> Yeah, to be honest, it was quite bewildering and very difficult, but obviously, I knew I had to be strong, you know, for my wife as well because if I broke down, I don't think she could have handled it herself. So, I had to be strong for the whole family. But it was very difficult (Pearson et al., 2023; Patrik, Rwandan bereaved father).

> …I did have my grief and cry, then in the process of facing death and having to deal with funeral and things like that, there was that numbness of grief to be able to still

> function, to care for others, to do for my wife and even for the grandparents (Pearson et al., 2023; Singaporean bereaved father).

Pearson et al. (2023) additionally noted that the benefit of shutting off their emotions meant that they could avoid some situations and feelings which allowed them to fulfil the gendered and cultural scripts: "...in Chinese culture, there's a poem saying that men can lose their blood, but not lose their tear"/ "Our men, they don't cry, but they cry inside." (Pearson et al., 2023; Rita; Pauline). Even in private, doing so brings shame and potentially a sense of failure. Being less than what is expected of a man within their cultural context: "Actually, my whole being was confused, and I became totally weak, but I acted bravely like a man. ..... then came back home" (Arach et al., 2022; P 2012, a 30-year-old father of 4).

The impact of cultural customs on the individual experience of loss

In some other West African cultures, it was common practice for the father to organise the funeral and bury the baby in an unmarked grave; the reasons for this cultural custom were not always apparent. It was also against some cultural customs to see the baby following the loss. Some mothers felt neglected and overlooked in these moments, especially immediately following the loss. There was expressed uncertainty about how their baby was handled after they had been taken from them:

> I do not even know what the child looked like. It came out of me lifeless and that (lifeless) was what my life was: without a child … my smile went sour. I just wanted the placenta to die inside of me; my strength was drained in the blink of an eye. They

> probably wrapped him up in some cloth or something. They just carelessly packed everything (lifeless foetus and placenta), put it in a carton and gave it to my husband. I felt used; there was no question or answer for what has just happened to me. The child came out of me; I thought it should be mine, but I was wrong. They made all the decisions without a single word from me. All I knew was he came out of me without life (Adebayo et al., 2019; NW 5).

In addition to leading the funeral arrangements, medical staff also look to the father to lead for direction. It is common practice for the cultural norms to be maintained by medical staff in the absence of the father/ husband, which can be challenging for the bereaved mother.

> It happened in my hands; they took her from me and made me go to a neighbour's room. Before they allowed me to come out of that room (the neighbour's room), they had already taken her away. My husband was not even around but they waited for him to come; on the other hand, I was present and pleaded with them to allow me to see her for the last time; I was denied that opportunity. It burned my heart to the extent that I started feeling deep pains in my chest (Adebayo et al., 2019; NM 1).

In some other cultures outside of these West African communities, a taboo around seeing the baby following the loss also persisted. This created a dilemma in some couples about whether to see the baby following the loss. The decision of whether to see the baby or not was often accompanied by difficult emotions. Adebayo et al. (2019) and Ayebare et al. (2021) interpreted the fear of going against cultural customs as a fear of future perinatal losses. However, in complying with the cultural custom of not seeing their baby following the loss,

some women expressed an internal conflict in not having or taking the opportunity to see their baby. Some shared persistent avoidance, maintained by the customs but necessary to avoid emotional distress:

> My kids never knew they had an older brother who died…there is no evidence of him anywhere – no pictures – and I never talked about him. Why would I want to bring back such memories that almost ruined me? Now they know, but they cannot make me talk about him (Adebayo et al., 2019; NW 9).

> I didn't get a chance to hold her. I think I was afraid, and I did not understand anything; I was more confused and also, it is against our customs to hold dead babies (Ayebare et al., 2021; Joy, mother).

Other Southeast Asian cultures and Australia's CALD populations expressed similar conflict in deciding whether to see the baby. However, the reasons differed and appeared to be motivated by internal fears rather than pressure from cultural customs. Nonetheless, there were conflicting opinions on whether to see the baby, with some individuals being more motivated than others. Some parents worried they would "always have imagined what she looked like and would have regretted not knowing". They expressed that they "wanted" to see their baby (Sun et al., 2014; Father 3). Some engaged in redirecting their emotions onto their partner out of fear:

> My husband did not want me to see the infant because doing so would make things much more painful. However, I wanted to check and see if anything was wrong with

> my baby. He appeared normal, but his life was taken away before he was born [weeping] (Sun et al., 2014; Mother 1).
>
> We could not stop crying when we saw him. My husband comforted me and asked me not to think of it too much. How can I not think? After seeing him, I swore that I would never forget that he is the second son in our family (Sun et al., 2014; Mother 10).
>
> It is similar to the past, when poor families gave up their children to other families; they would not look at their baby after the birth, out of fear of becoming attached to him or her. I thought I would feel conflicted if I saw our stillborn baby because his appearance would always be in my mind, so we chose not to see him (Sun et al., 2014; Mother 4).
>
> I decided following the delivery that for my recovery and mental health...not to see the child. I tried not to look, instead focusing on my wife. [Baby] was not fully-formed, I didn't want the picture of the unformed child, who was blue, to haunt me. [Instead] I was focusing on my wife, and she was hungry. So, I went and got food (Pearson et al., 2023; Harrison).

The role of a Higher being in the sense-making of the loss

The final theme demonstrates the importance of individual relationships with God or a higher power for bereaved parents in processing and healing from their experiences of

perinatal loss. For most of the articles found, the role of God or a Higher being is often mentioned. The reasons may vary, but shared beliefs include that the baby's loss was “God’s will” and “life and death are in God’s hands” (Asim et al., 2022; Participant 2). It was often said that ‘God’s will’ is “perfect”, even if the rationale is not understood by the individuals who have experienced the loss. Other perspectives include the loss serving as a test for faithfulness in God, and the challenge may be a blessing in some ways as it leads to a closer relationship with God. Finally, a common notion is that God or a Higher being provides a way to cope and provides hope for the future and, ultimately, healing from this experience.

“God’s will” transcends human desires

Poopla et al. (2022) reported that the loss was interpreted as an assay of faith amongst all the Christian and Muslim participants. Participants often accredited the perinatal loss to diabolical powers; however, the belief that their babies would not have died if it had not been divinely ordained often remained: ‘…in the first place, the pregnancy does not belong to me, it is God’s. When he decided to take the baby back, I cannot question him... he knows the best’ (SK17); ‘... I convinced myself that God allowed it… the baby would not have died if God had not permitted it.’ (SK20). Others believed “God’s time is the best…” (SK3).

The Israeli participants within the Hamma-Raz et al. (2014) study frequently mentioned the role of “God’s will” in the face of perinatal loss. Medical staff contended this, but the women shared that they remained firm in their beliefs:

> It does not mean that I now have complaints or grievances with God ... I am certain that God decided what was best for me, so that is what is best for me because he loves me most of all. He knows what is good for me.

> There was nothing I could do. I had made plans, then I had to resign myself to God's will. Things did not always go as I would have liked. Was it right to say thank you only when things went my way and to be sad when they went according to God's plan?

Some mothers expressed that God's love for them remained and "everything that God did was for the best…". Once individuals could accept that the loss occurred because of God, they could refrain from their "incessant crying".

These beliefs are further echoed by Ayebare et al. (2022) and Punaglom et al. (2022), where bereaved parents also disclosed a belief that all events occur in life due to God's decisions as they know they did everything within their power to avoid troubles. Others relied on the fact that perinatal loss, so their experience is not exclusive to them. It was felt that birth and death are inescapable and as per the laws of karma and nature.

> So [pause] I tell them that it's not you who decided to get this pregnancy, it was God's plan, he is the one who decided that you conceive and, it's the same God who has taken away this baby... (Ayebare et al., 2022; Ritah, health worker).

Such beliefs in God supported them to arrive at a place of acceptance and the ability to manage the emotional responses to loss.

It's a test of my faithfulness

Some participants shared that the experience was purposeful, as God was using the experience to test their faith. Rather than distancing themselves from God out of resentment, it was viewed that it was necessary to draw closer to God to show their faithfulness, which is deemed essential.

> ... each one of us should take heart and accept our trials and tribulations with faith ... we need to console ourselves that on this earth we are going to have challenges... we should not see it [stillbirth] as the end of the world (Punaglom et al., 2022; FGD).

> I caught myself and said, 'Wait a minute. This was a test from God' God gave me strength, and there were worse things. I suddenly realised that we had an opportunity to sanctify God's name, and I turned to God and said, "Help me sanctify your name and get through this test with strength" (Hamma-Raz et al., 2014).

> The moment that I made peace with the fact that I believed that God put me to the test, He knew that I could withstand it. What really happened was that I could not cope with anything else ... I cried. And I continued. I tried not to sink into self-pity or "What if?" My faith kept me together (Hamma-Raz et al., 2014).

God provides a way to cope and hope for the future

The view that God or a Higher being ordained their perinatal loss meant that it was imperative and sensical to lean on Him as a coping mechanism. Poopla et al. (2022) advised that bereaved mothers advised fellow women who experienced a stillbirth "to be patient and God will bless them with a new child" (SK7).

Similarly, in Australia, community workers reported:

> When [CALD men] are very much connected with their religion and their culture about the loss of the baby, their grief is much, much lower. But if a person cannot connect with their religion or culture, I think they don't know what to do. There's no conclusion (Pearson et al., 2023; Mark, ecumenical hospital chaplain).

This was mirrored in the Israeli, Pakistani and Thai cultures:

> I remember myself praying to God and asking Him to strengthen me and take care of me because I could not face the situation alone. I felt as though we were closely acquainted, we were in continuous contact. It really kept me together (Hamma-Raz et al., 2014).

> To deal with my grief I pray and go to Holy Shrine. Going to a shrine makes me relaxed because lots of females go there whose babies were born dead or they are sad.

> Then I get patience by looking at them and try to conceive again (Asim et al., 2022; Participant, 6).

It appears that connection with God was fundamental in coping with the tragedy, and this was often achieved through going to their place of worship, praying and/or offering sacrifices. Individuals felt at a loss without his presence and connection to him; with his presence and connection to him, individuals appeared to feel grounded despite experiencing the loss.

> He taught us to pray to Buddha to ask him to prepare to take away the child's spirit. And when everything was ready, we found ourselves not worrying about it, because we trusted the Buddha to take care of the baby (Tseng et al., 2018; Buddhist participant).

> Christians believe that, after death, people return to God's arms… After the pastor's prayers, God sent the child's spirit to Heaven after labour had been induced...After that, I think it is unnecessary to do a memorial service for him, because I believe he's in the arms of God (Tseng et al., 2018;Christian participant).

Some burial processes were considerably shorter and different to the burials of those who were older and/or born alive before dying. This left some parents feeling as though their babies were "less human" (Ayebare et al., 2021), which was often reinforced by using 'it' to describe the baby who died.

> The baby has to first be born and he stays for about 2 days, that's when they give him a name. One whom God takes away from earth after being born is the one who gets a name...But with the other one [referring to a stillborn baby] remember, he is born already dead, that one doesn't get a name, he doesn't (Ayebare et al., 2021; Obei, father semi-rural Uganda).

Ayebare et al. (2021) argued that the hesitancy to ascribe the baby a name was habitually embedded in the practice of passing down traditional family names. Using familial names for a baby who has died was believed to bring bad luck to the entire family. Subsequently, the usual baptism and naming ceremonies were not carried out for stillborn babies, even in instances where parents were religious.

> No condolence money is collected. No money is collected as condolence fee from the community members. After burial, no last funeral rites are done. No gathering and cooking is done after burial like for older people. They take it like as if you have not lost anyone (Mugisha, father, semi–rural Uganda).

> We buried it [baby] without informing anyone else; me, my friend and my dad plus my brother… we proceeded and buried at that time without letting the neighbours know… where you bury, the grave isn't supposed to be seen; you bury and just dig around it to camouflage around. You can even plant there something. Only family members are supposed to know and not all [family members] even because if you know Shafik is a witch doctor and has a bad heart; you don't show [him] (Shafik, father, urban Uganda).

Similarly, Pearson et al. (2023) found differing cultural perspectives on appropriate rituals following perinatal loss:

> [For a stillborn baby] they pray together a little, they don't do 40 days like a born one. A born one they do… after the death, three days, and then a day of burials. And then the 40 days after that... But the [stillbirth]… then they just pray once (Solomon).

Overall, the results demonstrated the complexities of navigating perinatal loss in the context of religio-cultural perspectives and responses.

Discussion

Religious and cultural perspectives surrounding perinatal loss undoubtedly influence how bereaved parents make sense of their loss and their grieving process. A total of 11 studies were included in this study, and conclusions were influenced by contributions from 429 participants. The synthesis produced three themes: (1) The discourse and manifestation of religio-cultural scripts; (2) parental responses to loss and (3) the role of a Higher being in the sense-making of loss. The findings show that religio-cultural perspectives have the potential for both positive and negative experiences for bereaved parents, particularly bereaved mothers who are commonly believed to have been at fault for the loss.

The theme of discourse and the manifestation of cultural scripts detailed the community responses to perinatal loss and the influence of religio-cultural scripts on the responses and

parental experiences of perinatal loss. The findings showed that religio-cultural scripts across cultures involved witchcraft, sin, and repercussions of defiance of cultural customs and norms. These scripts often resulted in individuals seeking guidance from spiritual leaders. This finding is consistent with the literature, with many cultures reporting similar beliefs of witchcraft, sin, curses, poor karma, and other supernatural forces influencing the perinatal period and/or perinatal death (Frøen et al., 2011; Noge et al., 2020; Paudel et al., 2018; Raman et al., 2016) The findings within this study also showed religio-cultural scripts significantly impacted participants cross-culturally and seemed to be more targeted towards women. Those who experienced supportive responses from the community shared positive effects compared to those who were shunned from their communities, leading to worsened experiences following loss.

The parental responses to loss appeared to be influenced by religio-cultural scripts and customs, influencing gendered differences in the experience of loss. The findings show that patriarchy remains strong within most collectivist cultures. Within some Nigerian, Ugandan and Kenyan communities, there is the expectation that the baby's father will arrange the funeral and burial processes alongside community leaders. It is a cultural custom for burial sites to be unmarked, so the family cannot visit this place to avoid bad omens. Hospital staff often liaise with the father; the mother is often left without much communication. This practice directly contradicts Western psychological theories surrounding the process of grief, such as Worden's task model (2009), which states that families tend to keep the loved one's memory alive through the discovery of a continuing bond with the deceased person. Pearson et al. (2023) showed the tendency for fathers to minimise or hide their emotional responses to the loss to adhere to the societal scripts surrounding men being supporters. This led to

internalised distress in many, crying in private and experiencing an overwhelming sense of sadness. This is mirrored in the literature (Obst et al., 2020).

The role of a Higher being in sense-making was clearly apparent and again differs from mainstream beliefs within the literature. God and beliefs in Higher beings were central for many in navigating their grief. Prayers, rituals, and faith in 'God's will' were common across cultures and religions. This, too, was coherent with the literature, as for many cultures, religious coping can have positive effects on mental health outcomes (Ahmad & Dein, 2021; Dein, 2013; Khan & Watson, 2006; Rosemarin et al., 2009; Tarakeshwar et al., 2003; Tepper et al., 2001)

These findings raise the question of whether these practices and community religio-cultural perspectives increase the likelihood of disenfranchised grief (the experience of grief that is not acknowledged, publicly mourned, or socially supported, thus creating distress in individuals; Doka, 1989) within these populations. Notably, this experience was less common in Taiwanese culture, with rituals following perinatal death providing a sense of containment for parents as they felt vindicated that they were caring for their baby the best they could, ensuring they had a good afterlife (Sun et al., 2014 & Tseng et al., 2018), potentially mediating some of the challenging experiences following the loss.

The findings showed gendered differences in the responses to loss in the context of cultural customs. Within some cultures, fathers were often offended that they had to pay for burial funds and hospital fees without experiencing the pride of fatherhood, creating frustration. Mothers showed resentment and distress by the changes to their bodies, which was heightened

by the lack of worthiness of the experience given the loss of their baby. The scars acted as an ongoing reminder of the loss, which was difficult for them. Within collectivist cultures, the role of the woman/ wife remains traditional, with high expectations of women providing offspring and taking care of the home/ family. Perinatal loss strips them of this, leaving many with feelings of worthlessness and often objectified as many partners leave the relationship to seek other women who can fulfil this role. This adds an additional layer to the loss; not only are they losing their baby, but they also often lose their marriage, community, body, and social standing. These losses are further intensified by the taboo of expressing emotions such as sadness following the loss. Comparatively, Markin and Zilcha-Mano (2018) and Burns and Covington (2006) argue that bereaved parents within Western cultures are often compelled to grieve the loss of pregnancies within cultural contexts which inhibit the free discussions and expressions of perinatal loss within public spaces. This appears to be for different reasons, involving discomfort from the masses rather than ingrained intergenerational scripts involving spiritual beliefs.

This study shows a commonality amongst the collectivist cultures externalising their understanding of loss. Negative experiences were associated with community scripts of the role of witchcraft and the repercussions of sin by their parents or family members. This resulted in distress, exclusion from the community and internalised blame. Internalised blame relating to the role of sin and witchcraft may create challenges in Eurocentric therapeutic approaches, such as thought-challenging due to potential intrapersonal conflict. Furthermore, in some cultures, showing emotion was deemed to indicate that they did not have a strong belief in their faith and were in violation of cultural customs, isolating them further.

However, individuals who externalised the understanding of the loss by attributing this to God's doing, presence and/or divine plan expressed this as a fundamental part of healing and growing from the loss. This also resulted in a reduction of distress and an increased ability to experience peace and acceptance. These findings bore similarities to the theories of locus of control underpinned by social learning theory (Rotter et al., 1962; Bandura & Walter, 1977). Individuals with an internal locus of control (LOC) tend to adopt the view that they directly have control over what happens in their lives. In contrast, those adopting an external locus of control will believe that events or occurrences in their life are due to luck, fate, or a higher power. Despite the overwhelming evidence showing an association between an external LOC and poor mental health outcomes (Holder & Levi, 1988; Khumalo & Plattner, 2019; Molinari & Khanna, 1981; Petrosky & Birkimer, 1991) and functioning (Brannigan et al., 1977; Lefcourt, 2014), this study offers a contrasting and alternative view. An external LOC involving the role of God has an anecdotally positive impact on one's psychological well-being and adjustment following loss across cultures, which supports Mark's (1998) argument that the bias for an internal LOC in Western literature may lead to inappropriate conceptualisations of work with clients who adopt this approach.

Clinical implications

The religio-cultural customs and perspectives on perinatal loss appear incongruent with the public health guidelines for professionals supporting families with perinatal loss in the UK. The National Institute for Health and Care Excellence (NICE, 2014) advise discussing the option of seeing a photograph of the baby, having mementoes of the baby, seeing the baby, and holding the baby with bereaved parents following perinatal loss. Whilst this may be

culturally appropriate for Western populations, this advice violates the cultural rules across several non-western cultures, as found in this study. Those living in the UK with these cultural backgrounds may find additional difficulty in making these decisions as they defy their inherited cultural norms. Consideration and sensitivity should be given to the differences in cultural appropriateness when offering such support.

The NICE guidelines (2014) outlining psychological support for parents who have experienced perinatal loss are slim but recommend trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing for post-traumatic stress disorder (PTSD) for women who have experienced perinatal loss. There is no other guidance for psychological support following perinatal loss if they do not meet the threshold for a PTSD diagnosis. The findings of this research pose the question of whether third-wave approaches such as acceptance commitment therapy (ACT) and compassion-focused therapy (CFT) may be suitable approaches to support individuals who hold such religio-cultural perspectives. ACT aims to increase the meaning of one's life and support them in gaining acceptance of the pain that they are feeling (Harris, 2019); this can be applied in a trauma-focused intervention (Harris, 2021). ACT also leans on the use of mindfulness as a coping skill to manage these challenges, which has roots in spirituality (Maaske, 2002). CFT has an additional focus on compassion in the context of shame and self-criticism (Gilbert, 2014; 2009), and females from Southeast Asian and Black African cultures seem more vulnerable to this, given the influence of religio-cultural discourses surrounding perinatal death. Narrative therapy (White & Epston, 1990) may have some positive bearings as it allows one to retell their story and may combat some of the negative experiences associated with the religio-cultural scripts embedded within their communities.

Conclusion

Religio-cultural understandings and practices significantly impact the phenomenon of perinatal loss. The findings should serve as an additional consideration for professionals working with these populations. Incorporating religio-cultural perspectives and scripts surrounding perinatal loss may also be beneficial during assessment, formulation, and intervention. As recommended by NICE guidelines (2011), seeking consultancy or initiating joint work with respected community members, such as spiritual care teams, may be beneficial.

The findings show the importance of distinguishing between GMEGs rather than continuing to group them within research. This study observes that significant differences exist when accounting for cultural customs, even when following the same religion. The findings may also provide some insight into the underrepresentation of GMEGs within perinatal services. However, this cannot negate the ongoing systemic and institutional racism present within healthcare services and gatekeeping support for GMEGs.

Strengths

A varied inclusion of religious beliefs was included within the synthesis. The perspectives of community members and bereaved parents were included, providing a broader sense of perspectives and contributing to a more holistic understanding of the phenomenon.

Limitations

Only articles translated into English were included in this study. The study could not capture perspectives from a broader range of cultural contexts, impacting the transferability. Both are a consequence of the practical constraints present within the timeframe of doctoral research. This study would have also benefitted from greater representation of male perspectives.

Future directions

This study may be replicated by examining various religions individually to provide more insight into each religious perspective. A greater understanding of the role of God/ religion/ spirituality and how these maps onto existing psychological models of grief is needed. Given that this often has a positive impact on bereaved parents, more needs to be done to incorporate religion into psychological theories of loss.

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An exploration of Black British Caribbean bereaved fathers' experiences following perinatal loss: An interpretative phenomenological analysis

Introduction

Prevalence of baby loss in the Black community

Data shows that perinatal loss disproportionately impacts global majority ethnic groups worldwide (Unicef, 2020). This trend is mirrored within the UK, with non-White ethnic groups leading the infant mortality rates (National Child Mortality Database, 2023; Office for National Statistics, 2021). Despite fluctuations in national trends of stillbirth, infant mortality rates have declined from 2007-2019 (Office for National Statistics, 2021). Notwithstanding this decrease in the number of stillbirths and infant mortality rates, those from Black ethnic groups remain disproportionately affected (Matthews et al., 2022). Black babies have the highest mortality rate (Knight et al., 2023).

Research shows that the overrepresentation of this demographic is present in all forms of death within this period, particularly in deaths resulting from chromosomal, genetic, and congenital deformities, as well as perinatal deaths concomitant with prematurity (Office for National Statistics, 2021). It is equally important to note that there is statistical evidence showing that Black women are now almost four times more likely to die during pregnancy (Knight et al., 2023; Dayo et al., 2023) compared with previously being five times more likely to die than their White counterparts (Bowyer, 2008). Similarly, national statistics reveal that

Black and Asian women were more likely to give birth in deprived areas compared to their White counterparts.

Legislation and policies around baby loss

At present, UK legislation does not provide much consideration for fathers within the context of perinatal loss. Despite the new endorsement of a baby loss certificate by the government (for loss before 24 weeks; GOV.UK, 2024), the current legal framework advises that if a miscarriage (including late miscarriage) occurs before 24 weeks of pregnancy, no maternity benefits such as maternity pay and leave are awarded. A principle echoed in paternity rights: paternity leave is granted if the loss occurs 24 weeks gestation and onwards. Paternity leave involves a mandated entitlement of two weeks' leave, and in the context of perinatal loss, it must be taken within 56 weeks of the loss.

Such policies indicate a potential for additional challenges for fathers following various forms of miscarriage and attempting to process such experiences. This notion is supported by Meunier et al. (2019), who found that bereaved parents reported negative experiences upon returning to work following perinatal loss. Bereaved parents reported experiencing a taboo and lack of recognition of the loss and process of grief, which was reflected both within the organisational policies and relationships with colleagues and management.

The psychological impact of loss

Baby loss seems to have a varied impact on mothers and fathers. A systematic review revealed symptoms of anxiety and depression in bereaved fathers but notably, at a lower rate in comparison to bereaved mothers. It also showed comparable levels of PTSD in both mothers and fathers (Badenhorst et al., 2006). Burden et al. (2016) found that some parents shared that they were finding relief from the grief with their living children. Contrastingly, some parents reported difficulty in managing their grief and parenting their living children (Burden et al., 2016). Other research has found that parents may attempt to continue bonds with their lost baby through several ways, including rituals, symbolism, visible presence, holding a space for them within their family and long-term behaviours such as changes to ways of thinking following the loss (Côté-Arsenault, 2003). Côté-Arsenault (2003) stated, *"babies are no longer taken for granted because parents know from experience that bad things can happen"*.

Loss can be devastating for a couple, resulting in a breakdown of family dynamics and, in some cases, divorce (Campbell-Jackson & Horsch, 2014; Hamama-Raz et al., 2010). On the other hand, it has been found that couples felt closer following the loss, and this feeling deepened over time (Avelin et al., 2013). However, the contributing factors that facilitated the deepening of the bond remain unclear.

Father's experiences of loss

McCreight (2004) argues that institutional policies and structures habitually marginalise the father's role in parenting. O'Leary and Thorwick (2005) report that the father's role during pregnancy and birth is ambiguous and often positioned to act as a supportive figure for

the mother. This is echoed in the literature as fathers in heterosexual couples often report feeling a sense of responsibility and drive to fulfil a supportive role for their partners, and often without much guidance on how to do this (Cleaver et al., 2018; Fernández-Basanta et al., 2023; McCreight, 2004). Heterosexual fathers leaning into a 'supporter role' within their relationships with their partners following perinatal loss has been observed across many studies (Bonnette & Broom, 2012; Burgess, 2022; Jones et al., 2019; Nguyen et al., 2019; Noble-Carr et al., 2022; O'Leary & Thorwick, 2006; Pearson et al., 2023). It has been questioned whether the preoccupation with fulfilling this role impacts their ability to grieve (Obst & Due, 2019). Equally, a sense of guilt (Gold et al., 2018), isolation (Ávila et al., 2020; Jones et al., 2019; McNeil et al., 2021; Obst et al., 2021) and anger (Azeez et al., 2022; Badenhorst et al., 2006; Cacciatore et al., 2013) are a common experience amongst fathers following a loss of their baby or infant child. Complicated grief is defined as a persistent and heightened sense of mourning which creates challenges in healing. It is associated with an increase in substance use in bereaved fathers (McNeil et al., 2021; Burden et al., 2016).

Attachment and loss

Research has shown that having an insecure attachment style may complicate (Eisma et al., 2023) or intensify the experience of grief (Meier et al., 2013; Stroebe et al., 2005). Schenck et al. (2016) found that those with an insecure attachment style were more likely to experience complicated grief. Further research shows an association between bereaved individuals with an insecure attachment style and the experience of anxiety and dissociative experiences (Lyons-Ruth & Jacobvitz, 2008; Sekowski & Prigerson, 2022) and poor psychological and physical health (De Rick & Vanheule, 2007; Parkes, 2003). Huh et al. (2020)showed that

bereaved parents showing insecure anxious attachment styles were more likely to develop post-traumatic growth through deliberate rumination. Contrastingly, they found that insecure-avoidant attachment styles were positively associated with the risk of maladaptive grief. Similarly, Shevlin et al. (2014) found that bereaved parents with secure attachment styles showed significantly fewer trauma-related symptoms compared to those with insecure attachment styles following perinatal and/or postnatal loss. This suggests that secure attachment styles may be a protective factor in mediating and/or lowering psychological distress stemming from trauma.

Theories around attachment theory led to an additional curiosity about the attachment styles of the children and grandchildren of the Windrush generation. During the mass migration of populations from the Caribbean, many parents were separated from their children during their critical periods of development (Anim-Addo, 2000; Melzak, 2013). Upon migrating, many of this population were heavily impacted by structural and overt forms of racism (Slaven, 2022; Wardle & Obermuller, 2019). Experiences of racism are associated with poor mental health (Brown et al., 2000; Wheeler et al., 2011; Williams & Williams-Morris, 2000). Per attachment theory, during these experiences, there might be a decrease in the ability to provide containment and attune to their infant's needs. It may be plausible that this may have negatively impacted individuals from this generation and subsequent generations, potentially increasing the chances of an insecure attachment style through experiences of intergenerational trauma. Given the body of evidence showing the link between insecure attachment style and challenges with emotional regulation and adjustment, it could be further hypothesised that this demographic may face additional challenges in processing and managing their grief following baby loss.

Study Aims

Whilst research exploring fathers' experiences of perinatal death is gaining momentum, the existing literature neglects the lived experience of one of the most impacted populations - Black Caribbean men. Due to this, the impact of intersectionality and systemic racism on this demographic who have experienced loss is poorly understood. Therefore, this research aims to understand these lived experiences to inform clinical practice and policy.

Within this study, Black British Caribbean is operationalised as those who identify as being from the Black racial group and of Black Caribbean ethnicity living and/or born in the UK. Baby loss is operationalised within this context as a loss between the late miscarriage period (loss occurring after 13 weeks gestation up until 23 weeks +6 days) and the end of the neonatal period (28 days). This is not intended to invalidate loss at an earlier gestation period but an attempt to form a more homogenous sample.

Research aim: This study aims to explore the experiences of baby loss, considering the personal meaning and sense-making of this experience in Black British Caribbean fathers.

Research question: What are the experiences of Black British Caribbean fathers who have experienced baby loss?

Method

The study included five participants aged between 30 and 60 years old. All participants were born and live in the UK presently, each stating their religion as Christian, Muslim and Spiritual. The Caribbean countries of origin included Barbados, Jamaica, and Saint Kitts.

Table 1

A table outlining the demographics of participants

Demographics	N
Age	30-60 (M = 37)
Ethnicity	
Black British Caribbean - Jamaican	2
Mixed Heritage: Black and White ethnic background; Black British Caribbean – Jamaican	1
Mixed Heritage: Black and White ethnic background; Black British Caribbean – Bajan and Jamaican	1
Black British Caribbean – Saint Kittian and Jamaican	1
Length of time living in the UK	
Born in the UK	5
Religious identity	
Christianity	4
Islam	1
Spiritual	4

Note: Employment was removed to maintain anonymity. Some participants identified with a religious group and spiritual.

The length of time since the loss at the time of the interview varied between five months and ten years. The forms of loss were an amalgamation of late miscarriages, stillbirths, and neonatal deaths.

Table 2

A demographic table regarding participants and key relationships

Participant name[2]	Time since loss	Baby name	Stage/ type of pregnancy loss occurred	Additional children	Relationship status	Romantic relationship with baby's biological mother at time of interview
Abel	10 years	No name given	Late miscarriage	2	Cohabitating with long-time girlfriend	No
Dan	5 months	Ben	Stillbirth	3	Married	Yes
Michael	5 months	Theo	Stillbirth	1	Married	Yes
Ryan	6 years	James	Neonatal death	1	Cohabitating with long-time girlfriend	Yes
Clive	2.5 years	Adam and Asher	Stillbirth and late neonatal death (identical twins)	3	Girlfriend	Yes

Ethical considerations

The University of Birmingham granted ethical approval research ethics committee (approval number: ERN_0388; Appendix A). In line with the University of Birmingham Code of Practice for Research and The British Psychological Society (BPS) Code of Human Research Ethics, steps were taken to ensure that this study maintained high integrity and was ethical throughout the project (Appendix E).

Informed consent

Participants were guided to the information sheet via a QR code or URL link displayed on the poster or social media post (Appendix F). The information sheet was reviewed by several

[2] All names are Pseudonyms.

professionals, including a speech and language therapist, to ensure the information was accessible (Appendix G). All feedback was reviewed, and necessary changes were made. A screening call was made during which the information was summarised for participants. Following this, participants' understanding of the information sheet was reviewed, opportunities for questions and concerns were given, and consent was checked again before setting up the interview.

Right to withdraw

Participants were advised of their right to withdraw until 14 days after the interview. The rationale for this was that the analysis stage would begin after this point. With the steps of anonymisation and analysis, identifying the initial source of the data would be challenging. Participants were reminded of their right to withdraw at each stage of contact, including at the end of interviews.

Confidentiality

During the opt-in process, participants were permitted to provide a pseudonym name rather than their full name. The transcription process included methods to pseudonymise them and their loved ones by providing them with a pseudonym name.

Debriefing

Following the interviews, individuals were provided with a space to debrief. Space to reflect on their feelings and sources of support were signposted.

Compensation

Initially, participants were not provided with compensatory vouchers following the interviews. However, after completing the first two interviews, it was discovered that individuals took annual leave to partake in the interviews. An application was made to the ethics committee to compensate individuals who participated in the interviews with a £15 Amazon voucher. The earlier participants were contacted and compensated. This modification was reflected on the information sheet and not on the poster in an attempt to attract participants who were not primarily motivated by financial rewards.

Managing data

Each interview was recorded on an encrypted Dictaphone. Each file was immediately transferred to the university research data store to maintain the protocol outlined by the Data Protection Act (2018) and deleted from the Dictaphone. This was only accessible to the lead researcher and university supervisor. This recording was accessed to transcribe and pseudonymise the data; once this had been done, the initial audio records were deleted from the research data store. The transcripts were then uploaded onto the research data store.

Risk to self

This study is classified as ‘sensitive’, holding the risk of increasing distress in participants. As a result, several protocols for risk management were developed. These management strategies were reviewed with The University of Birmingham Ethics Committee, and overall, the study was evaluated as ‘low risk’. Signposting information was shared following the screening call and again after the interview (Appendix H).

Risk of harm to others

It was acknowledged that this study could potentially cause distress in the lead researcher, given the nature of the topic and aspects of their identity. Additional supervision was provided to them, and they were given a space to debrief and process the impact of the interviews.

Procedure

Before the commencement of interviews, a panel of professionals reviewed the research poster, information sheet, and interview schedules, including ‘experts by experience’ practitioners, clinical psychologists, speech and language therapists, and researchers. Materials were additionally reviewed by five members of the public, who identified as Black British Caribbean fathers. Feedback was sought to ensure that the content of the materials was sensitive and attractive to the target demographic. Modifications were implemented based on the collective feedback obtained.

Advertisement posters were displayed in community settings such as gyms, places of worship, and Caribbean-owned businesses. Digital posters were shared via social media on sites such as Twitter, LinkedIn, Facebook, and Instagram. Some charities supporting individuals who have experienced various forms of baby loss promoted this study on their social media/ online channels.

Data collection

The study implemented a snowballing and opt-in recruitment technique through these channels. The lead researcher contacted the individuals via the mode shared by participants to complete a screening call and arrange a time for the interview. The duration of the recruiting for interviews took place between June 2023 – March 2024. Interviews took place between July 2023 – February 2024.

All interviews took place remotely via a video conference call in a place participants identified as safe, comfortable, and confidential. Remote interviews were advertised as the main method of interviews to reach a wider geographical scope across the UK in the hope of recruiting a larger participant pool. Given that those from lower socio-economic backgrounds are most affected by this experience, remote interviews were seen as advantageous, accounting for reduced cost to travel/ work disruptions. Telephone calls were also offered to mediate digital poverty, but no participant requested these. The duration of the interviews ranged between 1 hour 13 minutes and 2 hours 39 minutes, averaging 1 hour 57 minutes.

The lead researcher engaged in 1-1 and peer supervision throughout the project. Themes and interpretations were discussed and finalised through a collaborative process within peer supervision and research supervision to achieve high inter-rater reliability, reflexivity, trustworthiness, and creditability (Yardley, 2007).

Interview material

This study involved the use of semi-structured interviews consisting of 9 questions (Appendix I). These questions were clustered into themes: cultural identity, identity before the loss, details of how the loss occurred, immediate responses to loss and the long-term responses to their loss. Each question was followed by further prompts to enrich the data and understanding shared.

Data analysis

This study utilises an interpretative phenomenological analysis (IPA) methodology that seeks to examine a person's lived experience and how they make sense of this experience (Larkin et al., 2021; Smith, 2011). In summary, the IPA approach is underpinned by three main components: phenomenology, hermeneutics, and ideography (Larkin et al., 2021; Smith, 2011). Each of these elements demonstrates the multi-layered nature of this approach, lending itself well when trying to make sense of an individual's experiences, which is indubitably complex. The theory is underpinned by Husserl (1997), Heidegger (1927), Merleau-Ponty (1962) and Sartre (1948).

IPA is concerned with hermeneutics, which is the theory of interpretation (Larkin et al., 2021; Smith, 2011). IPA allows one to thoroughly explore how a phenomenon appears and the sense-making of this said phenomenon (Larkin et al., 2021; Smith, 2011). Ideography is the focus on 'the particular': pursuing an idiographic commitment, situating participants in their personal contexts, exploring their perspectives, and starting with a detailed examination of each case before moving to more general claims.

The analysis process involved several stages; following the transcription process, the transcript was read through whilst listening to the audio recording from the interview. Whilst doing so, additional notes and reflections were made in a separate document. The nature of these notes involved recollection of the interview experience and initial observations from the transcript. Step two involved an examination of the semantic language and content to deepen the familiarity with the content and identify how the participant referred to, understood, and thought about the issues raised within the interviews. Exploratory notes are statements or reflections noted on one side of the transcript, and they vary in length based on the issues raised (Larkin et al., 2021). Building on this step, experiential statements were written on the adjacent side of the transcript. Such statements were formed by considering the initial exploratory notes and constructing comments relating to the sense-making of the events or the participant experiences; these statements were made throughout the transcript.

The statements were printed, cut out and placed in a random order to disrupt the sequence of the initial interview. The subsequent step involved mapping the experiential statements into groups where they fit together, along with a group where several statements did not appear to map neatly to other groups that had been formed (see Appendix J). At this stage, some

experiential statements were placed aside and not included within the latter stages of analysis. This was done in accordance with the relevance of the research question. Once these groups had been established, they were placed into categories referred to as personal experiential statements (PETs). These were inputted into an Excel spreadsheet under the participant's name. Following the completion of this process, a summary of each participant was written.

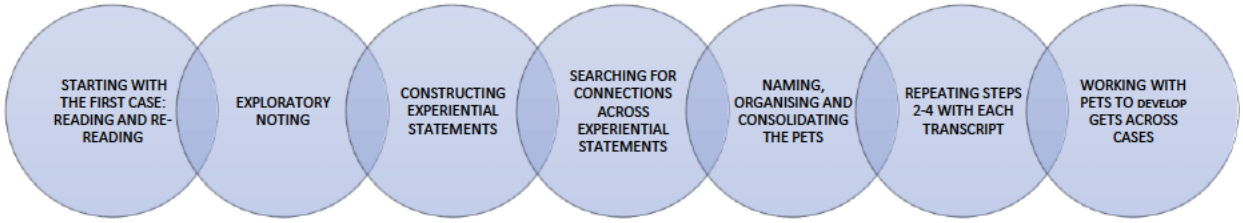
The following step of analysis involved repeating the abovementioned steps for each participant and transcript. Once this process of analysis was completed for each transcript, the PETs were reviewed, looking for the shared features of the experiences across the transcripts to establish the group experiential statements (GETs). This process was key in forming an understanding of the convergence and divergence across the participant experiences. Similar to the process of creating PETs, at this stage, the PETs were printed, reorganised from the initial order they were input and mapped onto one another in relation to their experiences and how they made sense of these experiences.

The analysis was also completed in accordance with Nizza et al. (2021) four quality markers of a high-quality IPA which involved: 1) "constructing a compelling, unfolding narrative"; 2) "developing a vigorous experiential and/or existential account"; 3) "close analytic reading of participants' words" and 4) "attending to convergence and divergence". The first marker was achieved by using themes and sub-themes to provide a progressive and coherent narrative, with appropriate usage of direct participant quotes and author interpretation. The selection of the participant quotes was discussed in both peer and individual supervision as I progressed in stages one - seven, as outlined in Figure 1. The second marker was achieved by ensuring a focus on the key experiential and/or existential

meaning of participants' accounts within the transcripts, ensuring depth in the analysis. This was achieved through stages one – five, as outlined in Figure 1. The third marker was achieved by thoroughly analysing and interpreting the participant extracts within the narrative to support the process of giving it meaning. The final marker was achieved by demonstrating awareness and including convergent and divergent narratives, utilising idiographic depth and systematic comparison.

Figure 1

A diagram demonstrating the seven stages of an IPA



Note: stages outlined per Larkin et al. (2021)

Ontology

IPA lends itself well to a critical realist ontological perspective (Cuthbertson et al., 2020; Willis, 2023). It is compatible with positivist and post-modernist approaches. Within the context of this research, this study is influenced by both the critical realist position and cultural relativism, as the concepts within descriptive, normative, and epistemological relativism are underpinned by the research design and the intersectionality within the participant group.

Epistemology

An epistemological position is framed as a theory of knowledge about beliefs surrounding how a phenomenon may "come to be known" (Giacomini, 2010, p. 131) and how valid knowledge is formed (Hiller, 2016). Although IPA traditionally aligns itself with an interpretative epistemological stance, this research will additionally consider a contextualist stance given the additional focus on race, ethnicity, culture, and religion/ spirituality, which will impact one's sense-making of their experience. This additional lens allows space to consider the role of their individual contexts that may affect their reality.

Reflexivity

Conducting this study was emotive throughout each stage of implementation. There was an emotional burden that I inherited by being a black woman of childbearing age. It brought up difficult emotions as the research suggests that baby loss is something that my friends, family and I are more likely to experience. This brought a closeness to the data and the participants. Additionally, I was able to connect to the themes of race, culture, discrimination/ systemic racism, and relationship with religio-cultural scripts and services. Particularly experiencing the intersectionality of my identity as a British-born Black British Caribbean Christian woman with an immigrant mother and grandparents. Whilst this provided benefits during the interviews in being able to build rapport quickly and understanding the nuances in the issues discussed, it also created a sense of closeness with the data. It was helpful in providing a deeper analysis, but I had to make additional efforts to ensure that the analysis process and subsequent conclusions were not overly biased but truly represented the participants' individual and group experiences. This involved peer and individual supervision of the

transcripts, analysis at each stage, and drawing conclusions. It is important to note that the supervision involved input from individuals identifying as both male and female from various ethnic backgrounds, which enriched the process and encouraged my own reflexivity when engaging with the data.

Despite the similarity in our experiences and demographics, I did not enter the research with many assumptions about what I may find as I recognised the differences in gender and how this is likely to shape the lived experience in a way beyond my imagination. I was curious about whether the theme of racism would appear during the interviews due to the stark health inequalities for black women and babies across maternal care. However, I purposely did not include any questions referring to this in the semi-structured interview schedule but responded to this when brought up by participants.

The interviews were conducted remotely; each participant shared that it was helpful to be in a space where they felt safe rather than travelling to an unknown place. They felt that this may have negatively impacted their ability to be as open. They shared that it was a positive experience talking to someone who was from a similar background and showing interest in their experience as they are often overlooked. Whilst this was pleasing, it also added internal pressure to ensure that the analysis was 'perfect' to represent their experience in full. These feelings were explored in supervision, with further exploration of the overlapping feelings portrayed in the transcripts and how this may provide further insight into the lived experience of this group.

Throughout the process of both papers, extensive breaks were needed to manage the emotional impact of the data found. It was felt necessary to take breaks from data collection

and analysis processes to allow distance from the experience. This was felt to be beneficial not only to the researcher but to allow for a more in-depth analysis process when in an optimal place emotionally.

Results

The findings showed a complexity in the experience of grief and sense-making of loss. This experience was intensified by the intersectionality of external positioning resulting from their gender, race, ethnicity, and culture. The changes in their romantic relationships, relationships with their living children and the understanding of their spiritual and religious beliefs further compounded this experience and resulted in four GETs: 1) Silenced by the positioning from others, 2) God knows, 3) The shifted experience and appreciation of fatherhood and 4) Navigating support whilst invisible.

Table 3

A summary of group themes and contributing participants

Group experiential themes (GETs)	Subthemes	P1: Abel	P2: Dan	P3: Michael	P4: Ryan	P5: Clive
Silenced by the positioning from others		X	X	X	X	X
	Societal scripts concerning masculinity and gender roles	X	X	X	X	X
	Big, black and dangerous	X	X		X	X
	Familial and cultural scripts	X	X		X	X
God knows		X		X	X	X

The shifted experience and appreciation of fatherhood		X	X	X	X	
	Continuing bonds with the deceased		X	X	X	
	A more intentional father	X	X	X	X	
Navigating support whilst invisible		X	X	X	X	X

Silenced by the positioning from others

Societal scripts concerning masculinity and gender roles

Each participant shared their challenges of the awareness of societal scripts around masculinity and gender roles. Participants felt that society does not consider men as emotional beings:

> It's the perspective of what tough is meant to be... it's like be strong, stay positive, this that and the other, but some of being strong might not necessarily be deemed as a positive thing … sometimes being strong might be crying over something that you need to let out to then bring those emotions in and deal with them, but you're growing up in a way of, being strong isn't crying, which in a turn kind of makes you weak in the end because then you don't know how to deal with the emotions when they do actually burst through in the end (Ryan, 170-179).

The societal script surrounding gender roles and masculinity often leaves men feeling unsure of how to process their emotions and trapped by them, Abel notes: "… as a guy in that sense that you just are kinda stuck, like, what do you do?". Dan noted that he was suppressing his emotions and felt that resilience and the ability to continue despite this varied per individual. Many described battling feelings of anger, sadness, and regret, indulging in unhelpful coping skills, such as avoidance and isolation, to navigate the loss.

> Where I'm having to keep so much inside, it made me very, like aggressive in a sense… I was so angry, but because I have so much inside, I'd be drinking and stuff. And I used to just, you know, go out like clubbin' or whatever. Just to - literally just to drink... but sometimes I was just so angry like I was just waiting for the suttin' to happen every time, I'll go just so I could release something, you know what I mean? (Abel, 903-910).

> Going back to the culture of being strong, so one of my biggest regrets with losing James is those little minutes of extra time that I could have spent. So me going downstairs to smoke a cigarette, I'm not going down because I cared about smoking a cigarette, that was me going down to try and recompose to keep that game face on that, 'I'm alright, I'm tough, I'm not crying', like, 'I'm going to stay strong for Maya', cos if she's breaking down and I'm breaking down, that's the only thing that he's going to experience in this world is, two people crying over him (Ryan, 761-771).

> …I used to go for walks or if I was on my own, I'd have a moment before I went to the bathroom, yeah it was just or I would sit in the garden, or I dunno, just any time I would get a minute to myself I would walk my dog and deal with my emotions then, any other time other than that I was just there for my Mrs and over a period of time [sigh]- see I'm not a big talker (Dan, 678-84).

These societal scripts surrounding gender roles and masculinity had an impact on how they navigated their grief, as it often felt like there was no space for them within society. It was deemed inappropriate to show emotions, and this belief appeared to be internalised, manifesting itself within their relationships. Michael shared that it was inappropriate and unnecessary to show his 'brokenness' to his partner during the immediate event of the loss and the grief that followed. He felt that if he showed that he was "cut up and broken", it would have taken away from his partner's experience of the labour and the loss. He felt it was more beneficial for his partner to be 'strong' and support her and cried privately. Dan was advised by a relative that he had to remove his stillborn baby from the toilet, and the rationale for this alluded to be based on his gender. This perspective was echoed by each of the participants:

> For me, it was more so being there for my Mrs, making sure that she was alright cos she was broken…but it was like if I'm broken too with her and showing it, then it's not helpful for her even though she was saying "be – express yourself". And in time I did, but in the beginning, I was like nah I can't, I can't be broken in front of her (Dan, 673-84).

> … and like I said to you, holding everything, everything in, I can't be sad, I can't be sad, I can't be sad. I've gotta be strong for everyone else, gotta be strong and like, and then it was like, cos I wasn't showing it on the outside, it ate me up on the inside so much that everything from my mental health, my diabetes, everything deteriorated (Ryan, 1073-78).

This script around men being strong appeared to be mirrored within their inner circles, with each participant feeling alone and/or overlooked within close circles. It was acknowledged in part that some people don't know what to say in response to this experience. This silence was interpreted in a variety of ways, such as "their life continues" whilst the bereaved parents' lives come to a halt. It was reported that this left those around them unsure of what to say or how to support them. Any emotional support received felt short-lived; "we had flowers that lasted longer than what we were getting from other people" (Dan, 846-47), leaving the bereaved fathers feeling undervalued. On the odd occasion that friends referenced the loss within the conversation, the conversation would be steered towards their partner, intensifying the feeling that their emotions did not matter and leaving them feeling silenced.

> … from what I can remember in the room, had one of my cousins that focused on me, but everybody else, all of my other family members, her family members, was all just cuddling her (Ryan 961-966).

> But then outside of everything. It's like, guys you're on this man-to-man thing, it's like, so your friends are not really talking to you… they might just generally be like, how's the Mrs, how's she getting on (Ryan 1350-53).

It was felt that society does not know how to handle men's emotions, as if it's a foreign concept that they feel pain too. Some participants felt that if they were women, they would have received more support. In the moments where some individuals showed emotions to others, there was a concern with how they were being perceived.

> I feel like if I was a woman, I probably would've had a different response. And I think that's just because people relate to women and to be more emotional. So, people just expect them to be emotional anyway, where with, guys, we're not expected to be emotional… So, we already feel like we can't be emotional and then if we do be emotional, we're thinking ahh like, you just have things in your head like ahhh, they think this, or do you think that (Abel, 882-890).

Biases around the legal framework also left men feeling as though they had fewer rights. Most participants felt forced back into work before feeling ready due to a lack of legal protection when taking extended time off work. One individual was eventually forced to leave his employment due to his ignorance of the company's sick policy, trying to go to work on days he felt able, as he felt this was what was expected of him as a man.

This feeling of invisibility was also echoed by professionals within the workplace, with reports of feeling unsupported by their managers. Some did not feel ready to return to work

but felt pressured to act within the social script of providing for their household. One participant sharing he 'broke down' for the first time since the loss as he did not have anyone to be 'strong for' in that setting. Another likened his state to having dementia with memory loss and feeling disillusioned. Both shared that the support was minimal and, when offered, it felt disingenuous.

> It's just 'you've had your time, now we need you back at work'. Even [though] I wasn't ready to go back to work. It was just like I had to. And, yeah, it was just, yeah, it was just that bit of pressure really. It was just my work commitments, really. I wish they were a bit more understanding… when I went back to work, I didn't have a meeting to see my – like a welfare check to see where my state of mind was at – it was just like, 'right, you're back now fall back into shift' (Dan, 891-98).

Although participants noticed they had high levels of visibility within society because of their race and culture, within the maternity and hospital settings, they were often positioned as invisible. This feeling of being overlooked often left them feeling unequipped to cope with situations as they arose. Many felt that most of the communication was directed towards their partner, and although they had empathy and understanding as to why most of the attention was focused on their partner, struggled with this at times. This was more apparent where men had experienced neonatal death rather than stillbirth.

> …it might not even be a malicious thing…but from my standpoint, I wanted to be involved in all of these things. I wanted to, like, even though I'm with James, it was

> like kind of felt like they were trying to stop me from even touching my child before his mum had seen him. It was like… I was angry about it (Ryan, 678-683).

> Even when, like, when he, when he passed like, they would just walk past, when we were like, we were in a room … they'd come in, and it's always, mom are you alright, but it's not even just with the doctors, the family, everything's just like, are you alright, everyone's cuddle, hugging Maya, everyone's this, that and the other, consoling her, and it's like you're just expected to just, to a degree, just be okay like, I'm not losing my child as well (Ryan, 688-696).

This feeling of exclusion was heightened by the loss that occurred during the pandemic, with partners being physically separated from one another. Clive reported that this made his partner vulnerable as he was unable to advocate for her while she was in a disempowered position.

Most of the fathers raised feelings of conflict with trying to maintain the societal expectations around gender roles and masculinity but then faced the incongruence of how they felt internally. Clive shared being negatively impacted by the positioning and expectations of how men should deal with their emotions, "big boys don't cry and all of that sort of stuff". Some men felt their partner thought they were being cold as they did not physically show their emotions around them, but they were trying to put on a brave face, as they felt expected to:

> … the culture and, like the upbringing, was just another kind of, set me up to a degree to fail because I could have done the same thing and cried with her, and then after, say, a couple of minutes or so of crying, some words of motivation to ourselves, sort of right, cool right … let's have some laughs with him, and some smiles and some cuddles, and whatever, whatever … off the back of that, me and Maya had a rough patch where it was like, she didn't see that, she just saw me being numb. Oh like, when I'm sitting here and you could just go downstairs and, you were just numb, and then you're telling me not to cry (Ryan 799-816).

Despite the majority feeling that their romantic relationships served as an overall positive experience with the loss bringing them closer in the long term, for most, in the immediate instance, the influence of gender roles and scripts around masculinity created friction. Each of the men described compromising or minimising their own feelings to protect/ prioritise their partners as per the gender norms, but this left them with complex emotions that they didn't feel they could express:

> Things like giving him back to her and cutting my cuddles short just so she could have more, but then like I said, it, perspective wise, everyone looking at me it may look like, oh, I just weren't interested, but I'm thinking about everything else that's going on around me, and I'm thinking you know what, as much as it's killing me inside, if I'm feeling like this, just being a manly man and saying, right, well how do you think a woman's gonna feel. Cos you're supposed to be tougher than the woman - that's how you, you are grown as a man. (Ryan, 830-845).

> I know what this is going to be like, the guilt, everything that's going to eat up inside, from switching this machine off and holding our child whilst he dies, you ain't got it in you to basically feel like a murderer for however long, and I said you know what, it's better I bear that burden. (Ryan, 956-960).

> Cos my Mrs was talking to her mum, and she wanted to speak to me. She's gone, "Dan, I'm sorry, but you know what you're going to have to do". So yeah [sigh], once I got my head together, and I spoke to the lady at the hospital, and she told me what I had to do and everything. Yeah so I had to do that - put my hands down the toilet and put him in a towel and then take him to the hospital (Dan, 637-42).

> It was again being that supportive person and to do it in a way – with more of me at that time, not needing her to support me 'cause, I need to support her through what she's just been through. (Michael, 488-91).

In situations where the bereaved fathers were unable to maintain societal gender norms, they expressed a sense of guilt. In other circumstances, they felt they were being overly attentive but still not doing enough, leaving them feeling insecure.

Big, Black, and dangerous

Each participant referenced the awareness and experience of being subjected to stereotypes. Most participants felt stereotypes influenced the level of care they experienced,

thus complicating their grieving process. Each participant expressed anger about what had happened but felt the need to assure me that they were not violent. This is a clear example of how they have internalised racial stereotypes.

Many of the shared stereotypes involved being “womanisers”, coming from a “broken home” [single parent household], “criminals”/ “thugs”/ “on road” [being part of a gang and/or engaging in criminal activity], “loud” / “boisterous”, “aggressive”, “low self-esteem” and “deadbeat” fathers. This impacted how they navigated their grief and made sense of their loss – it was noted how challenging it is to overcome these stereotypes outside of loss, but within this experience of loss, there was an additional internalised pressure which plays out across many domains of life and relationships. Most of the participants shared how they had been positioned by others, for instance, when anxious about subsequent births and asking questions to medical professionals, it was seen as him being ‘difficult’ and ‘aggressive’ rather than an anxious father who had experienced a previous neonatal death. In some ways, participants described the positioning they faced as ingrained:

> I’ve not been aggressive or anything like that, but again, like I was saying, it was like because I’m young, because of the colour of my skin, where I look like I come from, and stuff like that, it was just automatically perceived (Ryan, 925-29).

> Well, some people could see things as racism. Some people see it as It's just day-to-day it’s how people talk, but obviously, I always think there's always something behind it. Erm… just the way people talk, the way they talk to ya … and it's like how

> someone would talk to you wouldn't be the same way someone would talk to someone else (Dan, 193-99).

Two participants showed signs of internalised blame. One detailing the research which shows that black individuals are more likely to experience loss, he internalised this as that he had done something “wrong” to cause the loss. Another participant shared feeling guilty as he felt that if he was not Black, his babies would not have died, and his partner would not have experienced this level of trauma.

> It's hard for me not to think I've just totally, totally ruined someone's life and, that's that person that you love, you feel like you’ve brought all of this into their lives and stuff… even the outside the hospital and the two racist security guards, that's what they were. That's what it was. I know it, I, they compete in my traumas, I sit here and think, I should only think about my sons, I should only, and rightly so, but even our experiences of entering the hospital were different (Clive, 1567-77).

Results showed the perceived challenges with the intersectionality of gender, race and culture within this experience. Each participant referenced the challenges faced by the stereotypes and wanted to avoid affirming them through how they presented themselves. Although anger is an expected emotion within the process of grief or even more socially acceptable within gender if from a White racial background, within this subgroup of individuals, the experience of anger was felt to be wrong. Most participants tried not to display their anger or express themselves openly as they felt they would face negative consequences as a Black man in the UK. There appeared to be a parallel process playing out

between the hypervigilance of the black man from society and the hypervigilance they carry surrounding these stereotypes.

> Then you get labelled all these things… like, I don't believe that, you know, because, like, someone's just angry and they just want to be that way, like there has to have been something that's making them be that way. So that was the only downside I would say is me feeling like, you know, I would then be labelled something different, like, well, he's angry. Oh, he's, he's being violent, you know, so he, he must automatically be a bad person. You know, it's like, that's not fair in that sense. (Abel, 917-927).

> You have still trained yourself with that stereotype threat of don't be big, black and dangerous, don't do it, I've seen it so much. I've seen it in my work, which is why people don't access services, because this, you know, even on the back of my mind, when, when Adam died, I was very aware that if I kicked off in any particular way, there's a good chance that the Police could turn up, it could be the same thing, I would be taken away and I wouldn't be able to be with [my partner] … even at the worst possible time, you are still aware of that… you're never totally free to just, you're always hyper-vigilant without even knowing it (Clive, 2108-2121).

Familial and cultural scripts

Family scripts were seen as an overlapping factor of cultural scripts, with most participants developing their cultural identity through primary socialisation. Every participant shared

family expectations of not adhering to the negative societal stereotypes – to be humble, a provider, a protector, and a good and strong man. Some family scripts involved the view that Black individuals are treated differently from other racial groups. It was also viewed in some spaces that showing your emotions defied what was expected.

> My family always thought that we've gotta do double the work basically to try and achieve the same standards as people that are not necessarily like us, and if anything, we gotta do triple the work because, like, going back to the fact of not fitting in necessarily on either side, but yeah, just work hard, take care of the family (Ryan, 157-161).

Cultural attitudes and family scripts are generally involved in moving past difficult life experiences. This was experienced negatively for most participants as they felt confused about how they were experiencing their grief as well as unsupported, isolating themselves as a consequence. The expectations of what it means to be a Black Caribbean man did not waiver despite their loss, creating increased pressure on some participants.

> You watch your people's body language, you can tell how people react to what you say and how they are around ya. So you just know what, and I distanced myself away from a few people because I thought, 'you know what, we aren't the same' (Dan, 1086-88).

> I had those times where I thought, am I milking it? …should I be past this now? And I was like nah, I should be able to have my feelings. I should be able to be able to process it the way I want to, you know what I mean? – who is anyone to tell me how

> to grieve because who wants to tell me how I should feel about the loss of my child? Yeah, So just, I kind of put that to the side and this time you start to come round in the ways of how to cope and deal with your day-to-day (Dan, 1069-77).

> My family wanted me around because we were going through things within the family. So it was, it was, there was a lot of pressure on me around that time of where I needed to be. And if that wasn't, then someone's gonna get upset, someone's gonna be feeling away. So, yeah, there was a lot of pressure (Abel, 616-621).

> Yeah, back then, it was literally, yeah, just get on with it. I'm not allowed to feel anything else, But, you know, I'm basically here to just try and make everybody else happy. And this disregard how I'm feeling - not talk about it… I didn't talk to anybody about it (Abel 1186-90).

Some participants noted the taboo of openly discussing loss within their cultural and familial circles. One participant shared the view that it is important to move on, as repeatedly thinking and talking about the loss would result in depression. In some cases, individuals experienced shame, isolation, and increased distress as they felt silenced by this additional space.

> I think it's one of the last taboos that we don't talk about it all. So, but this is, any community it seems to me, it seems you know, from abortion to a stillbirth, to, especially here, I think they're, they're a bit, we don't talk about it at all (Clive, 1992-1996).

> … and if you wanna, you know, go back to culture in that sense that from my experience, you know, a lot of things are not spoken of or … it's not like something that people want to talk about, basically. So even in terms of, with that loss…like, family knew and stuff, but there just wasn't that support. And it goes back to, again what I'm saying, like that, that mindset of you just have to get on with it. And, yeah, I think I was in a place where it's, like trying to get on with it, but it just seemed impossible as well. And so, like I said, I have to, I was trying to do it, like, pretty much on my own (Abel, 797-810).

Overall, the complexities of positioning and how this interferes with the sense-making process of the loss were evident. Participants describe being trapped with little to no freedom in how they experience their grief. It appears there is no safe place to be transparent in their feelings out of fear of judgement or violating a variety of scripts. Participants also spoke about the complexities of being from both Western and non-Western backgrounds, the differences within each culture, and the expectations that both cultures bring. The description of these challenges bore similarities to the notion of cultural homelessness, which appeared to be heightened by the positioning of stereotypes and societal scripts of masculinity and gender roles. It has also been demonstrated, in the earlier stages of loss, how this population may struggle to operate in a way that is free, authentic, and a true representation of how they feel.

God knows

This theme shows the cyclic movement in their relationships with God, a higher power and spirituality. Each participant described holding religious and/or spiritual beliefs, with each identifying roots in Christianity and Islam. Their religious practices varied, but each shared familiarity with religious scripts which intersected with culture in some ways. The relationship with their faith, spiritual beliefs and religious scripts varied throughout their experience of baby loss.

It was a frequent belief that the pregnancy was a "blessing", "miraculous", and a gift from God. The loss disturbed their relationship with their spiritual beliefs and relationship with God. Some questioned whether the loss was a punishment from God, demonstrating a further internalisation that they had done something wrong which resulted in the loss. Others expressed rage and distanced themselves from God, as they were unable to understand why this had happened to them. Some participants saw the experience of loss as a "test of faith" in their understanding of the world, God, and the universe.

> I can't understand what happened, I can't understand, so it feels like a punishment, I know it's not, I know it's not, but that's shaken my faith because I don't believe what I believe in is about punishing you, so you lose, you lose your faith, but you need your faith to get through (Clive, 1777-82).

> So, at first, when he passed like, I was angry, I was angry with God, I was angry with everything like… I'm not saying I wasn't with him anymore, but I, I, the only way I could, I could explain it was, I wrote a song basically, staying that to God at the time,

> which I was wrong for, that if he thinks Satan is his worst enemy, (laughs) that I'm now both of their worst enemies (Ryan, 1138-42;1136-41).

> I was just unhappy, like, I just because I couldn't understand what was going on in my life and because that was the only thing I identified with in terms of life, like how it works, and, you know, ultimately, that's, that's all I knew who to blame. Like, I'm thinking, well, if you govern all of this, that you're the top dog, basically, like the one that's responsible for this. So, you know, I felt, yeah, I felt angry. I felt sad. I felt like, you know, forget religion and all this stuff that's long (Abel, 596-600).

Some individuals had challenges processing the religio-cultural scripts shared within their community, whereas some showed a less emotional connection to such scripts. Such statements involved phrases such as "everything happens for a reason" and offering to pray for them.

> The only thing I would say is again, it's probably from my nan, and my cousin again is in terms of obviously 'everything happens for a reason', so there's a reason for this happening particularly…We don't know the reason, but there's obviously a reason for our path not having Theo at this given moment in time. So yeah, and that's the only thing I can probably take from it (Michael, 182-85;187-91).

> That was what I would hear the most. And it's like I ain't trying to, like, I did not want to hear that; I can't, at the end of the day, I can't see the reason. So, you're telling me, you know, things happen for a reason. It sounds nice, but I don't know what that

> reason is. So that's not what I need right now. I need emotional support, too. So, I used to hate when people said that to me man. Yeah, I hated It. I hated it. (Abel, 841-44).

Maintaining the religio-cultural scripts felt like an impossible task to do in the early stages of their grief, adding to their distress and resulting in isolation at times. During the earlier stages of grief, some participants found it hard to believe the religio-cultural scripts, “I just don't understand, and I can't see the reasons why, but I also, so it’s a real test of your faith” (Clive, 1788-90).

> And it goes back to, again what I'm saying, like that, that mindset of you just have to get on with it. And, yeah, I think I was in a place where it's, like trying to get on with it, but it just seemed impossible as well. And so, like I said, I have to, I was trying to do it, like, pretty much on my own (Abel, 807-811).

In the long-term response to loss, it was often raised that despite the initial aversion towards the religio-cultural scripts, most participants reported later agreeing to said sayings. They felt it supported their grief journey in arriving at acceptance, understanding, relinquishing control, and increasing gratitude for the life experiences that followed the loss. Most participants shared that beyond the initial experiences of being angry with God or blaming him for the loss, they felt they no longer held that position in the later stages of their grief. Others felt their faith was what was necessary to “get through” the loss.

You can still keep a smile and be positive after all of these negative things happen. It's like, now it's just got to the point if something happens, I'm just like, it teaches you in Islam to do it anyway, saying, Alhamdulilah, which is praise be to God, erm for anything, any good situation, or bad situation. So now anything happens, I'm just like, Alhamdulillah, it is what it is…God knows what he wants to do and why he's doing it (Ryan, 1489-92).

I think it's just understanding death just understanding that understanding pathways, I think it's just everything I can it comes back to that whole thing. Everything happens for a reason so yeah, I think it's just dealing with it in, in and around what you can possibly do in any given moment in time (Michael, 792-96).

It's funny because I understand the saying, 'everything happens for a reason'. I can see that now... I think I don't think I was ready in that sense, to be a dad as much as I would have wanted to. I think I don't believe that I was ready when I look at myself now and, and then. I feel like I, it would have probably prevented me from growing the way that I have … but, yeah, so I've accepted it, and I do believe that it was an unfortunate situation. But, yeah, I do see that the positives of, of that happening. And, yeah, why maybe that did happen. So now I don't blame God in that sense, because I understand (Abel, 956-57; 967-72).

The shifted experience and appreciation of fatherhood

Each participant discussed the transition of the fatherhood experience. Many took pride in engaging in activities that honoured their deceased baby, creating a tradition and legacy for them. Most participants shared that the loss improved their parenting styles and increased their appreciation for their other living children.

Continuing bonds with the deceased

Continuing bonds appeared to be important for the bereaved fathers. They wished to act in ways that would make their bereaved baby proud. Others felt it was important to keep a space reserved for them within the family unit. This was achieved in many ways, such as planting a tree in honour of them, a family tradition of a mutually loved place, decorating, and maintaining their resting places. Each felt to be important for the fathers, although, interestingly, the individual with the longest time since loss no longer accessed their keepsake for the baby in comparison to the others with more recent loss, loss occurring at a later gestation or neonatal loss.

> … just creating a legacy kind of creating a lasting happy memory rather than being a sad memory, so we are still remembering for the good reasons, not for the sadness that it brought in that given moment in time (Michael 523-25).

> Me and her sister got her a suitcase with his footprints on it… it's like he's walking wherever as well, and then we got her a blanket with his face on it, so it's like, you can lean on him, be covered by him, and be all together. (Ryan, 1196-1202).

A more intentional father

Four of the fathers shared that the experience of loss has improved their parenting and appreciation of their living children. Michael noted he will "never shout" at his child. Despite wishing to have their baby alive, they felt their loss was not in vain due to the positive changes that came with the loss:

> So, with my daughter now, it's just, I can only say that it's made me an even better parent than I could have imagined myself to be before… I would have been a good parent anyway. I would have put him above everything anyway, but the level of understanding to me with her now is different (Ryan, 1263-65; 1267-69).

> I think it's just made me want to take my role as being a dad more serious. I'd say I'm probably, like, very protective over my kids now, though. Yeah, well, I've always been protective as a person for my loved ones, but, yeah, for my kids now I'm mad protective of like - And I think some of it is the element of, of going through, like, if I lost… I don't even like talking about that's how real it is- but you know what I mean? (Abel, 1029-1037).

Other fathers noted the increased appreciation for their living children, "then when she came, because of him, it was like, I don't know how you can love your child more". Ryan shared that the loss has helped him move away from the "traumatic discipline" that is common within his culture and towards a more nurturing stance.

> I think we were all close before … everyone says, like, were inseparable. But then that's just made it even stronger; I think it's just like the value, isn't it? So, it's like anything… imagine having a million pounds and losing that million pounds, but then you win a million pounds again. You're gonna value it more a second time round. (Michael, 673-75; 681-85).

> Sometimes, my friends would be like, oh, come out, and I'm like, can't I have my daughter to think about? Like, oh you're allowed a break like, I'm like, why would I want to break from my daughter? But you're allowed entirely your happiness too, and I'm like, my daughter is my happiness, like, do you not get it? (Ryan 1269-74).

Navigating support whilst invisible

Accessing support was challenging for many reasons, but not for the stereotypical reasons of a lack of willingness to engage. The bereaved fathers expressed several barriers put in place by others, such as racially biased practices, a lack of clarity of where to go for support or the battle of trying to access support, even when going through the advised channels. Bereaved fathers also felt isolated within their close community, often feeling as though there was a time limit on grief and expectation to have processed the loss in a timely manner. This created friction within some spaces, leading to further withdrawal and internalised distress. This experience is likely to have been intensified by the turbulence within their religious and spiritual relationships, positioning, and entrapping nature of the racial stereotypes, intersecting with judgments based on other aspects of their identity such as gender, age, culture, and education levels. Additionally, in the initial stages of crisis and loss, each

participant shared prioritising their partner's needs over their own. Accessing support for themselves may be lower on their agenda despite potentially needing and benefiting from it in the moment.

> … then we were phoning the Ambulance service, phoning the hospital and everything, and them saying, "We can't get an ambulance to ya for about an hour, hour and a half". So, I was like what do you mean, I got my Mrs, she's just gave birth down the toilet, my baby has died and is down the toilet, what do you expect me to do? Flush the toilet? I've gone, there should be someone here to deal with these situations. They said, "Sorry, we can't get anyone to ya; you're either going to have to do it yourself or get someone else to get the baby out of the toilet" (Dan, 615-24).

> I argued with the people going down to the morgue where I was like, I'm not ready for him to go, so I laid with him for a couple of hours. Fell asleep with him resting on my chest… (Ryan, 1079-82).

> Some narratives would come up, they just will, they're generalisations, or where are we, that of stuff, and, and I think with some people and some institutions, there's not even a process of, of thinking that this might just be a stereotype or a, and I need to get to know this person or this community, they feel like they already know. And actually, when you check it out, it's not based on anything else but stereotypes, attitudes, and assumptions, and, and that makes communities vulnerable and, and it makes institutions, you know, that's where you get that institutional bias from (Clive, 241-250).

> There isn’t the support there and stuff, but there’s also that whole, it goes back to what I know, I live, I live in a predominantly White area and stuff, and there’s that whole process of self-exclusion, and going back to those young men that I talked about on my caseload and stuff it’s, even though there are services might be set up, a lot of time you exclude those yourself from no services coz you don't want to go there and face that exclusion anyway. Do you know what I mean, you just don't want that clumsy answers. You don't want that stuff, because you're very raw and stuff. So you are, you are on your own and that's just the experience that that is just the experience (Clive, 1683-95).

Only two of the five participants were referred for further support following the loss. The support was not offered within NHS services but through a local charity that offered support to the couple. One participant noted that he was ‘lucky’ to be referred for further support through the charity and showed awareness that this was an unlikely occurrence. Another noted the challenges of men being forgotten by others:

> And yes, fortunately, we were passed onto [charity[3]] as a support network, but I know there are a lot of hospitals that don't usually do that… it’s one of the rare things in the country and, people have to search for it. I think there's a lot to be said for supporting people in in those circumstances and against supporting people when they've had a baby. Same principle, exactly the same principle. The level of support shouldn't change, in my opinion (Michael, 1168-75).

[3] Name of charity removed to maintain anonymity.

> … not taking away from women at all, never will…I feel men are just forgotten about… men suffer from depression, we are left with thoughts and experiences …they've been through with miscarriages, and I do get it not every man wants to talk, that pride or whatever, but I feel like once men are made to feel comfortable enough to you know, they've got someone to go to and talk to who will listen and not judge em and listen, just literally you just listen to em. So, I think there'd be a lot more man that I that would be willing to yeah, talk (Dan 1113-24).

In the occurrences where medical professionals did notice them and ask how they were doing, it was often felt that it was not genuine, with a lack of care and "humanity". This resulted in further frustration with the system and holds the potential to further complicate the grief journey, with encounters serving as a trigger for previous wounds surrounding discrimination:

> …after being in the hospital for so long and having to keep going back and forth, I did get asked a few times 'oh how are you', but it to me it just sounded like, standard questions... Obviously, everyone's different. You've got people that generally do care, and you get people that just do their job… there's been time that we've gone back to the hospital there would be certain people remembered who we were before. So, I took into consideration what they were saying more than a person who I had seen before, but then we went back to em, it was like who are ya? (Dan, 511-14;519-20; 526-30).

> Professionals are very risk-averse, and that uniform is armour…we don't remember many humans in that situation, and the people that were compassionate and human in a small amount of time you never forget them… When we were in the, the, the neonatal ICU… they were a very specialised staff, I mean very specialised, unbelievably so, and they kept saying, oh I'm sorry for your loss, have you talked to anybody? And so, you feel like they're saying to you, do you want to talk about it? And as soon as we went to, both of us, we even sort of laugh about it, as soon as we went to say something, that's where their training stopped, and then they would signpost you to someone … it's weird how systems stop people from just being people. We really remember all of the compassion and love, and there wasn't a great deal of it, and we remember the people who were just stuck in those systems, and we will always remember the people who lied, and didn't give the care at all. It's a weird one (Clive, 1791- 1812).

The system was seen as perpetuating a mirroring process of invisibility, with the bereaved fathers feeling as though there was no space for them in the medical professionals' minds, there was no physical space made for them at the hospitals, pushing them aside and reinforcing the feeling that they lack importance or value. The view that Black Caribbean men could be in emotional pain, even when they have pre-existing challenges, appeared to be a difficult concept for others to recognise, increasing the sense of isolation and that nobody cares. This feeling is likely to have been intensified by the societal, cultural, and religious scripts and previous experiences of racism. Some participants reported that the stereotypes professionals hold about black men stopped them from thinking about them compassionately

and offering support in the same way they may treat others from non-black racial backgrounds.

> People are doing what they thought was expected of them, like ‘are you alright?’, it’s like they were pretending to offer that ear to talk to, but it felt like they wasn’t really listening -so just trying to play that part without actually caring. So, you know, I’ll just stop talking and was like, I’ll just do what you want me to do, yeah. and that's, yeah. And then, yeah, and that made me feel a certain way towards certain people. But yeah, that’s just how it is (Dan, 926-32).

> But I don't think like, I don't think there's enough support for it like, like I said, I think it just goes back to the whole narrative of, you’re just expected to be tough and to, to like, it doesn't really mean much to you like. Because I would get discharged from my mental therapies for not showing up because I was literally like I said to you, I couldn’t move. Rather than them checking in and saying something's up, we haven't caught up with him for a certain period of time; he’s just lost his child, and he already suffers from mental health issues; has that triggered it? They just was like, oh he's disengaging, and just releasing me back to my GP (Ryan, 1273-86).

> Because there's a chance that you're not going to get the right services, you're not going to get this, you're not going to get that, it is real, if you raise your hands you, it's like you're supposed to have a chip on your shoulder or you don't understand and stuff and you know, those who feel it, know it. We do know it, cos it’s just the truth, and

> it’s just as hard for us as it is for other people to talk about, but it is, it’s quite intangible, and everyone will go, well where’s your proof, oh no, I’m not this, I’m not that, well there’s just so much proof (Clive, 1609-1617).

One participant interpreted the medical professionals as laughing at him, which may show insight into how he feels he is viewed within the wider society. It could be interpreted that at some level, he feels society sees him as a joke, insignificant and unable to see or appreciate his pain, even when up close:

> And even when we go to the hospital erm, there was a lady – when we got asked to go the hospital, there was the lady who was on the phone and then we got to reception. She was laughing and joking with her mates but minutes before my Mrs had given birth to Ben down the toilet and I had Ben in my hands. So, she was laughing and joking. But were we going to talk to her? She was just like ‘ahhh, yeah, we'll just put you in that room’. But she didn't know what we was there - she didn't know what was there for. So then after when she realised, she came in, and she was just so apologetic and so sorry and everything… there's tons of people reception, and we're emotional, but she knows nothing. So obviously, before we got there, she was talking to her mates, having a laugh and a joke, and when at the time, I was like, what’s she laughing for? (Dan, 538-550).

This was echoed by Clive, who felt he was being laughed at and taunted by racist security guards, which had a knock-on impact on how he navigated the loss. He understood his mistreatment as a direct cause of “confirmation bias”. He has since internalised this event as

though his racial identity has resulted in the loss of his twin babies and was avoidable if he had another identity.

In the instances where participant's partners were admitted to the hospital to give birth, they were advised that they could not wait with their partners as there was no space for them. This created further emotional challenges for fathers as they were unable to be present and support their partners. It was regarded as an oversight of the system.

> But yeah, I think it's just a bit of an odd, odd feeling because it's they should have somewhere for you to go just even if it's overnight. I mean, I know they can't foresee that it might be 12 hours, it might be 10 hours, it might be 2 hours. They can't foresee that, but they should have a place for parents to like a dad to stay, for example, even if it's like a room where we just, you can just stay (Michael, 406-413).

This experience was echoed by Clive, who was often refused the ability to stay with his partner during the crisis leading up to the loss. These restrictions were heightened by COVID-19. He was able to access support through a charity via the second specialist hospital, which offers accommodation to parents with babies and infants hospitalised within the neonatal intensive care unit.

Another participant detailed receiving nappies as part of an automated service to parents surrounding the expected birth date. It was felt that hospitals and similar services are not well equipped to deal with loss, with the lack of consideration that not all pregnancies result in live births. The first anniversary following the loss was intensified by the system overlooking this

– what was intended as a kind gesture resulted in increased distress on an already challenging day. It was also expressed that babies are the "key card" to access support, and without this, parents, especially mothers, are neglected and overlooked by the system. This holds the potential to create further distress within the family unit and increase the pressure on fathers/ partners to minimise their experience of grief to support their partner. Additionally, the insensitivity in complying with protocols may heighten distress.

> It's surprising how much care for mothers, it's not surprising, is all triggered by the baby, so you know a health visitor and all of the, so all of the care for the mum is all vicariously through the baby. The baby's almost like the key card to services. Well, what do you do if you don't have the key card? So, it's a whole world that neither of us knew, but watching my partner and stuff there's not a lot of support out there. All sorts of stuff that you've gone through all of the same things, the same changes, physically, changes, all of that sort of stuff and that access isn't there (Clive, 1401-08).

> Normally, when you have a baby, you get a midwife that comes round, and then they see the baby, and they see it. Make [sure] your mom's OK. But same process should be in place when you've lost a baby because you've still given birth…I'm quite emotional about talk about it…but it's kind of those processes need changing from my perspective because no matter, you haven't got a tangible asset in your hands as a baby, but you've still gone through that whole labour process. You've still been through the whole thing (Michael, 1155-1166).

The lack of discussions surrounding loss within cultures, despite the high levels of loss within their community, combined with the lack of support and signposting offered by medical professionals confused individuals, often left participants feeling unsure whether this experience was exclusive to them:

> So, like, it is down to professionals and organisations to take it more seriously and, you know, offer more support. But I can't even tell you where you would go? Right? Maybe the NHS? I don't know (Abel, 1053-56).

It was also felt that organisations should be offering support to the family/ couple as bereaved fathers do not always know how best to support or navigate the loss in a healthy way. This may result in improved communication and support within their romantic relationships:

> I don't think there's any family that should have to, yeah, go through something like that and not have professional support because, yeah, like you're saying we're, we're two people have, But, you know, we're not going to know how to best support each other or what strategies or is it, you know (Abel, 1046-51).

Overall, the findings demonstrate the complexities of positioning, religious beliefs, and culture in the experience of baby loss. These factors appear to have a profound impact and may complicate the experience of grief.

Discussion

Summary of Findings

In this study, four group experiential themes were identified and have been presented above, including 1) Silenced by the positioning by others, 2) God knows, 3) The shifted experience and appreciation of fatherhood, 4) Navigating support whilst invisible. The findings demonstrate how the intersectionality of race, gender, culture, and religion complicate bereaved fathers' experiences following the loss of their baby. This study showed some convergence with the existing literature on the experiences of men's grief following perinatal loss. However, there have been clear examples of how the divergence in experiences within this population undoubtedly intensifies an already challenging experience.

The first theme encapsulated the experiences of being silenced through the many ways they were positioned by aspects of their identity. The findings showed this occurred in three main ways: by gender, stereotypes pertaining to their race, and through cultural scripts. Each of these was challenging in isolation, but the layering of each experience demonstrated a sense of feeling trapped and silenced. The study findings pertaining to the challenges men face in the experience of baby loss are echoed within the wider literature (Obst et al., 2020; Pearson et al., 2023). The positioning due to gender showed the participants leaning into a supporter role, as per societal gender norms and is supported by the literature (Obst et al., 2020). However, the findings within this study show the conflict and interplay of two competing scripts. Participants discuss the perceived need to be strong as a man and support

their partner but not appear ‘too strong’ to avoid being positioned as ‘the angry, aggressive/ violent black man’.

Nguyen et al. (2019) found similar experiences with bereaved fathers reporting the necessity of fulfilling a supporter role and a sense of pressure to hide their emotions to avoid increasing distress in their partners (Brandt et al., 2022; Evans & Fisher, 2022; Rohde et al., 2016). This sentiment was echoed in this study as participants felt it would be unhelpful to show their distress to their partners. Whilst at times this was reported in relation to the appreciation of the traumatic experience on their partner, it was acknowledged that this difficulty in showing emotions may be influenced by other factors given the bereaved father’s continued reluctance and/or difficulty to share their emotions with their partner even when prompted to do so. These findings resonated with Samuelson et al. (2001), who found that bereaved fathers shared the desire to maintain their supporter role even in moments where their partners shared a desire for emotional vulnerability.

Doka (1989) formed the concept of disenfranchised grief, the experience of grief following loss that is not openly acknowledged, socially supported, or publicly mourned. The initial theory reported that grief may be disenfranchised in three main ways: the loss is not recognised, the griever is not recognised, or the relationship is not recognised. The study has shown that it was common for Black Caribbean bereaved fathers to experience all three, potentially increasing the risk of complicated grief and poor psychological health.

The findings within this study additionally show similarity to the emerging theory of the socio-ecological model of men’s grief (Obst et al., 2020; see Appendix K), surrounded by the

concept of ‘double disenfranchised grief’. ‘Double disenfranchised grief’ was first termed by Cacciatore and Raffo (2011) in their study exploring the experiences of maternal bereavement within a lesbian couple. The study found that due to the lack of societal recognition of their standing as legitimate parents, the partner who had not experienced the pregnancy or loss was likely to experience an added level of disenfranchisement following baby loss. Obst et al. (2020) argued that there is a similar process with men following pregnancy loss, given the neglect of the impact of the wider socio-ecological process for men following loss.

Whilst the current study adds evidence for this emerging theory, it lacks appreciation for the element of race and racism both on an individual and systemic basis, along with the frequent experience of intergenerational trauma. The current study shows how experiences of race and racism are interwoven throughout their experiences and how they make sense of baby loss. It could also be argued that the intergenerational and/ or persistent individual experiences of race and racism centre the individualised experience of grief as proposed in the model (Appendix K). As research continues to show health inequalities within maternal care, but additionally across all institutions for this population, it’s likely that previous experiences of discrimination and poor treatment will impact their sense-making and grieving process. Additionally, the fact that biases create positioning within each element of the model speaks to the unique suffocating and intensified experience for non-White populations, arguably especially those from Black ethnic groups, as they are persistently disempowered and experience the harshest level of discrimination and inequalities across several institutions (Goodfellow & McFarlane, 2018; McCluney et al., 2021).

The experience of being silenced through positioning also revealed some of the challenges faced due to cultural scripts and taboos. Many cultural scripts involved expectations of being a family man and protector and avoiding fulfilling a self-fulfilling prophecy regarding the stereotypes of Black Caribbeans. These expectations were not moderated during the experience of loss, which created further distress in the participants. Additionally, taboos in talking about these experiences left participants feeling confused and silenced.

Existing literature has shown that religious practices and relationship with God are key factors in mediating psychological distress within Caribbean populations (Authur & Whitley, 2015; Cinnirella and Loewenthal, 1999; Walker, 2020). Other research exploring the perceived causes of mental health within Jamaican populations found community scripts involving psychological causes such as *"thinking too much*" and spiritual or religious beliefs such as Obeah (black magic). The notion of 'thinking too much' as being harmful and the expressed desire to avoid this due to concerns of being depressed was prevalent within this study. Such attributions may explain the religious scripts expressed to participants from their families and close communities, along with the conflict that ensued, as British-born participants are likely to have been impacted by the vastly different attributes that account for mental health causes and responses within British society. This may result in further feelings of being dismissed in the initial stages of loss as it further reduces spaces that are perceived as safe to explore their true feelings. It could be argued that the findings show parallels with the notion of cultural homelessness (Vivero & Jenkins, 1999) – not fully being accepted or fitting in with all the non-Western ideals whilst not fully being accepted within the White ethnic majority country. This is mirrored within their experiences of navigating the loss and working alongside professionals.

The theme, ‘God knows’, summarises the experience of the initial tensions with the religio-cultural scripts, the relationship with their figure of God and the universe developing into a positive experience. The theme of ‘the shifted experience and appreciation of fatherhood’ recapitulated the increased appreciation for their relationship with their living children. These experiences drew similarities to the theoretical underpinnings of post-traumatic growth. This was observed in the participants' reports of increased resilience and perceived strength and character development, improved appreciation and relationship with partner and other children, and increased spiritual growth/ connection. This is convergent with the findings within a systemic review assessing post-traumatic growth in parents following perinatal death (Alvarez-Calle & Chaves, 2023). However, the impact of the positioning of gender, race, and religio-cultural scripts poses the question of whether these reports are an accurate representation of how participants truly felt or whether it was a further demonstration of the internalisation of these scripts. Additionally, it may be argued that the ability to reach high levels of posttraumatic growth may be hindered in this population, given the additional triggers surrounding racial discrimination.

The theme of ‘navigating support whilst invisible’ captured the experiences of feeling invisible and overlooked by professionals. It speaks to the common stereotype that people from Black populations are ‘hard to engage’. These findings show that Black Caribbean men are keen to access support but often are dismissed. This finding is concerning, given the evidence of the beneficial impact of receiving support from friends and family following a baby loss (Obst et al., 2020). Nguyen et al. (2019) review also showed reports of men feeling overlooked by health professionals as well as members of their community who tend to set

precedence in focusing on their partner's well-being over the bereaved fathers. Fascinatingly, some evidence showed that acknowledgement of their experience from health professionals, employers and members of their community felt validated and empowered to share their loss experience more openly (Abboud & Liamputong, 2002; Abboud & Liamputong, 2005; Bonnette & Broom, 2011; McCreight, 2004). This finding further highlights the importance of training within these institutions to reduce the impact of biases in providing support to this population.

Most participants reported being better fathers following the loss, which was an interesting concept given that there was poor evidence to support the idea that they would have been 'bad' fathers should they not have experienced the loss. This unique take on the matter increases curiosity about the impact of the societal stereotypes and biases that surround Black men and their ability to be good and present fathers.

Conclusions

The findings within this study show the importance of considering the impact of intergenerational trauma and scripts when exploring lived experiences. It also highlights the importance of exploring how the intersectionality of parts of an individual's identity impacts the sense-making of their experiences. This is likely to be more necessary when working with Black Caribbean populations given the complexity and continued discrimination faced following the legacy of colonisation and the challenges faced following the mass migration following the Windrush generation. As this study shows, Black Caribbean men are grappling with many sources of distress following a baby loss. This involves the layering of societal

scripts surrounding gender, societal stereotypes of Black Caribbean men, familial scripts and expectations, personal relationships with God or a higher power, romantic and intimate relationships, and experiences of attempting to access support from professionals. The combination of these factors is likely to result in a heightened experience of disenfranchised grief.

Strengths and areas for improvement

Strengths

Being a Black British Caribbean woman born in the UK with many experiences of systemic racism, it was imperative to practice reflexivity throughout each stage of the study. A reflective diary was kept throughout this process, commenting on thoughts and feelings arising, the impact of the content and process, and memories that arose (Appendix L). The process of reflection and reflexivity was also implemented through peer supervision and research supervision, sharing thoughts and concepts to explore the perspectives of others and whether my personal experiences, assumptions and/or biases overshadowed the participant's experiences, statements, and sense-marking. This was done more frequently within the analysis process, allowing for a more holistic, neutral, interpretative stance.

Using a critical realist ontological stance and a contextualist epistemological stance allowed for greater consideration of the intersectionality of race, gender, culture, and religion/spirituality in participants' sense-making. It could be argued that this additional lens helped enrich the data analysis process, conveying the nuances within this population group.

Limitations

The study lacked the inclusion of participants from several Caribbean countries, potentially impacting the application and transferability of the findings to the wider Caribbean populations due to the nuances within each culture. The varying impact of colonisation across the Caribbean may impact the sense-making of some populations within the umbrella of 'Black Caribbean' culture.

The study equally lacked a wide variation in the geographical coverage of participants. Whilst this is expected within the smaller participant pool associated with IPA studies, it does pose challenges to understanding how local geography may impact individuals' sense-making, reality, and overall experience.

Clinical implications

This study is not designed to overshadow the experiences of perinatal death in other communities but instead to highlight the differences in experiences of those from this population. This study shows the need for healthcare professionals to improve their cultural competency and interweave this within their responses to families. Mental health services and charities should take care to provide pathways for Black British men, given the overrepresentation in the perinatal death data but underrepresentation within services, showing the potential of chronic isolation in their experience.

Raghunandan and Moodley (2021) share that Caribbean cultures have been found to engage in holistic and/or spiritual treatments. The lack of inclusion of these approaches within Western medical models will likely intensify the segregation of these approaches, strengthening the preference for holistic and spiritual approaches for Caribbean populations. This legacy may have contributed to the lack of reporting of cultural scripts involving seeking professional support following a baby loss.

Future directions

The study would benefit from being replicated across other cultures and Black ethnic groups. This would allow for an increased understanding of the differences that may appear within the Black population, incorporating the nuances within the varying cultures. Notably, each of the participants was in an interracial relationship; it may be beneficial to replicate this study with Black British Caribbean men who are in relationships with a partner from the same racial background to understand whether there are further differences or similarities in their experience of loss given the stark health inequalities that negatively impact Black women.

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Press Release: Literature Review

"Child killer", witchcraft or a test of faith? Religious and cultural perspectives dominate the experience of baby loss in parents internationally.

Religious and cultural perspectives on pregnancy loss can produce both positive and negative experiences in bereaved parents across cultures. The authors argue further consideration of religious and cultural scripts/ customs must be sensitively explored with parents who have experienced a pregnancy loss or neonatal death. As it stands, the findings show that current public policy guidelines (NICE guideline, 2014) directly contradict some religio-cultural scripts and customs adopted by some non-western cultures, potentially increasing the disparity in perceived and actual support in non-western or non-white populations.

The existing research generally includes an underrepresentation of non-white ethnicities who potentially subscribe to non-western and religio-cultural perspectives and responses to loss.

A qualitative review involving 11 studies was conducted to gather insight into the religious and cultural perspectives and responses to loss during pregnancy and shortly after. Further consideration of how these perspectives and responses influence the experience of bereaved parents was given. The study involved perspectives from over 400 participants, revealing four key themes: (1) The discourse and manifestation of cultural scripts; (2) parental responses to loss and (3) the role of a Higher being in the sense-making of loss.

Community responses were underpinned by support and responses from family and local community members, as well as being excluded from their community following their loss. In South Asian communities, it was common for bereaved mothers to be accused of being "careless" and a "child-killer" following their experiences of stillbirths. A similar blaming culture was apparent in some West African populations, with reports of being blamed for the loss by in-laws, particularly mothers-in-law. This differed from reports from Taiwanese populations, including reports of community members engaging in ceremonies alongside bereaved parents to promote healing. Similarly, populations within Northern Uganda and Kenyan cultures express the importance of providing community support to bereaved families so mothers can heal emotionally and fathers can maintain their expected duties as the 'provider'. Support often involved arranging the funeral, maintaining household duties around the house and financial support.

The findings also showed that it was common to be excluded from their local community due to the loss. Pakistani women shared experiences of being banned from social gatherings following the loss of their babies as the local community feared they would lose their babies, too.

The study showed cultural scripts significantly impacted the experience and sense-making of the loss in parents, particularly mothers. These scripts took form in many ways. One leading cultural script took form in the notion of witchcraft, sin, and curses. There was a dominant script across South Asian and West African populations surrounding the role of witchcraft,

sin, and curses in the loss of participants' babies. It was often stated that the loss was a direct consequence of sinful acts such as adultery and prostitution. These notions were usually directed towards the women, altering their experience of the loss. Other scripts included families being subjected to bad omens, spiritual attacks, and curses due to violating cultural norms or committing sins. This view was shared by local community members and professionals. These scripts often led to bereaved parents seeking guidance from religious healers.

In some cases, cultural scripts served as a minimisation of the loss. Bereaved mothers reported finding it hard to accept these statements in the immediate experience of the loss. Phrases included expressing gratitude that they survived the birth and have opportunities to reproduce. Other statements involved notions that if the baby were indeed theirs, it would have survived. It was also enforced that women should not cry nor express any emotion following the loss. This led to increased distress and suicidal thoughts.

The final themes showed that there were gendered differences in the relationship and responses to the religio-cultural scrips and customs. This was apparent across most cultures. However, the difference within South Asian cultures was not referenced. Across all cultures, there was reference to the role of God in the experience of the loss. For most participants, it served as a positive, providing understanding and comfort to the difficult situation.

The authors concluded that further research needs to be conducted in this area to allow for practical adaptations to existing theories and approaches. This would allow for more representation in services that provide support to bereaved parents following the loss of their baby.

Press Release: References

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Press Release: Empirical study

"Big boys don't cry": the unheard experiences of Black British Caribbean fathers following a baby loss.

Perinatal loss is defined as involuntary loss of foetus during miscarriage, stillbirth or loss of a baby born alive up until 28 days after birth (DiMarcoet al., 2001; Fenstermacher & Hupcey, 2013). The definition of perinatal loss in the UK differs from the internal definition and is medically defined as a loss between 24 weeks gestation and death within 7 days of being born alive (NHS, 2020). Miscarriages, stillbirths, and neonatal deaths (baby loss) disproportionately affect non-White individuals globally. The prevalence of all forms of baby loss is positively associated with poverty and lower socio-economic status (Knight et al., 2023). Similar statistics are prevalent within the UK, with pregnancy loss and neonatal death disproportionately affecting Black and Asian individuals. However, it is most prevalent in Black babies and women. Similarly, all forms of baby loss are also associated with living in lower socio-economic backgrounds within the UK.

A qualitative study involving analysis of accounts from five bereaved fathers identifying as Black British Caribbean resulted in the curation of 4 themes: 1) Silenced by the positioning by others, 2) God knows, 3) The shifted experience and appreciation of fatherhood and 4) Navigating support whilst invisible. The findings demonstrate how the intersectionality of race, gender, culture, and religion complicate bereaved fathers' experiences following the loss of their baby.

The theme 'silenced by the positioning by others' captured the experiences of being silenced through the positioning in relation to the different aspects of their identity. The findings showed this transpired in three ways: by gender, stereotypes pertaining to their race, and through cultural scripts. Each of these was challenging in isolation, but the layering of each experience demonstrated a sense of feeling trapped and silenced. Societal gender norms surrounding masculinity resulted in fathers feeling overlooked by professionals, friends and employers, which resulted in the suppression of their feelings. Additionally, societal scripts surrounding

gender norms resulted in men prioritising the feelings and experiences of their partners as their experiences were often more validated, but also through the recognition that they had physically experienced the birth trauma.

The expressed stereotypes expressed by the Black men involved being 'criminals', 'womanisers', 'loud', 'aggressive', 'violent' and 'deadbeat or bad fathers'. Participants felt these stereotypes resulted in the poor treatment they received from others. This created further distress in the fathers. This theme also captured the influence of familial and cultural expectations and scripts. This involved being a provider, leader of the family and supporter. Other expectations involved being an upstanding citizen, with a 'good job', respectful, and showing humility. The findings showed a hypersensitivity to these stereotypes and familial expectations, resulting in them attempting to avoid fulfilling them by censoring their grief reactions. It also led to a feeling of isolation and sadness as it felt they had little to no avenues of support due to how they were positioned by each of these factors.

The theme 'God knows' portrayed the disruption in relationship with God, higher power, and the universe. The study also found a strong aversion to the religio-cultural scripts such as *"everything happens for a reason"* in the immediate experience of the loss. However, as time passed within their grief journey, they found favour in these scripts, stating it helped their process of grief, relinquishing control and gaining acceptance of the loss.

The study found that fathers expressed a shifted experience and appreciation of fatherhood following the loss of their baby. This was found in all the participants who had other living young children prior to or following the loss. There was the expression that they are better fathers due to the increased gratitude for life.

Lastly, the findings showed that Black Caribbean men are indeed keen to access support but are often overlooked or dismissed by professionals. This leads to feelings of disappointment, sadness, and an aversion to seeking further support.

Overall, the study demonstrates the nuanced experience of baby loss in this demographic due to the different aspects of their identity. This study provides evidence for services to increase

their cultural competency and anti-racist practice. In doing so, this may mitigate some of the additional challenges this population faces following baby loss.

Press Release: References

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Appendix A: University of Birmingham ethical approval

UNIVERSITY OF BIRMINGHAM

Dear George Johnson

RE: Exploring Black Caribbean men's experiences of unexpected baby loss: An interpretative phenomenological analysis

Application for Ethical Review: ERN_0388 -Mar 2023

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Committee.

On behalf of the Committee, I confirm that this study now has ethical approval.

Any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards,

The Co-Chairs of the Science, Technology, Engineering and Mathematics Committee

E-mail: ethics-queries@contacts.bham.ac.uk

UNIVERSITY OF BIRMINGHAM

Dear Dr George Johnson and Cherise Williams

RE: Exploring Black Caribbean men's experiences of unexpected baby loss: An interpretative phenomenological analysis

Application for Ethical Amendment: ERN_0388-Jan2024

Thank you for your application for amendment to the above project, which was reviewed by the Science, Technology, Engineering and Mathematics committee.

On behalf of the Committee, I confirm that this amendment has full ethical approval.

Any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards,

The Co-Chairs of the Science, Technology, Engineering and Mathematics Committee

E-mail: ethics-queries@contacts.bham.ac.uk

Appendix B: CASP Quality Findings

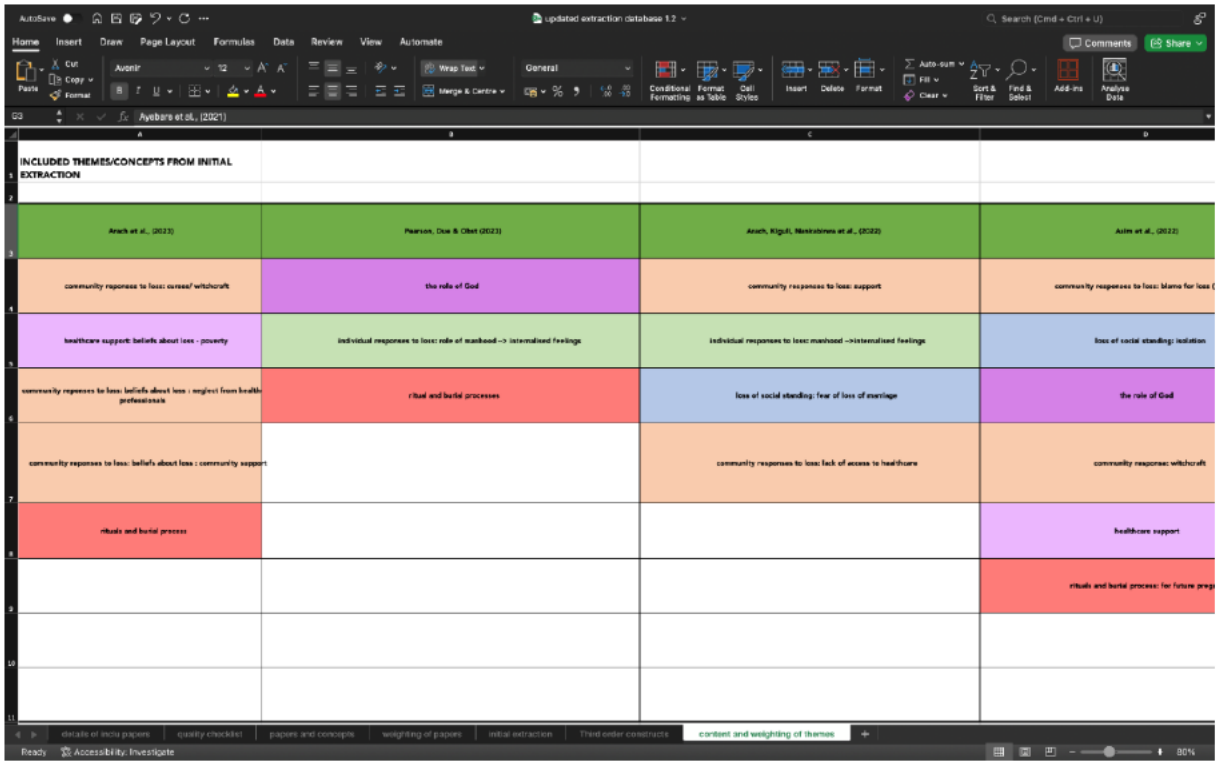
	Are the results valid?		Is it worth continuing?									What are the results?			Will the results help locally?
Author and year of publication	Was there a clear statement of the aims of the	Is a qualitative methodology appropriate?	Was 'baby loss' defined/	Does the paper reference the local	Does the paper reference religion?	Does the paper outline a procedure for translation?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable are the results?
Arach et al , (2023)														
Pearson, Due & Obst (2023)														
Arach, Kiguli, Nankabirwa et al , (2022)														
Asim et al , (2022)														
Popoola, Skinner & Woods (2022)														
Punaglom, Kongvattananon & Shu (2022)														
Ayebare et al , (2021)														
Adebayo Lui & Cheah (2019)														
Tseng et al , (2018)														
Hamma-Raz, Hartman & Buchbinder (2014)														
Sun, Rei & Sheu (2014)														

Appendix C: Weighting of included papers

Weighting of papers - chronological order				
	Y	C	P	N
1. Arach et al., (2023).	10	0	2	0
2. Sun, Rei & Sheu, (2014).	11	1	2	0
3. Adebayo, Liu & Cheah (2019).	10	2	0	0
4. Arach, A.A.O., Kiguli, J., Nankabirwa, V. et al. (2022).	10	0	2	0
5. Ayebare, et al., (2021).	10	1	2	0
6. Hamama-Raz, Hartman & Buchbinder (2014).	10	0	1	1
7. Pearson, Due & Obst, (2023).	9	0	2	1
8. Popoola, Skinner & Woods, M. (2022).	9	0	4	0
9. Punaglom, Kongvattananon & Shu (2022).	9	1	3	0
10. Tseng, Hsu, Hsieh, Cheng (2018)	9	2	2	0
11. Asim, Karim, Khwaja, Hameed & Saleem (2022).	7	0	5	1

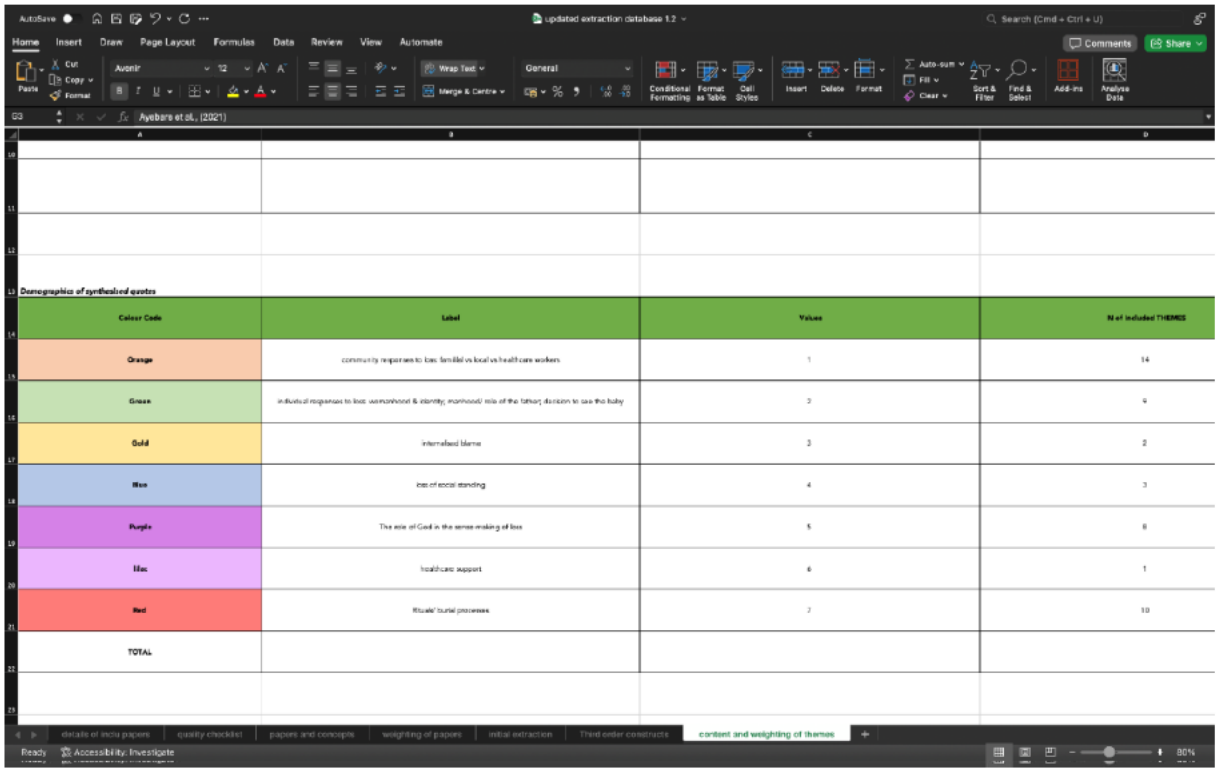
NOTE: The translation score was not included within scoring given that it does not apply to every paper

Appendix D: Example of extraction grids



INCLUDED THEMES/CONCEPTS FROM INITIAL EXTRACTION

Anach et al., (2023)	Pearson, Doe & Obot (2023)	Anach, Kigudi, Nankabirwa et al., (2022)	Asim et al., (2022)
community reponses to loss: curses/ witchcraft	the role of God	community responses to loss: support	community responses to loss: blame for loss (
healthcare support: beliefs about loss - poverty	individual responses to loss: role of manhood -> internalised feelings	individual responses to loss: manhood ->internalised feelings	loss of social standing: isolation
community reponses to loss: beliefs about loss : neglect from health professionals	ritual and burial processes	loss of social standing: fear of loss of marriage	the role of God
community reponses to loss: beliefs about loss : community support		community responses to loss: lack of access to healthcare	community response: witchcraft
rituals and burial process			healthcare support
			rituals and burial process: for future preg



Demographics of synthesised quotes

Colour Code	Label	Values	N of included THEMES
Orange	community responses to loss: familial vs local vs healthcare workers	1	14
Green	individual responses to loss: womanhood & identity; manhood/ role of the father; decision to see the baby	2	4
Gold	internalised blame	3	2
Blue	loss of social standing	4	3
Purple	The role of God in the sense-making of loss	5	8
Lilac	healthcare support	6	1
Red	Rituals' burial processes	7	10
TOTAL			

Appendix E: RAMP & Data Management Plan

BIRMINGHAM

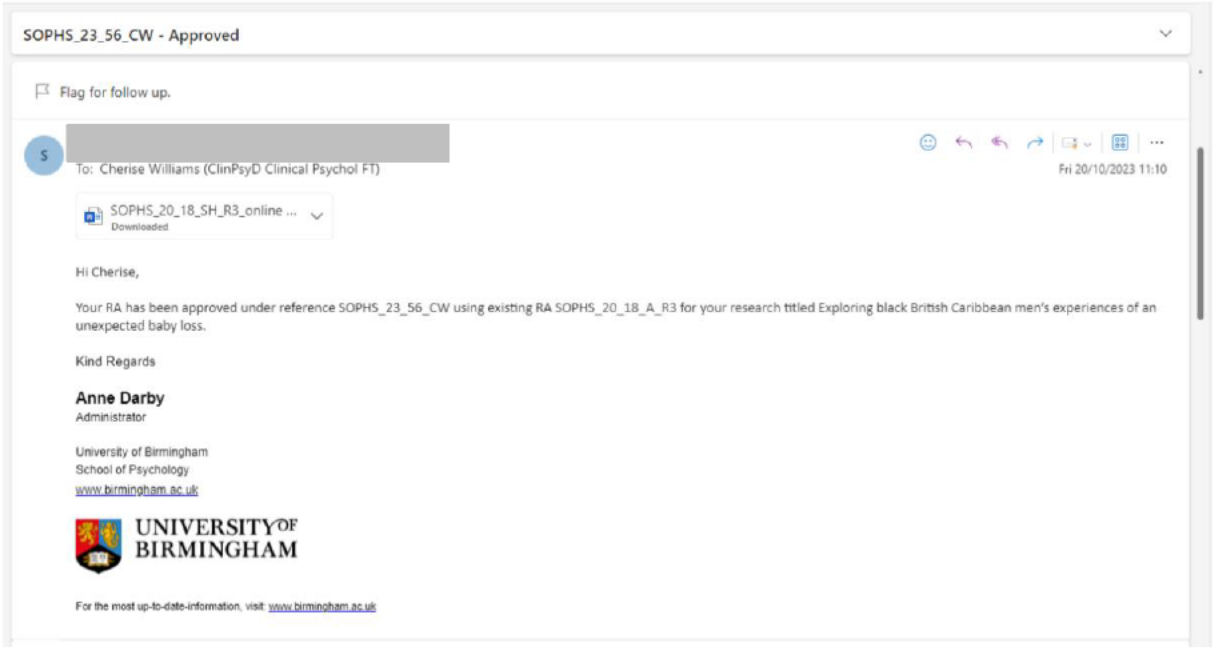
GENERAL HEALTH AND SAFETY RISK ASSESSMENT FORM

Site	**Online only**	**Department**	**School of Psychology**	**Version / Ref No.**	**SOPHS_20_18_A_R3**
Activity Location	**Location of participant's choice**	**Activity Description**	**Experiment or questionnaire performed online only on electronic device. Participants receive or download digital material and perform the activity in a location of their choice.**		
Assessor	**Removed for confidentiality purposes**	**Assessment Date**	**October 5th 2023 amended to remove Covid**	**Date of Assessment Review**	**October 5th 2023**
Academic / Manager Name	**Removed for confidentiality purposes**	**Academic / Manager Signature**	**Removed for confidentiality purposes**		

Hazard Assessment				Control Assessment									Actions		
Hazard Category	Hazards Identified	Who might be harmed? Staff Students Contractors Others	How might people be harmed?	Existing Control Measures	Initial Risk Rating S	L	R	Are these adequate? Yes/No	Changes to/ Additional Controls	Residual Risk Rating S	L	R	Owner	Due Date	Action Complete
Biological	Virus Transmission between participant and experimenter	Researcher Participant	Potential exposure to contagious illness.	To ensure that the activity does not increase the risk of transmission between researchers and participants, these individuals will never interact in person. For this, all personnel involved in the study will be reminded that in-person activity cannot take place and that all activity in this risk assessment can only take place using computer-, tablet, or phone-mediated communication. Any other in-person interaction is not allowed and should be reported by the experimenter as a breach of protocol. Personnel and participants will be reminded prior to commencing of the study that they should not interact with other people directly during the activity.	5	1	5	Yes					PI	Prior to re-commencing study	
Ergonomic	Poor workstation and space	Participant Researcher	Muscle damage, fatigue.	• Before commencing the experiment, instructions will be given to the participant on setting up an adequate environment and on maintaining a comfortable posture during the experiment. • Participants will be advised of the approximate length of the survey before commencing, and a progress bar will inform them of how much is left to complete • Participants will be provided with a save and return function to enable participants to complete the survey over multiple sessions as best suits their individual needs • Participants will be instructed to make breaks during the procedure to avoid discomfort and fatigue. • Participants will be initially instructed to stop the procedure and report any discomfort or fatigue during the experiment.	2	2	4	Yes					PI	Prior to re-commencing study	
Psychosocial	Accumulated stress	Participants, Researcher	Mental fatigue with the possibility of affecting future activities.	• Participants will be advised of the approximate length of the survey before commencing, and a progress bar will inform them of how much is left to complete • Participants will be provided with a save and return function to enable participants to complete the survey over multiple sessions as best suits their individual needs • Appropriate breaks should be taken between sessions. • Participants will be informed that they are allowed to leave/have a break from the experiment at any point without giving a reason, and that their data will not be used if they choose to leave.	2	4	8	Yes					PI	Prior to re-commencing study	
Safety	Falling/tripping	Participants	Tripping on computer, tablet or phone wires	Instructions provided to the participants before the commencing of the experiment will ensure that environment will be cleared of tripping hazards before activity commences.	3	2	6	Yes					PI	Prior to re-commencing study	
Psychosocial	Stress	Participants, Researcher		• Participants will be informed their data will be kept anonymous. • Participants will be advised to contact research team if they experience stress or upset during or following completing the survey	1	2	2	Yes					PI	Prior to re-commencing study	

Safety	General	Participants, Researcher	University personnel do not follow risk assessed procedures because they are unfamiliar, unaware they must be followed or do not have the skills/knowledge to follow them	The personnel involved will: • review this risk assessment before the activity takes place. • identify any necessary training required to adhere to risk assessed procedures and meet with PI to discuss training needs. • complete training as required to meet needs discussed with PI. • The PI will maintain a record of the above actions. • The PI will provide approval for any student research activity after the risk assessment will be approved.	3	1	3	Yes					PI	Prior to re-commencing study	
Safety	General	Researcher	Researcher does not have the awareness/ skills or experience to deal appropriately with the research protocol	All personnel involved will: • receive training for the experimental procedure before the activity will take place. • report misunderstanding and incidents to PI and to H&S chain. • PI reviews incidents and monitors execution of the activity to ensure appropriate action has been taken.	2	1	2	Yes					PI	Prior to re-commencing study	
Reputational			Poor publicity or complaints	All personnel involved in the activity to be clear on relaying complaints to PI or manager. PI to address complaints with participants and report them following the appropriate channels. Draft instructions for students Draft communication procedure Draft escalation procedure	2	3	6	No		2	2	4	PI	Prior to re-commencing study	
Psychosocial	Mental health and wellbeing	Participants	Participant distress in response to the content of the activity	• Participant information sheet explicitly states whether there is any risk of distress due to the specific content of the activity. • Participant information sheet explicitly states participation is voluntary/right to withdraw. • Participant information sheet explicitly states if confidentiality will be breached following disclosure of information that could indicate someone is at imminent risk of harm. • Ethically approved informed consent/assent and debriefing procedures will be followed. • Research procedures will include safeguards like continuous monitoring through cameras, a button for reporting discomfort, and an ongoing performance monitoring from the activity. If signs of discomfort are shown, a system should be in place to provide participant with an alternative activity, a way to stop, or a way to decrease discomfort by removing the content causing it. PI should be reported within 24 hours of this event and a discussion should take place to continue or modify the activity. • UoB policies and procedures on working with children/vulnerable adults to be always followed. If data collected via online interview, PI to ensure that where possible interviews occur within working hours so support can be accessed promptly if needed. If not possible to be within standard working hours, a PI/Supervisor must be available for support access. • Support contacts to be provided where relevant. For example, providing mental health support contacts if content may be distressing for participants.	3	1	3	Yes		2	1	2	PI	Prior to re-commencing study	
Psychosocial	Mental health and wellbeing	Researcher	Researcher distress in response to participant survey/interview responses	Researcher/student to debrief with named supervisor/peer following any disclosure of sensitive or distressing information Researcher students can access the University of Birmingham counselling services Researchers to maintain contact with supervisory team, research group and colleagues in University Supervisor and student to arrange appropriate person to debrief following exposure to potentially distressing	3	2	6	Yes		3	1	3	PI	Prior to re-commencing study	

				survey/interview responses. To be scheduled on a regular basis if content is likely to be distressing.											
Data Management	GDPR	Researcher Participant	Data loss or conflict due to sharing/loss of data	Experimental protocol will follow procedures that will have been approved to adhere to GDPR regulation. PI has set up procedures, to store and file sensitive data according to regulations. Researchers and Participants will be informed of the approved procedures to deal with data storage and transmission.	3	2	6	Yes					PI	Prior to re-commencing study	



SOPHS_23_56_CW - Approved

Flag for follow up.

S [redacted]

To: Cherise Williams (ClinPsyD Clinical Psychol FT)

Fri 20/10/2023 11:10

SOPHS_20_18_SH_R3_online ...
Downloaded

Hi Cherise,

Your RA has been approved under reference SOPHS_23_56_CW using existing RA SOPHS_20_18_A_R3 for your research titled Exploring black British Caribbean men's experiences of an unexpected baby loss.

Kind Regards

Anne Darby
Administrator

University of Birmingham
School of Psychology
www.birmingham.ac.uk

UNIVERSITY OF BIRMINGHAM

For the most up-to-date-information, visit: www.birmingham.ac.uk

The University's Data Management Plan (adapted for CAP doctorate trainees)

1. Overview
a. Researcher's Name: Cherise Williams
b. Title of Research Project: Exploring Black British Caribbean men's experience of unexpected baby loss
c. Length of Project (incl. Start Date & End Date): 2022-24
d. A brief statement of the aim(s) of the project: to gain a better understanding of how Black British Caribbean men experience unexpected baby loss.

2. About the Project Data
a. Briefly describe the data that you will collect for the project: A number of semi-structured interviews will be carried out which will be transcribed and grouped into themes. These interviews will occur virtually as recruitment will be national. The interviews will be recorded utilising an encrypted Dictaphone and accordingly transcribed. This will be anonymised and held on the research data store at Birmingham university. This will only be accessible by myself and my research supervisor Dr George Johnson. Quotes will be used to evidence the proposed themes during the analytical process.
b. Frequency of new data (how often will you get new data and over what time period?): This will be dependent upon recruitment but there is the aim to collate all data/ complete interviews within 3 months. Thus, to allow for sufficient time to analyse the data.
c. What format is the data in? Prior to transcription, the initial data will consist of a recorded audio interview. This data will be transformed into a transcription which will be in written format. As mentioned above, this will be anonymised using pseudonyms.

d. Could the data be considered high value and/or vulnerable (e.g., is your data likely to attract "hactivists"?)? How could this be mitigated?

I would say unlikely, but this is based on conjecture. The research topic is niche and does not appeal to the masses and therefore, the likelihood of data being targeted to be hacked is not high. However, the data will solely be stored upon the research data store at university of Birmingham which should mitigate the potential of this issue. Equally all documents will be password protected, adding an additional layer of protection. Only research supervisor(s) will have access to this.

3. Data Collection and Storage

a. What different versions of the data do you create (e.g., versions of data files)?

Audio recordings of each interview to be uploaded on the research data store. Consideration of also recording via an encrypted Dictaphone (provided by the university research team) to mitigate any technical difficulties which may occur via video recording through zoom/ teams. If so, this too will be uploaded onto the university secure storage system. Following this, the recordings will be transcribed and anonymised through this process. This will be uploaded on the research data store, and the original audio and/or video recordings will be deleted.

b. What additional information is necessary to understand the data (e.g., abbreviations, supplementary notes)?

n/a

c. Where will the data be stored?

University research data secure storage system (RDS) as per protocol.

d. Describe the system to name and structure any electronic files.

University secure storage system (RDS). All electronic files will be password protected.

e. Describe the regime for backing up the data.

Unknown at present. Guidance to be sought from research supervisor regarding this.

f. Describe the procedure to be used to ensure files can be restored from the backups.

Unknown at present. Guidance to be sought from research supervisor regarding this.

4. Data Availability to Others

a. Who owns the data?

The researcher and research supervisor. Following my end of my studies, my research supervisor will obtain the necessary information to access the data. This will be stored for 10 years following the project, in line with the guidance of the university.

b. Are there restrictions on who can use the data, and if so, what are they?

The research supervisor and I. It is not necessary for anyone else to have the data.

c. If the data can be made openly available, at what point can this happen?

n/a

5. Archiving (preserving the data for future use)

a. What data should be kept beyond the end of the project?

Transcripts

b. How long should it be kept?

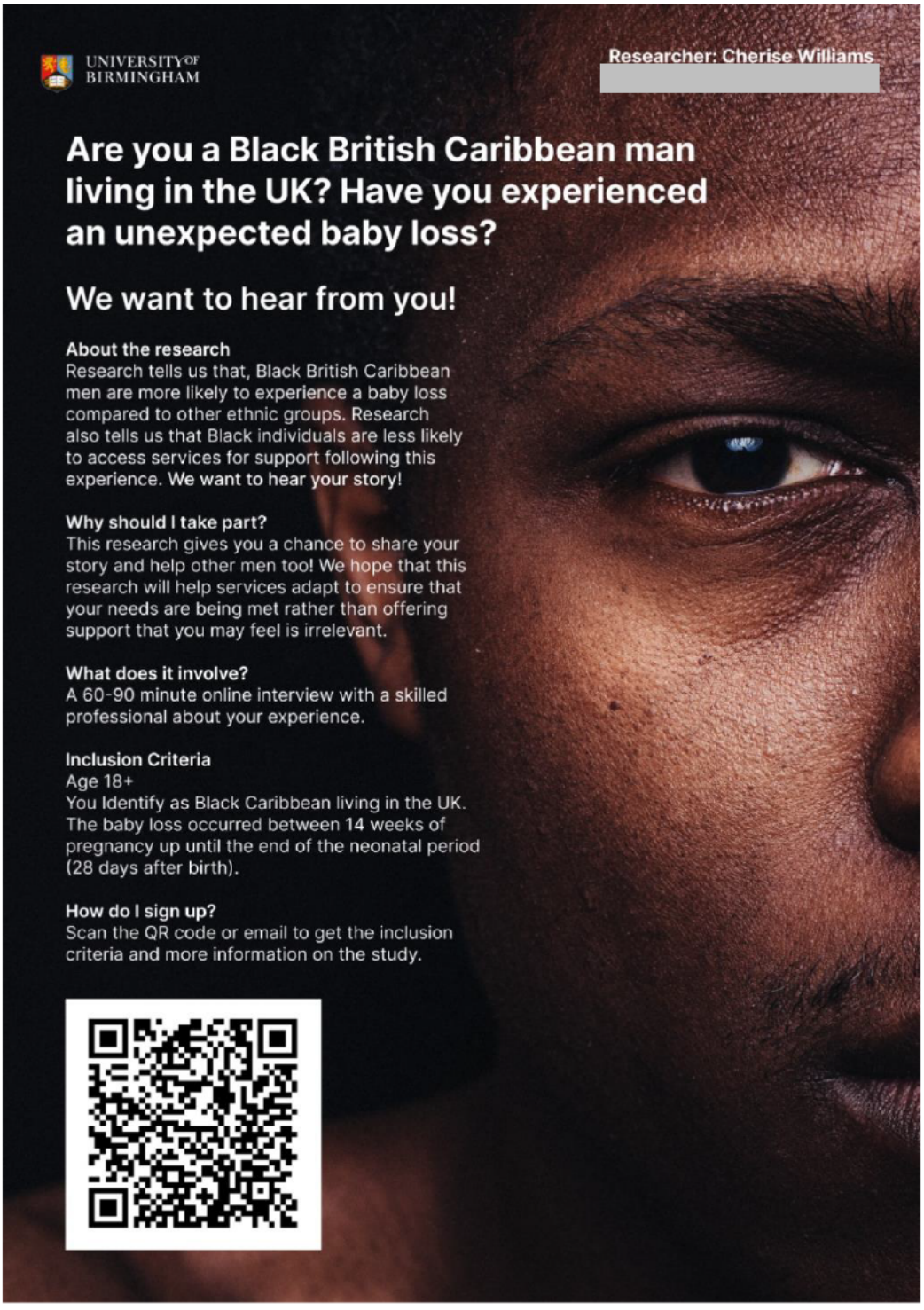
10 years and this will be automatically deleted from the archive at this time.

c. Where will the data be archived? **On the university secure storage system**
d. Who will create and maintain the archive of data? **Dr George Johnson**
e. Are there restrictions on who can access the archived data? **Yes**
f. What are the likely (estimated) costs of preserving the data? **unknown**

6. Implementing this Plan
a. Name of person responsible for implementing this plan: **Cherise Williams and Dr George Johnson**
b. Frequency of review and/or updates of this plan: **Within supervision which should occur monthly.**
c. Actions required in order to implement this plan:
d. List any further information needed to carry out the actions above: n/a

Notes:

Appendix F: Recruitment Poster



Appendix G: information sheet and consent form

Welcome to the research study!

Information sheet:

Research title:

Exploring Black British Caribbean men's experience of baby loss

You are invited to partake in this research project as part of doctoral research. Before you decide whether you wish to take part, it is crucial that you understand the rationale and summary of the study along with what participation will involve.

Please take your time to read the following information, and feel free to consult others if you wish. If you have any questions about what you have read, please get in touch with me – contact information is provided at the end of this document. If you decide to participate, you will be directed to a consent form which will provide further provisions on what you are consenting to. Despite providing consent, you can withdraw from the study without giving a rationale. Thank you for taking the time to read this.

Summary of the research project:

This study seeks to understand how those who identify as Black British Caribbean men have experienced an unexpected baby loss. The aim of this study arose from the recent increase in studies demonstrating that Black women and Black babies are most likely to die during pregnancy (including stillbirth) and within the neonatal period (up to 28 days following birth). Despite this increase in research, there remains a lack of attention focused on Black men's experience of this loss. Additionally, there is a lack of black families' access to mental health/ perinatal mental health services despite mostly being affected. This study aims to provide men with a voice to share their experiences. Additionally, there is the hope that the study can provide insight to NHS services that aim to provide more effective treatments to this group and improve their access to services.

Inclusion criteria: Who can take part?

- Age 18+

- Men who identify as Black British Caribbean (Caribbean countries include: Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Montserrat, Navassa Island, Netherlands Antilles, Puerto Rico, Saint Barthelemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and Grenadines, Trinidad and Tobago, Turks and Caicos Islands and United States Virgin Islands).

- Participants must be the biological parent of the baby who passed away
- Baby loss is defined in this study as the second trimester (14 weeks onwards) through the neonatal period (up to 28 days following birth). Advised terminations due to your baby's ill health are also included. Miscarriages can occur up until the 23rd week of pregnancy, and therefore, miscarriages that occur 14 - 23 weeks and 6 days will be included.

- Men who reside in the UK presently and at the time of the birth and death of their baby

- No time limit on when the loss occurred

- The baby's ethnic identity: the biological mother doesn't need to identify as Black British Caribbean. This means the baby could be identified as mixed ethnicity.

Exclusion criteria: Who cannot take part?

• Not currently residing in the UK
• Residing in a secure setting at present (i.e., prison; mental health hospital)
• Presence of a psychotic disorder presently or at the time the loss occurred
• Men who do not identify as Black British Caribbean
• Baby loss within 1st trimester (13 weeks of gestation and less)
• Partner/ Baby's birth mother also passed away during the period of pregnancy or up until the neonatal period

Why have I been chosen?

You have been chosen to partake in this study as there is little understanding of Black Caribbean men's experiences following a baby loss. As you fit this description, we hope to use our discussions to improve our knowledge and inform the current psychological literature.

Do I have to take part?

No. All participation is voluntary and will not impact your ability to access support or services.

What will happen to me if I take part? What do I have to do?

You will be sent a link to a page to allow you to choose your desired slot for the virtual interview. You will be asked to attend an interview which is expected to last 60-90 mins. This will be recorded via an encrypted Dictaphone to allow the transcription process to be carried out later. You will be asked to create a unique code to identify your transcript should you wish to withdraw your data. You are encouraged to engage in an open discussion involving your experiences. You can choose to decline to answer any questions, at any time. Once the interview is over, the researcher will facilitate a debrief which will allow you to discuss the process and any emotions that may have come up during the discussion. You will be provided with an information sheet involving information on who to contact for emotional support at a later time should you wish.

Monetary compensation:

As we understand that some individuals may need to take time away from work to partake in the research, we will provide a £15 Amazon voucher upon completion of the interview. This does not impact your right to withdraw your data up until 14 days after the interview.

What are the possible disadvantages and risks of taking part?

As we will be discussing an emotional topic, this may bring up difficult emotions around the loss of your baby. We hope this discussion will not cause any more distress you may already face on a typical day. What are the possible benefits of taking part?

As you may be aware, there is little focus on men's experience of unexpected baby loss. At present, there is no research which covers Black Caribbean experiences of this. Engaging in this process may induce some positive feelings as you are being offered a space to be heard. There is the intent to publish this research; therefore, the findings may be used to improve clinical knowledge of your experiences. Thus, services may be altered to ensure that individuals from this demographic receive care that is relevant and beneficial.

What if something goes wrong?

If during the interview, you find it increasingly difficult to continue with the interview (i.e., because it is difficult to discuss and you find it overwhelming

emotionally), you can ask to pause or stop the interview. If you do not ask, but the researcher feels that the discussion is causing distress, the interview will be paused and may be stopped. You will be given the option to rebook the interview within 7 days should you wish to. However, the researcher will not reach out to do so, and this will be solely voluntary. If you are unhappy with anything that occurs during the interview process, you should let the researcher know if you feel comfortable doing so. In the instance that you do not, you can contact the research supervisor with the contact information provided at the end of this document.

Will my taking part in this study be kept confidential and where will the information be kept?

During this process, it will be difficult to remain anonymous throughout each stage of this study. When signing up for this study, you will need to provide a name (it does not need to be your given name) and an email address to receive the link for the online interview. This information will not be kept and will be deleted following the signposting information being shared following the interview. When you sign up for the study, you will be asked to create a unique code which will be associated with your transcribed data. This is so it may be identified in the case you wish to withdraw your data within 14 days following the interview. This code will be kept on the university's secure research store.

The interview will be recorded on an encrypted Dictaphone and the recording will be uploaded onto the university secure research store. The data will be transcribed into a written format, and the audio will be deleted. The transcribed data will be uploaded on the secure data store where it will remain for 10 years. All data is kept on this secure data store just in case participants wish to request a copy of their transcript beyond the study. Only my research supervisor will have access to this information during this time.

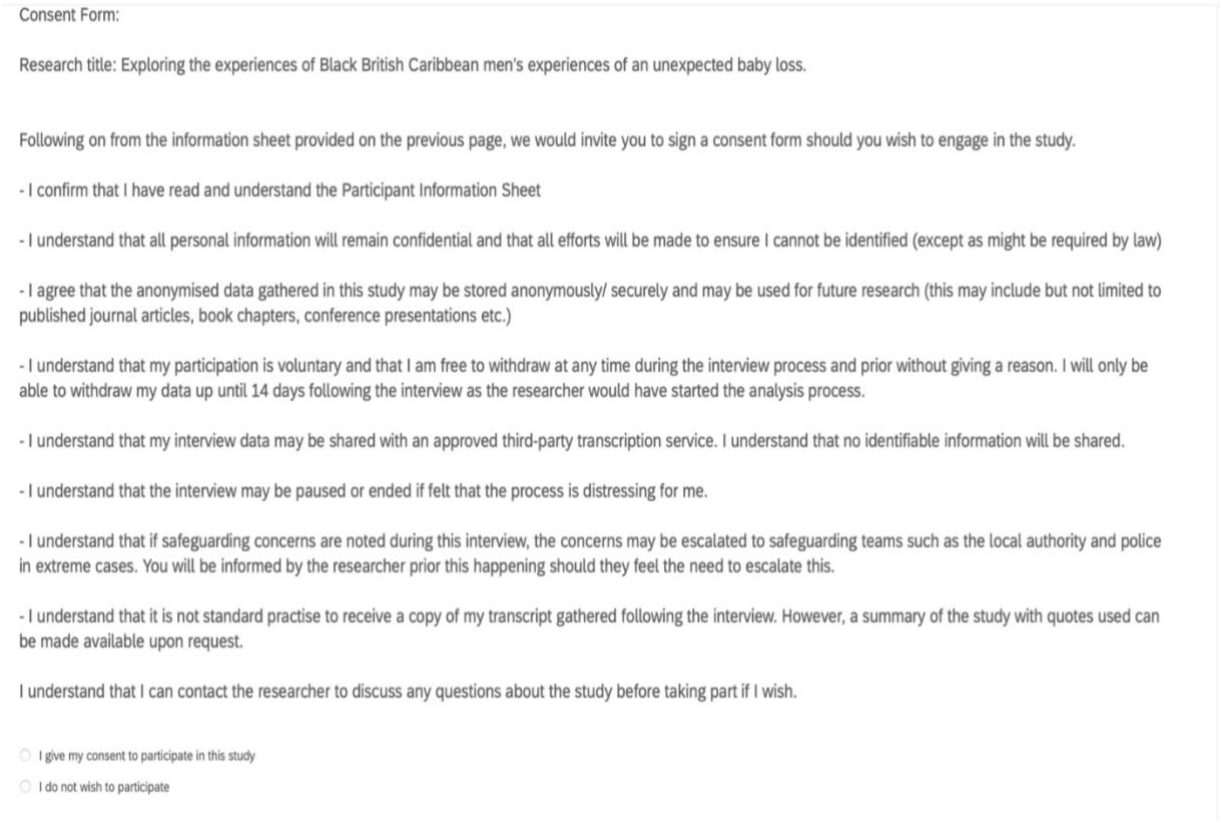
All data will be automatically deleted beyond this period of time. Third parties such as approved audio transcription services may be provided access to the audio recordings to transcribe if unforeseen circumstances may arise for the researcher. Once the data is transcribed and analysed, pseudo names will be allocated to each person who participates in the study. No detailed identifiable information will be sort or associated with the pseudo names. This is in a further attempt to reduce the chances of individuals being identified. Should you wish to withdraw from the study within 14 days following the interview, your data will be discarded.

As mentioned, this research is part of doctoral research. In some instances, the research completed for this process may be published, meaning it may become available in journals and online more generally. All information within such

formats will be anonymous and therefore, not including any identifiable information about you.

- Researcher name: Cherise Williams
- Researcher contact details: [redacted]
- Research supervisor name: Dr George Johnson
- Research supervisor contact details: [redacted]

Screenshot of the virtual consent form:



Consent Form:

Research title: Exploring the experiences of Black British Caribbean men's experiences of an unexpected baby loss.

Following on from the information sheet provided on the previous page, we would invite you to sign a consent form should you wish to engage in the study.

- I confirm that I have read and understand the Participant Information Sheet

- I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified (except as might be required by law)

- I agree that the anonymised data gathered in this study may be stored anonymously/ securely and may be used for future research (this may include but not limited to published journal articles, book chapters, conference presentations etc.)

- I understand that my participation is voluntary and that I am free to withdraw at any time during the interview process and prior without giving a reason. I will only be able to withdraw my data up until 14 days following the interview as the researcher would have started the analysis process.

- I understand that my interview data may be shared with an approved third-party transcription service. I understand that no identifiable information will be shared.

- I understand that the interview may be paused or ended if felt that the process is distressing for me.

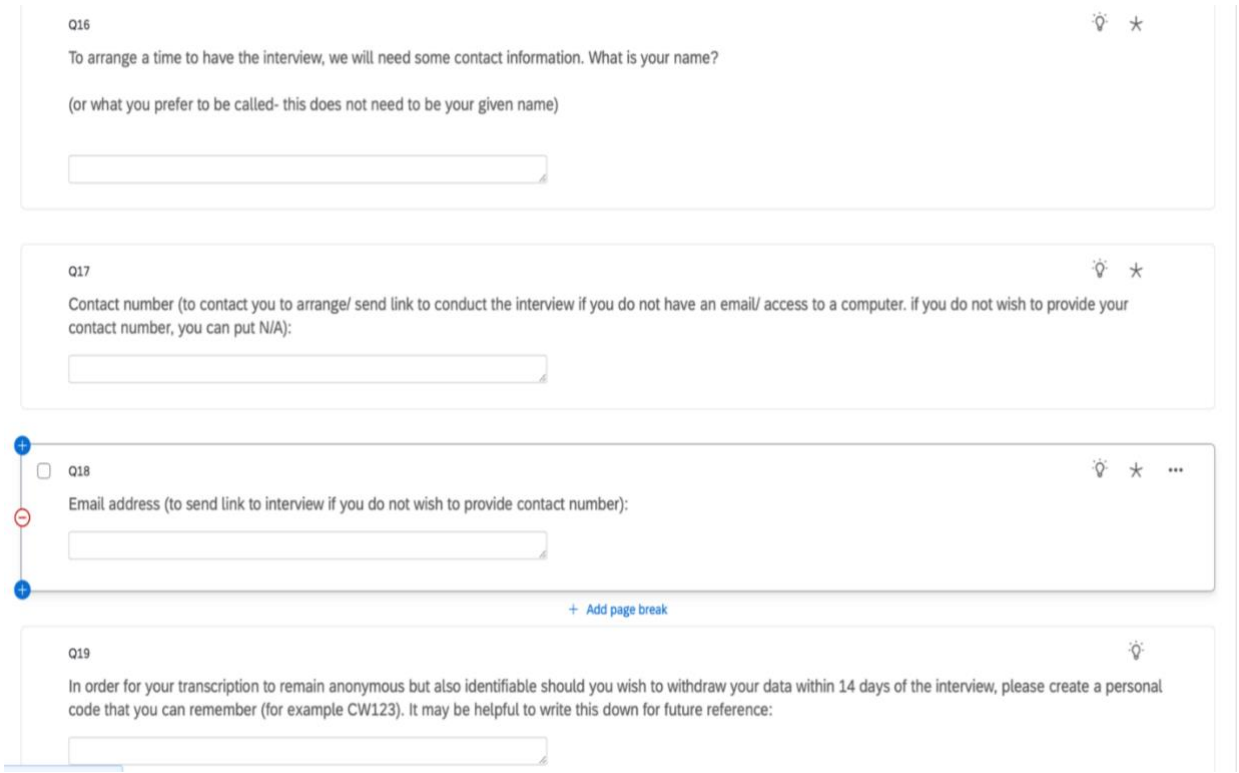
- I understand that if safeguarding concerns are noted during this interview, the concerns may be escalated to safeguarding teams such as the local authority and police in extreme cases. You will be informed by the researcher prior this happening should they feel the need to escalate this.

- I understand that it is not standard practise to receive a copy of my transcript gathered following the interview. However, a summary of the study with quotes used can be made available upon request.

I understand that I can contact the researcher to discuss any questions about the study before taking part if I wish.

○ I give my consent to participate in this study

○ I do not wish to participate


Q16
To arrange a time to have the interview, we will need some contact information. What is your name?
(or what you prefer to be called- this does not need to be your given name)
Q17
Contact number (to contact you to arrange/ send link to conduct the interview if you do not have an email/ access to a computer. if you do not wish to provide your contact number, you can put N/A):
Q18
Email address (to send link to interview if you do not wish to provide contact number):
+ Add page break
Q19
In order for your transcription to remain anonymous but also identifiable should you wish to withdraw your data within 14 days of the interview, please create a personal code that you can remember (for example CW123). It may be helpful to write this down for future reference:

Appendix H: Signposting information

Signposting information:

We understanding that talking about the loss that you have experienced can be difficult. If you feel the experience of loss has impacted your overall wellbeing and emotional state, it might be helpful to speak with a professional such as your GP, who can offer support and refer you onwards for talking therapies. You can do this by contacting your local GP surgery. If you are not signed up to a GP currently, you can find contact details for your local GP surgeries here: https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/

Additionally, Cruse is a charitable organisation which specialises in grief. You can find information for your local centre on their website: https://www.cruse.org.uk

Below are some other organisations which can offer support or advice on baby loss:

Tommys: https://www.tommys.org

FivexMore: https://www.fivexmore.com

Maternity action (includes information on fathers' rights):
https://maternityaction.org.uk/advice/miscarriage-stillbirth-and-neonatal-death-rights-to-time-off-and-pay-for-parents/

Make birth better: https://www.makebirthbetter.org

The Dad network: https://www.thedadsnet.com/category/miscarriage/

The Birth Trauma Association: https://www.birthtraumaassociation.org.uk/for-parents/fathers-partners-page

Sands: https://www.sands.org.uk.
telephone: 0808 164 3332
email: helpline@sands.org.uk

The Compassionate Friends: National Helpline: 0345 123 2304 (Daily 10:00am-4:00pm, 7:00pm-10:00pm)
Email: helpline@tcf.org.uk
Web: www.tcf.org.uk

The Lullaby Trust: Lullaby funds research, supports bereaved families and promotes safe baby care advice, including helpline for bereaved parents and their families, friends, neighbours and anyone else who has experienced the sudden death of a baby.
Bereavement Helpline: 0808 802 6868
Web: www.lullabytrust.org.uk

TAMBA: Bereavement Support Group is for parents who have lost a twin/multiple or both/all twins/multiples. The support Group offers parent to parent support via their befriending service and via their closed face book bereavement support group.
Helpline: 01252 332 344 (usually 9am to 4pm weekdays but it can vary)
Email: support-team@tamba.org.uk

Web: https://twinstrust.org/bereavement.html

Below are organisations which offer emotional support to men generally:

Man up: https://www.manup.how

Bereavement for Men: https://www.strongmen.org.uk

Mind: https://www.mind.org.uk

Prosperous Minds: Instagram – prosperousminds_

Samaritans: free listening support, 24/7 – 116 123

SHOUT: Text for free on 85258

THE CALMZONE: Call **0800 58 58 58**

PAPYRUS UK: a charity for the prevention of young suicide (under 35) in the UK | Call PAPYRUS HOPELINEUK on 0800 068 4141

Support for your partner if needed:

Life After Loss: an online support community set up in November 2006 by bereaved mothers who find support and friendship through sharing their grief over the loss of a baby at any stage of pregnancy or after birth.
Web: www.lifeafterloss.org.uk

Sands: https://www.sands.org.uk

FivexMore: https://www.fivexmore.com

Maternity action:https://maternityaction.org.uk/advice/miscarriage-stillbirth-and-neonatal-death-rights-to-time-off-and-pay-for-parents/

Make birth better: https://www.makebirthbetter.org

Tommys: https://www.tommys.org

Appendix I: Interview schedule

Setting the scene prelude: 5 minutes.

CW: Thank you so much for taking the time to meet with me today. How did you find setting up the devices? – brief check-in with their day?

*"I think it would be nice to do some introductions and share some information about the purpose of the study. My name is Cherise, and I am a trainee clinical psychologist studying at the UoB. *check pronunciation of name**

- Reference why there is a focus on black British Caribbean. Space for questions.

- Advise that breaks are permitted; I can check in during the interview but would encourage you to ask for a break. If things become a bit difficult, I will suggest taking a break and potentially stopping there and resuming the interview another day if you wish.
- How would I know that you might be finding things a bit challenging? What would I notice?

- Advise that there would be 9 main questions with some prompts:

- Some may be challenging, so it's ok to take a moment. We hope to have a conversation or discussion for around 1-1.5 hours.

- Advise they can stop the interview at any time if you no longer wish to engage in this process. Withdraw 14 days after interview – no longer able to identify data because analysis process started. All data is anonymous

- Before we start, how would you like me to refer to your baby?

<u>The context:</u>

1. ***How would you describe your culture?***

√ **Prompts:** is this important to you? How does being from x country influence your day-to-day life? [if noted in the demographic questionnaire, maybe ask a question about how being born/ connected to birthplace but living in the UK for x years has impacted their cultural identity?] Do you feel connected to this culture? What do you think some of the expectations are of you as a black Caribbean man? What part

does spirituality or religion play in your day-to-day life? Were there any spiritual/ religious, or cultural beliefs that you held about the pregnancy?

2. ***How would you describe yourself before the pregnancy?***

√ **Prompts:** what were some of your hobbies/ interests? How would your loved ones and close friends have described you before your pregnancy? What would you say some of your qualities were?

3. ***How would you describe your relationship with your baby's biological mother around the time of the pregnancy?***

√ Prompts: Were you in a committed relationship before and/or during the pregnancy? Was your child's biological mother also from your same background/ culture? Did she share the same spiritual/ religious beliefs as you? Did they have any expectations of you as a father or partner?

4. ***What was the pregnancy like for you?***

√ Prompts: how did the pregnancy come to be? - was it planned or unplanned?) can you remember how you find out? what were your first thoughts and reaction? What were your initial feelings about the pregnancy? what did your community think, feel, and react? how did your family & friends respond when they found out? what did your loved ones [family, close friends, place of worship] say? (where they born in this country?). What immediate impact did the pregnancy have on you? what did you anticipate? what did you hope for? how did you prepare yourself? Was this your first pregnancy, or did you have any other children? Were there any spiritual/ religious or cultural practices that you did during the pregnancy? Why did you do this? What did you believe it would do?

The baby loss:

5. ***It would be nice to hear about your baby. Could you please tell me about them?***

√ *Prompt: had you got as far as giving them a name? Were they a girl or boy? How would you like me to refer to them throughout this discussion?*

6. ***How did you find out that you were losing your baby? (Use their name if applicable)***

√ Prompts: what happened? At what stage of the pregnancy did this happen? Was the loss sudden or expected, given your experiences during appointments? where were you when you found out? who told you? Did they ask you how you felt? what was your response to their reaction? - how did you feel? what impact did it have on you in that moment? did you have any spiritual or religious experiences around the time of the loss that you felt was connected? what happened? what did you take from this? how did it make you feel?

7. ***Do you remember what your immediate response to the loss was?***

√ Prompts: Did you have contact with any medical professionals? If yes, what was their response to you and your partner? How did you understand their response? How did they respond to your partner? Did they respond to you both differently? what was the response of the community? What impact did the baby loss have on you? how did you process the loss? Did you feel as though you were

able to come to terms with it? If yes, how did you do this? What things did you do to be able to do this? What things did you, your friends, and your community do to recognise the loss? how did you manage through this time? what impact did this have on your relationships? How did you mark the baby's passing? did you have a nine-night or a funeral? How did the child's biological mother's family respond? How did the baby loss impact your relationship with the baby's biological mother? Did the loss impact your spirituality or relationship with God? If yes, how would you say that it did? How did you make sense of the loss, culturally?

Long-term response to the loss:

8. How do you feel about the loss now?

√ Prompts: How much time has passed? What impact has it had on your life? What meaning have you taken from the loss, if any? From what you've described, it's been a difficult situation, to say the least, do you think you have found any positives from this experience? Have there been ongoing negative experiences or challenges since the loss? How did the experience of the loss impact your relationships with any other children you have/ have had since? Have you entered a new relationship since this experience? Do you feel the loss has impacted how you view future romantic relationships? do you feel that the loss has had a long-term impact on your spirituality/ relationship with your religion/ God? Has the loss impacted how you view your culture now? How did your spirituality or religion help you make sense of this loss? How did your culture influence your understanding of this experience? Do you think that the expectations of you as a black Caribbean man that you mentioned earlier impacted how you processed your loss? … How you felt in your

relationship?... How people responded to you following the loss? Looking back, do you think anyone could have done anything differently that would have helped you through this process?

9. ***Is there anything that we haven't talked about that you feel would be important to talk about?***

Debrief:

10. How have you found talking about this today?
11. What are you planning to do for the rest of the day?
12. Sometimes we have delayed reactions when talking about something that was challenging…Is there anyone that you can talk to later if you feel emotional?
13. Remind them of signposting information.

Thank you again for talking with me – It's been an honour talking to you and hearing parts of your story.

Appendix J: IPA analysis steps

Analysis stage: Experiential statements being grouped into PET's (Dan)

Figure 1: Statements in randomised order

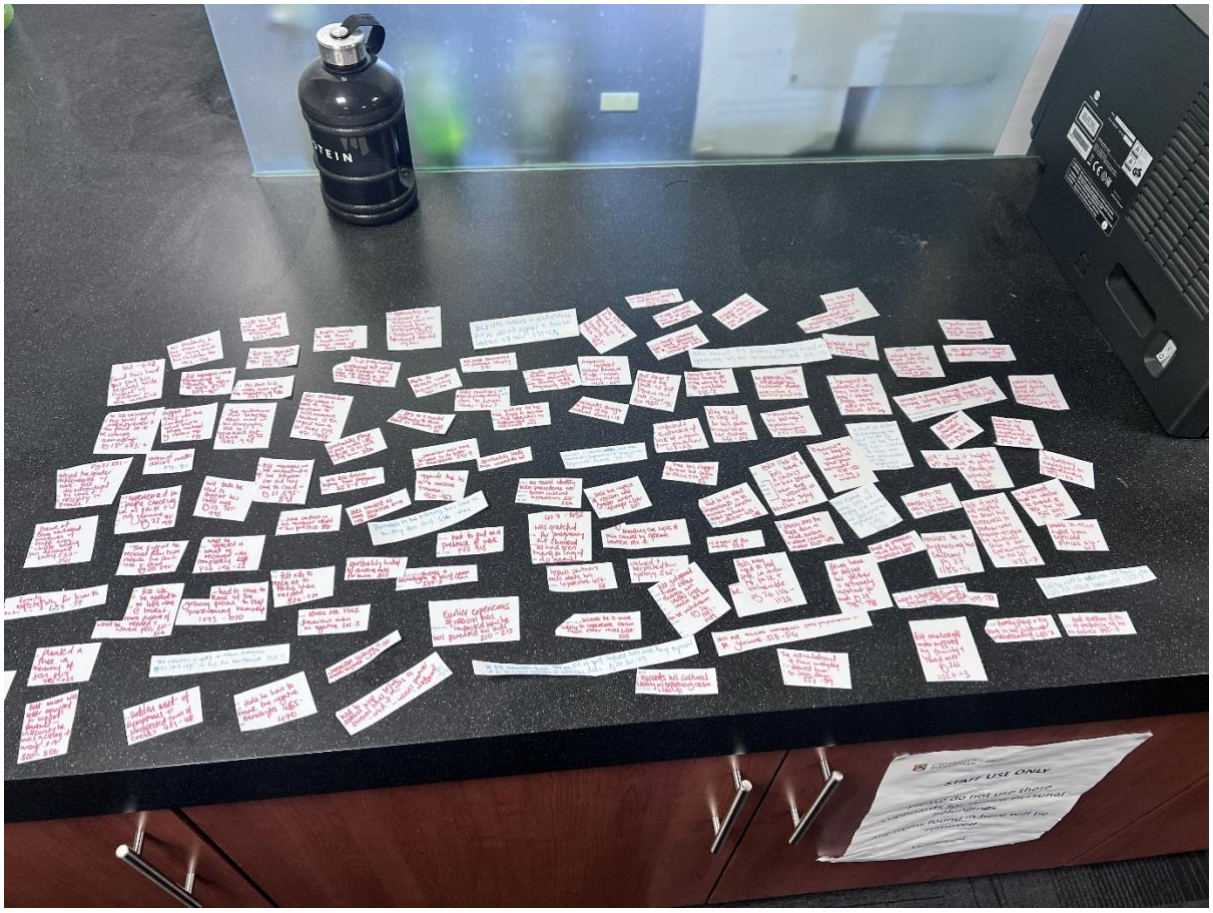
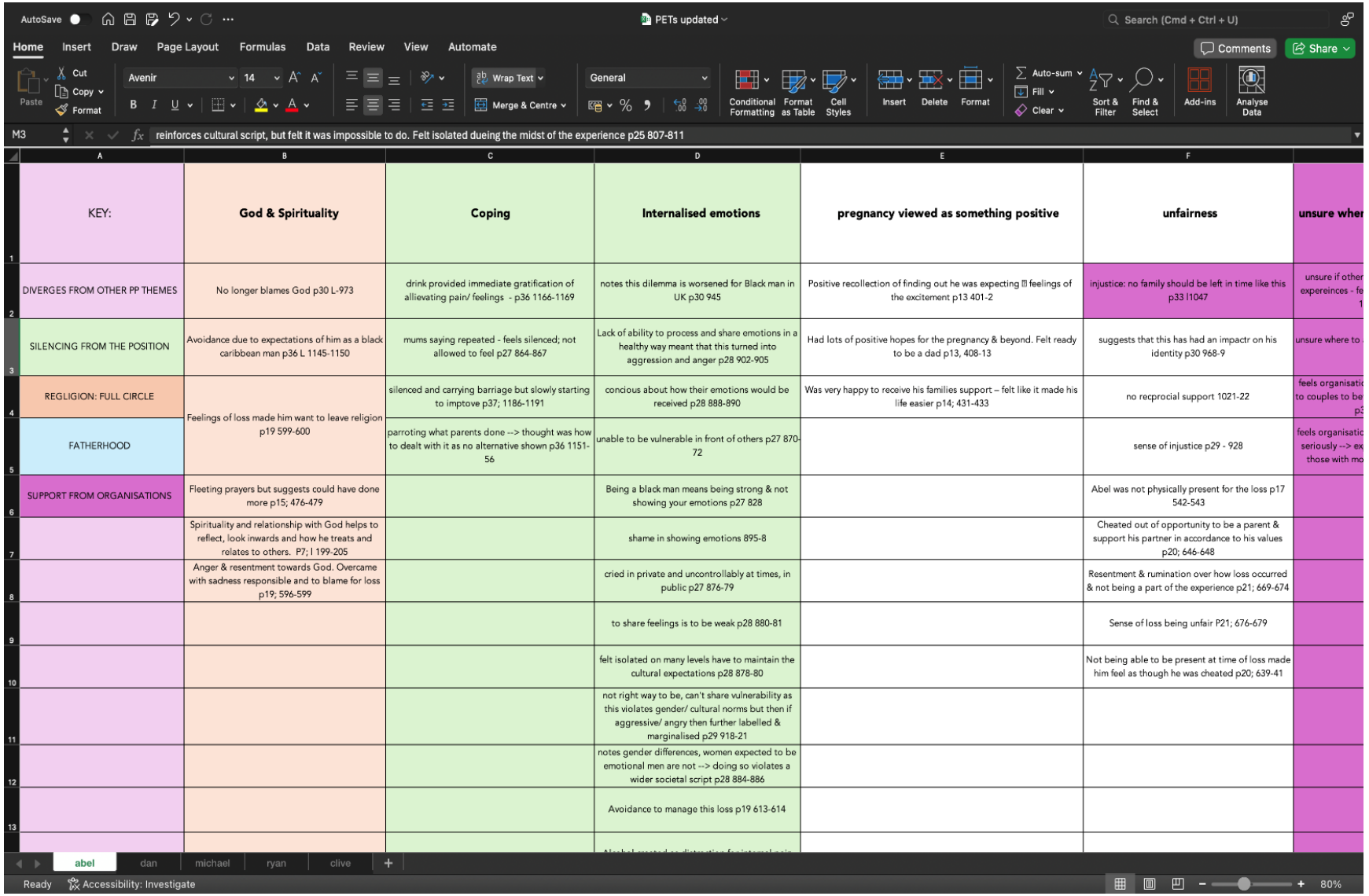


Figure 2: Statements are grouped into PETs

Figure 3: PETs being grouped to GETs



	KEY:	God & Spirituality	Coping	Internalised emotions	pregnancy viewed as something positive	unfairness	unsure wher
2	DIVERGES FROM OTHER PP THEMES	No longer blames God p30 L-973	drink provided immediate gratification of allievating pain/ feelings - p36 1166-1169	notes this dilemma is worsened for Black man in UK p30 945	Positive recollection of finding out he was expecting [illegible] feelings of the excitement p13 401-2	injustice: no family should be left in time like this p33 l1047	unsure if other expereinces - fe
3	SILENCING FROM THE POSITION	Avoidance due to expectations of him as a black caribbean man p36 L 1145-1150	mums saying repeated - feels silenced; not allowed to feel p27 864-867	Lack of ability to process and share emotions in a healthy way meant that this turned into aggression and anger p28 902-905	Had lots of positive hopes for the pregnancy & beyond. Felt ready to be a dad p13, 408-13	suggests that this has had an impactr on his identity p30 968-9	unsure where to
4	REGLIGION: FULL CIRCLE	Feelings of loss made him want to leave religion p19 599-600	silenced and carrying barriage but slowly starting to imptove p37; 1186-1191	concious about how their emotions would be received p28 888-890	Was very happy to receive his families support – felt like it made his life easier p14; 431-433	no recprocial support 1021-22	feels organisati to couples to be p3
5	FATHERHOOD		parroting what parents done --> thought was how to dealt with it as no alternative shown p36 1151-56	unable to be vulnerable in front of others p27 870-72		sense of injustice p29 - 928	feels organisati seriously --> ex those with mo
6	SUPPORT FROM ORGANISATIONS	Fleeting prayers but suggests could have done more p15; 476-479		Being a black man means being strong & not showing your emotions p27 828		Abel was not physically present for the loss p17 542-543	
7		Spirituality and relationship with God helps to reflect, look inwards and how he treats and relates to others. P7; l 199-205		shame in showing emotions 895-8		Cheated out of opportunity to be a parent & support his partner in accordance to his values p20; 646-648	
8		Anger & resentment towards God. Overcame with sadness responsible and to blame for loss p19; 596-599		cried in private and uncontrollably at times, in public p27 876-79		Resentment & rumination over how loss occurred & not being a part of the experience p21; 669-674	
9				to share feelings is to be weak p28 880-81		Sense of loss being unfair P21; 676-679	
10				felt isolated on many levels have to maintain the cultural expectations p28 878-80		Not being able to be present at time of loss made him feel as though he was cheated p20; 639-41	
11				not right way to be, can't share vulnerability as this violates gender/ cultural norms but then if aggressive/ angry then further labelled & marginalised p29 918-21			
12				notes gender differences, women expected to be emotional men are not --> doing so violates a wider societal script p28 884-886			
13				Avoidance to manage this loss p19 613-614			

Appendix K: Socio-Ecological Model of Men's Grief

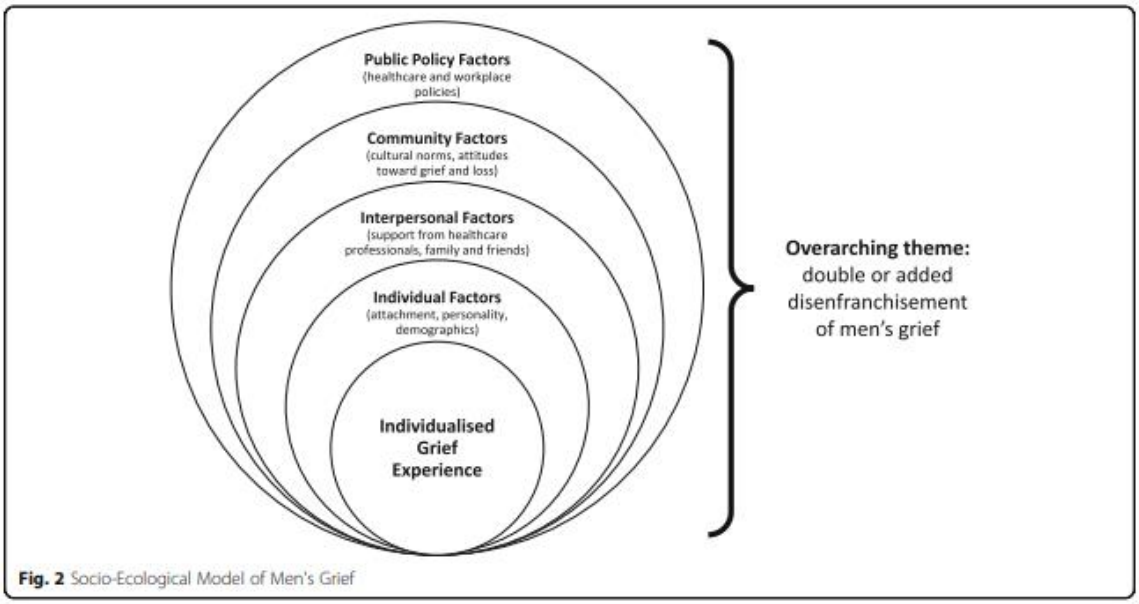
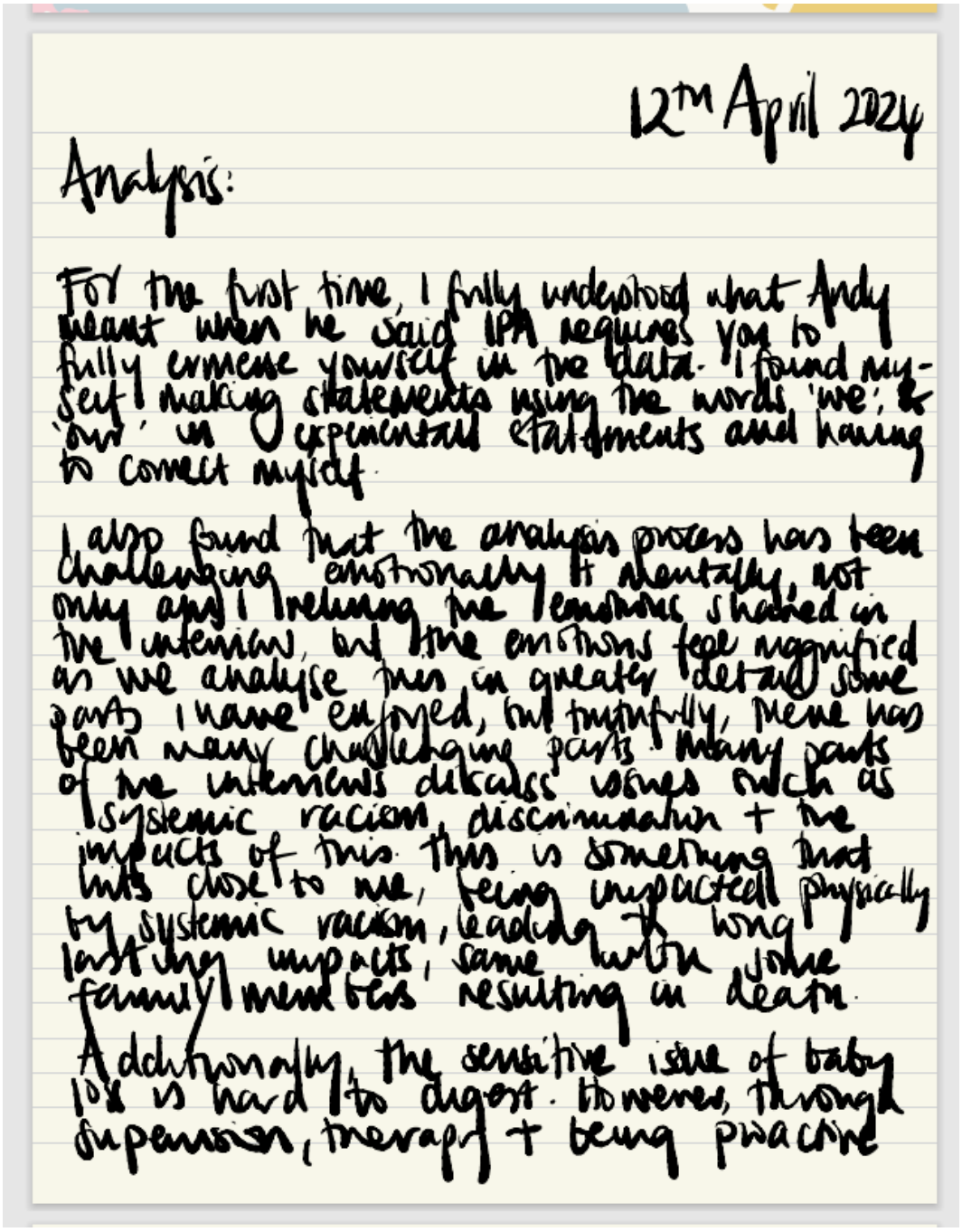


Fig. 2 Socio-Ecological Model of Men's Grief

Taken from: Obst, K. L., Due, C., Oxlad, M., & Middleton, P. (2020). Men's grief following pregnancy loss and neonatal loss: a systematic review and emerging theoretical model. *BMC pregnancy and childbirth*, *20*, 1-17.

Appendix L: Example of reflexive log entries



12TH April 2024

Analysis:

For the first time, I fully understood what Andy meant when he said IPA requires you to fully immerse yourself in the data. I found myself making statements using the words 'we', & 'our' in experiential statements and having to correct myself.

I also found that the analysis process has been challenging emotionally & mentally, not only am I reliving the emotions shared in the interview, but the emotions feel magnified as we analyse them in greater detail. Some parts I have enjoyed, but truthfully, there has been many challenging parts. Many parts of the interviews discuss issues such as systemic racism, discrimination + the impacts of this. This is something that hits close to me, being impacted physically by systemic racism, leading to long lasting impacts, same with some female family members resulting in death.

Additionally, the sensitive issue of baby loss is hard to digest. However, through supervision, therapy + being proactive

in finding things to do, I have managed to get through.
Its been a good process and I'm looking forward to running the process.

Feb : interviews.

I just had a very tough interview. The participant was v. emotive, becoming tearful at the end which made me want to cry. Lucky the interview took place on Teams so he could not see this. He also went into get depth about the visual state of his deceased babies, this was v. graphic for me. I think I'm going to talk to Lauren to reflect on this together.