

# The silent cry: A psychiatric-mental health nurse's guide for fathers experiencing perinatal loss

Mamilda Robinson<sup>1</sup>  | Courtney D. Robinson Esq.<sup>2</sup>

<sup>1</sup>Rutgers University School of Nursing, Rutgers the State University of New Jersey, Newark, New Jersey, USA

<sup>2</sup>Advanced Wellness Services, Rockaway, New Jersey, USA

## Correspondence

Mamilda Robinson, Rutgers University School of Nursing, Rutgers the State University of New Jersey, 65 Bergen Street, Newark, New Jersey 07101, USA.  
Email: [mamilda.robinson@rutgers.edu](mailto:mamilda.robinson@rutgers.edu)

## Funding information

There is no funding for the study

## Abstract

**Introduction:** The effects of grief on fathers that have experienced perinatal loss merit further exploration.

**Aim:** The purpose of this paper is to draw attention to the experience of grief felt by fathers when facing perinatal loss. A father's grief and loss are frequently unrecognized and underappreciated by healthcare professionals who customarily attend only to the needs of mothers.

**Results:** Data for this study were based on a couple's lived experience. This is a co-authored piece by a husband and wife. This literature suggests that the lack of resources for fathers might result in unresolved grief which if prolonged could be expressed in potential losses during subsequent pregnancies.

**Implications for Practice:** Content from a review of the literature provides evidence helpful in addressing the recognition and management of grief in fathers experiencing perinatal losses. The grief and any related trauma due to prenatal losses can be managed in fathers with different methods, including support services, counselling, and if needed psychotherapy and pharmacotherapy. Psychiatric-mental health nurses can play an important role in the recognition and management of grief and planning interventions to support grieving fathers.

## KEYWORDS

childbirth, coping, grief, loss, maternal mental health, trauma

## 1 | INTRODUCTION

The loss of a child at the perinatal stage is one of the most heart-wrenching losses a parent can experience (Hendson & Davies, 2018). The intensity of the grief experienced by parents can occur when witnessing the birthing of a stillborn or the loss of a newborn. It is said to be much greater than the loss of a spouse or a parent (Christiansen et al., 2013). The magnitude of such loss is often so profound that it can impede the grieving process and resolution.

Healthcare systems, like the culture at large, tend to focus attention on mothers in such situations, to the detriment of the fathers

and to families altogether (Williams et al., 2020). Even scientific research that proposes to study families sometimes examines only mothers (Gold et al., 2017). Yet for healthy grieving to occur within the entire family system, perinatal loss must also be addressed in grieving fathers.

The purpose of this paper is to highlight the lived experience of perinatal loss in a family and discuss how health professionals can approach grief in fathers. The observations come from the authors as they experienced multiple significant perinatal losses. In connection with our initial perinatal loss, we experienced medical inattention and subsequent grief-related responses during our

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial](https://creativecommons.org/licenses/by-nc/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.

© 2022 The Authors. *Journal of Psychiatric and Mental Health Nursing* published by John Wiley & Sons Ltd.



successive perinatal losses. The key lesson from this experience, which is supported by the literature and research, is that psychiatric and mental health professionals, including psychiatric-mental health advanced practice nurses, can provide needed services and support for fathers experiencing grief in response to the loss of their infant (s).

The potential problems associated with ignoring and neglecting fathers' experiences in such situations are significant and sometimes serious. The literature suggests that based upon the resources, a fathers unmanaged grief might even lead to more serious maladaptive coping and overwhelming stress. To prevent long-term problems when the loss of a child occurs careful attention by healthcare professionals should be paid to the grieving father as well as the grieving mother.

## 1.1 | Background

When the expected happy event of childbirth ends in grief and loss mothers are frequently offered various types of supportive services and mental health interventions. Though care and supervision of a grieving mother are essential, problems occur when society caters primarily to maternal grief and loss. Fathers may be experiencing the loss just as acutely.

Additionally, many fathers become caregivers for their wives during this time. These fathers can also be working to provide for their families, or they are too busy running in and out of the hospital to fulfil errands and dual responsibilities in the absence of the mother to share these tasks. The compilation of all the factors mentioned can and often does interfere with fathers receiving care after perinatal loss (Jones et al., 2019). Hence, grieving fathers often feel neglected and are left to face their grief alone. The lack of supportive intervention for their grief can lead to prolonged distress. Christiansen (2017) emphasized the need for healthcare providers of bereaved parents to be equipped with the information necessary to support grieving in couples after the loss of a child. This support can mitigate sustained grief in fathers that have experienced perinatal loss and can be the first form of defence against any risk for long-term distress.

## 1.2 | Lived experience

The lived experience described here took place over a 10-year period from 23 February 2007, until 27 December 2017. My wife and I experienced our first of five infant losses when we were a young couple and recent graduates from college.

During this experience, I felt like I was not heard; everyone was more concerned about the loss that the mother was experiencing, especially in a situation like ours, where you see the child and lose the child and then everyone expects you to be strong. Shortly after entering law school, while my wife started her nursing career, she went into preterm labour and delivered at only 22 weeks. The baby

was extremely small because it was delivered early, and the doctor informed us that the baby would need a lot of care to survive. There was no attention given to me. The doctors, nurses and even both sides of our family gave support to the mother.

Our newborn stayed in the NICU for about 100 days. During this time, the medical team consulted mainly with my wife, in part because she was the mother, but also because she had Neonatal Intensive Care Unit (NICU) nursing experience and because I was still commuting 2h away to attend law school. My wife and I had different views during the 100-day experience about how to deal with our baby's prognosis.

In my view, there was a clear divide between my wife and I as we dealt with our newborn's condition. While I was the one who saw the baby deteriorating, my wife saw our baby as a newborn fighting for his life. Everyone treated her like she was in charge because she was the one who gave birth. The doctor did not care that my view mattered as much as my wife; it was the "mother's choice." This further increased the distress that I was experiencing! Culture also played a major role in our situation, given that we are both from Caribbean-African cultures. In our culture, the man is expected to be strong. As a result, I held in all of my feelings and did not really talk to anyone other than my mother. The frustration of not being heard coupled with the realization that I was about to lose my child was unbearable. I felt empty and hopeless given that my partner whom I looked to for comfort seemed to be far drifted apart from me. In fact, it seemed like she was my enemy. I found it very distressing to see my child experience such an ordeal yet had no control regarding his outcome. I felt cheated throughout the entire ordeal. Moreover, I felt disrespected and ignored as my opinion did not matter, even though I was and still am the father of our child.

My wife recounts her experience with our baby's hospitalization: "During the critical period of our baby's hospitalization, we were not on the same page with the doctor's recommendation to "pull the plug" on the baby. My husband agreed, but I refused, believing that the fervent prayers of many people would help our baby to survive. He stated that he "could no longer continue to see his son go through this." While I pleaded with God, my husband assessed the facts and statistics and sided with the doctors' view that they should give comfort care and "pull the plug," because the care being provided was futile. Since we were not in agreement, the hospital could not proceed with this course of action without conducting an ethical hearing. During the hearing process, our son sustained five cardiopulmonary arrests, and the ethical hearing could not continue. Our baby passed away in our arms on 31 May 2007, after 100 days in the NICU."

After this initial perinatal experience, we underwent a thorough reproductive evaluation with a reproductive endocrinologist. All the tests showed that we were a healthy and fertile young couple that could have another baby as soon as possible. However, my husband insisted that he did not want children despite his general love for children. This was the first indication that the loss of our baby could have more lasting effects. The risks of prolonged grief increased as we lost two more pregnancies. These were the second-trimester loss of our baby girl who was stillborn at 20 weeks as well

as a first-trimester loss. I felt that my husband no longer wanted to be with me. Despite his frustration, I knew he still wanted children.

One day, after much inquiry, my husband finally said:

"I love children, but I cannot bear to see my children go through so much and then lose them. The best thing to do is to stop making attempts to have more children. I will live vicariously through my nieces and nephews." Then, he asked, "How do I know that if we got pregnant again, this would not happen?" Though of course, I could not predict the future, I assured him that we would have a full-term pregnancy. He remained sceptical. As he describes it: "After the third loss, I thought that it was not something that was meant to be. However, I left it up to [my wife] to decide if she wanted children, and I participated."

Despite our previous experiences, we successfully became pregnant and delivered an 8-pound 3-ounce baby boy, on 28 August 2011, 5 years after our first child. Later, we unfortunately sustained two more first-trimester losses. Still on 27 December 2017, we gave birth to another baby boy, and he weighed 6 pounds 14 ounces. Our family grew in the midst of our coping with our memories from multiple losses.

We did not endure this ordeal entirely without help. Because of the initial profound loss and our differing responses, it took a toll on our marriage, and we immediately sought counselling.

I recognized that it was my duty to be there for my wife; however, it did not seem that the same was reciprocated. Sometimes, I wondered if we had the same goal in mind. Due to our differences in perspectives of the outcome of our child, we drifted apart. I sought comfort where I could find it while she sought comfort in religion and her side of the family."

While couples therapy helped us to reconnect and ultimately enabled us to move forward with having a family, it did not address the ways that shortcomings in the healthcare system contributed to our losses and grief. A lack of support from healthcare professionals exacerbated my ongoing grief during and after the birth of our child.

The inattention of medical personnel to my experience contributed to my distress. The repetition of losses and lack of empathy and attention of the healthcare provider teams inspired us to explore the consequences of unresolved grief and loss in fathers.

### 1.3 | Implications

The above experience underscores the importance of receiving attention and care at the onset of perinatal loss. Once support and attention were received, I was able to verbalize my fears and to give childbirth another chance. What is unique about our journey was the number of losses we endured and over such a long period of time.

Our reflections on these experiences caused us not to underestimate such magnitude of grief. When a baby dies, the mental schema containing everything a person assumes to be true about the world and themselves from previous experience also dies. It is an incredibly troubling psychological event for parents, involving

intense fear, helplessness and horror that a child has pre-deceased the parent. Regardless of the gestational length of the pregnancy, these feelings can persist for both parents. The situation of perinatal bereavement can be complicated by the fact that, for both parents, the primary person to whom they would turn in times of crisis may be too distressed to provide support. There may also be differences between partners in the ways they cope with their loss, which might add to individual distress and lead to marital strife.

This tragic phenomenon could potentially change parents' perceptions of pregnancy forever if feelings of grief are left unresolved. Although not always the case, prolonged distress can occur (Christiansen, 2017; Christiansen et al., 2014).

As time passed after the event, we just learned to cope with it. Because much of what happens at the time of delivery resembles the circumstances of the initial loss, it can be difficult for parents to repeat the experience of prenatal care, labour, and the birthing process without the stimulation of painful memories (Hendson & Davies, 2018). Rather than being a time of joy, expectation and a new beginning, the subsequent pregnancy can trigger fear and anxiety and can remind parents that death is a possible outcome.

We were scared the same thing would happen, so we tried to protect our emotions. We developed an attitude that "bad things will likely come, so we made sure never to get overly excited. We would always consider negative possibilities or outcomes regarding the situation."

To minimize the effects of such catastrophic thinking, it is important that prompt intervention is initiated at the outset of perinatal loss to manage current loss and grief as well as prepare parents for possible subsequent losses (Morris et al., 2018). Positive contacts with healthcare professionals have an impact on how well both parents are able to cope with the loss and their related distress and loss related to grief (Abboud & Liamputtong, 2005).

Providing initial care for perinatal loss is especially beneficial for fathers since they might mask their feelings because of culture or competing demands on their time and attention. The full range of a father's grief reactions may not be understood because most measurements of grief focus on feminine emotions of loss (Jones et al., 2019; Obst et al., 2020). Also, data on fathers are less plentiful but fathers initially seem to experience less distress than mothers following perinatal losses (Christiansen, 2017). Fathers have reported feeling worried as they approach subsequent pregnancies but mask their stress to stay strong for their wife and the rest of the family.

After the event, I was looked at as a comforter, instead of someone who needed comfort.

Therefore, it is necessary that fathers are more carefully assessed since they might not express their grief and distress often. Fathers also report being concerned about the chances of having a child with disabilities and have been shown to have higher trait anxiety scores than fathers who have not sustained a loss (Jones et al., 2019). Overall, when data are adjusted, there are more similarities than differences between mothers' and fathers' responses to perinatal loss (Christiansen et al., 2014). While these similarities



exist, it is unknown whether the same support services would be helpful to fathers.

### 1.4 | Long-term mental health risks of unresolved grief

When left untreated, prolonged grief can become debilitating, complex and persistent. Estimates of the proportion of parents experiencing complications vary between 5% and 20% (Morris et al., 2018). Several factors complicate the parents' grief after a baby has died. Often the loss of a baby is unexpected, sending both the parents into a state of emotional shock and rendering them unable to recognize or request the personal help they need (Christiansen, 2017). Any depression and anxiety experienced can complicate grief. A nurse can distinguish between depression and grief reactions with careful assessment. While they share many common characteristics such as feelings of sadness, insomnia and poor appetite, strategic questioning reveals significant distinctions between grief and loss.

In the experience of guilt, the experience centres around the death of the loved one and thoughts of death that involve the desire to be reunited. On the contrary, depression is associated with more global feelings of worthlessness and in some instances even suicidal thoughts (Christiansen, 2017).

When the loss is sudden, unanticipated, or resulting from trauma, other complications can arise. Individuals often feel overwhelmed, unable to cope, incapable of comprehending the loss, and may see the world as incredibly chaotic. Utilizing appropriate measures to address crisis supports cohesive clinical intervention while promoting safety and resilience for persons that have experienced a traumatic event. Treatment incorporating trauma-informed principles—namely, promoting safety, trustworthiness and transparency, fostering collaboration and mutuality, supporting empowerment, choice and control, providing opportunity for peer support, and generating awareness and responsiveness to cultural, historical, and gender issues is needed. This is highly warranted when dealing with sudden, unexpected grief such as the loss of a child (Nizum et al., 2020).

## 2 | INTERVENTIONS

Grief due to prenatal losses can be managed in fathers with different methods than those used for mothers. Support services, psychotherapy and pharmacotherapy when warranted may be used to treat the complications of grief (Sadock & Sadock, 2015).

### 2.1 | Support services

Support services can be provided by the treating clinician, clinical staff and loved ones at the early stage. These types of services for

mothers can include remaining at the patient's bedside, maintaining their comfort and providing them with referral sources. Often, mothers are offered clergy services, as well as the option to see a mental health clinician. Some institutions provide practitioners with screening tools to determine the possibility of postpartum depression. Healthcare services should ensure that fathers are also offered services during empathic face-to-face interactions or direct contact via telephone based upon their preferred channel of communication. As a result, fathers will receive an equal opportunity to benefit from support services.

### 2.2 | Mental health services and psychotherapy

Compared to the mothers, fathers who have sustained losses experience more delayed grief reactions up to 12 years (Jones et al., 2019). Therefore, ongoing evaluation and counselling is an indispensable component of treatment. Especially in the event of any subsequent pregnancies, the availability of psychotherapy is essential to fathers maintaining their mental health. Psychodynamic therapy may be especially useful in the treatment of many patients with sustained grief.

### 2.3 | Pharmacotherapy

Initial supportive therapy may be supplemented with medications. Given their efficacy, tolerability and safety, the selective serotonin reuptake inhibitors (SSRIs), such as sertraline (Zoloft) and paroxetine (Paxil), are preferred in the first-line treatment of more serious clinical presentations. The SSRIs reduce symptoms from all the trauma related to grief symptom clusters and can improve symptoms unique to grief and trauma besides those of depression or other anxiety disorders. Buspirone (BuSpar) is serotonergic and may also be useful.

## 3 | ROLE OF THE PSYCHIATRIC-MENTAL HEALTH NURSE

The role of psychiatric-mental health nurses (PMHNs) in the care of fathers experiencing immediate and prolonged grief is important. Nurses have an opportunity to recognize and respond to the genuine needs of the father for mental health support. The role of the PMHN is to carefully assess the grieving father as he may present differently than mothers at this time. The PMHN is in a position to listen, interpret and comfort the parents during the time of intense grief. Therefore, psychiatric-mental health professionals must be very strategic in addressing all aspects of care involved with fathers experiencing perinatal loss.

The PMHN, along with other healthcare providers such as psychiatric social workers and advanced practice nurses (APNs), should educate staff involved in the care of fathers and provide support



and referral sources for staff that may have difficulty providing grief care. Trauma-informed approaches could be applied for grieving fathers (Nizum et al., 2020). The most beneficial commodity that a healthcare professional can offer to a grieving family is a nonjudgmental, deep sense of caring and personal involvement. As the most important second phase of the interaction, the PMHN could offer resources and provide referrals to the appropriate mental health providers if needed (Hendson & Davies 2018).

Because of the emotional demands surrounding caring for families' nurses might feel the need to distance themselves from the grieving mothers and fathers. They may feel inadequate to deal with the immense psychological pain and loss expressed by parents (Hendson & Davies 2018). Nonetheless, caring for bereaved patients is an essential aspect of the calling of nursing. For nurses to give optimal care, they need peer support, education and experience with the care that is needed. They also need effective and appropriate coping strategies to deal with the stress that results from providing high-quality care, compassionate communication and support to families through the crucial perinatal period (Hendson & Davies, 2018).

## 4 | CONCLUSION

The loss of a child is a devastating event that severely disrupts the lives of parents and families for many years. While mothers are often given support and medical interventions, health professionals can help by making sure to provide early support and mental health intervention for fathers that have sustained perinatal loss. Special attention should be given to the entire course of multiple losses as appropriate. An integrated healthcare model with perinatal nurses and psychiatric-mental health nurses along with maternal-child health staff can be developed to promptly identify and address fathers that have experienced perinatal loss. The PMHN, along with the psychiatric-mental health APN, would address the needs of fathers who are experiencing the trauma of grief in the wake of perinatal loss. Prompt and skilful intervention can decrease the intensity of distress and trauma while promoting healthy grieving over time. The ultimate goal is to buffer parents' initial trauma and prevent any further prolonged distress.

### CONFLICT OF INTEREST

I have no knowledge of any conflicts of interest associated with this study, and there has been no financial support for this work that could have influenced its outcome. As corresponding Author, I grant consent for submission of this manuscript.

### DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

### ETHICAL APPROVAL

Ethical approval is not required for the study.

### ORCID

Mamilda Robinson  <https://orcid.org/0000-0003-2731-6753>

### REFERENCES

- Abboud, L., & Liamputtong, P. (2005). When pregnancy fails: coping strategies, support networks and experiences with health care of ethnic women and their partners. *Journal of Reproductive and Infant Psychology*, 23(1), 3–10. <https://doi.org/10.1080/02646830512331330974>.
- Christiansen, D. (2017). Posttraumatic stress disorder in parents following infant death: A systematic review. *Clinical Psychology Review*, 51, 60–74. <https://doi.org/10.1016/j.cpr.2016.10.007>
- Christiansen, D., Elklit, A., & Olf, M. (2014). Parents bereaved by infant death: sex differences and moderation in PTSD, attachment, coping and social support. *General Hospital Psychiatry*, 36(6), 655–661. <https://doi.org/10.1016/j.genhosppsy.2014.07.012>
- Christiansen, D., Elklit, A., & Olf, M. (2013). Parents bereaved by infant death: PTSD systems up to 18 years after the loss. *General Hospital Psychiatry*, 35(6), 605–611. <https://doi.org/10.1016/j.genhosppsy.2013.06.006>
- Gold, K., Leon, I., Boggs, M. E., & Sen, A. (2017). Depression and post-traumatic stress symptoms after perinatal loss in a population-based sample. *Journal of Women's Health*, 25(3), 263–269. <https://doi.org/10.1089/jwh.2015.5284>
- Hendson, L., & Davies, D. (2018). Supporting and communicating with families experiencing a perinatal loss. *Pediatrics & Child Health*, 23(8), 549–550.
- Jones, K., Robb, M., Murphy, S., & Davis, A. (2019). New understanding of fathers' experiences of grief and loss following stillbirth and neonatal death: A scoping review. *Midwifery*, 79, 102531.
- Morris, S., Fletcher, K., & Goldstein, R. (2018). The grief of parents after the death of a young child. *Journal of Clinical Psychology in Medical Settings*, 27, 321–338.
- Nizum, M., Yon, R., Ferreira-Legere, L., Poole, N., & Lulat, Z. (2020). Nursing interventions for adults following a mental-health crisis: a systematic review guided by trauma-informed principles. *International Journal of Mental Health Nursing*, 29(3), 348–363.
- 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(11), 11. <https://doi.org/10.1186/s12884-019-2677-9>
- Sadock, B. J., & Sadock, V. A. (2015). *Kaplan and Sadock's synopsis of psychiatry* (10th ed.). Lippincott, Williams & Wilkins.
- Williams, H. M., Topping, A., Coomarasamy, A., & Jones, L. (2020). Men and miscarriage: A systematic review and thematic synthesis. *Qualitative Health Research*, 30(1), 133–145. <https://doi.org/10.1177/1049732319870270>

**How to cite this article:** Robinson, M., & Robinson Esq., C. D. (2022). The silent cry: A psychiatric-mental health nurse's guide for fathers experiencing perinatal loss. *Journal of Psychiatric and Mental Health Nursing*, 29, 619–623. <https://doi.org/10.1111/jpm.12849>