Article

"It Is Not Something You Can Easily Forget": Ghanaian Parents' Experiences of Child Loss

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Grace Owusu Asare[1], Francis Annor[1] and Joana Salifu Yendork[1]

Abstract

The loss of a child comes with trauma, which affects parents and the entire family. Yet, there is limited support for parents who lose their child and little empirical research has been devoted to the experiences of parents who lose a child in the Ghanaian context. Based on interviews with 20 participants purposively sampled from the Accra Metropolis, this study explored parents' psychosocial experiences of child loss using a qualitative approach. The study's findings indicated that bereaved parents showed signs of complicated grief and experienced spousal neglect, self-blame, and emotional pain. Bereaved parents may become sensitive to child comments years after child loss. The quality of interaction after child loss influences how parents experience the loss. Findings underscore the need for a joint effort by government and other stakeholders in the health sector to address issues related to child loss and provide improved services to those who suffer child loss.

Keywords

grief, bereavement, prenatal loss, perinatal loss, postnatal loss

[1]Department of Psychology, University of Ghana, Accra, Ghana

Corresponding Author:
Francis Annor, Department of Psychology, University of Ghana, Accra, Ghana.
Email: fannor@ug.edu.gh

Child loss can be conceptualized in three forms; prenatal, perinatal, and postnatal (Bardos et al., 2015; Regan & Rai, 2000). Prenatal loss, commonly referred to as sporadic abortion, is characterized by spontaneous expulsion of the fetus before it reaches any viable age (Bardos et al., 2015; Regan & Rai, 2000). According to the United Nations International Children Emergency Fund (UNICEF), a death that happens after the fetus has attained a viable age is known as perinatal death (United Nations Inter-Agency Group for Child Mortality Estimation, 2018). Perinatal death consists of neonatal death and stillbirth. Neonatal death happens when a baby dies within the first seven days of birth. Stillbirth, on the other hand, happens when a baby is born without any sign of life or dies after 28 weeks of gestation (World Health Organization [WHO], 2018). The death of a child who is beyond a week old and up to five years old is classified as postnatal death (WHO, 2018). All the types of child loss discussed will be referred to throughout this paper.

Child loss is a traumatizing event for any family to experience because it is often abrupt and unexpected, and mostly truncates the attachment developed between the child and parents (Ainsworth & Eichberg, 1991). The loss of a child likely creates physical and emotional vacuum in the family, which has short- and long-term implications for the functioning of the family as they adapt to the loss (Dyregrov, 1990). In the short-term, child loss leads to intense strain on communication in the household as parents and siblings are unable to talk about the loss (De Montigny et al., 1998). Schwab (1992) also reports disruption in couples' sexual relationships after the death of a child. Additionally, child loss can take a toll on the extended family, as grandparents, for instance, have been reported to grieve not only for their departed grandchildren but also for their bereaved children (De Montigny et al., 1998).

Child death not only creates a vacuum in the family, it also leaves parents with psychological effects (Attachie, 2013). Following the loss of one's child, a parent may experience emotional distress (Denckla et al., 2011; Nolen-Hoeksema, 1991). Grieving individuals may express a decreased energy and activity while they withdraw themselves from all social contacts (Bonanno & Kaltman, 2001). Most women live with depression as well as anxiety years after delivering a stillborn (Attachie, 2013). Anxiety has been found to be high in women who have suffered miscarriage before or during the first trimester, as fear of losing a child again becomes a threat that produces anxiety (Kinsey et al., 2015). Betz and Thorngren (2006) found that women who miscarried underwent mental mishaps similar to losing a close relative, which is sometimes carried into the next pregnancy. The emotional loneliness and pain left by the loss of a child may trigger grieving responses.

Grieving is an active process of working through one's emotional pain (Kübler-Ross & Kessler, 2005). According to Kübler-Ross and Kessler (2005), one must navigate successfully through a series of stages to achieve closure from the loss of a loved one. One may experience denial, aggression towards oneself

or the departed, ask questions, mourn, and then finally accept the death of the deceased (Kübler-Ross & Kessler, 2005). Conventionally, the grieving process begins with a period of high or acute distress which progresses to a lower state of distress over time (Van Baarsen, 2002). Mostly, those who have lost their spouses or children are unable to resolve the internalized representation of the deceased to incorporate the reality of death (Newson et al., 2011). Failure to accomplish this task results in complicated grief (Shear & Shair, 2005).

Grief expression can have both emotional and economic impact on their sufferers. Grief may erupt emotional problems such as denial, feelings of unpreparedness to face the painful experience, anxiety for subsequent pregnancies, guilt, and depression, among others (Denckla et al., 2011). Studies suggest that mothers who lost their children sometimes experienced complicated grief especially during the first year of the loss (Christiansen et al., 2013). Grieving is termed complicated when it transcends six months after the death event (e.g. Newson et al., 2011; Prigerson et al., 2013; Rando, 1993). Symptoms of complicated grief include, anger, hatred, guilt, sadness, and psychosomatic pains. Economically, the combined effects of mental problems and mortality issues associated with child loss can negatively impact a nation's productivity. Therefore, not only does child loss task the bereaved emotionally, it also takes a toll on the economy of the nation in general.

Globally, although significant efforts have been exerted by world leaders to reduce child death (Wardlaw et al., 2014), the prevalence of child loss remains high (Volgsten et al., 2018), hence the need for continued research in the area. For instance, globally, it is estimated that 5.4 million children under five years of age died in 2017, with nearly half of the deaths occuring within the first month of life (United Nations Inter-agency Group for Child Mortality Estimation, 2018).. More than 2.7 million babies are born still worldwide each year (Burden et al., 2016). Moreover, the general prevalence of miscarriage or spontaneous abortion is estimated to be between 10 to 20% of all pregnancies (Cohain et al., 2017).

Africa is the continent that records most of the numbers globally (WHO, 2018). Sub-Saharan Africa, presently records about 77 deaths out of every 1000 live births; this is almost eight times higher than the 9.6 per 1000 under-five deaths in Europe (WHO, 2018). Some countries in Africa record as high as 100 deaths to every 1000 live births (WHO, 2018). In Ghana, estimates suggest annual under-five mortality rate of 90 deaths per 1000 live births and infant mortality rate of 59 deaths per 1000 live births (Ghana Statistical Service, 2014).. Furthermore, the Healthy Newborn Network (2016) suggests that 22 stillbirths out of 1000 live births are recorded in Ghana annually. The high prevalence of child loss, especially in Ghana, makes it necessary to research into how child death affects individuals and families.

In Ghana, the psychological experiences of bereaved parents have received little empirical attention. Bawah et al. (2019) researched into the economic

impact of child loss. In their intervention study, they proposed that the presence of nurses in poor communities would not only prevent child loss, but will also close the poverty gap. Attachie's (2013) study on the psychological experiences of parents who experienced stillbirth in Ghana suggests that mothers experienced depression and anxiety after stillbirth. Osei-Mensah (1999) also noted the importance of funerals in grieving and recuperating. Children who die in Ghana may receive a cursory to no funeral at all. This apparent lack of social support can increase the pain bereaved parents go through. Given the adverse economic, psychological, and emotional impact on individuals and the country, coupled with the scarcity of studies on this subject, this study will map the experiences of parents, both mothers and fathers, on prenatal, perinatal, and postnatal loss. Findings will be beneficial in designing interventions to address the emotional, psychological, social, and economic aftermath of child loss.

The study draws on the five stages of grief proposed by Kübler-Ross and Kessler (2005). In navigating grief one must successfully transvers through a series of stages to achieve closure from the loss of a loved one. One may experience denial, aggression towards oneself or the departed, ask questions, mourn, and then finally accept the death of the deceased (Kübler-Ross & Kessler, 2005). The following research questions were addressed: 1) what are bereaved parents' experiences of child loss? and 2) what influence parents' expression of pain following child loss?

Methods

Design and Participants

A descriptive qualitative approach was used to explore Ghanaian parents' experiences of child loss. This approach best suits studies that focus on exploring the lived experiences of phenomena (Bradshaw et al., 2017). The current study sought to explore in-depth what bereaved parents go through when they lose a child. The exploration of these experiences is based on the severed connection between a parent and their child and how parents undergo grief in Ghana. This approach is relevant because information is needed directly from participants (Bradshaw et al., 2017). Qualitative designs provide information about people's subjective experiences of an event and their reasons for doing so (Colorafi & Evans, 2016).

The current study was undertaken in the Greater Accra region, a cosmopolitan area. Parents who had experienced child loss, at some point in their lives, but not beyond 8 years were selected through purposive and snowball sampling. Twenty (20) individuals who had experienced prenatal, perinatal, and postnatal loss participated in the study. The participants were aged between 24 and 60 years, and most ($n = 18$) were women. About half of the participants ($n = 11$) were married; the remaining participants were either single or

cohabiting. Participants were sampled from various educational backgrounds, including those who had never attended school to tertiary leavers. Again, participants were of various ethnic groups as well as religion. There were nine participants with experience of perinatal loss, eight with experience of prenatal loss, and three with experience of postnatal loss.

Procedure

The study took off after the researchers gained ethics clearance from the University of Ghana's Ethics Committee for Humanities (ECH: 017/18–19). We also obtained permission from the management of three health facilities (one public hospital and two private hospitals) to meet potential participants. Participation in the study was entirely voluntary. Participants were briefed about the requirements of the research and were informed of their autonomy to quit at any point without any reason. Face-to-face semi-structured interviewing was conducted with each participant with the aid of an interview guide. The semi-structured interviewing provided flexibility to probe accounts of parents. Among others, questions on the interview guide required participants to narrate events prior to their loss and after the loss as well as their experiences of the loss. The interviews lasted between 15 minutes and 3 hours with an average duration of 55 minutes. With the permission of the participants, the interviews were audio-recorded with a digital audio recorder. In the course of interviewing, the emotional state of the participant was considered throughout the process. Where participants cried for more than two minutes, the interviewer asked if they were willing to continue. This was to ensure that participants were not brought to any psychological harm in the process of collecting data.

Trustworthiness

In the current study, Shenton's (2004) criteria for ensuring trustworthiness were followed to deal with issues of reliability and validity. Credibility was ensured by documenting initial codes to enable revisiting and checking in the course of time for stability. Again, ethical protocols, such as informed consent and assurance of confidentiality were adhered to. This was done in order to allow participants the freedom to provide reliable responses. Pseudonyms were also used in the reporting of findings to conceal the identity of participants. To ensure transferability, interviews were recorded, transcribed, and read over several times. This allowed for familiarization of data and the production of thick descriptions of phenomena. Confirmability was also ensured by involving all the authors in the analysis thereby limiting the possibility of an individual's views dominating the interpretation of participants' responses. Finally dependability was addressed by evaluating the effectiveness of the processes being used in the current study. Dependability tests the rigorousness of the methods selected for a study.

Data Analysis

The interview data were analyzed using thematic analysis. Braun and Clark (2006) recommended phases of thematic analysis which included getting familiar with the data, generating initial codes, searching for themes, reviewing of themes, and then writing a report were followed. The first author transcribed the interviews, read and re-read the transcripts over again under the supervision of the co-authors. This process allowed for the immersion of researchers into the data. Initial codes were generated, followed by detailed description and classification of the codes. Texts that had similar codes were compared across interviews, after which meanings were formulated to produce potential clusters of themes. Identified themes were then defined and labeled in accordance with the essence of themes and their relation to the research questions. Finally, themes were then interpreted in light of research questions and empirical findings.

Findings

Four broad themes capture participants' experiences of child loss. These themes include emotional experiences, social experiences, psychological experiences and economic experiences. The themes are explicated in the succeeding subsections.

Emotional Experiences

This theme reflects parents' emotional experiences such as sadness, emotional pain, reliving the loss and anger. Almost all the parents ($n = 18$) reported one or another form of emotional experience. Most of these parents were those who had suffered perinatal and postnatal loss.

Emotional pain: Most of participants ($n = 14$) reported experiencing emotional pain following child loss. When probed, most parents could not describe the feeling, but were certain of experiencing emotional pains. Bereaved parents may experience this negative feeling due to the distress that accompanies child loss. Parents expressed pain by their inability to say that their child had died. Rather they used figures of speech and proverbial language. To some parents, nurses' attempt to cover up the incident added to their emotional pain. Parents told their stories as:

> The first one (perinatal loss) was very painful, because you have given birth, you have been with the child all night, . . . and the following morning you have to inform your family that the child has gone back (died). (Mansa, two perinatal losses, one prenatal loss)

> I knew that it was their fault, the nurses, it was their fault and they tried to cover it up. They destroyed all our documents. By the time we went for our records there was nothing of the child, empty folder. . . . That also added to the pain. (Mensah, one perinatal loss)

However, the source of emotional pain seemed to vary for the various types of child loss. Parents who had experienced miscarriage hinted that their emotional reaction was due to embarrassment, especially the ones that happened in the open. For example, two parents who experienced miscarriage said:

> I did [become sad], especially the market experience, the disgrace and all. Even the other two [miscarriages], I did not feel that much sadness (Beturia, three prenatal losses).

> Had the doctor attended to me when the little blood came, I would not have lost the pregnancy. There was blood everywhere and everyone was staring at me . . . (Bissu, one prenatal loss)

Parents who experienced perinatal loss sourced their emotional pain from going through the physiological pain of labour, having the baby and losing it. For example:

> . . .child birth is hard so if you give birth and you don't get the child, it's painful. Even if you already have a child, it's painful but if you don't, it's very painful (Thelma, one perinatal loss)

> Consider all the pain you go through during pregnancy, and when it's time to deliver, the pains you go through it's not easy. After you give birth and you are shown your baby, all the pains vanish. You get some sense of joy. So when you are told that you have lost the baby, it hurts. You feel the pains. It's painful. (Dina, one perinatal loss)

Lastly, parents who experienced emotional pain following postnatal loss attributed their pain to the manner of suffering their children had to endure before passing away, as reflected in the following quotes:

> It wasn't easy. If I remember the manner of suffering the child had to endure, it wasn't easy . . . I can't express it, it wasn't easy (Afi, one postnatal loss)

> As I looked at my daughter who had done nothing wrong suffering from illness. I couldn't bear the pain. I wish I could trade places with her . . . her stomach bloated and nothing we did helped. (Mudraka, one postnatal loss)

Crying/Sadness. Crying was bereaved parents' way of letting out emotional pain. Distressed parents cried or became sad in response to the loss of their child. This response may probably be intensified by the feelings of helplessness that death brings. Parents' perception of loss and feelings of helplessness may

illustrate the intensity of their expression of distress through crying, as one participant put it:

> . . . In fact, I cried a lot. . . .I cried very much. I really cried. I cried till I was tired but I couldn't do anything about it (Mudraka, one postnatal loss).

Afi, who had also experienced a postnatal loss said:

> It was a difficult time for me. I spent most of my day crying. If the tears could bring her back, she would have been alive by now.

Likewise, Mansa, who had experiences of two perinatal losses and one prenatal loss, had this to say about her emotional experiences:

> In fact I really cried, that the strong child I had given birth to the night before which I had pushed and given birth to, she had laid on my arms, how could you tell me that she has passed away? . . . It really hurt me. It hurt me.

A few parents ($n = 4$) reported varying forms of physiological changes such as loss of appetite and insomnia, which were related to their experience of sadness that followed their loss. Parents who became overwhelmed with grief lost appetite and became spaced out as well. The following extracts capture such experiences:

> After I lost my baby and returned home, I used to cry but my mothers would speak with me. Then I felt pains in my neck, I didn't even know where my mind wandered. Even, I wouldn't eat anything I was offered (Thelma, one perinatal loss).

> I wouldn't eat anything, lost appetite. I didn't see the point of anything. I didn't understand why everything was there and my baby was not. (Mercy, one perinatal loss)

Reliving the Loss. For some parents, time did little to heal the pain that accompanied the loss. These parents recounted their experiences of reliving the loss. Cues for recall included the sight of children on their way to or from school, children who were born around the time they lost theirs, and the hospital card or pictures of their child. The sight of these cues reignited the pain that accompanied the loss. The pain from child loss is not something parents forgot easily. For example:

> Till date, whenever I pick the hospital card when I was pregnant, I become sad. Since then (begins to cry) I made my mind not to give birth again so I did family planning for 5 years (Dora, one perinatal loss).

> . . . Because, my friends, those I got pregnant with, whenever I see their children, it reminds me of mine (loss). Even those I was visiting the hospital with them, they had gotten their children, so whenever I see them (the children) I start to cry. . . . It is not something you can easily forget, regardless of how many children you give birth to . . . (Georgina, one perinatal loss).

> . . .Late in the night, when it is quiet and you are alone, and you reminisce how you woke up to feed the previous babies how they would cry, but this one did not make it, and maybe you see some cot sheets and other things, you pick them up and (voice lowered) the pain comes back (Kukuwaa, one perinatal loss)

Anger/Hate. Some parents ($n = 7$), particularly those who ascribed external reasons for their loss, expressed feelings of anger and hate in response to the loss. Parents' anger was directed at the perceived cause of their loss. Parents who suspected that nurses were the cause of their loss directed their anger towards the nurses. These parents also expressed hatred for medical practitioners in general. For some parents, the anger and hatred towards medical practitioners as well as the medical facilities where the loss occurred lingered several months and years, even after giving birth to children after the loss. One parent described how she continued to avoid the health facility where she experienced the loss saying:

> (Till date) when I get to [that] hospital, I just pass by it. . . . I do not consider it (hospital) as anything good . . .I see the whole thing as rubbish (Mercy, one perinatal loss).

Other participants shared their experiences in the following quotes:

> . . . I hated that woman [nurse] very much. Before the incident (loss) happened when you go there, they won't give you a face; they will treat you like garbage. Now after you (midwife) killed our son, you've come to apologize (Mensah, one perinatal loss).

> I was disgusted at them (health professionals) that they asked for my number to call me afterwards. You refused to take care of me and I have lost my baby, why would you want to call me? (Georgina, one perinatal loss)

In addition to hatred was anger. Most bereaved parents channeled their anger to the entities they believed in. The parents who perceived God as all-powerful and benevolent blamed evil spirits for the loss but channeled their anger at God because they considered God powerful enough to prevent the spirits and the loss. The perception that someone else or something else was responsible,

directly or indirectly, for the loss could have ignited the anger. For instance, two parents said:

> I told God that if I lose this pregnancy, I wouldn't worship Him again because you (God) didn't create us to come to this world to come and give birth and have our children die . . . I was angry at God, on the other hand I was angry at the doctors and nurses. I thought because I have suffered an initial miscarriage and perinatal loss, they would ensure that the delivery was successful but they didn't. (Mansa, two perinatal losses, one prenatal loss).

> It was after I went there and entered the ward and looked at the baby that I realized that the baby wasn't breathing. So I approached them (nurses) and asked them (in an angry tone) 'why?' 'You are not paying attention to the children; you are just conversing'. That was when one of them went to pick an apparatus to attempt to revive the baby but to no avail. Then turned to me that the child could not make it. So I told them that they are also women and they would also suffer same fate as they have made me suffer. (Fafa, one perinatal loss)

Psychological Experiences

This theme represents cognitive experiences of parents who had lost their children in the past. Some of the experiences parents reported include shock from the unexpected event, disbelief of the loss, shame, guilt and psychosomatic pains.

Baffled. Parents found it difficult to reconcile the loss with their cognitive structures. Parents attributed their difficulty in understanding why they lost their child to a number of reasons. First, parents had received assurance from health professionals about how well the pregnancy was developing; hence they did not expect to lose their babies or pregnancy. Also, parents recounted being regular at the hospital and showing no signs of ill-health, and thus struggled to understand why they lost their child, as reflected by the following quotes:

> . . . 'What happened?' I will be asking: 'what happened?' I was going to the hospital, they were checking on me regularly, I was taking my medicine, I was eating, and I was not vomiting, . . . So, 'what went wrong?' . . .I didn't come back with my baby (Mercy, one perinatal loss)

> I was completely healthy, and the baby was also healthy. . They checked her and said everything was fine. Nothing was wrong . . . (Akosua, one perinatal loss)

For some parents, the difficulty with coming to terms with the loss was worsened by the inability of medical staff to identify the specific cause of the loss. A participant who had experienced three child losses said: *" . . . I said ah, I don't understand, this is the third time. And she (midwife) said she could not tell why*". She added:

> I didn't understand, because when I conceived the first time, I used to work very hard (and I experienced a miscarriage). So when I miscarried again I panicked, I became afraid. I kept asking, 'what is happening to me?' (Beturia, three prenatal losses)

Shock. Some parents reported being in shock and being unable to assimilate the loss immediately. Though these parents had accepted that the loss had occurred, they were hesitant to believe that it has happened to them. To these parents, the experience could be a dream or a movie. For example, some parents said:

> I couldn't believe whether it's a true story I was being told or that it's a movie I was watching. That's how it (shock) started (Mercy, one perinatal loss).

> I did not know that something like this [could happen], because I did not dream that I will give birth and lose my child (Serwaa, one perinatal loss)

Shame. For some parents, it was difficult stepping out after the loss due to shame. They attributed the feeling of shame to their sense of loss and the belief that they had fallen short of society's standards. Typically, the expected result of a pregnancy was a baby; hence for some parents, the loss of their child after having been seen with the pregnancy meant they could not live up to societal expectations. Consequently, these parents refrained from visiting public places. Another reason for parents' sense of shame was their unwillingness to explain to other people who may inquire of their loss. Some parents also withdrew from public spaces because they felt a sense of loss that they could never replace. This experience was exclusive to parents who lost their babies in perinatal loss. For example, one parent said:

> I couldn't go into public, I felt shy. It was as though I lost something I can never find (Serwaa, one perinatal loss).

Another parent also shared her experience as follows:

> I felt shy going into public. Because, everybody has seen that you were pregnant, and you have given birth but the child did not survive. This will cause people to inquire the whereabouts of the child. So far as I would respond that the child has died, it will prolong the grief and I will always remember. (Kukuwaa, one perinatal loss)

Psychosomatic Pain. A few parents ($n = 4$) reported experiencing physical pains in some parts of their bodies following child loss. Although psychosomatic pain manifests as physical pains they may indicate an underlying psychological phenomenon such as depression. Four participants reported bodily pains resulting from the emotional pains. One parent mentioned that child loss had the potential to affect the health of the bereaved parent. According to the parent, losing a child can be bothersome to the individual to the point of getting them ill. In the African context, somatization has been considered as a symptom of depression (Ngcobo & Pillay, 2008). The following extract illustrates parents' attempt to link their experience of physical pain with emotional pain:

> Everyday I was agonizing about the loss to the point that I developed some (health) problems. I started to feel pains from my hands to my elbow (Serwaa, one perinatal loss)

Guilt. Guilt was another psychological experience of some bereaved parents. Guilt is defined in literature as holding one's own actions or inactions as the cause of the problematic situation (Tilghman-Osborne et al., 2008). Three parents blamed themselves directly or indirectly for the loss. One parent misdiagnosed her symptoms as malaria and ingested medication that aborted the fetus. Another attributed her child loss to being punished by God for some wrong she had done in the past. What these accounts have in common is parents' interpretation of their actions as a distal or proximal cause to the loss event, as illustrated in the following extracts:

> I caused it, I brought if upon myself. ... I prayed that God should remove the pregnancy. ... I regret that. ... I blame myself, that it was my fault. ... It makes me feel like I have spilled blood. I become burdened. ... Even lately I go to the church house and pray and ask God for forgiveness. (Dora, one perinatal loss)

> Sometimes when I think about it, I feel that I shouldn't have listened to my mother. ... She said that the substance coming from the child's mouth was not an ailment the hospital could treat. ... Now I have lost my newborn baby. Because of that, I don't talk to her again. (Kukuwaa, one perinatal loss).

Social Experiences

Parents live within a society and thus are affected by how the society responds to their loss. The experiences discussed in this theme represent parents' reflections on how society treated them as well as their interactions with others after child loss. Sub-themes include blame, spouse-related stress, rejection of consolation, and sensitivity to child comments.

Blame. Some parents reported being blamed for the loss. Sources of blame encountered by the parents were nurses and community members. According to some parents, peoples' attempt to rationalize the loss as a result of something the parent did, or did not do, made them feel judged. Apart from community members blaming the parents, some health professionals also accused parents of the loss. These experiences are reflected in the following extracts:

> Even if somebody wants to know what happened, the person assumes that it was because I didn't go to the hospital early. . . . I would prefer they asked than pass judgments based on their assumptions. (Mercy, one perinatal loss)

> . . .Because the nurses kept checking on the baby intermittently, so why would they blame me for the death of the baby? Was it because I was with the baby? Am I supposed to know everything about a baby? (Rekiatu, one perinatal loss; first pregnancy)

Spouse-Related Stress. Through the experiences of having to comfort oneself, bereaved parents recounted negative feelings that emanated from the lack of spousal support. Some of the male spouses became scared and confused about the experience of child loss. This led to physical and sexual neglect. This created a problem for parents because they needed to manage their pain as well as calm their spouse. Some parents rather decided not to talk about the loss for fear of arousing sorrow in their partner. A father tearfully recounted his feelings as: *"I don't talk about it (child loss) not even with my wife, because there is the fear that it would complicate things"* (Mensah, one perinatal loss). Others also added that:

> My husband became concerned about how I go through pains (experience child loss) whenever I become pregnant, he became afraid. That also gave me another problem. He had become engulfed with fear, that he wouldn't have intimate relations with me. Now if I want a baby, he is the one I would go to, and he is also scared so where can I go. (Mansa, two perinatal losses, one prenatal loss)

> The man [husband] also became confused; he would not even come to me. . . . If he were with me, he could have cheered me up and have spoken to me, it would have given me some encouragement. . . . It would also help me to take some of the pain from my mind and reduce the grief. But this time he didn't . . . so I was not only grieving my departed child, I was also grieving that he wasn't there with me. (Kukuwaa, one perinatal loss)

Rejection of Consolation. Some parents were selective of the conditions under which they accepted consolation. Bereaved parents declined the attempts of some people at comforting them. One parent reported walking off when people began to express their condolences. Other parents preferred to totally shut out people in order to deal with bouncing back their own way. Parents who preferred to be by themselves advised that people refrained from offering consolation since this only brought back the pain. These sentiments are captured in the following quotes:

> I wanted to be alone. I wanted to be lonely. When people come to you they will mention the loss and things you are going through. But if you are alone, you can encourage yourself and decide to forget. You can do whatever you can to let the pain leave you. (Kukuwaa, one perinatal loss)

> Once you start talking (about the loss) . . . you rather bring the whole thing back to me and I will cry so it's better you don't ask me any question, don't ask me anything and leave me be. Immediately you start to offer your condolences and try to make me feel better, I'm likely to cry. Sometimes when I meet somebody and he says 'it's okay God will . . .', I just walk away. (Mercy, one perinatal loss)

Sensitivity to Child Comments. Perhaps, due to the pain of child loss and yearn for a child of one's own, some bereaved parents became sensitive to comments about children. For instance, one parent became offended when a deaconess in her church prompted her to hand a baby to her mother during a baby dedication. Though the bereaved parent acknowledged the deaconess' comment as innocuous and impersonal, she became unsettled by it. She recounted her experience as thus:

> Because I was looking for some [a child] it hurt me. . . . I shouldn't have taken it personal but it hit my heart very hard so I gave the child to the mother and went to the inner room to weep uncontrollably. Why should the woman say that, 'give the baby to the mother'? (Mansa, two perinatal losses, one prenatal loss)

Financial Loss

Parents incur significant cost throughout the journey from pregnancy and childbirth. Expectant parents pay for hospital visits, secure items for the baby, and if they do not experience miscarriage, pay for the birth itself. Additionally, in an event of a child loss at the hospital, the parents may have to pay to dispose the body off. In some cases, the need to provide intensive care to newborns or infants to aid their survival adds to financial costs incurred by parents in the

event of child loss. The following quotes illustrate parents' narratives on financial costs associated with child loss:

> . . . (The) pain was that a woman will become pregnant, will go the hospital, her feeding, buying medicine, and making all these expenses. Everything we bought for the baby, we gave it out. That was where the pain sprouted from because you are thinking that all this money [is lost]. (Ofori, one perinatal loss)

> . . . It was my sister who signed off the papers. . . . Even that we had to pay. We had to pay for them (hospital officials) to take the body (of the baby). (Mary, one perinatal loss)

Discussion

The current study sought to explore the experiences of parents who have lost their children in the past. Bereaved parents reported symptoms of complicated grief as documented in literature. There is also evidence of faith crisis as parents deal with the impact of the loss. In addition to emotional experiences are psychological, social, and economic effects of child loss that are met with parents who lose their children.

Child loss is associated with significant emotional pain. Although most parents could not explain the nature of their pains, they reported accompanying physiological symptoms such as loss of appetite, insomnia, and anguish. Bruneau et al. (2012) explained emotional pain to be pains present without any physical stimulus. They suggest that emotional pains result from sadness and anger from an experience. Findings from the current study suggest that parents who experienced loss provided unique but shared reasons for their pain. For instance, mothers who had experienced miscarriage identified embarrassment as their source of pain. Adolfsson et al. (2004) found that the miscarriage process could sometimes be frightening and unexpected to the woman. Parents who experienced perinatal loss cited the pain of going through labour and delivery and losing the child as the source of their emotional pain. This finding corroborates that of Radestad et al. (1998) that the pain of going through labour and delivery can make saying goodbye to the baby more distressful. Though the joy that comes with arrival of a newborn could assuage the physiological pain and risk associated with the childbirth process (Chadwick & Foster, 2014; Knops, 1993), perinatal child loss ultimately results in such positive emotional experiences being short-lived. Finally, parents who experienced postnatal loss attributed their emotional pain to the child's agonizing fight for their lives. Although these emotional experiences have been prescribed as part of the normal process of grieving (Badenhorst & Hughes, 2007; Kübler-Ross & Kessler, 2005), they may be indicative of complicated grief. Grieving is termed

complicated when it lasts beyond six months after the death event (Newson et al., 2011). The current study indicated that some parents lived with the pain of their child loss for as long as 8 years. While some studies suggest that parents could grieve for much longer (e.g., Goldstein et al., 2018), this finding underscores child loss as a significant precursor to complicated grief (e.g. McCallum & Bryant, 2013; Newson et al., 2011; Prigerson et al., 2013; Rando, 1993; Shear & Shair, 2005). For some parents, grief seems to be prolonged by mementos such as the child's pictures and clothes that serve as constant reminders of their loss. Thus, in contrast to Attachie's (2003) study, keeping of mementos may aggravate rather than help assuage parents' emotional pain.

Symptoms of complicated grief observed in the current study included sense of anger, hatred, and guilt, which were expressed mainly by parents who had experienced perinatal and postnatal loss. Drenovsky (1994) reported that anger following child loss could be expressed in two ways: towards the departed child and other people. In the current study, parents who reported anger mostly blamed others, particularly health workers, as the cause of the child loss event. The perception that health workers may have contributed to incidences of child loss seems to underscore systemic problems within the health sector in Ghana. Evidence of negative attitudes on the part of health workers, which may be a consequence of excessive workload and lack of adequate resources, has been reported both anecdotally (e.g., Adofo, 2010; Graphic Online, 2015; Peace FM Online, 2016) and in empirical studies (e.g., Moyer et al., 2014). As highlighted in previous studies (e.g. D'Ambruoso et al., 2005; Mannava et al., 2015), negative experiences at health facilities can result in negative attitudes towards health workers and ultimately undermine professional health-seeking behaviour. Some experiences of anger in the current study point to the possibility of faith crisis resulting from the loss a child, as parents blame God for failing to intervene in their situation. As suggested by Neimeyer and Burke (2017, p. 43), major life stressors such as the loss of oness child "can erode a believer's sense of a secure relationship with God and/or the religious community".

In reference to the five stages of loss, parents' expression of anger in response to child loss could indicate their progression to the second stage, which is characterized by anger towards oneself, the departed or other people (Kübler-Ross & Kessler, 2005). This is followed by guilt, which signals a further progression into stage three of the grieving process. Parents in this stage must have answered the 'what if' questions with reasons that implicated themselves of the loss, which has the potential of eliciting guilt (Kübler-Ross & Kessler, 2005). In the current study, guilt and shame were sourced from parents blaming themselves for the loss. Differentiating between guilt and shame, Tilghman-Osborne et al.(2008) suggest that guilt bears on holding one's actions or inactions as the cause of an event, whereas shame bears on the individual assigning blame to their entire self. Although Tilghman-Osborne et al. (2008) have explained guilt and shame as

cognitive, there is evidence that shame has a social component. In the current study, feelings of shame also bothered on parents' sense of being perceived as the cause of the loss. This finding corroborates that of Badenhorst and Hughes (2007) who reported that parents' shame could emanate from being perceived as the cause of the loss. Murphy (2012) also added that parents might preempt that people may think less of them. These thoughts could underpin parents' sense of shame.

The findings from the study suggest that child loss has significant adverse impact on parents' cognitions about the event and individuals associated with it. Most parents in the current study reported being confused by the loss event, due to the unexpected nature of the loss and lack of clear communication from health workers on the cause of the loss. This is consistent with the finding of Goldstein et al. (2018), who reported that parents expressed shock and disbelief following child loss. Gradually, as they made efforts to come to terms with the loss, some parents begun to feel a deep sense of loss. According to Janoff-Bulman (1989), confusion emanates from lack of cognitive structures to accommodate the loss, which leads to shock and disbelief when parents are processing the news of child loss. In the current study, confusion resulting from lack of information about the cause of the loss seemed to fuel suspicion of foul play and, consequently, mistrust of health workers. Suspicion and mistrust further bred doubt of infant loss and eventually a recession into ambiguous loss. In this state, bereaved parents refused to accept the reality of their infants' death. Ambiguous loss leads to unresolved grief (Betz & Thorngren, 2006). Ravaldi et al. (2018) reported in a study that parents coped better when midwives bathed stillborns in the presence of their mothers in comparison to those who denied mothers from seeing their stillborns. Grief resolution can be facilitated if nurses give bereaved parents some form of closure after child loss.

Parents who lost their children experienced psychosomatic pain. Parents' feelings of physical pain may have resulted from the psychological experience of child loss. For instance, stress from the child loss incident could cause neural reactions to produce pain (e.g. Gudmundsdottir, 2009). Kersting et al. (2009) found that prenatal loss had the potential of eliciting psychosomatic pain. Psychosomatic pain may also suggest an underlying psychological experience such as depression. Ngcobo and Pillay (2008) described depression in the African context as variant from what pertains in the Western world. Parents who scored high on depression in Africa recounted feelings of emotional pain. Also, Tylee and Gandhi (2005) reported a link between psychosomatic pains and depression. Thus, it is plausible some parents in the current study experienced depression following child loss, which would corroborate past research (e.g., Kinsey et al., 2015; Sutan et al., 2010) suggesting that parents who experienced child loss are at risk of becoming depressed. According to Kübler-Ross and

Kessler (2005), depression was essential for the commencement of the healing process.

Child loss has implications for family relationships. Specifically, child loss impacted negatively on marriages. Some parents became afraid to engage in sexual intercourse with their partners causing a friction within the family. Gold et al. (2018) reported that women who have experienced stillbirth or miscarriage had a significantly high chance of having their relationship terminated than those who did not. Another source of parents' pain was spousal neglect during times of bereavement. Also, the physical absence of a partner during the grieving process after child loss caused more pain. The bereaved parent was then grieving for the departed child as well as the absent partner who had neglected them. These experiences can throw light on why relationships to those who had experienced child loss terminate faster than those who have not as found by Gold et al. (2018).

Child loss also has financial meanings for parents. For many parents the loss of the child meant a loss of significant financial investment. Parents cited spending extra on disposing the body of the deceased baby or child, having to give away items bought to care for the baby, and general expenditure during pregnancy. This finding corroborates the observation by Fox et al. (2014) that parents who experience child loss return to work in dip of their finances than when they left. Based on data from 213 parents who lost a child in the USA, Fox et al. (2014) estimated the average cost associated with the death of a child to be $21,332. This amount was due to improper emotional and social care of bereaved parents that can eventuate to global burden.

Limitations and Direction for Future Research

This study has a number of limitations worth acknowledging. First, although the use of a qualitative approach facilitated an in-depth exploration of parents' lived experiences of child loss, it did not permit a direct examination of the link between the event of child loss and its associated experiences. It is possible that some of experiences narrated by parents may have preceded the loss of their child or even contributed to their responses to the loss. Additionally, although we included a fair representation of parents with experience of different kinds of loss in our sample, the small sample size coupled with the fact that the study was conducted in a single city suggest the need for caution to be exercised in generalizing the study's finding. Indeed, generalizability of findings was not our focus in this study though we anticipate that some of our findings may find applicability in other contexts. Studies that adopt a quantitative approach, ideally with longitudinal designs and large sample sizes would enable researchers to directly examine the causal linkages between the event of child loss and psychosocial experiences associated with it and also address issues of generalizability of findings.

Moreover, our findings also suggest that parents' emotional experiences of child loss may be associated with the perceived cause of the loss. We therefore recommend that future studies examine parents' perceptions of the cause of child loss, as this could provide insight into possible preventive measures against child loss.

Our findings point to possibility that the experience of child may depend on the type of loss. We therefore recommend that future research explore the extent to which outcomes of child loss differ across different types of loss, ideally using quantitative approaches. This could contribute to the design of interventions targeted at parents who experience specific forms of child loss.

Implications for Research and Practice

In spite of its limitations, the current study has provided insight into the child loss experiences of Ghanaian parents. Our study advances the five stages of navigating grief proposed by Kübler-Ross and Kessler (2005) by providing evidence that bereaved parents not only go through emotive and psychological experiences but that there are also social and economic components in the loss experience. Additionally, while Kübler-Ross and Kessler (2005) suggest that bereaved parents may direct their anger at the deceased, our findings suggest that bereaved parents direct anger to sources they believe contributed to the loss. Thus, it seems reasonable that bereaved parents would not direct their anger towards their departed babies and fetuses because they cannot contribute to their own demise.

Practically, our findings underscore the need to address issues of stigma associated with child loss, as stigmatization could aggravate the emotional and psychological experiences associated with child loss. This can be done through mass education. Additionally, nurses and midwives who directly care for bereaved parents must be trained to handle child loss professionally. Furthermore, the inclusion of psychologists in the team of professionals caring for families who lose their child would enhance the team's capacity to provide the needed support to enable parents deal with the loss. This would create an avenue for a relatively faster healing.

Findings from the study have shown varying impacts of child loss on parents. Therefore, we suggest a post-loss mental health care to address potential issues of mental health problems related to child loss. Findings from the current study suggest instances of prolonged grief, which can have psychological effects on families . Also, it was found that child loss could potentially disrupt intimacy between couples. Therefore, family counselling would aid to reinstate the family and also provide healthy avenues for bereaved parents to heal following child loss.

Conclusion

Child death is painful because it normally happens unexpected. This study not only underscores the emotional and psychological experiences associated with child loss, but also demonstrates the social and financial implications of child death on bereaved parents. The study has brought to fore the underlying reasons for parents' experiences of emotional pain following child loss. Also, it is now known that parents in Ghana, a developing country, respond similarly to parents in developed countries in situations of child loss.

Due to the similarity of experiences of child loss across cultures and races, it is incumbent for both researchers and policy makers to set aside resources to address this issue. Another reason to pay attention to child loss is the fact that bereaved parents tend to stay with the negative experience for a long time. Addressing issues of child loss will build a better human resource for the work place, better community members for the society as well as better spouses for the family.

Ethical Approval

The study took off after the researchers gained ethics clearance from the University of Ghana's Ethics Committee for Humanities (ECH: 017/18–19).

Declaration of Conflicting Interests

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ORCID iD

Francis Annor https://orcid.org/0000-0002-4332-1504

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Author Biographies

Grace Owusu Asare is a research assistant at the University of Ghana. She holds an MPhil in Social Psychology. Her research interest is in the area of social health behaviour.

Francis Annor is a senior lecturer in the Department of Psychology at the University of Ghana. His research interests include work-family interface, occupational stress, workplace violence, and employee well-being.

Joana Salifu Yendork is a senior lecturer at the Department of Psychology, University of Ghana. She has advanced training and experience in both qualitative and quantitative research. Her areas of research interest are child and adolescent mental health as well as the influence of contemporary religion on mental health. She has published widely on these topics.