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"There Is Nothing I Can't Face Now": Coping With Child Loss Among Bereaved Parents in Ghana

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Abstract

Coping resources play a critical role in parents' recovery from the trauma associated with child loss. In Ghana, little is known about how parents cope with child loss despite the relatively high prevalence of child loss in the country. This study, therefore, sought to map out coping strategies bereaved parents adopt in response to child loss. Twenty Ghanaian parents were purposively sampled and their accounts were thematically analyzed. Findings from the study show that bereaved parents adopted both cognitive and behavioral coping mechanisms. Religion and social support also emerged as useful coping resources for bereaved parents. Additionally, bereaved parents showed evidence of posttraumatic growth following child loss. The findings underscore the need for practitioners to develop programs around adaptive coping methods that bereaved parents are familiar with to enhance their chances of developing progressive outcomes in the course of managing the distress associated with child loss.

Keywords

child loss, bereavement, coping, posttraumatic growth, Ghana

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Introduction

Although child death has plummeted in comparison to a decade ago (Wardlaw et al., 2014), evidence suggests that the prevalence of child loss remains high (Volgsten et al., 2018). About 15,000 under-five child deaths are recorded daily around the world with Africa coming ahead of the continents in incidence rates (Roser et al., 2013). In Ghana, 90 children are estimated to die out of every 1,000 births and 29 still births are recorded out of every 1,000 live births (Ghana Statistical Service, 2014). The high occurrence of child loss in Ghana makes it necessary to investigate the coping mechanisms bereaved parents adopt. Although death is an irreversible loss (Machado, 2010) and often results in adverse psychosocial outcomes for parents (Asare et al., 2020), parents' coping resources play a critical role in their recovery from child loss.

Coping is commonly defined as individuals' cognitive and behavioral efforts or responses towards managing external and internal demands that help to buffer the impact of such demands (Folkman & Lazarus, 1980; Heffer & Willoughby, 2017). Among various categorizations of coping strategies is the distinction between problem-focused and emotion-focused coping (e.g., Yoon et al., 2018). Yoon et al. (2018) define problem-focused coping strategies as those centered on managing the stressor, whereas emotion-focused coping manages the emotions that result from the stressor. In the case of death, one can only engage in emotion-focused coping, as they cannot do anything to stop the stressor.

Emotion-focused coping comprises but is not limited to avoidance and confrontation (Baker & Berenbaum, 2007). Avoidance coping—for example, wishful thinking, distancing, self-blame, mental and behavioral disengagement, denial, and alcohol use––entails a change of behavior of the bereaved person to prevent them from feeling uncomfortable. Unlike avoidance coping, confrontational coping—also referred to as grief work (e.g., Bonanno & Kaltman, 2001; Kübler-Ross & Kessler, 2005; Nolen-Hoeksema, 1991)—is characterized by actively working through one's grief by talking to people, writing out how one feels, and consciously making efforts to overcome the pain from one's loss (Stroebe, 1991).

Bereaved parents may also employ cognitive mechanisms to cope with emotional experiences associated with their loss (Gillies & Neimeyer, 2006). Some parents attempt to carve meaning from the child loss incident. Reconstructing meaning helps the bereaved to adapt to a world without their loved one (Gillies & Neimeyer, 2006). Parents try to make sense of death by finding benefits in the experience and undergoing identity change. In addition, positive reappraisal is a cognitive exercise where negative events are reframed to be seen in a positive light. Folkman (2001) mentions that positive reappraisal is an antecedent to successful coping. Those who can reappraise negative events develop a sense of growth and a changed self. Such people tend to become resilient, confident, and more independent. Also, they may adopt new social roles and understand how fragile life is. Consequently, they are less likely to be helpless in future loss events (Gillies & Neimeyer, 2006).

Social support and religion have also been found to be important in maintaining good mental health when faced with trauma and adverse life circumstances such as the death of a child. Kreicbergs et al. (2007) suggested that parents address their grief when they can talk about it with family and friends, a process that helps them cope with the pain. Accordingly, studies have shown that social support from family members and significant others facilitates adaptation after child loss (e.g., Aho et al., 2009; Cao et al., 2020; Meyer et al., 2018; Thuen, 1997). With regards to religion, Lichtenthal et al. (2011) suggested that the belief system of bereaved parents helps in finding some significance in the death event. In one study, McIntosh et al. (1993) found that religious participation and religious importance enhanced parents' perception of social support, cognitive processing of loss, and ability to find meaning in the death following the loss of a child. These coping processes in turn enhanced parents' well-being and reduced their distress. However, people who hold benign beliefs such as "God is good," "the universe is a benevolent place," "good things happen to good people," and "God has control over peoples' circumstances," among others, may have a harder time coming to terms with the loss of their child. Their assumptions may be unsettled or challenged to the point of questioning the power of God.

To date, the literature on coping with child loss is predominantly Western-centered with South Africa making some contributions in Africa. Research focusing on how Ghanaian parents cope with child loss is lacking despite its occurrence in the country. In Ghana, in the Akan tradition for instance, the longer a person has lived the more protracted they will be mourned (Osei-Mensah, 1999). The implication is that children and babies receive cursory or no mourning. Funerals serve as an acknowledgment of loss from the social group and also reassert the family's solidarity (Osei-Mensah, 1999). Therefore, the apparent neglect of mourning children in certain cultures may take a negative psychological toll on bereaved parents, denying them the therapeutic element of funerals. Social support is beneficial to recuperating; thus, when bereaved parents are denied support, they may take longer to heal. This study, thus, explored the methods Ghanaian parents employ to cope with the loss of their child.

The study is guided by the dual-process model of coping by Stroebe and Schut (2010) and the integrated model of meaning reconstruction by Gillies and Neimeyer (2006). The integrated model of meaning-making draws on the works of Kübler-Ross and Kessler (2001), Folkman (2001), Stroebe and Schut (2010), and Janoff-Bulman (1992) to explain how people make meaning from the loss of a loved one. The model proposes three stages of grief response: meaning-making, benefit finding, and behavioral changes. Gillies and Neimeyer (2006) propose that successful navigation of the processes would lead to post-traumatic growth, whereas failure to navigate the processes would lead to post-traumatic stress. The dual-process model of coping by Stroebe and Schut (2010) proposes that bereaved people oscillate between loss-oriented coping, which is focused on the loss, and restorative-oriented coping until a balance is reached. This means that the bereaved will not only be in a state of bereavement, but they will also take steps to confront the grief, which eventually leads to recovery from pain-related loss.

Methods

Design and Participants

A descriptive qualitative approach was used to explore how Ghanaian bereaved parents respond to child loss. Rooted in naturalistic inquiry, qualitative description involves presenting "a comprehensive summary of an event in the everyday terms of those events" (Sandelowski, 2000, p. 336). In qualitative descriptive studies, the researcher seeks to gain an in-depth understanding of events based on individuals' interpretations of those events (Bradshaw et al., 2017). The goal of qualitative description is to provide a rich description of experiences using less inference and less abstract presentation of information (Bradshaw et al., 2017; Sandelowski, 2000). Thus, in this approach, researchers "stay closer to their data and the surface of words and events" (Sandelowski, 2000, p. 336). The descriptive qualitative approach was chosen because the narration of experiences was required directly from parents who had gone through child loss (Bradshaw et al., 2017). The basis of attempting to understand how bereaved parents respond to child loss stems from the severed connection between a parent and their child.

The study was conducted in the Greater Accra region and included parents who had lost their child in the past, but not beyond 8 years. Twenty parents were selected for the study using purposive and snowball sampling techniques. The participants were predominantly women and their ages ranged from 24 to 60 years. About half ($n = 11$) of the participants were married and the rest were single or cohabiting. Participants' educational levels ranged from those who have received no formal education up to tertiary leavers. Also, participants belonged to various ethnic groups in Ghana and the majority ($n = 13$) were Christians. Eight of the parents had experienced prenatal loss, nine had experienced perinatal loss, and three had experienced postnatal loss; definitions of these types of loss are presented elsewhere (Asare et al., 2020). Table 1 presents demographic information about the participants.

Data Collection Procedure

Ethics clearance was obtained from the Ethics Committee for the Humanities (ECH: 017/18-19) at the University of Ghana before the commencement of the study. We obtained permission from the management of one public and two private hospitals to meet potential participants. Informed consent was obtained from each participant. The participants were informed about the voluntary nature of the study and of their autonomy to quit at any point without providing any reason. The participants were also assured of confidentiality and anonymity. Data were obtained using semi-structured interviewing, allowing flexibility to engage parents to further explain their accounts.

Permission was sought from participants to have their interviews recorded. All the interviews were conducted by the first author under the supervision of the co-authors. The shortest interview lasted for 15 min whereas the longest interview took 3 h. In all,

Table 1. Demographic Characteristics of Participants.

Participant demographics	Number of participants
Age	
24–35	12
36+	8
Gender	
Male	2
Female	18
Educational background	
No formal education	2
Basic education	11
Secondary school and above	7
Marital status	
Married	11
Not married	9
Religion	
Christianity	13
Islamic	6
Traditional	1
Type of loss	
Prenatal	8
Perinatal	9
Postnatal	3

the interviews took an average time of 55 min. While interviewing, the interviewer took into cognizance the emotional state of the participant. When a participant cried for more than 2 min, the interview proceeded only if the participant was willing to continue. This was to ensure that no psychological harm was done to participants in the course of data collection. Indeed, this was anticipated and we, therefore, made provisions for psychological support but no parent expressed a need for it.

Data Analysis

Thematic analysis was employed in analyzing the data. Specifically, we followed the six-step approach to thematic analysis, which entails getting familiar with the data, generating initial codes, searching for potential themes, reviewing candidate themes, defining and naming final themes, and writing a report (Braun & Clarke, 2006). Following transcriptions of the interview by the first author, the transcripts were read and re-read over again in collaboration with the co-authors. After getting immersed in the transcripts, initial codes were generated, followed by a detailed description and classification of the codes. Interview extracts associated with the codes were collated and compared across interviews for code similarity. This was followed by the

formulation of meanings to produce a potential cluster of themes. We defined and labeled potential themes in tandem with the essence of the themes and their relation to the research questions. Derived themes were finally interpreted based on the research questions and the meanings of the coded interview extracts.

Trustworthiness

Trustworthiness is a measure adopted in qualitative studies to address issues of validity and reliability. We followed Shenton's (2004) criteria for ensuring trustworthiness in this study. Credibility was ensured by documenting initial codes to enable us to revisit and check stated codes over time for stability. In addition, ethical protocols such as assurance of confidentiality and informed consent were adhered to, as indicated earlier. This enabled participants to feel at ease so that they provide reliable responses.

To conceal the identity of our participants, pseudonyms were used in the report. To ensure transferability, recorded interviews were transcribed and read over many times to allow for familiarization of data as well as to produce thick descriptions of phenomena. Furthermore, confirmability was ensured by including all the authors in the data analysis process so that the possibility of an individual's view dominating the interpretation of participants' responses would be limited. Finally, dependability, which tests the rigorousness of the methods selected for a study, was addressed by evaluating the effectiveness of the processes used in the current study.

Findings

Participants in this study used diverse coping strategies to address grief. Parents coped with child loss through behavioral strategies including confrontation, engagement in traditional practices, and bearing children. Parents also coped with their loss cognitively by providing meaning structures that buffered them. Cognitive coping covers making meaning and finding benefits from the loss. Religion and social support also served as useful resources for coping with child loss. Some parents experienced posttraumatic growth following their grief experience. The succeeding subsections elaborate on the themes and sub-themes identified in the study.

Behavioral Coping

Confrontation. Most parents relied on confrontational coping strategies in response to the loss of their child. These strategies involve giving away the clothes of the child to facilitate forgetting. The departed child's belongings served as a constant reminder of their loss. Some parents also took on new roles as nursery teachers to gain some comfort from being with children while addressing the financial stress that accompanied the loss. Some accounts of confrontational coping are below:

> Sometimes when I see the things, I feel pain so I packed her things and put them away. (Gertrude, perinatal loss)

> After 3 months, I decided to go back to work. So, I got a job in a school. You know children can do things to cheer you up, you know that children are funny, they will do something that will make you laugh so that you forget about the experience. (Selena, perinatal loss)

Engagement in traditional practices. In Ghana, there are traditional practices that are intended to promote coping with child loss. Some of these practices include telling bereaved parents that they might not be able to have another child if they did not truncate their grief. Such scare tactics seem to have become part of traditional coping processes. Most parents received this particular piece of advice from home and the hospital alike. Parents who wanted children in the future paid heed and stopped crying. Other traditional practices intended to facilitate coping included feasting and wearing white clothes to indicate victory over death. Although funerals are normally not performed for children in Ghana, some ethnic groups offer special prayers or a brief sitting to comfort the bereaved parents. The following extracts illustrate how engagement in traditional practices enabled parents to cope with their loss:

> The nurses at the maternity ward told me that if I cried too much, I will find it difficult to have children again. So that was what made me stop crying. (Missy, Prenatal loss)

> They [the traditional elders] say the final farewell [to the deceased child/baby]. So now, we [the living] don't have anything to do with you [the dead] again. We pray and part with them. (Judith, postnatal loss)

> In my case, my husband and I wore white garments and ate chicken. … This was done to signify our victory over death (Mary, perinatal loss)

Bearing children. Some parents also gained some comfort from having children or giving birth. Parents who delivered after losing their child told themselves that the current child was a replacement for the child they lost. This belief helped to assuage the pain associated with the loss. Other parents comforted themselves with the thought that they had other children aside from the one(s) they lost. For example:

> And after I delivered, all the [emotional] pains I was going through [as a result of my previous child loss], even if I remember, the [emotional] pain is not as deep as before I gave birth… I don't know what would have become of me if I didn't give birth. (Fidelia, multiple child loss)

> What will I do? It was difficult but because I already had children, I moved on. (Juliana, prenatal loss)

Cognitive Coping

Cognitive coping focuses on altering the thought to assimilate and accommodate a stressful event. It helps to develop new mental structures that can withstand the trauma and stress that accompany the loss. In the current study, bereaved parents engaged in meaning-making and positive appraisal. They also engaged in negative cognitive coping mechanisms such as denial and dissociation.

Meaning-making. Meaning-making focused on carving an acceptable reason for the loss occurrence. The process of meaning-making required that parents provide acceptable explanations for the loss event. This was a way of coping with grief and coming to terms with the loss. Some participants reasoned that God probably took the 'deformed' baby so that He could prepare a better one for them. Others reasoned that the baby was not meant to stay alive. Also, some parents resorted to religion to make sense of the loss, by simply trusting that God did what was best for them. These patterns of thinking were parents' way of coping with their loss cognitively.

> …God must have considered my need to bring up a healthy child. In His wisdom, He decided to take this one from me so that I would not suffer to bring up a deformed child, in case the [deceased] baby became deformed. (Fidelia, multiple child loss)

> I didn't know what the child was going to become, maybe she would be a sickler, a disabled, or something I didn't know. Also, maybe God did not make it how He wanted so he has taken it. That is what my mum told me. That stayed with me and made me calm. So, God has taken it back to prepare it again and give it to me. (Dina, perinatal loss)

Positive appraisal. Another cognitive method of coping parents employed was finding benefits from the loss. Benefit-finding did not imply that parents were glad about the loss; indeed, most parents were saddened by their loss. Rather, the adoption of positive appraisal was a means of finding a balance in parents' belief in a benevolent world. Some parents took solace in the belief that their circumstances were better when compared to those of others. Also, parents reasoned that the death was a release from future financial and time commitments had the child been deformed. This line of thinking enabled parents to perceive some good in the loss. The following are quotes about benefit-finding:

> When I hear stories of other people, I realize mine (child loss) is even good. Some people give birth only to see that their baby is deceased, others go through 9 months of pregnancy only to lose their baby. Some are successful in childbirth and get to hear the cry of their baby, only to eventually lose them. That is worse. They have carried the baby for 9 months, they have gone through delivery, and they wake up and their child is not beside them? ... That one is worse. (Betty, prenatal loss)

> …what comforted me was when I was in the surgical ward, I saw children in worse conditions. I use to tell myself that if she had lived this is how she would have suffered. (Lily, perinatal loss)

Denial. Some parents could not immediately come to terms with the loss; hence, they resorted to the use of defense mechanisms such as denial. Denial is a mechanism that people employ in an attempt to avoid coping with a stressful event, by telling themselves that the event has not happened. In the current study, parents provided themselves with reasons their children were not with them or denied the loss outright.

> … he (deceased baby) wasn't with me. So, I took it as he has traveled or something like that. ... It took a long time though; it took a long time before I told myself (that the baby has died). It took some time. (Selina, perinatal loss)

> For me, because they didn't let me see the baby, I dismissed the deceased baby they claimed to be mine. I know my child is alive somewhere, but what can you do? (Noah, perinatal loss)

Dissociation from the loss. Some of the bereaved parents either dissociated themselves mentally from the loss or refrained from places that reminded them of the loss. This was done to facilitate forgetting and grief resolution. An instance is a participant's resolve to stay away from their hometown, where the loss occurred. Another is a parent's decision not to know to whom the clothes (of the deceased child) belonged.

> So, I had to leave the mountains and return to Accra because I cannot stay there...I cannot stay there. ...because of the incident with the child and things like that, if you stay there…you will grieve… I don't feel like I should go there. (Selena. Perinatal loss)

> I told myself to forget about the event. I decided it was somebody's clothes I was packing. So, I went ahead to fold them. I told myself that whoever the owner was would come for them because they weren't mine. (Dina, perinatal loss)

Religious Coping

Religion played a major role in bereaved parents' coping. Religion was a source of anger and emotional support as well as a place of refuge from the pain. As a source of anger, some parents could not fathom why God, a powerful entity, could allow the devil to bring them misfortunes. Conversely, some parents reported that they found comfort in their religious beliefs. Parents drew comfort from reassuring words from the Bible and the Quran. Others counted themselves lucky to be chosen by God/Allah to have their faith tested with the anticipation that they would receive a future reward. The following are selected quotes from parents:

> God is omnipotent. He is all-powerful. So, why would He allow the devil to bring me such misfortunes? Whenever that thought occurred, it made me really angry. I said that if I miscarry this pregnancy also, I will not serve God again. (Fidelia, multiple child loss)

> I would cry, but I thought about how God (Allah) tests His children. I felt this was a test from God… (crying) … but it gave me hope, that I would be rewarded in the future. (Aisha, perinatal loss)

Social Support

Being by oneself when experiencing pain from loss can be emotionally tasking. Social support can be very essential in such moments. The participants in the present study expressed the significance of such support in the management of distress associated with child loss. Several parents in the study stressed how the absence of such support can negatively affect the bereaved parent. One parent expressed pain from being alone throughout the child loss experience. Having someone to talk to would have been helpful, according to this parent.

> …And thinking about the loss, it was a lot to cope with and unfortunately, there was no one for me to talk to, no one for me to tell so I had to keep it to myself... because I was alone, and no one was there. (Ruth, Perinatal loss)

Other parents expressed the wish that their partners are there for them since coping with loss can be emotionally tasking.

> When it happens, the husbands should support their wives. If the men do not gather the courage to support the women, it will make the women think till they go insane. …In conversations, the man should be gentle because the woman has become a child. She is not in the right frame of mind. (Fidelia, multiple child loss)

Support from extended family. Bereaved parents had several sources of support from mothers, siblings, aunties, and other members of the external family. Families are also affected when there is a loss. Therefore, their presence can help in assuaging the pain, as reflected in the following quotes:

> My mothers and other elders were here to keep me company. In the evening, we would sit outside and chat, they would crack jokes and we will laugh. It allowed me to take a break from obsessing over the loss… (Betty, perinatal loss)

> …my sister also spoke with me… she said that I should give everything to God. (Dina, perinatal loss)

Support from spouse. Spouses were also another source of support. Parents reported being encouraged when their spouses spoke with them. Having the spouse present and

encouraging each other helped the bereaved parents in the coping process. Spousal support took the form of advice, and encouragement, as expressed in the quote below:

> …my husband said that whatever God does is good and that I should take care of the other children… my husband spoke with me so it helped me a lot (Adele, Perinatal loss)

Support from friends. Many bereaved parents recounted how helpful it was to have friends visit them. For most parents, those whose company they welcomed were people who had also experienced child loss. Parents supposed that such people could better appraise the situation and provide helpful advice:

> So, she too anytime when she sees me and I am crying she would say 'hey', and follow it with a body bump, 'what are you doing?'… that was what happened and it helped to relieve the pain. (Dina, perinatal loss)

> .... Madam Olivia told me that she has lost all of her children but I have three surviving children and I have lost only one. This really encouraged me to keep going (Adele, perinatal loss)

Posttraumatic Growth

This theme reflects parents' expression of growth after loss experience. After experiencing child loss and engaging in some or all of the coping strategies, some bereaved parents had achieved posttraumatic growth. These experiences were expressed in two ways: change in orientation and self-encouragement.

Change in orientation. Some parents asserted that the experience had put them in the position to encourage others. Others mentioned that they never thought something like that could happen to them, but now they felt they could cope with any pain in the future. Some parents reasoned that God only tests people with strong 'hearts'; therefore, getting tested by God supposes that they have strong hearts. Other parents reported that the situation had made them stronger people. They expressed a belief in their strengths as well as a need to adopt preemptive measures against future losses.

> I never thought that something like this [child loss] would ever happen to me. But after the incident, I feel like there is nothing I can't face now. (Regina, perinatal loss)

> So, He (God) tests us, sees the strength that we have, and the heaviness of our hearts before he gives us the type of challenge. And it's true. God tests people he thinks can (endure) (Dina, perinatal loss)

Self-encouragement. Parents expressed the ability to encourage themselves to overcome the loss. Some parents decided that since they were the ones going through the pain,

they were in a better position to encourage themselves. This created a sense of empowerment and the ability to get over anything else in the future:

> I spoke with myself at some point. You have to advise yourself. You have to pray and talk with yourself. You are feeling the pain, you are experiencing the loss, so you have to take the initiative to get well otherwise it will take a toll on you ... (Adele, perinatal loss)

> …the experience has changed me. It has changed me. After the loss, I decided not to let the pain overcome me. And so, I feel I can handle anything that happens in the future (Lucy, postnatal loss)

Discussion

The study sought to explore strategies bereaved parents in Ghana adopt in coping with child loss and their experiences of posttraumatic growth. Previous studies on the process of coping with loss, on one level, have either focused on cognitive restructuring or behavioral processes. Cognitive coping methods focus on meaning-making and benefit derivation narrowly (e.g., Attig, 2004; Folkman, 2001; Gillies & Neimeyer, 2006). In the current study, bereaved parents employed meaning-making as well as benefit finding to assimilate the loss event. Currier et al. (2006) suggested that engagement in a meaning-making process in response to child loss improved parents' grief symptoms. Meaning-making and positive appraisal facilitate grief resolution (Gillies & Neimeyer, 2006), and can be beneficial during bereavement. According to cognitive theorists, parents' initial response to a child loss event is a disruption of their assumptive world that bothers their view of the world as a good place (e.g., Janoff-Bulman, 1992). This experience is fostered when parents did not have schemas of the possibility of child loss before experiencing it. Parents' attempt to return to stability necessitated providing acceptable reasons for the occurrence of the loss as well as finding benefits from the loss (Folkman, 2001).

Some parents adopted behavioral methods to cope with the emotional experiences associated with child loss. Behavioral or restorative methods of coping describe the grieving process as an active way of coping where the bereaved individual has to actively work out their pain either through social support or by performing activities to consciously cope with the pain that accompanies the loss (Gomez & McLaren, 2006; Kübler-Ross & Kessler, 2001). Restorative approaches to coping adopted by bereaved parents in the present study included putting away the clothes of the departed infants, talking to people about the loss, and finding new jobs to cope with the financial stress that accompanied the loss. Interestingly, parents who took jobs did so in schools, where they would be close to children. Another restorative method of coping was engaging in traditional practices. Traditional beliefs of community members about truncating grief for fear of impairing future fertility underscores the value Ghanaians put on having children. This belief seemed to be effective in encouraging parents to have hope for

future children. Also, bereaved parents showed how having children before or after the loss helped them cope with child loss.

Additionally, bereaved parents engaged in avoidance as a way of shielding themselves from the emotional experiences associated with the loss. Specific avoidance coping strategies parents employed include denial and physical and mental dissociation from child loss. Dissociation has been said to be a useful strategy for mitigating stress associated with traumatic events (e.g., Jong & Reis, 2013). Gomez and McLaren (2006) identified avoidance coping as a risk factor for complicated grief, whereas Stroebe and Schut (2010) found that avoidance was equally effective as confrontation, especially in cases of death. In the current study, parents who engaged in denial still showed signs of distress and grief although they believed their babies were not deceased. Ravaldi et al. (2018) found that parents cope better when midwives bathe and dress their stillborn babies in their presence. Perhaps, this practice provides grieving parents with some form of closure about the loss of their child, which helps them to cope with their grief.

Parents received social support from family and friends in the form of advice and encouragement, which helped to truncate their grief. In most parts of Ghana, raising a child is considered a collective effort. Hereby, the loss of an infant becomes everyone's loss; thus, the need to offer support. Consistent with previous studies, this finding underscores the value of social support in aiding recovery from traumatic events such as child loss (e.g., Aho et al., 2009; Cao et al., 2020). The use of scare tactics emerged as a common strategy adopted by family and friends to encourage bereaved parents to truncate grief based on the belief that prolonged grief could harm the parents' prospects of bearing children in the future. This finding corroborates a recent study in Ghana (Meyer et al., 2018) in which similar scare tactics were employed to divert bereaved parents' attention from the emotions associated with child loss.

Religion was also identified as a major means of coping with child loss. In line with the observation that religion could facilitate or hinder coping with loss (Thompson & Vardaman, 1997), we found that religion offered both negative and positive coping outcomes. On the one hand, religion was a source of anger and frustration to some bereaved parents who interpreted their experience of child loss as a betrayal of their reliance on God. Some people who experience loss may have their spiritual resources tasked, leading to difficulty in accommodating and incorporating the loss event into their existing (religious) assumptions (Atig, 2004). This may result in interpreting the loss as the work of demonic sources, a reappraisal of God's power, and questions about God's presence (Thompson & Vardaman, 1997). Thompson and Vardaman (1997) reported that religious faiths that portrayed God as a punisher and therefore needed to be obeyed led to negative religious coping, which was associated with a greater likelihood of posttraumatic disorder. On the other hand, religion provided an avenue for emotional support and rationalizing the experience of child loss. In a previous study in Ghana, religion was found to enhance coping by promoting positive emotions and fostering resilience, hope, and an optimistic outlook on events (Salifu Yendork & Somhlaba, 2017).

Findings from the current study suggest evidence of post-traumatic growth among bereaved parents after navigating through the loss experience. Posttraumatic growth manifested in a change in orientation and a boost in one's self-efficacy to handle tougher situations in the future. Parents' perception of their resilience increased after navigating through the pain of child loss. Luszczynska et al. (2009) found that self-efficacy in a traumatic situation protected parents from sliding into posttraumatic stress disorder. Therefore, parents who have experienced child loss and gained self-efficacy would be shielded from posttraumatic stress disorder in a later stressful situation. Parents also became more open to the outcomes of situations after child loss. Specifically, some bereaved parents mentioned that child loss has engendered in them an increased sense of awareness and agency in unexpected situations. These changes in the orientation of parents are consistent with the integrated model of meaning-making by Gillies and Neimeyer (2006). The third stage, after meaning-making and positive appraisal, entails a change in mindset.

Limitations and Directions for Future Research

Our study is not without limitations. First, although the use of a qualitative approach enabled an in-depth exploration of parents' experiences of coping with child loss, it did not allow us to examine which of the coping strategies were more effective. Notwithstanding, future studies may employ quantitative measures to test bereaved parents' psychological well-being as a way of triangulating the current study. Studies that adopt a quantitative research design with relatively large samples would be able to ascertain the relative effectiveness of the various coping mechanisms identified in this study. Secondly, given that the study was conducted in one region and was based on a small sample, the findings may not be generalizable. Indeed, the generalizability of findings was not our focus in this qualitative study, though we anticipate that some of our findings may apply to bereaved persons in other contexts. Findings from the study suggest that some bereaved parents were only comforted by their loss after having another child. Other parents considered their existing children and consoled themselves. Therefore, further studies exploring the importance of childbirth may be conducted to put this finding into a better perspective.

Practical Implications

The current study has provided insights into the coping practices of bereaved parents as well as the aftermath of some of the coping methods. Bereaved parents are, therefore, advised to engage in positive coping mechanisms such as confrontation rather than avoidant practices such as denial. We also recommend the implementation of measures in health facilities that will help minimize the pain associated with child loss. For instance, responses from our participants indicated that mothers who lost their babies during childbirth were put in the same wards as those who had successful deliveries. This practice could be a painful reminder to bereaved parents about their loss whilst on

post-birth recovery in the health facility. Thus, keeping mothers who experience child loss in a different ward whilst recovering may help to mitigate psycho-emotional pain after child loss.

Moreover, most health facilities in Ghana do not have any formalized procedure for providing psychological assistance for parents who experience child loss. Currently, the assistance provided to bereaved parents is largely informal in the form of emotional support from nurses and midwives. Only a few major health facilities have in-service clinical psychologists who are available for parents who need psychological services. We, therefore, recommend the institution of programs in health centers that would aim at providing counseling services for parents who have lost their babies, fetuses, or children. This would prevent bereaved parents from engaging in maladaptive coping strategies. Providing a counseling program for those who have lost a child would not only facilitate the positive grief response of the bereaved but would also create a positive image for the health facility.

Finally, our findings suggest that traditional practices such as scare tactics, feasting and wearing of white clothes, and special prayers for bereaved parents may be effective means of coping with child loss. By diverting attention from the negative emotions associated with child loss, such practices help to shorten the grief experience to avert the possibility of complicated grief and facilitate post-traumatic growth. We wish to encourage such traditional practices in addition to the provision of formal psychological interventions to aid coping.

Conclusion

This study has provided insights into the coping strategies and resources employed by bereaved parents in response to child loss in the Ghanaian context. Findings from the current study suggest that coping with child loss, although unique, has shared characteristics among bereaved parents. Also, parents who employed maladaptive methods of coping such as denial showed signs of grief years after the child-loss experience. In contrast, parents who adopted adaptive coping mechanisms such as confrontation achieved post-traumatic growth. Before the loss, all parents have pre-loss mental structures; the post-loss mental state of the bereaved can be linked with the coping method they opt for. Finally, the importance of traditional practices, religion, and support from family members and friends cannot be downplayed during grief resolution.

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Ethical Approval

Ethics clearance was obtained from the Ethics Committee for the Humanities (ECH: 017/18-19) at the University of Ghana before the commencement of the study.

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References

Aho, L. A., Tarkka, M. T., Åstedt-Kurki, P., & Kaunonen, M. (2009). Fathers' experience of social support after the death of a child. *American Journal of Men's Health*, *3*(2), 93–103. https://doi.org/10.1177/1557988307302094

Asare, G. O., Annor, F., & Yendork, J. S. (2020). "It is not something you can easily forget": Ghanaian parents' experiences of child loss. *OMEGA-Journal of Death and Dying*, *2020*, Article 0030222820981230. https://doi.org/10.1177/0030222820981230

Attig, T. (2004). Disenfranchised grief revisited: Discounting hope and love. *OMEGA-Journal of Death and Dying*, *49*(3), 197–215. https://doi.org/10.2190/p4tt-j3bf-kfdr-5jb1

Baker, J. P., & Berenbaum, H. (2007). Emotional approach and problem-focused coping: A comparison of potentially adaptive strategies. *Cognitive and Emotion*, *21*(1), 95–118. https://doi.org/10.1080/02699930600562276

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review*, *21*(5), 705–734. https://doi.org/10.1016/s0272-7358(00)00062-3

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, *4*, 1–8. https://doi.org/10.1177/2333393617742282

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101. DOI:10.1191/1478088706qp063oa.

Cao, X., Yang, C., & Wang, D. (2020). The impact on mental health of losing an only child and the influence of social support and resilience. *OMEGA - Journal of Death and Dying*, *80*(4), 666–684. https://doi.org/10.1177/0030222818755284

Currier, J.M., Holland, J.M., & Neimeyer, R. A. (2006). Sense-making, grief and the experience of violent loss: Toward a mediational model. *Death Studies*, *30*(5). 403–428. https://doi.org/10.1080/07481180600614351

Folkman, S. (2001). *Revised coping theory and the process of bereavement*.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, *21*(3), 219–239. https://doi.org/10.2307/2136617

Ghana Statistical Service (2014). *2010 population and housing census report: Mortality*. Author.

Gillies, J., & Neimeyer, R. A. (2006). Loss, grief, and the search for significance: Toward a model of meaning reconstruction in bereavement. *Journal of Constructivist Psychology*, *19*(1), 31–65. https://doi.org/10.1080/10720530500311182

Gomez, R., & McLaren, S. (2006). The association of avoidance coping style, and perceived mother and father support with anxiety/depression among late adolescents: Applicability of resiliency models. *Personality and Individual Differences*, *40*(6), 1165–1176. https://doi.org/10.1016/j.paid.2005.11.009

Heffer, T., & Willoughby, T. (2017). A count of coping strategies: A longitudinal study investigating an alternative method to understanding coping and adjustment. *Plos One*, *12*(10), Article e0186057. https://doi.org/10.1371/journal.pone.0186057

Janoff-Bulman, R. (1992). Happystance. *PsycCRITIQUES*, *37*(2), 162–163.

Jong, J. D., & Reis, R. (2013). Collective trauma processing: Dissociation as a way of processing postwar traumatic stress in Guinea Bissau. *Transcultural Psychiatry*, *50*(5), 644–661. https://doi.org/10.1177/1363461513500517

Kreicbergs, U. C., Lannen, P., Onelov, E., & Wolfe, J. (2007). Parental grief after losing a child to cancer: Impact of professional and social support on long-term outcomes. *Journal of Clinical Oncology*, *25*(22), 3307–3312. https://doi.org/10.1200/jco.2006.10.0743

Kübler-Ross, E., & Kessler, D. (2001). *Life lessons. Two experts on death and dying teach us about the mysteries of life and living*. Touchstone.

Kübler-Ross, E., & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. Simon & Schuster.

Lichtenthal, W. G., Burke, L. A., & Neimeyer, R. A. (2011). Religious coping and meaning-making following the loss of a loved one. *Counseling and Spirituality*, *30*(2), 113–135.

Luszczynska, A., Benight, C. C., & Cieslak, R. (2009). Self-efficacy and health-related outcomes of collective trauma: A systematic review. *European Psychologist*, *14*(1), 51–62. https://doi.org/10.1027/1016-9040.14.1.51

Machado, C. (2010). Diagnosis of brain death. *Neurology International*, *2*(1), 7–13. https://doi.org/10.4081/ni.2010.e2

McIntosh, D. N., Silver, R. C., & Wortman, C. B. (1993). Religion's role in adjustment to a negative life event: Coping with the loss of a child. *Journal of Personality and Social Psychology*, *65*(4), 812–821. https://doi.org/10.1037/0022-3514.65.4.812

Meyer, A. C., Opoku, C., & Gold, K. J. (2018). "They say I should not think about it:": A qualitative study exploring the experience of infant loss for bereaved mothers in Kumasi, Ghana. *OMEGA - Journal of Death and Dying*, *77*(3), 267–279. https://doi.org/10.1177/0030222816629165

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology*, *100*(4), 569–582. https://doi.org/10.1037/0021-843x.100.4.569

Osei-Mensah, A. (1999). Women's roles in the mourning rituals of the Akan of Ghana. *Ethnology*, *38*(3), 257–271. https://doi.org/10.2307/3773817

Ravaldi, C., Levi, M., Angeli, E., Romeo, G., Biffino, M., Bonaiuti, R., & Vannacci, A. (2018). Stillbirth and perinatal care: Are professionals trained to address parents' needs? *Midwifery*, *64*, 53–59.

Roser, M., Ritchie, H., & Dadonaite, B. (2013). *Child and infant mortality*. Our world in data. https://ourworldindata.org/child-mortality

Salifu Yendork, J. S., & Somhlaba, N. Z. (2017). "I am happy because of God": Religion and spirituality for well-being in Ghanaian orphanage-placed children. *Psychology of Religion and Spirituality*, *9*(Suppl 1), S32–S39. https://doi.org/10.1037/rel0000094

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-Stroebe&Schut

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75. https://doi.org/10.3233/efi-2004-22201

Stroebe, M. (1991). Coping with bereavement: A review of the grief work hypothesis. *Journal of Death and Dying*, *26*(26), 1–42. https://doi.org/10.2190/tb6u-4qqc-hr3m-v9ft

Stroebe, M., & Schut, H. (2010). The dual-process model of coping with bereavement: A decade on. *OMEGA-Journal of Death and Dying*, *61*(4), 273–289. https://doi.org/10.2190/om.61.4.b

Thompson, M. P., & Vardaman, P. J. (1997). The role of religion in coping with the loss of a family member to homicide. *Journal for Scientific Study of Religion*, *38*(1), 44–51. https://doi.org/10.2307/1387881

Thuen, F. (1997). Social support after the loss of an infant child: A long-term perspective. *Scandinavian Journal of Psychology*, *38*(2), 103–110. https://doi.org/10.1111/1467-9450.00015

Volgsten, H., Jansson, C., Svanberg, A. S., Darj, E., & Stavreus-Evers, A. (2018). A longitudinal study of emotional experiences, grief and depressive symptoms in women and men after miscarriage. *Midwifery*, *64*, 23–28. https://doi.org/10.1016/j.midw.2018.05.003

Wardlaw, T., You, D., Hug, L., Amouzou, A., & Newby, H. (2014). UNICEF Report: Enormous progress in child survival but greater focus on newborns urgently needed. *Reproductive Health*, *11*(1), 1–4. https://doi.org/10.1186/1742-4755-11-82

Yoon, Y., Cederbaum, J. A., & Schwartz, A. (2018). Childhood sexual abuse and current suicidal ideation among adolescents: Problem-focused and emotion-focused coping skills. *Journal of Adolescence*, *67*(1), 120–128. https://doi.org/10.1016/j.adolescence.2018.06.009

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