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By Stephanie Dianne Rose

Entitled
THE EXPERIENCE OF MEN AFTER MISCARRIAGE

For the degree of Doctor of Philosophy

Is approved by the final examining committee:

Heather Servaty-Seib, Ph.D.
Chair

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Erina MacGeorge, Ph.D.

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Approved by: Dr. Rick Olenchak 11/5/2015
Head of the Departmental Graduate Program Date

THE EXPERIENCE OF MEN AFTER MISCARRIAGE

A Dissertation

Submitted to the Faculty

of

Purdue University

by

Stephanie Dianne Rose

In Partial Fulfillment of the

Requirements for the Degree

of

Doctor of Philosophy

December 2015

Purdue University

West Lafayette, Indiana

To my curious, sweet, spunky, intelligent, and fun-loving daughter Amira, and to my unborn baby (lost to miscarriage February 2010), whom I never had the privilege of meeting. I am extremely happy and fulfilled being your mother. Thank you for your motivation and inspiration.

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ABSTRACT

Rose, Stephanie D. Ph.D., Purdue University, December 2015. The Experience of Men After Miscarriage. Committee Chair: Heather Servaty-Seib, Ph.D.

Miscarriage is a relatively common event that occurs in approximately 15 to 20 percent of identified pregnancies (Maker & Ogden, 2003). Men and women often view miscarriage as a real and meaningful loss (Johnson & Puddifoot, 1996; McCreight, 2004). The vast majority of research focused on the experience of miscarriage has emphasized the feelings, thoughts, and behaviors of women (Conway & Russell, 2000; McCreight, 2004). However, minimal research exists focused on men's experience after miscarriage (Rinehart & Kiselica, 2010). The present phenomenological study examined the experience of men after miscarriage including aspects such as responses (e.g., emotions and behaviors), coping, meaning-making, and perspectives of masculinity and gender roles. Data were collected through individual, in-person, interviews with nine men affected by miscarriage. Men also completed two measures examining their perspectives on masculinity and gender roles. I organized the data that were represented by all participants into five superordinate themes: men's emotional and behavioral expressions, men's views of their partners' emotional and cognitive expressions, coping, meaning reconstruction, and men's perspectives on masculinity and gender roles.

The present study revealed certain significant and unique insights into men's experience following miscarriage including diversity of response, diversity of partner response, coping, meaning-making, and views of masculinity and gender roles. Most men found that supporting their partners helped facilitate, rather than hindered, their own responses and coping. Most participants appeared accurately attuned to their partners' experiences. Unlike the results of prior research studies, the majority of participants did not report relationship conflict (i.e., related to miscarriage) with their partners. Additionally, all participants participated in meaning-making activities to help them to make sense of, find benefit from, and reconstruct their understanding of themselves and their worlds.

The results of the present study offer implications for the fields of thanatology and counseling psychology, including the recognition of the unique and diverse responses that men experience, factors that may affect men's responses (i.e., views on masculinity and gender roles), men's interactions with their partners, ways that men cope, and types of meaning reconstruction activities. Limitations of the study were in the areas of sampling, research paradigm, and research design.

CHAPTER I INTRODUCTON

Overview of the Problem

Miscarriage is a relatively common experience that can have a significant impact on people (Johnson & Puddifoot, 1996; Maker & Ogden, 2003; McCreight, 2004). Miscarriage occurs in approximately 15 to 20 percent of identified pregnancies (Maker & Ogden, 2003). Men and women often view miscarriage as a real and meaningful loss (Beutel, Willner, Deckardt, von Rad, & Weiner, 1996; Conway & Russell, 2000). The vast majority of research focused on the experience of miscarriage has emphasized the feelings, thoughts, and behaviors of women. However, minimal research exists focused on men's experiences following miscarriage (McCreight, 2004; Rinehart & Kiselica, 2010). Society needs to be concerned about men's responses following miscarriage because men can be overlooked, not expected to react or may react in different ways than what is generally known or accepted, and may lack support (Gerber-Epstein, Leichtentritt, & Benyamini, 2009; Murphy, 1998). Due to minimal scholarly literature available, society may have difficulty recognizing the response of and need for support of men following a miscarriage.

The focus of the present study was to give men a voice by reporting (in their own words) their experience following miscarriage. Regarding miscarriage, men have lacked a

voice in society, psychology, and thanatology. The study explored men's lived experiences from an open, inductive approach.

Society has often overlooked miscarriage and men's and women's responses to miscarriage (Conway & Russell, 2000; McCreight, 2004; Puddifoot & Johnson, 1999; Rinehart & Kiselica, 2010). Some people find that memorials and rituals are helpful expressions following a death loss. However, memorials (i.e., funeral, burial) are not often implemented for miscarriage (Maker & Ogden, 2003). Men and women may not feel comfortable disclosing a miscarriage occurrence to family and friends (Conway, 1995; McCreight, 2004; Rinehart & Kiselica, 2010). Miscarriage information is often not available to people, and misconceptions persist (Maker & Ogden, 2003). For example, some women may believe that they caused the miscarriage, and they may blame themselves (Adolfsson, 2011; Conway & Russell, 2000). The lack of awareness and information of the impact of miscarriage may contribute to experiences of isolation, anxiety, and self-blame (Adolfsson, 2011; Conway, 1995; Conway & Russell, 2000; Doka, 2002; Hughes & Page-Lieberman, 2005; Murphy & Merrell, 2009**).**

Men's responses following death have historically been overlooked by the fields of psychology and thanatology; however, a recent focus on men's responses to death has emerged (Doka & Martin, 2010; Stroebe, Stroebe, & Schut, 2001). Researchers have recently re-focused on men's unique experiences and perspectives following several decades of critical recognition and attention given to women's experiences (Levant, 1992). The field of psychology highlights men's issues through a society devoted to men's issues and the development of practice guidelines devoted to boys and men (Glicksman, 2013). Parallel to the re-focus on men's experience in the field of

psychology, scholars in thanatology (i.e., study of death and dying) have recently emphasized the unique grief responses of men (Doka & Martin, 2010; Stroebe et al., 2001). Historically, grief scholars, researchers, and clinicians have emphasized the stereotypical feminine grief responses, often demonstrated through affective expression, as being normative (Stroebe et al., 2001). The stereotypical masculine experience of grief, often demonstrated through cognitive and physical means, has historically been viewed as inferior (Doka & Martin, 2010).

When mourners experience a lack of acknowledgment of their grief, they may experience disenfranchised grief (Doka, 2002). Disenfranchised grief is associated with both individuals and types of losses that are unrecognized. Men as a group are often unacknowledged as grievers. Miscarriage is a type of disenfranchised loss, and the resulting response might be termed disenfranchised grief (Doka, 2002). Disenfranchised grievers are generally not validated, lack social support, and are not allowed the usual rights of grievers (Attig, 2004). Because they are not acknowledged, grievers may wonder if their thoughts, feelings, and behaviors are abnormal (Doka, 2002). Although limited research exists on men's expressions, scholars have examined the grief of men who have experienced the death of spouses, children, and gay partners and friends from AIDS (Arnold & Gemma, 2008; Benedict & Zhang, 2008; Boykin, 2010). Overall, bereaved men in the U.S. tend to receive less social support than women (Farberow, Gallagher-Thompson, Gilewski & Thompson, 1992; Ha, Carr, Utz, & Neese, 2006). Men may be socialized not to ask for or accept help throughout childhood or adulthood. Men's responses following loss have often been unacknowledged whether they have lost a child, partner, or friend.

The possible overlooked nature of men's grief responses following miscarriage is likely indicated through the fact that researchers have primarily examined the experience of women following miscarriage, with little attention to men's experience following miscarriage. When researchers have examined men, it has often been within the context of the couple relationship. Research suggests that men and women often grieve differently after miscarriage with women grieving longer and more intensely (Abboud & Liamputtong, 2003; Beutel et al., 1996). Women tend to heavily rely on their partner for support; therefore men are often tasked with the responsibility of caring for their partners while managing their own grief (Johnson & Puddifoot, 1996; Murphy, 1998). Some men may experience denial and internalization of grief (Lasker & Toedter, 1991; Stinson, Lasker, Lohmann, & Toedter, 1992). While the research on men's grief responses in general is growing, there remains just a small amount of literature focused on men's grief following miscarriage. At times, the study of men's experience of grief, broadly, and of miscarriage specifically, has been overshadowed by the examination of women's experiences.

Little research exists, but what does suggests that men do often bond with the unborn baby during pregnancy and, in connection, grieve miscarriage (Johnson & Puddifoot, 1996; McCreight, 2004). Research suggests that, similar to women, men's viewing of ultrasound images of their unborn baby may facilitate their bonding with the unborn child and perception of the child as a person (McCreight, 2004; Murphy, 1998). Men may blame themselves for the loss and experience emotions such as sadness and anger (McCreight, 2004; Murphy, 1998).

There is a need for an in-depth examination of men's lived experience following miscarriage, including their overall responses and coping. Many men are affected by miscarriage, but they have often not been given a voice in the empirical literature. Men's experiences, separate from their partners' needs, must be understood. My review of theory in Chapter II is representative of my effort to present my existing scholarly knowledge with regard to the topic of miscarriage. The findings of the present study contribute to the overall field of thanatology, broadly, and body of work on miscarriage, specifically. The present study will also provide treatment-related guidance to counseling psychologists and other mental and physical health professionals.

Importance of the Study

The present study contributes to professional psychology and thanatology in the United States (U.S.). The field of counseling psychology has largely overlooked individuals' responses to death-related situations (Servaty-Seib & Taub, 2010), and psychology students may not receive adequate clinical training on working with clients who have experienced death losses (Ober, Granello, & Wheaton, 2012). Psychologists lack sufficient empirical research on responses to specific forms of bereavement (Rinehart & Kiselica, 2010). My study offers empirical findings that psychologists can use in their practice. The results of my study could be used to develop evidence-based approaches for intervening with men following a miscarriage.

The present study also contributes to the field of thanatology through a targeted focus on miscarriage and use of a qualitative methodology. More research is needed on perinatal death (i.e., miscarriage and stillbirth; McCreight, 2004; Worth, 1997). Many studies examine both miscarriage and stillbirth with little attention given to the

potentially unique aspects of each loss and more studies focused on miscarriage are needed (Robinson, 2011). Specific aspects regarding miscarriage including the effects of viewing ultrasound imaging and social support also deserve further examination (Conway & Russell, 2000; Johnson & Puddifoot, 1998). Additionally, the present study contributes to the promotion of different types of research methodologies within thanatology (Neimeyer & Hogan, 2001). The qualitative perspective offers more detailed, in-depth descriptions of the grief experience than quantitative methodology provides. This in-depth approach can be informative to counseling psychologists because they often counsel and work with patients on an individual level. Qualitative accounts of response to loss and grief can contribute to the development of theories (Neimeyer, 2004).

The thanatology literature often considers women's death-related responses as normative and may not highlight men's responses (Stroebe et al., 2001). The present study contributes to the paucity of research on men and death, and most particularly to the gap in the literature regarding men's specific and unique experiences following miscarriage. Much of the research on men's experience has been examined within the context of the couple relationship, and men's experiences have been compared and contrasted to women's experiences (Beutel et al., 1996; Conway & Russell, 2000). It is important to examine men separately from their partners because research suggests that some men may view and grieve miscarriage differently than women (Abboud & Liamputtong, 2003; Conway & Russell, 2000). In addition, men interviewed within the context of a study in which their partners are also interviewed may consider their partner's experience along with their own, and downplay their personal experiences. If

men know that the concentration of a research study is solely on men, they may be able to focus on their own lived experience with greater clarity.

Statement of Purpose

The aim of the present study was to phenomenologically examine the lived experiences of men following their partner's miscarriage; to give voice to men's unique responses and coping. I implemented Interpretative Phenomenological Analysis (IPA), an inductive approach where I examined men's responses a semi-structured framework (Patton, 2002; Smith, Flower, & Larkin, 2009). Little research has been conducted that is solely focused on men's experiences following miscarriage (Puddifoot & Johnson, 1996; Rinehart & Kiselica, 2010). Miscarriage is a significant life experience that men are likely to react to (Beutel et al., 1996; McCreight, 2003). Research suggests that men can bond with the unborn child during pregnancy and experience sadness and anger following miscarriage (Puddifoot & Johnson, 1996). Researchers focused on death-related topics have often given precedence to women's responses over men's responses (Stroebe et al., 2001). Similarly, researchers have examined women's miscarriage experiences more often than men's experience of miscarriage (McCreight, 2004; Rinehart & Kiselica, 2010). Miscarriage is a type of loss that is often marginalized by society, and men's response is often disenfranchised as well (Doka, 2002). Because there is a paucity of research focused on men's lived experience of miscarriage, counseling psychologists have little material to consult when working with grieving men.

Terminology and Concepts

In this section, I offer definitions for terms I use within the present study. Many of these terms have a variety of definitions in the scholarly literature.

- I use the term *bereavement* to refer to the state of having experienced a loss, often the loss of someone or something significant (Rando, 1995).
- I use the term *grief* to refer to the involuntary, normative responses individuals experience following a loss, including loss of an unborn child following miscarriage. Grief involves many dimensions (i.e., emotional, cognitive, behavioral, physical, social, and spiritual aspects; (Corr & Corr, 2012; Doka, 2011; Rando, 1995). It is important to note that I did not use the term grief in my interviews with participants. Rather, I define it here as many researchers studying miscarriage have used the term grief to refer to responses to miscarriage.
- I use the term *psychological distress* to refer to symptoms that may indicate more extensive and severe responses including anxiety and stress (Adolfsson, 2011). This term is often used by researchers who do not specifically conceptualize their research of miscarriage through the lens of grief, but rather view psychological distress symptoms as more pathological.
- I use the term *disenfranchised grief* to refer to grief responses experienced after losses that are not acknowledged or recognized by society (Doka, 2002). The losses are disenfranchised as well as the subsequent grief reactions.
- I use the term *miscarriage* to refer to the sudden death of an unborn child in the early stages of pregnancy (before 20 weeks).
- I use the term *perinatal loss* to refer to the death of a baby before birth, either as a miscarriage or stillbirth (Abboud & Liamputtong, 2003).
- I use the term *unborn child* to refer to a baby before it is born. The term *fetus* is often used in the literature and by medical personnel, but I draw on research that

suggests that parents often prefer to use the word *baby* (McCreight, 2004 Murphy, 1998).

- I use the term *sex* to refer to an individual’s biological makeup as male and female (APA, 2011; Prince, 2005).
- I use the term *gender role* to refer to traditional masculine and feminine characteristics and behavior that society dictates that males and females should display (Perrone, 2009; Perrone, Wright, & Jackson, 2009; Prince, 2005).
- I use the term *masculine* to refer to the gender role that society holds as traditionally male and involving behavior including dominance and competitiveness (Stets & Burke, 2000; Wong et al., 2013).
- I use the term *feminine* to refer to the gender role that society holds as traditionally female that is demonstrated in behavior such as passivity and emotional expressiveness (Stets & Burke, 2000).
- I use the term *gender identity* to refer to how individuals identify with and describe their gender as male, female, or transgender (APA, 2011; Wong et al., 2013). For example, a male may identify as a woman, and a female may identify as a man.

Relevance to Counseling Psychology

The study of men’s lived experience with miscarriage fits with the roles and themes of counseling psychology. With regard to other points of relevance with the field of counseling psychology, men’s issues and the study of grief align with the developmental perspective of the specialty. In addition, the purpose of the present study is in line with

counseling psychology's preventative role. The focus of the present study is consistent with the scientist-practitioner model often used in counseling psychology.

Men's issues and the study of responses following a death loss align with counseling psychology's focus on developmental and normative issues across the lifespan (Gelso & Fretz, 2001). These issues include significant life circumstances such as birth, adulthood, divorce, and death. Death losses are significant life events. Most people who seek therapy in connection with their responses following a death do not suffer from severe psychopathology and typically require brief treatment (Stroebe, Hansson, Schut, & Stroebe, 2008). The normative life circumstances of men, including miscarriage, are considered within the scope of research, training, and practice of counseling psychologists.

Next, the purpose of the present study is in line with the counseling psychologist's preventative role (Gelso & Fretz, 2001). In their preventative role counseling psychologists seek to examine and forestall issues that could become problems if left unresolved. The results of the present study can be directly applicable to counseling psychologists' work with individuals and groups. For example, my results could be used to develop psycho-educational material to provide to men (i.e., following miscarriage) in a class or workshop.

Finally, the focus of the present study aligns with counseling psychology and the scientist-practitioner model. This model incorporates sound research and effective clinical practice (Gelso & Fretz, 2001). Counseling psychologists consult available research in practice, and the results of this study can be used to inform their clinical work. I used an established methodology of qualitative phenomenological research in this study

which is gaining standing in the field of counseling psychology (Ponterotto, 2005). Some counseling psychologists are currently calling for a stronger qualitative research emphasis in training programs (Neimeyer & Diamond, 2001; Ponterotto, 2005). The present study contributes to the promotion of diverse research methods within counseling psychology.

CHAPTER II LITERATURE REVIEW

Miscarriage can be a difficult experience for both men and women. Research has examined the responses of women, men, and couples following miscarriage, including their thoughts, emotions, and behaviors. Scholars have also examined how men's and women's experience of miscarriage relates to social support, pregnancy details, and psychological distress (Adolfsson, 2011; Brier, 2004; Conway & Russell, 2000; Klier, Geller, & Ritsher; Swanson, Connor, Jolley, Pettinato, & Wang, 2007). Few studies have focused solely on men's responses following miscarriage (Johnson & Puddifoot, 1996; McCreight, 2004; Murpy, 1998; Rinehart & Kiselica, 2010). The purpose of the present study was to qualitatively explore the experience of men whose partners have experienced miscarriage.

In this literature review, I present and synthesize empirical findings relevant to my research purpose. I begin by highlighting a recent emergence in psychology on men's experiences and describing the historical focus on women in the field of thanatology. I then examine the literature on gender bias and grief and highlight the emphasis on women's responses as normative, often to the exclusion of men's responses. I follow this discussion with a focus on miscarriage viewed as a type of loss or as no loss. I review the empirical literature on the experience of women and couples after miscarriage, followed by a survey of the available research on men's experiences. I discuss miscarriage as a

type of loss that is often unacknowledged by society. In conclusion, I review the importance of the present study, its primary purpose, and my research questions.

Psychology and Men's Experiences

For the past several decades researchers have understandably focused on women's psychological experiences, prompted by women's marginalization in many societies including the U.S., but a focus on men's experiences emerged in the mid-1970s. In recent years, researchers have re-emphasized men's experience and worked to broaden perspectives and highlight intragroup differences and variability (Levant, 1992; Wong et al., 2013; Wong et al., 2011). Marriage and family therapists and psychologists helped lead the renewed focus on men's issues (Levant, 1992; Wong et al., 2011; Wong et al., 2013). Some people may believe that sex and gender are synonymous, but researchers have highlighted the distinction between the two (Prince, 2005). Sex refers to an individual's biological makeup (i.e., male, female, intersexed), and gender describes one's lifestyle and the role with which someone identifies (e.g., men, women, transgender). In contrast, gender role describes masculine and feminine characteristics and behavior that is influenced by society (Perrone et al., 2009).

Some scholars argue that masculinity is facing a "crisis" due to a changing western society where traditional gender roles are no longer in effect in many settings (Levant, 1992). Researchers such as Levant (1992) argue that there is a need for a "reconstruction of masculinity" (p. 384) wherein men are affirmed for displaying both traditionally masculine and traditionally feminine traits. Researchers assert that a social movement needs to occur with specific changes in the definition of masculinity and femininity.

Research on gender roles and masculinity has developed from an emphasis on traditional roles to a focus on how men construct roles (Levant, 1992; Pleck, 1981; Wong et al., 2013). Previous researchers tended to view masculinity as comprised of traditional gender roles consisting of personality traits that are opposite of traditional feminine personality traits (Pleck, 1981; Wong et al., 2013). One example of this perspective is the Gender Role Identity Paradigm that asserts that ascribing to traditional gender roles results in a consistent gender role identity. The theory posited that men have an innate need to maintain a gender role identity and to ascribe to traditional gender roles (Pleck, 1981). The theory indicates that there would be possible consequences for men who did not maintain a gender role identity or ascribe to traditional gender roles. From the researcher's perspective, these possible outcomes included homosexuality, negative views toward women, and hyper-masculinity.

Following the emphasis on gender role identity, researchers shifted to examining resulting stress from ascribing to strict gender roles (Levant, 1992; Pleck, 1981). For example, Pleck (1981) developed the Gender Role Strain Paradigm to counter the popular Gender Role Identity Paradigm. The Gender Role Strain Paradigm asserts that gender roles are not set but rather are tenuous and sometimes contradictory (Levant, 1992; Pleck, 1981). Gender role stereotypes are embedded in society and are underscored by those of authority and influence such as parents, teachers, and peers (Perrone et al., 2009). Currently, researchers tend to view masculinity from a social constructivist framework that asserts that individuals are involved in creating the meaning of gender, and gender roles are socially constructed (Perrone et al., 2009; Wong et al., 2011; Wong et al., 2013).

Counseling psychologist Wong and fellow researchers (Wong et al., 2011; Wong et al., 2013) criticized the existing masculinity models and quantitative masculinity measures for not directly connecting characteristics and stressful aspects of men's life to their gender. For example, a man may indicate that a certain personality characteristic is related more closely with his ethnicity than with his gender. Wong et al. attempted to fill this gap by creating a new model, the Subjective Gender Experiences Model (Shea & Wong, 2012; Wong et al., 2011; Wong et al., 2013). The model is based in social constructionist views on gender that assert that people pro-actively create their own meanings of gender. Wong et al. (2011; 2013) argue that language is an important vehicle for men to connect their life experiences with their gender. The researchers also describe the usefulness of men's description of theoretical as well as personally-relevant experiences, with an emphasis on men's subjective experience of stress. Wong et al. developed two corresponding measures based on the model, the Inventory of Stressful Masculine Events (ISME) (Wong et al., 2011) and the Subjective Masculinity Stress Scale (SMSS (Wong et al., 2013). The participants in the present study were given both measures to gain insight into their unique views on their masculine roles and any resulting stress. Wong et al. (2011; 2013) assert that further research needs to be conducted to better understand masculinity and men's unique experience of stress.

Different groups within the discipline of psychology have recently highlighted men's issues. The Society for the Psychological Study of Men and Masculinity, Division 51 of the American Psychological Association (APA), seeks to promote knowledge about the psychology of men through emphases on research, training, clinical work, and public policy. The division also publishes the *Psychology of Men and Masculinity* journal. In

addition, in 2005 APA provided funding for the creation of a task force to develop Practice Guidelines for Psychological Practice with Boys and Men. A draft that synthesizes the research and practice on clinical work with boys and men is currently being reviewed by APA's Board of Professional Affairs and Committee on Professional Practice and Standards (Glicksman, 2013). Certain areas warrant further investigation, namely issues involving sex and gender. Specifically, the study of men’s experience of miscarriage can promote the study and understanding of heterosexual men’s issues and grief. My examination of men’s experience of miscarriage fits with counseling psychology’s focus on men’s issues.

One common life experience that men face is response to loss. However, men’s grief has often been overshadowed by an emphasis on women’s responses to loss (Doka & Martin, 1998; Stroebe et al., 2001; Zinner, 2000). Researchers tend to emphasize the feminine grief experience as normative. A gender bias exists in the grief literature, and I examine this bias in the following section.

Gender Bias in Grief Literature

In the study of responses to death loss, researchers and clinicians have historically focused on women and the feminine experience (Doka & Martin, 1998; Stroebe et al., 2001; Zinner, 2000). Previous researchers often suggested that men responded in inferior ways when compared to women (Doka & Martin, 2010; Stroebe et al., 2001); more specifically, men have been viewed as avoiding or denying their reactions. Recently, researchers and clinicians have begun to advocate for an increased emphasis on the study of men’s perspectives, response, and coping (Doka & Martin, 2010; Stroebe et al., 2001). In addition, most of the literature on miscarriage as a specific loss experience has also

emphasized the responses of women. In this section, I begin with a brief discussion of the bias toward the feminine experience in the study of death-related loss, describe psychologically healthy responses to loss/grieving, and then describe a recent conception known as patterns of grief. It is important to note that I did not approach my study with an expectation that all participants would experience grief following miscarriage. However, it is important to address the grief-related literature base and to describe the feminine bias that has existed in order to provide background information and outline expressions that some participants described.

In the death-related literature, the stereotypical feminine response, demonstrated through affective expression, has been viewed as the norm. Historically, less affective types of responses (i.e., cognitive and behavioral) have been viewed as inferior to affective expressions (Creighton, Oliffe, Butterwick, & Saewyc, 2013; Doka & Martin, 2010; Stroebe et al., 2001). Men have been viewed as tending to express responses to loss through this type of less affective and more physical and cognitive approach (Stroebe et al., 2001). However, measures of grief often have an affective bias that indicates that women have higher levels of grief (Stinson et al., 1992). This bias in grief measures may also have created a lack of a clear picture of the nature of grief for men. Some people in society may hold the misconception that men respond to loss in less psychologically healthy ways than women, due to some men's seemingly avoidant and less affective methods of grieving. However, less affective types of responses should not be discredited, but further examined.

The recent approach in thanatology is to assert that there is no one psychologically healthy way to grieve (Rando, 1991; Wolfelt, 2004). People grieve in

different ways, whether in traditionally feminine or traditionally masculine ways, or a combination of both. Healthy grief can involve the expression of emotion, crying, journaling, ritual activities, prayer/meditation and other spiritual activities, creating art, working on a project, relying on social support, etc. Characteristics of psychologically unhealthy grief that could lead to negative outcomes include denial/avoidance, isolation/lack of reliance of social support, and impulsive behavior (Doka & Martin, 2009; Kersting & Wagner, 2012; Stroebe et al., 2001).

Another recent approach in thanatology is to examine potential differential patterns of grief and coping (Doka & Martin, 2009; Stroebe, 1998; Stroebe et al., 2001). This approach is connected to the idea that there are various healthy ways to respond to loss. The approach can be applied to how men and women respond to and grieve losses such as miscarriage, and therefore, is relevant to the present study. The researchers focused on potential patterns of grief assert that people may grieve in different ways but not necessarily in better or worse ways. Doka and Martin (2009) acknowledge that grief is multidimensional (i.e., emotional, cognitive, behavioral, social, spiritual) and is affected by various factors, one of which is gender. Other factors include culture, religion, and age (Doka & Martin, 2009). Doka and Martin assert that grief is not solely gender-based. Overall, Doka and Martin's patterns of grief theory is informative and can help broaden the definition of psychologically healthy grief. The patterns of grief theory acknowledges individual's idiosyncratic ways of grieving, rather than a sole focus on gender roles. However, one criticism is that Doka and Martin do not distinguish between sex and gender, but seem to group the two terms together. They do not discuss grievers whose gender role identification is not the same as their sex.

Doka and Martin (2010) conceptualized patterns of grief to include the main patterns of intuitive and instrumental. Intuitive grievers are open to examining and experiencing their feelings as a way to process grief. Some people may feel comfortable crying, alone and/or around others. They also are often highly communicative of their emotions, through verbal and written expressions. They tend to focus inside of themselves and not on outward activities. Intuitive grievers are likely to appreciate expressions of comfort and support from others (Zinner, 2000). Although women might be viewed as tending to grieve intuitively, Doka and Martin (2010) emphasize the need to look beyond sex and gender to a focus on the patterns themselves. In contrast, instrumental grievers implement more physical and cognitive methods of expression and coping (Doka & Martin, 2010; Puddifoot & Johnson, 1999). Instrumental grievers process their emotions less openly than intuitive grievers and attempt to focus on physical or cognitive tasks in order to cope with loss. Types of tasks that instrumental grievers may work on include creating a memorial for the deceased, doing craft projects, or engaging in carpentry. Instrumental grievers cope with grief by focusing outside of themselves instead of looking inward and examining and expressing their emotions like intuitive grievers. Instrumental grievers also may not accept or rely on comfort and support from others as much as intuitive grievers (Zinner, 2000). Instrumental grievers may even reject emotional support as being inconsistent with their tendency to downplay emotional expression. Additionally, Doka and Martin describe the lesser-developed concepts of blended and dissonant patterns. These are variations of intuitive and instrumental patterns. Doka and Martin assert that some people may be drawn to both intuitive and instrumental grief expression, known as the blended patterns of grief. Doka

and Martin also describe dissonant grievers who express their grief differently than how they experience it.

Both men and women may exhibit and use any of the four patterns of grief identified (i.e., intuitive, instrumental, blended, and dissonant) by Martin and Doka (2010), but societal expectations are generally aligned with stereotypical gender roles. Historically, societal expectations in the U.S. have been based on gender roles and dictated that men grieve instrumentally and women grieve intuitively. Grievers can experience a sense of isolation when they identify with the style of grief that is least expected for their gender role (Kubitz, Thornton, & Robertson, 1989; Zinner, 2000). Although men may be expected to grieve in a more instrumental pattern, according to Martin and Doka (2010), there continue to be remnants of expectation that all grievers will express their grief through an intuitive approach (Stroebe et al., 2001; Zinner, 2000). The instrumental style of grief, which may be found more commonly in men, needs further examination.

Just as recent attention has challenged assumptions about grief based on gender, researchers also continue to challenge previous assumptions connected with issues relate to narrow grief expectations (Corr & Corr, 2012; Kuber-Ross, 1969; Rando, 1995). Contemporary scholars assert that every person grieves differently, and each person's experience should be viewed individually (Corr & Corr, 2012; Doka, 2011). The way a person grieves depends on how he or she views the loss (Rando, 1995). Grief has been defined as a normative, multidimensional response to loss that involves emotional, cognitive, behavioral, physical, social, and spiritual aspects (Corr & Corr, 2012; Doka, 2011; Rando, 1995). For example, a grieving person may experience emotional grief

responses such as sadness, anxiety, yearning for the deceased person, anger, and guilt. Cognitively, a person may experience difficulty concentrating, disorganization, and lower self-esteem. Behaviorally, grief may be displayed through crying, hyperactivity, and sleep difficulties. Physically, a bereaved person may experience grief responses such as appetite disturbance, fatigue, and decreased interest in activities. A grieving person may socially withdraw, suffer boredom, and display dependency on others. Spiritually, grievers may doubt the goodness of a higher being such as God or may question the meaning of life. Alternatively, they may be strengthened in their faith and belief in an afterlife (Tedeschi & Calhoun, 2004; Tedeschi & Calhoun, 2006). Grief is composed of idiosyncratic responses in multiple life domains.

In sum, the grief responses of women have been thoroughly examined in the grief literature and set forth as an exemplar, and it appears that masculine responses to loss/ grief experience has often been mischaracterized or overlooked. Contemporary scholars assert the need to expand beyond past research and are pioneering innovative conceptions of grief that are not solely tied to gender (Doka & Martin, 2010). The aspects and elements of grief that may be unique for men must be understood in order for evidence-based clinical interventions to be implemented with this particular population.

Men and Grief

Although limited research exists on men's particular grief responses, scholars have focused on the grief of men who have experienced the death of spouses, children, and gay partners and friends from AIDS (Arnold & Gemma, 2008; Benedict & Zhang; Boykin, 2010; Stroebe et al., 2001). The literature in these areas is useful to the present study because it adds an empirical base beyond the limited scholarship available on

men's specific experience of miscarriage. Additionally, researchers are increasingly implementing qualitative research in the examination of men's expressions of loss.

The largest body of grief literature that focuses on men as grievers is the research that exists on the grief experience and adjustment of widowers (Balaswamy, Richardson, & Price, 2004; Benedict & Zhang, 2008; Stroebe et al., 2001). The loss of a partner greatly affects physical and mental health (Stroebe et al., 2001). Men and women experience a greater risk of mortality along with psychological distress and risk of depression when compared to their non-bereaved peers (Bennett, Hughes, & Smith, 2005; Parkes, 1996). Along with physical and mental distress, widows and widowers face practical adjustments to daily life. Researchers have observed that widows may have more financial difficulties than widowers since men are often the primary providers (Benedict & Zhang, 2008). On the other hand, widowers may have more adjustment than widows to household management tasks such as laundry, cooking, and cleaning (Benedict & Zhang, 2008). Widows and widowers experience grief, psychological and physical stress, and adjust to practical changes following the death of a spouse.

Another main area of bereavement research examines men's grief following the death of a child (Arnold & Gemma, 2008; Barrera et al., 2013). The loss of a child is one of the most devastating experiences a person can face (Arnold & Gemma, 2008; Barrera et al., 2013; Sanders, 1980; Schwab, 1996). Researchers such as Middleton et al. (1998) and Sanders (1980) have found that men who lost a child grieve at a significantly higher intensity than those mourning the death of a spouse or parent. Researchers have examined gender-based patterns of grief following the death of a child, and different patterns of grief among bereaved parents have emerged (Aho, Tarkka, Astedt-Kurki, & Kaunonen,

2009). Some researchers have found that among bereaved parents, men appear to experience less severe responses of shorter duration than women (Schwab, 1996; Sidmore, 2000). However, these results may be misleading due to gender biases and expectations about healthy ways of grieving. Some men in these studies may not be adequately identified as grieving due to some men's less emotional and more active styles of grief. In addition, Schwab (1996) discovered that men tend to display less emotion and grieve less affectively. Aho et al. (2009) found that men tend to express more denial than women (Aho et al., 2009). Schwab (1996) found that women expressed more despair, anger, guilt, and processed their emotions more than men.

One group of men that researchers have examined is the grief experience of gay men following the loss of a partner or friend due to AIDS (Boykin, 2010; Cherney & Verhey, 1996; Martin & Dean, 1993). Bereaved gay men following the loss of a partner due to AIDS face the difficulties of grief along with the social stigma of their sexual orientation, which Siegal and Hoefer (1981) referred to as a "double stigma" (p. 518). Some bereaved men may grieve silently for fear of the stigmatization of AIDS (Doka, 1987; Nord, 2001).

Men in the U.S. tend to receive less social support following a death loss than women (Farberow, Gallagher-Thompson, Gilewski & Thompson, 1992; Ha, Carr, Utz, & Neese, 2006). Bereaved gay men have reported a lack of social support and validation of their grief (Doka, 2010; McNutt & Yashushko, 2013; Wright & Coyle, 1996). Widowers and bereaved fathers tend to be more socially isolated and less likely to elicit help following deaths when compared to widows and bereaved mothers (Aho et al., 2009; Farberow et al., 1992). Others may not understand widowers' and fathers' grief and

withhold adequate support (Farberow et al., 1992; Wood & Milo, 2001). Specific to widowers, researchers have found that both widows and widowers with adequate social support experience greater well-being than those with little support. Some researchers have suggested that women's' heightened experience of social support, in comparison to men, may explain their better physical and mental health outcomes following death losses (Stroebe et al., 2001; Suitor & Pillemer, 2000). Most relevant to the current study, it is possible that men's responses following miscarriage may be related to social support received. Adequate social support may aid men's coping, and little or undesirable social support may hinder men's coping.

Researchers are increasingly implementing qualitative research methodology to explore the experience of grieving parents and grieving gay men (Cherney & Verhey, 1996; Neimeyer & Hogan, 2001; Wright & Coyle, 1996). Quantitative research may not be the best fit to examine these groups because the measures used may not align with some of the men's experiences because some measures examine intuitive grief responses to the extent of overlooking instrumental responses (Toedter, Lasker, and Janssen, 2001). For example, the Perinatal Grief Scale, often used in miscarriage research, focuses on affective issues such as sadness, self-blame, feelings of worthlessness, crying, and desire to talk about the unborn child. There are no items on the PGS- short form that address instrumental grief (i.e., cognitions, behaviors) (Toedter et al., 2001). Qualitative approaches are critical for populations that do not have a voice and for groups who have not traditionally had a voice. Qualitative methodology can reflect the unique meaning and perspective that individuals hold towards grief (Neimeyer & Hogan, 2001).

Scholars suggest that men may have been disenfranchised as grievers whether they have lost a child, partner, or friend. Bereaved gay men, doubly stigmatized (Siegal & Hoefer, 1981) following the loss of a partner due to AIDS, face the difficulties of grief along with the social stigma against their sexual orientation. Miscarriage is another type of unacknowledged loss and men who experience miscarriage face a double stigma regarding the misunderstood nature of their gender and response/grief, and their specific type of loss.

Miscarriage and Grief

In this section, I offer information about miscarriage, about how miscarriage can either be viewed as a loss or as not a loss, and a review of the empirical literature focused on women's, couples', and men's experiences following miscarriage. The review of this material provides a broader context to my more specific focus on men's responses following miscarriage.

Miscarriage: Loss or No Loss

View of physical and psychosocial loss. Parents may view the loss of a baby through miscarriage differently than society may perceive the loss, and the concepts of physical and psychosocial loss can help explain this difference (Conway & Russell, 2000). The occurrence of miscarriage is complicated, and the subsequent responses that may follow are multidimensional and often connected with experiences of guilt, lack of validation, and threats to identity, among other aspects (Corr & Corr, 2012; Rando, 1995). Rando (1995) defined two types of loss: physical and psychosocial. She described physical loss as the loss of something tangible such as the death of a loved one, loss of a house in a fire, or the loss of a body part. Rando described a psychosocial loss as the loss

of something not tangible such as a divorce or a job loss. Physical losses are often more obvious to others than psychosocial losses and therefore receive more recognition. People who experience physical losses often receive more support and acknowledgment of their loss than people who experience psychosocial losses (Rando, 1995). The loss of an unborn child through miscarriage could be viewed by society as a psychosocial loss because the unborn child was not visible to other people, and the loss may not be apparent. However, parents may also view miscarriage as a physical loss and as the physical death of the unborn child. Research indicates that individuals perceive miscarriage in distinct ways (e.g., as a loss, as a relief) and that those individual perceptions may be associated with similarly distinct responses. This variance may be a contributing factor to the marginalized nature of the miscarriage experience; it may be hard for others in U.S. society to know how those who experience miscarriage perceive and encounter this life event.

View of minimal or no loss. Research suggests that some men and women do not view miscarriage as a loss (Conway & Russell, 2000; Madden, 1994; Murphy, 1998; Swanson et al., 2007). Some studies have indicated that men and women may experience minimal perceptions and responses following miscarriage. Some men and women may also experience mixed emotions of sadness and relief (Conway & Rusell, 2000; Swanson et al. 2007). Factors that appear to influence response include relationship instability, unplanned and undesired pregnancy, lack of attachment to the unborn child, alleviation of physical pain, and length of time since miscarriage (Conway & Russell, 2000; Madden, 1994; Murphy, 1998; Swanson et al., 2007). For example, in her qualitative study, Murphy (1998) found one participant who experienced relief following the miscarriage,

partly due to his lack of perceived attachment to the unborn child. In their qualitative study, Swanson et al. (2007) reported on the experience of one woman who primarily experienced relief, along with mild sadness, following miscarriage. She indicated her emotions were due to inconvenient timing of the pregnancy, when she and her partner were close to separation.

Miscarriage and Attachment Theory

Miscarriage may be viewed as a death loss that affects both women and men. It is a distinct type of death loss with varying responses. In this subsection, I describe the theoretical perspective of attachment that delineates the bond between parent and unborn child during pregnancy and beyond. The level of attachment can contribute to the perceptions of a pregnancy and to the loss of an unborn child. I describe how one factor, the viewing of ultrasound images can contribute to the development of attachment. In conclusion, I expand upon the idea of grief that is not acknowledged or validated, known as disenfranchised grief.

Attachment theory is a useful lens through which to view the experience of miscarriage. Several researchers have applied attachment theory to miscarriage and perinatal loss because of the theoretical emphasis on pregnancy and infancy (Robinson, Baker, & Nackerud, 1999; Uren & Wastell, 2002). Theorists and researchers assert that parents often feel a strong connection and bond with the unborn child during pregnancy; a bond that continues to grow once the baby is born (Beutel et al., 1996; Brier, 2008; Johnson & Puddifoot, 1998).

Bowlby (1969) developed the theory of attachment and defined attachment as the "lasting psychological connectedness between human beings" (p. 194). Bowlby asserted

that adults' relationships and worldviews are shaped by how their early attachment figures responded to their needs. Securely-attached infants grow to view the world as safe and demonstrate confidence and independence in their interactions with others (Ainsworth & Bell, 1970). Insecurely-attached people may lack confidence and may be suspicious of others. Bowlby proposed that parents, often mothers, set the tone for their child's future relationships by either quickly and sensitively responding to their needs as the child's "safe haven" and "secure base" (p. 194) or ignoring or inconsistently responding to the child's needs.

Just as babies become attached to their mothers, mothers and fathers become attached to their offspring through the caregiving bond (Lyons-Ruth & Block, 1998; Solomon & George, 1996). Researchers have found that infants' level of attachment corresponds with maternal caregiving levels (Ainsworth & Eichberg, 1991; Bakermans-Kranenberg & Van IJzendoorn, 1993). Mothers' caregiving systems typically begin shortly after conception and strengthen throughout the pregnancy (Scheidt et al., 2012; Tsartsara & Johnson, 2006). In her study, McCreight (2004) found that prior to miscarriage or stillbirth, all men in her sample ($N = 14$) appeared to be invested in their paternal role and had bonded with the unborn child. She reported that all of the participants in her sample referred to themselves as a "parent" or "father" and referred to their deceased child as "baby" instead of "fetus." Parents are often highly motivated to protect their children through the set of behaviors known as caregiving (Bowlby, 1969; Solomon & George, 1996).

While most attachment researchers and theorists have focused on attachment following birth, some have examined pre-natal attachment and attachment after death

(Johnson & Puddifoot, 1998; Peppers & Knapp, 1980; Uren & Wastell, 2002). The relationship between a mother and unborn child is unique from other relationships because aspects of the relationship involve future realization (Uren & Wastell, 2002). Researchers have found that parents can be attached to their deceased babies and often maintain a continuing relationship known as a continuing bond after death (Johnson & Puddifoot, 1998; Uren & Wastell, 2002). Uren and Wastell studied women following prenatal loss and found that mothers reported a continuing relationship with their babies, regardless of the time passed since the child's death. Women persistently nurtured the bond with their baby through actions such as visiting the gravesite, celebrating birthdays, talking to their baby, creating memory books, and commemorating events such as the first day that the child would have attended school. The mothers reported planning to continue to maintain the connection with their babies in the future. The little research that exists on men's prenatal attachment suggests that men also develop a caregiving bond to the unborn child during pregnancy (Johnson & Puddifoot, 1996; McCreight, 2004; Rinehart & Kiselica, 2010). More research is needed on the inception of the caregiving system in men and men's involvement in caregiving (Solomon & George, 1996).

Viewing ultrasound images may contribute to men and women's attachment to the unborn child and thereby also contribute to their perception of the miscarriage as a loss (Johnson & Puddifoot, 1996; Johnson & Puddifoot, 1998; McCreight, 2004; Murphy, 1998). Johnson and Puddifoot (1996) conducted two similar studies and found that men who had viewed fetal ultrasound images endorsed higher levels of despair and difficulty coping than their peers who had not viewed such images. The researchers suggested that the viewing of ultrasound images may have helped men realize the reality

of the pregnancy and life of the unborn child. The researchers asserted that these men had greater visual imagery ability that enabled them to better consider the unborn child as real and bond with him or her. In her interviews with men, McCreight (2004) found that men who viewed ultrasound images reported a realization of the baby as a person. Murphy (1998) also found that men who reported a bond with the unborn child and realized the reality of the pregnancy appeared to experience a greater intensity of grief than men who reported that the baby did not seem real.

Disenfranchised Grief

Individuals who do view miscarriage as a loss and display attachment to the unborn child may experience a lack acknowledgment as well as minimal social support, and therefore, may experience disenfranchised grief (Doka, 2002). Disenfranchised grief, a term coined by Doka (2002), refers to grief responses experienced after losses that are not acknowledged or recognized by society; as the losses are disenfranchised as well as the subsequent grief reactions. Grievers are not afforded the usual rights of mourners and lack validation. Disenfranchised grief is often associated with certain types of losses such as miscarriage due to its sometimes stigmatized and often private nature (Doka, 2002). Miscarriage has historically been misunderstood and not often openly discussed partly due to its personal and misunderstood nature (Maker & Ogden, 2003). Women and men may not disclose their miscarriage experiences to others. In addition, certain groups of people (e.g., children, older adults) including men are sometimes considered disenfranchised due to the lack of acknowledgment of their grief (Doka, 2002).

Disenfranchised grievers are not afforded the usual rights of grievers (i.e., time to mourn, ritual implementation) and lack validation. Attig (2004) stated that all people hold

the fundamental right to grieve as they choose, without interference from others. He wrote, “Disenfranchisement of grief, as such interference, violates the mourner’s right to grieve” (p. 198). Those who grieve disenfranchised losses often experience isolation and lack of support. Since disenfranchised losses lack validation from others, grievers may wonder if their grief-related thoughts, feelings, and behavior are abnormal (Doka, 2002). They may question why they are experiencing grief since their expressions of grief lack validation from society (Conway & Russell, 2000). People can both actively and indirectly invalidate grievers’ behaviors and experiences.

Miscarriage can be considered a type of disenfranchised loss, and those who grieve following a miscarriage may experience disenfranchised grief (Doka, 2002). Miscarriage fits Doka’s (2002) definition of a disfranchised loss because it often lacks acknowledgment from society. Some people may not perceive miscarriage as a loss, whereas others grieve intensely. Grievers of miscarriage may feel isolated and lack support from others. Furthermore, men are considered disenfranchised grievers because of the lack of validation they often receive from society (Conway & Russell, 2000; Doka, 2002).

Women and Miscarriage

In this section, I review the literature that exists on women’s grief and psychological distress following miscarriage, and I conclude with limitations of the research (Adolfsson, 2011; Brier, 2004; 2008). Miscarriage can be a distressing, even traumatic event for women (Nikčević, et al., 2007; Shreffler et al., 2011; Swanson et al., 2007). However, some women may view miscarriage more positively and experience relief (Conway & Russell, 2000; Madden, 2008). Women who miscarry may experience

grief responses such as guilt, sadness, anxiety, and yearning for the lost baby (Adolfsson, 2011; Adolfsson et al., 2004; Murphy & Merrell, 2009). Research suggests that some women's grief following a pregnancy loss tends to be similar to grief following other types of death losses (e.g., loss of an older child), although grief following miscarriage is distinct in certain ways (e.g., cognitions of guilt and self-blame; Swanson et al., 2007). For some women, miscarriage grief is similar to other types of death losses in that women often experience cognitive and social disruption and negative emotions including sadness and anxiety. Post loss, some women may feel guilty for the miscarriage. They may wonder if they ate something that contributed to the loss or even blame themselves if they were ambivalent about the pregnancy.

Some researchers equate grief and depression, a fact that adds challenge to reviewing the empirical findings (Janssen, Cuisinier, Hoogduin, & de Graauw, 1996; Lasker & Toedter; Neimeyer & Hogan, 2001). Miscarriage researchers have difficulty measuring grief, and so some of them have attempted to measure it indirectly using depression measures (Lasker & Toedter, 1991). However, some researchers recognize that grief and depression are distinct (Adolfsson, 2011; Beutel, Deckardt, von Rad, & Weiner, 1995). In her meta-analysis of psychological responses after miscarriage, Adolfsson (2011) pointed out that some researchers used measures of depression when measuring post-miscarriage reactions, and therefore viewed participants' response as an illness**.** Adolfsson (2001) suggested that miscarriage researchers should use the Perinatal Grief Scale Short Version (PGS-S) to quantitatively assess grief responses and identify women who "grieve outside normal limits" (Adolfsson, 2001, p. 38; Potvin, Lasker, & Toedter, 1989). The PGS-S is a measure that was specifically designed to assess the

unique aspects of post-miscarriage grief including responses such as active grief, difficulty coping, and despair (Potvin et al., 1989).

Researchers commonly use either the short or long version of the PGS to measure the unique aspects of grief that may occur following miscarriage or stillbirth. Although I am using a qualitative phenomenological design, I offer information about the PGS because it is the most commonly used quantitative measure in the miscarriage literature. When creating the PGS, Toedter, Lasker, and Alhadeff (1988) drew from research on general grief and perinatal loss in order to survey the dimensions of grief experienced by people following miscarriage (Toedter et al., 2001). The measure consists of three subscales: active grief (i.e., crying and missing the unborn child), difficulty coping (i.e., adjustment to the loss; trouble with decision making), and despair (i.e., sense of hopelessness), and is used with many types of perinatal loss including miscarriage and stillbirth. The PGS has been used extensively with various types of perinatal loss and scores have demonstrated high reliability and validity and acceptable internal consistency (Toedter, Lasker, & Janssen, 2001). The short form was created soon after the original measure. Many researchers have used the PGS (Conway & Russell, 2000; Lasker & Toedter, 1991; Stinson et al., 1992) and it has been translated into various languages (Adolfsson & Larsson, 2006). The PGS exhibits a feminine bias demonstrated by an emphasis on questions focused on intuitive grief over instrumental grief. For example, questions include affective responses such as crying, yearning for the baby, and feelings of guilt and worthlessness. Examples of instrumental grief include constructing a memorial, ritual implementation, and thoughts about the baby. The PGS' feminine bias may not best characterize more masculine expressions of grief.

Beutel et al. (1995) sought to distinguish grief responses from depressive symptoms in women who miscarried by using a grief scale similar to the PGS and a separate depression scale. They conducted a longitudinal study and compared women who experienced miscarriage with cohorts of pregnant women and women from a community and found that almost half of the women who had a miscarriage had higher depressive levels and grief responses than the other two groups immediately after the miscarriage. The other half reported no changes in their emotional responses. The authors discovered that grief reactions occurred more often in women with a stronger investment in and hopeful attitude toward the pregnancy, and depressive reactions occurred in women who appeared ambivalent towards their pregnancy, experienced prior depression, or lacked social support. Women who displayed no response appeared to not have developed an attachment to the unborn child. Additionally, results also indicated that participants who presented with the initial grief response experienced an alleviation of symptoms at 6 months, and patients with depressive or mixed depressive and grief response continued experiencing symptoms at 12 months post-miscarriage. The researchers argued that some participants experienced a depressive reaction because they did not grieve the miscarriage.

Beyond a focus on grief per se, a number of studies have examined possible psychological distress (e.g., depression, anxiety, guilt, and stress feelings) of women following miscarriage (Adolfsson, 2011; Brief, 2008; Klier et al., 2002; Swanson et al., 2007). Current research suggests that women may face an increased risk for anxiety and depression symptoms after miscarriage (Adolfsson, Larsson, & Bertero, 2004; Adolfsson, 2011; Brier, 2004; Brier, 2008). Anxiety and depression symptoms are especially

heightened within six months following miscarriage (Beutel et al., 1995; Janssen et al., 1996). Geller, Psaros, and Kornfield (2001) compared the diagnostic interview results of women who had experienced miscarriage with those of a community cohort and found that women who had miscarried demonstrated a significantly higher risk for obsessive-compulsive disorder and panic disorder than the community sample, but no greater risk for phobic disorder. Similarly, Brier (2004) conducted a review of the literature and concluded that the occurrence of miscarriage appeared to increase the risk for anxiety disorders, specifically obsessive-compulsive disorder and post-traumatic stress disorder. Janssen et al. (1996) found that up to six months post-miscarriage, women exhibited greater symptoms of depression and anxiety than a cohort of women who delivered to term. Overall, researchers have found that psychological distress and disorders after miscarriage in most women tend to decrease with time (Beutel et al., 1995; Janssen et al., 1996; Brier, 2004; Brier, 2008; Broen, Moum, Bødtker, & Ekeberg, 2005; Nikčević, Kuczmierczyk, & Nicolaides, 2007; Shreffler et al., 2011).

Researchers have examined certain factors that have been found to be positively associated with psychological distress following miscarriage including miscarriage-related, reproduction-related, and personal life-related factors (Beutel et al., 1995; Goldbach, Dunn, Toedter, & Lasker, 1991; Janssen et al., 2006; Lasker & Toedter, 1991; Nikčević et al., 2007; Shreffler et al., 2011). Miscarriage-related factors include unidentified cause, time since loss, length of gestation, and prior pregnancy loss (Nikčević et al., 2007; Shreffler, Greil, & McQuillan, 2011; Simmons, Singh, Maconochie, & Green, 2006). Nikčević et al. and Simmons et al. found that women who knew an identified cause of miscarriage demonstrated less anxiety and self-blame than

women with an unidentified cause. Nikčević et al. also found that participants who lacked knowing an identified cause experienced continuing anxiety four months following the loss, while those who knew a cause experienced decreased anxiety four months post-loss. Simmons et al. found that women who did not know a cause soul-searched and wondered the reason for the loss. Janssen et al. found that one year following miscarriage, women's psychological functioning was comparable to that of women whose pregnancy had resulted in a live birth. The researchers also found that women experienced more intense psychological distress and grief following a later pregnancy loss than an earlier loss.

Reproduction-related factors that are positively associated with psychological distress following miscarriage include history of infertility, planned pregnancy, and desire for children (Beutel et al., 1995, Simmons et al., 2006). Simmons et al. and Beutel et al. found that women whose pregnancies were planned and desired reported greater psychological distress and grief responses than women whose pregnancies were unplanned and undesired. Additionally, Simmons et al. discovered that some women whose pregnancies were planned and desired experienced anger following the loss. These women related a sense of deservedness of the child.

Personal life-related factors positively affiliated with psychological distress include lack of social support and history of prior depression (Beutel et al, 1995; Lasker & Toedter, 1991). Beutel et al., 1995 found that women with a history of depression were more likely to experience psychological distress and symptoms of depression (e.g., sadness, irritability, withdrawal, hopelessness, negative memories of the pregnancy, and feelings of worthlessness, guilt, and shame) following miscarriage. The researchers also discovered that lack of social support predicted psychological distress and depressive

symptoms. More research is needed on the various factors connected with distress and the possible development of psychological disorders (Brier, 2008).

Certain limitations exist in the research literature focused on women and miscarriage. Researchers sometimes equate grief and depression, making it difficult to examine women's grief responses. Researchers also sometimes make the assumption that grief is an expected, normative response to miscarriage, and that an absence of grief may be pathological (Doka and Martin, 2010). Researchers have also examined miscarriage in combination with other types of fetal losses including stillbirth and induced abortion, making it difficult to determine unique aspects of the experience of miscarriage. Additionally, researchers have primarily used samples of white, married, educated, middle to upper-class women (i.e., examined level of education). The miscarriage experience of non-Caucasian, unmarried, low socio-economic status women lacks examination (Gold, Boggs, Mugisha, & Palladino, 2012; Toedter et al., 2001; Nikčević et al., 2007; Swanson et al., 2007).

The experience of women, to the neglect of men, has been the primary focus of empirical investigations on miscarriage. Much of the miscarriage research with men has been conducted within the couple relationship. In the next section, I review the miscarriage research conducted with couples.

Couples and Miscarriage

Much of the research that has examined men's experience after miscarriage has been done in the context of their relationship with their partner. Men's and women's grief responses after miscarriage are often compared and contrasted. One main finding is that men can grieve after miscarriage (Abboud & Liamputtong, 2003; Beutel et al., 1996;

Hamama-Raz, Hemmendinger, & Buchbinder, 2010; Serrano & Lima, 2006). However, conflicting research exists on differences between men's and women's responses following miscarriage. Most researchers report that women tend to have longer and more intense responses than men (Abboud & Liamputtong, 2003; Beutel et al., 1996; Hamama-Raz et al., 2010; Serrano & Lima, 2006; Stinson, et al., 1992). Abboud and Liamputtong (2003), Beutel et al. (1996), and Stinson et al. (1992) found that men did not affectively express their emotions as much as women but coped by internalizing their emotions. Men may not feel comfortable expressing their emotions due to societal norms (Abboud & Liamputtong, 2003; Serrano & Lima (2006); Stinson et al., 1992). Beutel et al. (1996) reported that women indicated crying more than men and also expressed more of a desire to discuss their loss than their partners. Additionally, findings indicate that women tend to rely heavily on their partners; therefore men may be tasked with the responsibility of caring for their partners while managing their own responses (Johnson & Puddifoot, 1996; Murphy, 1998).

Although most studies examining couples have found that men's expressions tend to be less intense than women's grief, Conway and Russell (2000) found that men scored higher than women on active grief (i.e., sadness, crying, missing the child), difficulty coping, and despair on the PGS. Conway and Russell recruited participants from healthcare facilities such as hospitals and doctor's offices who experienced a recent miscarriage. In the hospital settings, nurses approached patients about participation in the study after admittance, and doctors approached patients within three weeks of miscarriage. The researchers highlighted the uniqueness of their findings compared to other similar studies and suggested that perhaps the men who participated in their own

study were more distressed than men participants in other studies because they surveyed participants more quickly after the miscarriage than did other researchers. Additionally, they suggested that a limitation of their study was that their research design did not capture the full extent of responses because the study ended at four months post-loss, unlike other studies where researchers studied men one year after or longer post-loss (Stinson et al., 1992). Conway and Russell argued that more research on men's expressions following miscarriage needs to be conducted.

The timing of responses following miscarriage may be different for men and women. Stinson et al. (1992) examined men and women, using the PGS, at two months, one year, and two years post-loss and found that women tended to respond more intensely than men directly following perinatal loss whereas men's scores tended to increase over time. Men's scores on all of the PGS subscales even increased during the time period of two months to one year whereas women's scores decreased. Women's scores continued to decrease from one year to two years post-loss, and men's scores decreased as well. The researchers suggested that the scores increased because some men may have initially experienced denial and internalization of their responses due to societal expectations that men should not express emotion. They argued that some of the men may have used denial as a primary mode of dealing with their responses. Lasker and Toedter (1991) found similar results of what they termed a "delayed grief reaction" (p. 520) in some men in their longitudinal study of couples' grief following miscarriage.

Social support appears to operate differently for women and men following miscarriage. Researchers including Conway and Russell (2000), Hamama-Raz et al. (2010), and Lasker and Toedter (1991) have found that women often rely on their

partners as their main source of social support. In addition, men tend to recognize their partners' need for support and attempt to provide appropriate support, even to the extent of possibly neglecting their own responses (Beutel et al., 1996; Hamama-Raz et al., 2010). In their longitudinal study of men and women, Lasker and Toedter (1991) found that perceived social support was a negative predictor of scores on all three PGS subscales (i.e., active grief, difficulty coping, and despair) for men and women. The subscales of difficulty coping and despair were best predicted by the presence of inadequate coping resources including lack of social support. Perceived lack of social support was a risk factor for high active grief scores with lack of family support more critical in the long-term and lack of friend support more critical in the short-term. In their qualitative study, Hamama-Raz et al. (2010) found that more women expressed more loneliness and a sense of isolation following miscarriage than did men.

The study of men's experience of grief, broadly, and of miscarriage specifically, has been overshadowed by the examination of women's experiences. Overall, men are often an unacknowledged group in the grief and loss literature, broadly, and in the miscarriage literature, specifically. I examine the paucity of literature on men's experience following miscarriage in the following section.

Men and Miscarriage

In this section, I examine men's overall experience and responses/grief following miscarriage. In addition to their overall responses, I review information on their lack of social support and the possible disenfranchised nature of their responses/grief.

Limited research exists on men's experience following miscarriage (McCreight, 2004; Murphy, 1998), and research studies that do exist suggest that men are often

affected by miscarriage (McCreight, 2004; Murphy, 1998) and view it as a loss (McCreight, 2004; Puddifoot & Johnson, 1999). In her phenomenological analysis of five men post-miscarriage, Murphy (1998) found that men experienced initial emotions such as shock/disbelief, helplessness, and hope. She found that men also experienced later emotions including sadness, anger/irritability, guilt, numbness, and a desire to grieve affectively at times. She found that some men also experienced relief later on. In her qualitative study of 14 men following miscarriage (recruited from pregnancy loss support groups), McCreight's (2004) over-arching finding was that most men in the study responded affectively with emotions such as sadness and anger. McCreight (2004) also found that some men experienced a loss of a sense of identity as a father and blamed themselves. Men may also display avoidance at times (Abboud & Liamputtong, 2005; Beutel et al., 1996; Murphy, 1998).

Similar to men who grieve a variety of death losses (e.g., spouse, child, gay partner/friend), men whose partners' experience miscarriage are also likely to receive less social support than their women partners (Lasker & Toedter, 1994; McCreight, 2004). Additionally, men may feel isolated in their experience and not feel comfortable exhibiting or sharing their true responses (Abboud & Liamputtong, 2003; Beutel et al., 1995; Puddifoot & Johnson, 1997; McCreight, 2004).

Men who experience miscarriage may be at double risk for disenfranchised grief. In society in general, men are typically privileged. However, the field of thanatology has been dominated by the traditional feminine experience of grief (McCreight, 2004; Stroebe et al., 2001; Toedter et al., 2001). They have been potentially unacknowledged with regard to two domains: their gender related response to grief and their type of loss.

Miscarriage is a type of disenfranchised loss that is often not acknowledged by society (Doka, 1989). Men's possible responses (e.g., crying) may not align with what has traditionally been considered the acceptable or healthy way for men to grieve (Doka & Martin, 2010). More specifically, they may be less likely to grieve using an intuitive approach that is affective, expressive, and interpersonal. Therefore, society in general, and researchers specifically, seldom focus on men who experience miscarriage due to their membership in two marginalized groups.

Summary and Critique

In this section, I have reviewed the empirical literature on women's, couples', and men's experiences of miscarriage and possible associated grief responses. Researchers have primarily examined men's miscarriage experiences quantitatively, although qualitative studies do exist (Adolfsson, 2011). Researchers and practitioners primarily use self-report questionnaires due to their convenience and cost-effectiveness (Klier et al., 2002). Researchers commonly use the Perinatal Grief Scale (PGS) with men and women following miscarriage. However, little psychometric research exists on the use of the PGS with men (Toedter, Lasker, & Janssen, 2001).

The available quantitative research is limited because quantitative measures are often developed based on a feminine approach to grief. Quantitative research yields broad findings from typically large samples and lacks an individual focus on men's experiences following death losses. Qualitative research, on the other hand, draws from a small sample and highlights a more in-depth perspective of individual's experience (Neimeyer & Hogan, 2001). Furthermore, the qualitative approach used in the present study is needed, in part, to complement quantitative research by contributing to the development

of theory. An additional limitation to previous research is that researchers have often grouped gender with sex and implied or assumed that people's gender role is equal to their biological sex. In the present study, I specifically assessed men's perspectives on masculinity and gender roles.

The existing meaning reconstruction theory in the field of thanatology relates to the present study. This theory asserts that individuals find their own unique understanding of grief. Similarly, I used qualitative methodology and a phenomenological design in the present study to learn about men's experience of miscarriage and how men make sense of their loss and find meaning. The theory of meaning reconstruction holds a similar goal, and I discuss how this theory and my methodology intersect.

Meaning Reconstruction, Men, and Miscarriage

In this section, I explain how my method and design are connected with meaning reconstruction. In addition, I review research, focused on parental bereavement, and perinatal loss that has used the theory of meaning reconstruction.

Meaning reconstruction theory and the qualitative methodology of the present study are anchored in constructivism. Meaning reconstruction theory maintains that individuals need to integrate loss into their sense of self and reconstruct the way they view the world and themselves (Neimeyer, Burke, Mackay, & Stringer, 2009). The experience of loss can challenge people's views of the world and of themselves (Neimeyer et al., 2009). Qualitative phenomenological research attempts to examine and portray how people understand and make sense of their experiences (Patton, 2002; Smith et al., 2009). One element of the current IPA study was the exploration of men's

perceived meaning-making following miscarriage and the examination of what they learned through their loss experience.

The meaning reconstruction theory and the constructivist phenomenological approach both rest on the assumption that humans naturally attempt to organize events and experiences within a meaningful framework (Neimeyer et al., 2009). People either adjust their view of their loss to fit their worldview or expand their worldview to accommodate their loss (Neimeyer, 2006). Major losses can warrant substantial re-structuring of the self (Neimeyer, Prigerson, & Davies, 2002). Grief can be associated with positive outcomes such as personal growth but also with negative outcomes such as despair. IPA researchers attempt to examine and report how participants organize and make sense of certain life experiences (Guba & Lincoln, 1994; Smith et al., 2009). The participants are viewed as active participants in the research process, and participant and researcher collaborate to co-construct meaning (Ponterotto, 2005).

Meaning reconstruction has been a key theory of focus and investigation within a field related to miscarriage, the study of grief responses following the death of a child (Lichtenthal, Neimeyer, Currier, Roberts, & Jordan, 2013). While researchers have examined meaning reconstruction with bereaved parents, only a handful of studies have examined miscarriage through the lens of meaning reconstruction (Lichtenthal, Currier, Neimeyer, and Keesee, 2010; Lichtenthal et al., 2013). The studies that have examined meaning reconstruction with parental bereavement in general have found certain advantages to meaning-making in grief (Keesee, Currier, & Neimeyer, 2008; Lichtenthal et al., 2013). Keesee et al. (2008) found that meaning-making was associated with adjustment among bereaved parents. Participants who did not find meaning experienced

more intense grief responses (e.g., yearning for the deceased) than participants who could make sense of their loss. Bereaved parents noted common benefits of loss, including greater compassion, ability to better help others, and wisdom (Lichtenthal et al., 2010; Lichtenthal et al., 2013; Uren & Wastell, 2002).

With regard to perinatal losses, Uren and Wastell (2002) examined the construct of meaning-making for women who experienced stillbirth and found that a majority of the participants reported that they searched for meaning following their loss. Most of the participants viewed themselves as changed from the loss experience. Research suggests that parents bereaved by perinatal loss who find meaning from their loss often rely on spirituality and religious beliefs (Keesee et al., 2008; Lichtenthal et al., 2010; Lichtenthal et al., 2013; Murphy et al., 2003). Lichtenthal et al. (2013) examined bereaved parents' experience with sense-making after various types of child death losses including perinatal loss, violent death, and accidents. The researchers grouped losses as either violent or non-violent and classified perinatal loss as a non-violent death. They found that bereaved parents were better able to cope with and make sense of non-violent deaths compared to violent deaths, which is consistent with prior research (Murphy et al., 2003). However, one primary limitation of the study was that the researchers did not examine miscarriage separate from other types of perinatal death, and perinatal death was grouped with other types of non-violent deaths.

Purpose

The purpose of the present study was to explore the lived experience of men whose partners have miscarried. At this point little is known about the unique experiences of men following miscarriage. The information that does exist is limited by the use of

quantitative measures that were developed based on a primarily feminine approach to grief (Stroebe et al., 2001; Toedter et al., 2001)

Much of the available information on men's experiences following miscarriage is reviewed within the context of a couple relationship. Counseling psychologists working with men who have experienced miscarriage need more information upon which to develop and implement evidence-based interventions for these individuals.

To achieve this purpose, I implemented Interpretative Phenomenological Analysis (IPA), which is an inductive, qualitative approach where I openly examined men's experiences with a semi-structured framework (Patton, 2002). Consistent with IPA, I purposefully did not develop any hypotheses but allowed the data to direct the findings. Throughout the research process, I made note of my scholarly knowledge (e.g., theories) and personal perspective, background, and biases**.** Acknowledgement of scholarly knowledge, background, and biases is in line with the constructivist, IPA approach. IPA recognizes that research cannot be divorced from personal values.

Research Questions

The primary research question was: What is men's experience of miscarriage? This question underlies all the research questions. There were three sub-questions. The first was: What are men's responses to miscarriage? I explored men's emotions and behaviors. Second, what approaches did men use in coping with miscarriage? The final sub-question was: How do men make sense of their miscarriage experience? I explored the ways that men discovered meaning and significance from the miscarriage experience.

CHAPTER III METHOD

In this section, I describe the method of the present study. I describe the research paradigm and design. Next, I detail the participant demographic information, recruitment procedures, interview protocol, masculinity measures, and interview and member check procedures. I conclude by outlining the data analysis process, the procedures for determining validity, and information regarding researcher background.

A qualitative method is an ideal fit for examining the topic of men and miscarriage (McCreight, 2004; Murphy, 1998). Qualitative research is an appropriate methodology for exploratory studies, and little is known about men's experience following miscarriage (Patton, 2002; Smith et al., 2009). The purpose of the present study and the research questions best fit qualitative methodology because the study is constructivist and the questions/prompts are open-ended (e.g., "Tell me about your miscarriage experience). Qualitative research is inductive and allows the data to guide the research (Creswell, Hanson, Plano, & Morales, 2007; Patton, 2002; Smith et al., 2009). The qualitative method is a broad type of empirical approach, and the constructivist paradigm and phenomenological design fall under the qualitative method.

Paradigm

I planned the present study through the lens of the constructivist paradigm (Guba & Lincoln, 1994; Ponterotto, 2005). As the researcher, I did not present myself as the primary authority on knowledge, but I involved the participants as active members of the process. Both constructivism and IPA assert the ontological position that no single objective reality exists, but people construe multiple, subjective realities (Ponterotto, 2005; Smith et al., 2009). Constructivism and IPA also maintain the epistemological idea that meaning can be co-constructed through collaboration of researcher and participants (Ponterotto, 2005; Smith et al., 2009). I contacted the participants to conduct member checking and received their feedback on the accuracy of the interview transcript, as well as gleaned additional comments and reflections from them. The participants and I collaborated on developing themes from the data; therefore, co-constructing meaning and significance from the study. This paradigm fits with IPA, the design for the present study, which emphasizes co-construction of meaning between participant and researcher.

One tenet of constructivist research is that people hold different perspectives about reality that they create in their minds (Ponterotto, 2005). I recognize that the participants and the researcher are situated in and affected by culture and history (Morrow, 2005; Nielsen, 1991). My pursuit of discovery of multiple perspectives was demonstrated as I sought to explore the participants' varied realities and meaning construction. At the same time, I examined axiology (i.e., my values and prior knowledge) by noting my background, perspective, and biases. I examined but did not eliminate my perspective and biases (Ponterotto, 2005).

The constructivist paradigm shares similarities and differences with other paradigms. It differs from the positivist and post-positivist ontological perspective. The positivist approach is typically found in quantitative research and views the researcher as the authority on meaning (Guba & Lincoln, 1994). The positivist and post-positivist viewpoints focus on the empirical study of phenomena that is observable and measurable (Guba & Lincoln, 1994). Positivism asserts that one universal truth exists and can be pursued through research, whereas post-positivism assert that there may be multiple views of understanding reality. Lather (2006) has succinctly delineated the goals of main paradigms. The research goal of positivism and post-positivism is to predict and control phenomena. On the contrary, the aim of constructivist research is to understand phenomena instead of attempting to predict or manipulate it (Lather, 2006). Constructivism asserts the ontological position that no single objective reality exists, but people construe multiple, subjective realities (Ponterotto, 2005). Constructivism maintains the epistemological idea that meaning can be co-constructed through collaboration of researcher and participants (Ponterotto, 2005). The goal of critical theory research, another paradigm that includes feminist research and participant action research is to understand phenomena with the attempt to promote awareness and social change (Lather, 2006). In sum, constructivism fits with the design and goals of the present study.

Design

The phenomenological design is an ideal fit for examining the topic of men and miscarriage (Patton, 2002; Smith et al., 2009). This design is an empirical approach that seeks to examine and describe participants in specific settings (Denzin & Lincoln, 2000; Peshkin, 1993; Ponterotto, 2005). The data are primarily communicated in the form of

words instead of numbers and can come from sources such as interviews, observations, focus groups, and documents (Polkinghorne, 2005). Phenomenology is an appropriate design for exploratory studies, which fits the present study because little is known about men's experience following miscarriage (Patton, 2002; Scheel, Davis, & Henderson, 2013). Phenomenological research is inductive and allows the data to guide the research (Creswell, Hanson, Plano, & Morales, 2007; Patton, 2002; Smith et al., 2009).

As a research design, the purpose of the phenomenological approach for the present study was to explore the experience and perspective of men who have been affected by miscarriage. Phenomenological research focuses on increasing the understanding of human issues, and miscarriage is a common U.S. societal issue experienced by many people (Geller et al., 2009). Phenomenological research focuses on the essence of the lived experience of people regarding certain phenomena and the meaning that people draw from their experience (Creswell et al., 2007; Moustakas, 1994). Results from the present study were not used to create theories (Creswell et al., 2007; Patton, 2002; Smith et al., 2009). Phenomenology is also used for exploratory studies where little is known about a certain phenomenon (Scheel, Henderson, & Davis, 2013). The present study examined the under-studied area of the experience of men following miscarriage, and so phenomenological analysis was an appropriate design to implement (Scheel et al., 2013).

Phenomenology shares both similarities and differences with other qualitative designs. Creswell et al. (2007) outlined five main qualitative approaches used in counseling psychology: narrative research, case study research, grounded theory, phenomenology, and participatory action research (PAR). All of these approaches

typically use interviews as a primary data source, along with other sources such as observations and documents. All of the aforementioned approaches also typically examine more than one individual, and in the participatory action research approach, an entire community. One significant difference between phenomenology and other qualitative approaches is its purpose. The purpose of phenomenology is to explore the essence of a phenomenon shared by individuals. It differs from grounded theory that seeks to systematically construct a theory from the data. Phenomenology differs from participatory action research (PAR) because PAR seeks to incite a change in a community, and phenomenology does not overtly seek to enact change. Rather, phenomenology aims to represent the shared experiences of individuals. Phenomenology also does not emphasize story-telling elements such as chronology that narrative research highlights. Additionally, phenomenology lacks the focus on context that case study research stresses. In sum, phenomenology shares similarities to other qualitative approaches such as the data collection methods, but phenomenology's unique emphasis on the examination of a phenomenon differs from other qualitative approaches.

I implemented a specific type of phenomenology, Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). IPA is a constructivist, inductive qualitative methodology that emphasizes the "detailed examination of lived experience" (p. 47). IPA acknowledges the culture and systems where individuals interact. The process is idiographic, and emphasizes both the individual and group perspectives. The data analysis process begins with an individual focus on individual interviews and then moves to analyze the group. The design emphasizes both the parts and the whole. The

researcher and the participants both construct meaning. The researcher seeks to understand, describe, and interpret the participants' experiences.

Since IPA is a fairly new, open-ended approach, I chose two IPA studies to model as exemplars (Fox & Diab, 2015; Millward, 2006). Both of these studies implemented primary IPA features including: purposive sampling, small samples, data collection via interviews, semi-structured interview format, data analysis using IPA recommendations, and result and discussion written according to IPA recommendations. One of the studies (Fox & Diab) implemented member checking.

Participants

Table 1

Participant Demographics and SMSS Scores

	Age	Sex/ Gender	Ethnicity	Education	Couple Status	Ultra-sound Viewed	Planned/ Desired Pregnancy	Length	Time	SMSS Scores (Avg.)
Dale	65	M/M	C	College graduate	Married	Yes	No/No	16 weeks	31 34 years	1.1
Terry	50	M/M	C	Post-graduate study	Married	Yes	Yes/Yes	9 weeks	20 years	2.7
Chris	21	M/M	C	Some college	Engaged	Yes	No/No	Unknown	2 years, 3 months	2.4
Nathan	30	M/M	C	Post-graduate study	Married	Yes	No/Yes Yes/Yes Yes/Yes	10 weeks	1 year, 4 months (since most recent)	2.1
Wade	27	M/M	C	Some college	Married	No/Yes	Yes/Yes	6 weeks 10 weeks	8 months 2 months	2.0
Frank	31	M/M	C	College graduate	Married	Yes	Yes/Yes	7 weeks	6 months	2.4
Ken	31	M/M	C	Some college	Married	Yes	Yes/Yes	12 weeks	6 years since first one (3 total)	2.7
Larry	64	M/M	A-A	Post-graduate study	Married	Yes	No/Yes	6 weeks 9 weeks	22 32 years	4.2
Eugene	31	M/M	C	College graduate	Married	Yes	No/Yes	13 weeks	1 year	2.6

The sample consisted of nine men whose partners had experienced one or more miscarriages (see Table 1). Five of the participants' partners had experienced multiple miscarriages (i.e., two had experienced three miscarriages; three had experienced two). The miscarriages had occurred from approximately 6 months to 34 years prior to the interview. The miscarriages had occurred at various stages in early pregnancy. The length of gestation ranged from 6 weeks to 16 weeks.

As indicated in Table 1, the men's ages ranged from 21 to 65, with the mean age of 38.90 (SD = 15.50). (Some data in the table is approximated.) All nine participants noted their gender as man. All of the men were partnered in committed relationships at the time of the miscarriage. Eight of the nine men were married at the time of the miscarriage, and one man was in a committed dating relationship (and engaged at the time of the interview). Five of the men were employed full-time at the time of the miscarriage, and four were in school. Most men had viewed ultrasound images. The sample mainly consisted of cases where the pregnancy was planned and desired by the participant. There were only two cases (Dale, Chris) where the pregnancy was unplanned and not initially desired. Furthermore, men's scores on the Subjective Masculinity Stress Scale (SMSS) were included.

Although most of the participants lived in suburban areas, they lived in various regions of the United States at the time of miscarriage. Most specifically, four men lived in the Midwest, and five outside the Midwest. Locations included urban New Jersey, suburban Maryland, suburban North Carolina, suburban Colorado, suburban Ohio, suburban Indiana (3 men), and urban Oregon. The sample was largely homogenous with regard to race. There was only one African-American participant, and the rest were

Caucasian/European-American. The racial homogeneity of the recruitment areas did not yield a diverse sample of participants.

The sample size fits with the best practices in phenomenological research, but is larger than some IPA recommendations (e.g., three to six participants; Smith et al., 2009). Smith et al. asserted that "there is no right answer to the question of the sample size" (2009, p. 51). However, they recommended a small sample of three to six participants for student researchers. The researchers suggested a sample size of "between four and ten" (2009, p. 52) for professional doctorates. In line with best practices related to phenomenological research, 8 to 30 participants appeared to be sufficient for the purposes of the present study to gain adequate information and description of the phenomena (Creswell et al., 2007; Polkinghorne, 1989; Wertz, 2005). The goal of saturation, or repeated findings across participants, was obtained from this sample size (Wertz, 2005). However, in qualitative research the number of participants is a work-in-progress requiring ongoing evaluation (Wertz, 2005). I monitored and reevaluated the sample size during the data collection process to ensure that the resulting sample obtained is adequate to understand the phenomenon. Throughout the data collection process, I examined the interview transcripts in order to view the emerging themes and to look for saturation. I believe that saturation has been achieved. Many themes were represented by over half of the sample, and the resulting final five superordinate themes were represented by the entire sample.

Masculinity and Gender Roles. Participant scores on the ISME (Inventory of Subjective Masculinity Experiences) offered insight into how they view masculinity and gender roles, and their scores on the SMSS (Subjective Masculinity Stress Scale) offered

information on their perceived stress related to masculinity. See measure section below for detailed description of each of these measures. Regarding coding the present study, Wong recommended that I choose a “few” dimensions that fit the research questions (J. Wong, personal communication, July 11, 2014). Per Wong’s recommendation, I chose the two most representative themes in the data to code, family and responsibility (J. Wong, personal communication, July 11, 2014). I reviewed the responses throughout the data collection process and selected the two that were represented the most in the data. The themes of family and responsibility were clearly represented in participants’ responses, unlike other possible codes. I considered the code of Emotional Toughness to be the best fit to the research questions, but there was very little representation in the data. Wong et al. recommended coding of the Responsibility code for references to leadership, helping/protecting others, determination, hard work, setting an example for others, and leaving a legacy. Wong et al. recommended coding of the Family for references to provider for family, head of the household, and romantic/partnership relationships.

Most men reported desiring leadership, care-taking, and family responsibility roles on the ISME. Despite diverse views on gender roles, most men reported on the ISME that they desired to “provide for” their families (Frank, Ken, Larry, Chris, Eugene, Terry). There were three of the men who appeared to hold more traditional gender roles (i.e., emphasis on male as provider, leader). More specifically, Frank, Eugene, Terry reported on the ISME that they desired to “lead” their families and household. Ken also reported the desire to lead, but his responses indicated a combination of traditional and

non-traditional gender views. Most men reported family commitment and involvement, including being a good partner and father.

Many participants (Eugene, Larry, Terry, Dale, Nathan) reported that as men they care about others and contribute to society. Ken and Nathan demonstrated unique feminist perspectives. Ken asserted, “I need to be an ally to women,” and “I need to be aware of my privilege.” Similarly, Nathan reported, “I strive to look out for the interests of the physically weaker such as children/women/elderly.”

The participants completed the corresponding follow-up measure to the ISME, the SMSS. The mean response for the SMSS was 2.47, indicating that the participants rated their subjective masculinity experiences approximately halfway between (*rarely*) and (*sometimes*). The range was from 1.1 to 4.2, and the mode was 2.4. Overall, it appeared that the participants reported little stress from their subjective masculinity experiences. There was one outlier, Larry, whose responses ranged from 3 to 5, with mean of 4.2. He appeared especially stressed by his desire to be a “good father,” “good husband,” “a positive contribution to society,” and “healthy,” which were all rated as a ‘5,’ indicating the highest level of stress. Larry was also the only African-American participant. His experience of masculinity stress may have been influenced by interactions among factors such sex, gender, and race/ethnicity.

Measures

Interview protocol. When creating the interview protocol, I searched the literature for main themes related to women’s and men’s experience with miscarriage. To establish validity, I collaborated with my advisor and research team on the interview protocol. I also reviewed examples of past qualitative dissertations that used

constructivism and IPA (Ponterotto, 2005; Smith et al., 2009). I created four overarching probes, “Tell me about yourself,” “Tell me about your miscarriage experience,” “Tell me about how you are coping with the miscarriage,” and “Tell me about ways that you may have made sense of the miscarriage experience.” I asked follow-up questions as needed to evoke additional participant reflection and gain additional information. I did not need to ask all of the follow-up questions if the participant had already addressed the information. I created follow-up questions spontaneously, with the intention that the interview would follow a conversational style. I concluded the interviews when the participants appeared to have nothing left to say, or when saturation appeared to be reached.

Follow-up question topics covered primary themes from research literature on men and women including questions related to cognitive and emotional responses (Adolfsson et al., 2004), coping (McGreal, Evans, & Burrows, 1997), meaning-making (Neimeyer, 1997), gender role (Wong et al., 2011; Wong et al., 2013), and social support (Rinehart & Kiselica, 2010). The focus of the interview was on the men’s experience, but I included a couple additional questions at the end that pertained to the partner’s overall experience and initial response following the miscarriage, due to committee recommendations.

Demographic and background form. Participants completed a demographic and background form including questions about age, ethnicity, occupational information, relationship status, and gender identity. The demographic questionnaire also included questions about the details of the pregnancy including whether the pregnancy was planned, how the participant felt about the pregnancy, how long the pregnancy lasted, and if he observed ultrasound images. Questions regarding details of the miscarriage were

also included including the date and how much time passed since the miscarriage, and if the participant sought help. The final question on the demographic form was a process question about what the preceding interview was like for the participant.

Masculinity measures. Participants completed two accompanying masculinity measures: the Inventory of Subjective Masculine Experiences (ISME) (Wong et al., 2011) and the Subjective Masculinity Stress Scale (SMSS) (Wong et al., 2013; see Table 1). The authors of these scales identified a limitation of existing masculinity measures in that many of these measures do not link men's life experiences to their gender. With some measures, it is difficult to know whether gender effects men's stress, or another factor such as personality traits (2011). The authors attempted to improve upon existing measures of masculinity by giving participants the opportunity to directly link their gender to life experiences. The authors also provided men the means to report the possible multidimensionality of their roles.

Both of Wong et al.'s measures are grounded in the social constructivist theories of gender, which assert that men and women are involved in creating their own meanings of gender (Addis & Mahalik, 2003). Wong et al. (2011) defined men's subjective experiences of what it means to be a man. For the open-ended ISME, participants in the present study completed the sentence, "As a man…" 10 times. Main themes from the data included men's desire to protect and provide for their families (e.g., "As a man, I want to provide for my family.") They also communicated a desire to be "good" partners and fathers. Men also reported desire to contribute to society (e.g., "As a man, I volunteer in the community.") The authors created a coding manual for the ISME which provides 23 dimensions for researchers to code individual measures. Five of the 23 ISME dimensions

(i.e., Family, Responsibility, Emotional Toughness, Work, and Physical Body) demonstrated initial convergent, discriminant, and concurrent validity (Wong et al., 2011).

After participants filled out the ISME, they completed the accompanying follow-up measure, the SMSS. This measure examines the stress associated with masculinity. The participants were asked to refer to their above responses on the ISME and then to rate how often the masculinity experience was stressful for them. The instructions for the SMSS are: “Please refer to your responses above. For each ‘As a man…’ response, indicate how OFTEN this experience is STRESSFUL for you.”

Procedures

In this section I outline the recruitment process and the interview and member check processes. I received approval from the Purdue University Human Subjects Board for this expedited study. This approval was pursued prior to the proposal meeting in connection with a Purdue Research Foundation Fellowship. I submitted necessary revisions to the study method based on feedback (e.g., addition of masculinity measures) from the committee at the proposal meeting. I implemented the following procedures: participant and I signed the consent form (Appendix A), and the participant filled out the demographic form (Appendix B). I then conducted interviews based on the interview questionnaire (Appendix C). Prior to data collection, I recruited by distributing letters of information describing my study to gatekeepers (Appendix D), I provided letters of information to potential participants (Appendix E), I advertised the study and offered information about the study for potential participants (Appendix F), and I gave participants a hand-out with counseling resources following the interview (Appendix G).

Participant recruitment. Consistent with IPA, I used a purposive sampling strategy and initially sought to recruit a fairly homogeneous sample. Participants needed to meet certain criteria of being male and partnered in a relationship at the time of the miscarriage (Smith et al., 2009). Initially, I also sought to recruit men whose miscarriage had occurred within two years and who lived in the rural or suburban Midwest. However, I encountered recruitment and sampling challenges. I frequently consulted with my research advisor throughout the recruitment process and heeded her guidance. I encountered many participants who did not fit the above limitations of time and physical location, and so I adapted my initial criteria, which was also suggested by my committee, via the proposal meeting and e-mail communication.

Recruitment efforts lasted for approximately nine months, and I implemented a number of different approaches. I intended to use typical samples that are representative of an average Midwest small city. The first stage lasted approximately two-months and only yielded one participant. I actively attempted to recruit through distribution of flyers and information at healthcare facilities and community centers in a small, Midwest city and within an hour radius. Examples of these centers include obstructive-gynecology offices, community centers, auto mechanic businesses, the YMCA, churches, gyms, restaurants, and sports bars. I visited the healthcare facilities and community centers in-person to recruit. I personally visited these sites and distributed letters of information describing my study to the gatekeepers such as administrative assistants and office managers (Appendix D). I provided the gatekeepers with letters of information for them to distribute to potential study participants who they believe would fit the study criteria (Appendix E; i.e., man who experienced miscarriage within the past two years).

Additionally, I gave the gatekeepers a flyer to post that advertised the study and offered information about the study for potential participants (Appendix F). The flyer and the letters to potential gatekeepers and potential participants included information about the goals of the study, potential outcomes, procedures, and my contact information. Potential participants were able to voluntarily contact me to initiate involvement in the study. Following these procedures, I then sought IRB approval (i.e., through the form of an amendment to the present study) to post my study information in a weekly e-mail sent to staff of a local university. This action resulted in three participants. Next, I sought and received IRB approval (through an amendment) to post study information to the social media site Facebook. This action yielded the five remaining participants. In particular this process results in the participants who lived in more distant regions of the country at the time of miscarriage including North Carolina, New Jersey, Maryland, Colorado, and Oregon.

The final sample differs from the initial plan in terms of time since the miscarriage(s) and geographic location. Despite the lack of homogeneity for these issues in the sample, there was a sense of saturation and support for the main themes that I selected during the data analysis process. For example, all of the main themes are supported by all participants in the sample, a criteria suggested by Smith et al. (2009). The resulting data also provide adequate depth and detail into the lived experience of the participants, which is an IPA recommendation (Smith et al., 2009). The sample of nine participants is more than sufficient for the IPA process because IPA typically recommends a smaller sample. The sample size of the present study is also sufficient for qualitative research (Patton, 2002; Smith et al., 2009; Wertz, 2005).

Data collection. My process of data collection involved interacting with all or a subset of the participants at three different times. I conducted a face-to-face interview and then I conducted member checks two times via e-mail that helped increase the validity of the study (Cho & Trent, 2006; Yeh & Inman, 2007).

I conducted the interviews in a private conference room at Purdue. I interviewed each participant using a semi-structured protocol (Appendix C), fitting with IPA recommendations (Smith et al., 2009). This protocol allowed for participant flexibility. Prior to the interview, I provided each participant with an informed consent form that he and I both signed (Appendix A). Before the start of the interview, I discussed the purpose of the study, the audio recording procedure, and confidentiality. I asked each participant if he had any questions or concerns prior to beginning the interview. I implemented a conversational style with participants, consistent with Smith et al.'s (2009) description of the qualitative research interview as "a conversation with purpose" (p. 57). I sought to establish rapport by using the counseling techniques of validating, paraphrasing, and empathizing which appeared to help participants feel comfortable with me during the interview. Overall, the participants appeared to feel comfortable with me, as indicated by their openness and honesty in disclosing personal details of their experiences. Many spoke at-length about many aspects of the miscarriage and resulting responses.

Participants were able to elaborate on certain themes, as well as areas that may not have been included in the interview protocol (Seidman, 2006; Smith et al., 2009). However, I recognized that the process of IPA research is dynamic, and I explored new paths of inquiry as they emerged (Smith et al., 2009). The semi-structured format allowed for additional questions and comments. The goal of the interview style was for it to be

conversational with open, unrestrained responses. The participants appeared comfortable in talking with me and sharing personal details. Five men cried during the interview (Eugene, Dale, Frank, Chris, Larry). This method enhanced the overall quality of data obtained, given the research objective (Seidman, 2006; Smith et al., 2009).

After each interview was completed, I used a standard approach to conclude my interaction with each participant. I asked him if he had any additional information he desired to provide about his experience, thanked him for his participation, and informed him that I will contact him to seek his evaluation of the interview transcription in the form of a member check. I provided a demographic information sheet for him to complete (Appendix B). My purpose in providing the demographic form after the interview was in line with the phenomenological nature and semi-structured format of the present study. If I had given the form prior to the start of the interview, the themes may have primed the participant as to what information I was looking for in the interview.

I then compensated the participant at the conclusion of the interview by offering him the choice to receive a $10.00 gift card or to have $10.00 donated to the March of Dimes organization. Two of the nine participants chose to receive the gift card, and the remaining seven chose to donate to March of Dimes. I placed a donation of $100.00 to the organization in October 2015. I also offered participants a list of counseling resources in the local region, if he was interested in seeking professional help (Appendix G). I gave the participants the opportunity to create their own pseudonym, if they wished, and I used the chosen pseudonym, or a variation of it, on the transcription.

The interviews were audio recorded and later transcribed, and I followed the IPA transcription guidelines from Smith et al., 2009. As recommended by Smith et al., I

transcribed the interviews verbatim and made notes of non-verbal activities such as laughter, crying, significant pauses, and sighs. I began transcribing the interviews from the audio recordings when a majority of the interviews had been completed (i.e., seven out of nine). I did not begin coding until I had transcribed all of the interviews, which is consistent with IPA (Smith et al, 2009).

For the member checks, I provided each participant with a transcript of his interview to review. He was invited to ask questions, present further explanation or clarification, express reflections, and offer approval (Cho & Trent, 2006; Smith et al., 2009). Four participants responded (Frank, Dale, Larry, Eugene), and each of these men noted minor suggestions including grammatical/spelling errors in their transcripts. Eugene shared, “It was a rough read,” and Larry disclosed that reading the transcript was “really harder to read than I thought.” I contacted the participants individually via e-mail a second time to inquire if any desired to read the results in table format (i.e., Table H of superordinate and subordinate themes with supporting quotes-as connected to IPA). Six men responded (Frank, Dale, Larry, Eugene, Nathan, Ken), and I included the results in my response e-mail to them. I invited them to include any comments, questions, or thoughts they had, and none responded. I could not contact one participant because his e-mail was returned due to being an invalid address. Following the interview and member checks, most of the participants thanked me for including them in the present study.

Additionally, I attempted to collect supplementary materials as data sources. I looked for healthcare brochures on grief and miscarriage from healthcare facilities and community centers. However, I did not find any brochures related to grief or miscarriage.

In sum, the data for this study consisted of interviews, demographic and background forms, masculinity measures, and member checks.

Data Analysis and Interpretation

The primary purpose of the present study was to explore the overall experience of men following miscarriage. The underlying research question was: What is men's experience of miscarriage? I also sought to explore men's responses through the follow-up question: What are men's responses to miscarriage? I acknowledged that some men may experience grief, and some may not. My final follow-up questions included: What approaches do men use in coping with miscarriage? and How do men make sense of their miscarriage experience? I addressed these research questions by examining main themes from the three main data sources: the interview, follow-up member checks, and the masculinity measures.

In keeping with IPA design, I purposefully did not directly use a theory in data analysis (Maxwell, 1992; Smith et al., 2009). I examined the data inductively without the framework of set theories (Maxwell, 2005; Smith et al., 2009). Although I outlined relevant theories in Chapter II (i.e., attachment theory, patterns of grief theory, and meaning reconstruction theory), these were theories that I was familiar with before starting the current study. I outlined my personal biases and scholarly knowledge, including the theories, as described in the Researcher Background section below.

In IPA research, the primary approach to analyzing data is coding. Coding involves identifying themes from the data (Hatch, 2002; Smith et al., 2009). The coding process consisted of my searching for main themes and significant implications in the

interview transcriptions. I used an open coding process consistent with Smith et al.'s (2009) IPA. The authors present broad principles for the implementation of IPA instead of a specific method. During coding, I used constant comparison techniques (Bereska, 2003; Smith et al., 2009), where interview data were compared and contrasted. I reported main themes which appeared to represent the majority of men's perspective, as well as themes that characterized minority opinions. I recorded the details of coding steps throughout the coding process. The authors present broad principles for the implementation of IPA instead of a specific method.

The IPA process is idiographic and begins with detailed analysis of individual interviews before moving to the entire sample. I color-coded themes across interviews as I organized, and I compiled the themes by color in a separate Word document. Researchers identify emerging themes and note both similarities and differences among the participants (Smith et al., 2009). Researchers describe and interpret participants' experiences and perspective. In keeping with Smith et al.'s recommendations, I did not strictly implement the coding steps in a linear way. Instead, there was some necessary overlap between some of the steps.

Smith et al. (2009) suggests the following specific steps in the coding process: (a) Reading and re-reading; (b) Initial noting; (c) Developing emergent themes; (d) Searching for connections across emergent themes; (e) Moving to the next case; and (f) Looking for patterns across cases. I was mindful of these steps throughout the coding process, and I frequently referred back to Smith et al.'s book.

First, I immersed myself in the data of the interview transcripts by reading each interview multiple times. I became well-acquainted with the data from conducting and

transcribing all of the interviews by myself. Unlike certain designs, IPA does not require multiple readers (Smith et al., 2009). I was able to hear the voice and see the face of the participants during the interviews, and I heard the participant's voice again during the transcribing process as I listened to the recordings. These interactions aided my introduction to the data by familiarizing myself with the participant's vocal inflection, pauses, facial expressions, etc., which I noted in the transcripts. Through my initial readings, I was able to begin observing the overall flow of the transcript and main themes.

Second, as I read the transcripts, I made initial notes. These notes were open-ended and are similar to a free textual analysis. I commented on the content of the interview (i.e., descriptive comments), as well as the process (i.e., conceptual and interpretative comments). I recorded three types of coding comments: descriptive, linguistic, and conceptual. My descriptive comments involved observing the participant's experience and taking it at face-value. I commented on the events, thoughts, actions, emotions of the participant. I also made linguistic comments that went beyond examining the content to begin to explore the meaning provided by the participant. I noted vocal inflection, vocal volume, tearfulness, pauses, laughter, tone, pauses, and use of phrases such as "um" and "hmm." I also recognized when participants used repeated words and phrases and metaphors. Additionally, I offered conceptual comments that are more interpretative in nature and less descriptive. These annotations move beyond taking the content at face-value and instead probe the deeper themes, meanings, and underlying emotions.

The third step in the coding process involved my development of the emergent themes. I highlighted emerging themes of individual transcripts by color-coding (e.g.: yellow represented participant's support of partner; dark gray represented participant's response following the miscarriage). I tried to consistently follow IPA's emphasis on idiographic analysis and inductive approach. That is, a focus on individual interviews along with an emphasis on overall themes across interviews, apart from any theoretical framework. As the researcher I tried to keep in mind the entire transcript as I analyzed smaller parts of the interview. This process was hermeneutical in that "the original whole of the interview becomes a set of parts as you conduct your analysis, but these then come together in another new whole at the end of the analysis in the write-up" (Smith et al., 2009, p. 91). Additionally, consistent with IPA, I attempted to primarily focus on the data at-hand as I read over and coded each individual interview (Smith et al., 2009). I tried to divorce my knowledge of other interview data in order to concentrate on individual data.

During the fourth, fifth, and sixth stages of IPA data analysis, I began to search for connections across emergent themes. Due to the sheer volume of my sample size (i.e., Smith et al., recommend 3-6 participants), I followed Smith et al.'s recommendation that the emphasis in coding be given to the emerging themes represented by the sample with less emphasis on individual data. I sorted through and organized the emergent themes and created main superordinate themes from across all of the interview transcripts. I devoted more time and energy to the data analysis of themes across cases in this sixth step than I devoted to the analysis of the individual transcripts. My larger sample size resulted in less detailed coding of individual transcripts and a greater emphasis on the emergence of themes across transcripts.

Smith et al. (2009) urge researchers new to IPA to take risks with interpretation. The authors state that, in their experience, novice researchers often tread cautiously and stick too closely to description. In the same manner, as a researcher new to IPA, I was aware of feeling like I was taking a risk at times during the interpretation process. I was mindful of the need for interpretation, and I challenged myself to make interpretations when appropriate. However, it was reassuring to me to realize that other researchers face similar challenges.

As I analyzed the interview transcripts, I de-emphasized the emergent themes that (a) did not fit the goals of my study; and (b) were not representative of the participant sample. I determined what data represented the minority and what represented the majority by using a suggestion from Smith et al. (2009) where I chose to include the data that was represented by one-half or more of the participants. For example, only one participant reported that his wife experienced serious medical complications related to the miscarriage, so I did not include this idea as a primary theme. However this concept, did appear under some of the subordinate themes. The five final superordinate themes represented all nine participants.

In addition to searching for emergent themes, I noted possible connections and began to organize the data within the themes. I implemented three of Smith et al.'s (2009) analytic strategies to aid in identifying patterns between emergent themes. Abstraction was the first strategy, meaning that I clustered emergent themes together into one group and created a new name for that cluster. I also utilized a similar strategy named subsumption where I promoted an emergent theme to the status of a superordinate theme and organized accompanying emergent themes under it. For example, I collapsed the

emergent theme of hope for the future into the previous emergent theme of meaning-making. This change resulted in meaning-making developing into a superordinate theme, and hope for the future becoming a subordinate theme.

A third analytic process that I implemented was polarization where I examined opposite themes and focused on the dissimilarities instead of the similarities. For example, I contrasted the mostly negative emergent theme of men's emotional and behavioral expressions following miscarriage with the more positive theme of meaning-making.

During the final steps, I compiled codes that occurred in multiple interviews with accompanying interview quotes. I copied and pasted these codes with quotes into a Word document. I continued the hermeneutical focus and kept the entire data set, consisting of interview transcripts, in mind as I analyzed the smaller parts of the data. I also continued the process of noting descriptive, linguistic, and conceptual comments. I concluded the sixth step by creating a table of the superordinate themes, with the corresponding accompanying subordinate themes listed below each superordinate theme. I also included representative quotes from the interview transcripts with each theme (see Appendix H for an example).

As I copied and pasted data into one primary coding Word document, I started to group data by codes (e.g., coping and social support). I grouped the data by the original color codes that I had conducted with each individual transcript. I often included surrounding codes of different colors as part of the context of the interview portion. I continued to read over the data in the document and made additional descriptive, conceptual, and interpretative comments. The document comprised all of the data from

each participant that fit into the codes. I attempted to focus more on the interpretative comments that were necessary in the later data analysis stages of IPA.

As I noted codes across the interviews, I chose 13 initial themes: attachment with baby, viewing ultrasound images, men's emotional and behavioral expressions, partner's emotional and cognitive expressions to miscarriage, coping, social support, men's support for partner, hope for the future, relationship roles and dynamics, health complications, experience with medical professionals, meaning-making, and advice to other men. Once I had completed the individual coding of each interview transcript, I looked for codes that could be either combined with existing codes or expanded to create additional codes. The codes that lacked saturation by not representing half or more of the participants were de-emphasized. These codes were represented in the data, but with less emphasis than the main themes. I de-emphasized the following codes that did not represent half or more of the participants, thereby lacking saturation: attachment with baby, viewing ultrasound images, health complications, and experience with medical professionals. For example, I included the code of attachment with baby as a possible explanation for difference in the duration and intensity of men's emotional and behavioral expressions. I collapsed the following codes with other codes, to make larger superordinate themes: social support (i.e., collapsed with coping), hope for the future (i.e., collapsed under meaning-making), men's support for partner (i.e., collapsed under coping), and advice to other men (i.e., collapsed under meaning-making). The resulting five themes that I moved to the foreground were found in *all* participants and were considered superordinate themes: men's emotional and behavioral expressions, men's

view of their partners' emotional and cognitive expressions, coping, meaning-making, and masculinity/gender role.

Smith et al. (2009) relate that there is overlap in the processes of data analysis, interpretation, and the writing of findings, and I began writing during the coding process. I would write single sentences and paragraphs throughout the coding document that expounded on the descriptive and interpretative themes. I discovered new interpretive ideas during the writing process. IPA is an iterative process, and so I frequently referred back to the interview data to ensure that my interpretation appeared to make sense of the data.

Validity

In the present study, I worked to establish validity through high quality practice which is consistent with IPA recommendations (e.g., relevant topic, rigor, and credibility, Smith et al., 2009). I made efforts to establish excellence in the present study, through the utilization of Tracy's (2010) eight markers of valid qualitative research. I offer each in the context of the current investigation. First, the present study examined a worthy, practical topic: men's common experience of miscarriage. Second, the study demonstrated rigor through the use of appropriate and sufficient sampling, time in the field, and data collection and analysis. The present study also demonstrated rigor by incorporating an audit trail (see below; Bowen, 2009; Lincoln & Guba, 1985). Third, the present study attempted to display sincerity about the researcher and the research process through researcher self-reflexivity (i.e., biases) and transparency (i.e., methods, challenges). Fourth, this project demonstrated credibility in that it contains rich description and member reflections. Additionally, qualitative researchers seek to set the

details from a small sample within a larger frame of reference (Patton, 2002). In the present study, I strove to place the men's experience of miscarriage within the broader framework of men's broad experiences with grief. Fifth, I achieved resonance by using rich description and implementing direct quotes whereby readers may be able to relate to some aspects of the participants' experiences. Sixth, the results can make a significant contribution to the study of men and miscarriage, specifically, and the examination of men and grief, in general. The results can help inform research on men's issues and grief as well as clinical practice. Seventh, I employed high ethical standards that protected the participants. The current study was approved by Purdue University's Institutional Review Board (IRB). I followed ethical practices including informed consent, voluntary participant withdrawal at any time during the research process, confidentiality, and secure storage of research materials. Finally, the present study sought meaningful coherence through the consistency of the purpose, method, paradigm, and design. The purpose of examining men's experiences following miscarriage fits the qualitative method, constructivist, and phenomenological emphases on the lived experience and meaning construction of participants.

My utilization of best practices helped establish what Cho and Trent (2006) describe as transactional validity whereby the present study demonstrates an "accurate reflection of reality" (p. 322). In seeking transactional validity, researchers assert that validity of the text can be attained through the utilization of best practices such as appropriate methods and techniques (Cho & Trent, 2006). Researchers confer with participants to ensure that the data accurately reflects their perspectives. One primary form of transactional validity is to obtain participants' feedback through member

checking, which I described above. In keeping with IPA and the constructivist paradigm, I viewed the participants as co-creators of knowledge and used their responses to attain a greater level of understanding and meaning regarding their perspective (Smith et al., 2009).

Furthermore, I contributed to the trustworthiness of the present study by creating an audit trail. I created an audit trail by methodically recording theoretical and methodical decisions, detailing the research process, and organizing materials (Bowen, 2009; Lincoln & Guba, 1985; Smith et al., 2009). An audit trail also includes researcher's decision making and impressions regarding theoretical and methodical issues. Audit trails aid the dependability, sincerity, and credibility of qualitative research findings. I followed recommendations from Lincoln and Guba (2009) and from Bowen (2009) pertaining to his recommendations for grounded theory research.

I created the audit trail in the present document, which is consistent with IPA (Smith et al., 2009). Smith et al. suggest detailed recording of the research process in order to enhance validity. The audit trail consisted of recording and compiling: description of IRB procedures, literature review, provision of a theoretical framework, interview questionnaire and corresponding materials, masculinity measures ISME and SMSS, purposive sampling, description of coding and analysis, description of the process of collapsing codes, member checking, recording thick description, describing decision-making process and rationale behind decisions, and the inclusion of research results and discussion. In addition to the audit trail, I regularly consulted with my advisor and co-author, Dr. Heather Servaty-Seib. We communicated about major and minor aspects of

the present study, including decision-making, sampling problems, theoretical and methodological issues, research process, and many other aspects of the study.

Researcher Background

The researcher is an integral part of phenomenological research (Patton, 2002; Smith et al., 2009). The phenomenological researcher is an "instrument" in the research process and his or her worldview and perspective can influence the data (Morrow, 2005; Smith et al., 2009). IPA acknowledges that researchers hold unique biases (Smith et al., 2009). This view fits with IPA's view of multiple understandings of truth and reality (Smith et al., 2009). Smith et al. (2009) assert that different researchers will view and make sense of data in unique ways, which are not inherently right or wrong. The researcher's perspective and judgments determine the data analysis. Thus, it was necessary for me to examine my background and biases (Heppner et al., 2008; Morrow, 2005; Yeh & Inman, 2007).

My experiences can be divided into two categories: personal and scholarly. Personally, I have faced different experiences of grief in my own life. The first vivid memories involve the death of my beloved grandmother, which occurred when I was a teenager. I remember being surprised at the great amount of sadness I felt. Another significant loss that I encountered was an early miscarriage I had approximately five years ago. I was surprised at the depth of sadness and longing I felt for the unborn child I had never met. I grieved and coped with each of these losses through crying, talking to trusted friends and family, memorializing the deceased person, and journaling. These experiences have shaped my life and continue to shape my life. Personally, I identify as a

woman, with regard to gender identity. I tend to grieve affectively and intuitively by crying, talking to friends, and journaling. I also view myself as holding both feminine traits (e.g., emotional expressiveness) and masculine traits (e.g., independence). I have lived my entire life in the Midwest, and I have interacted in conservative, traditional environments. I was raised with traditional gender role ideology, which influenced my expectation that men would demonstrate less affective responses than they did. I was also familiar with previous literature that suggested that some men demonstrate less affective responses than their partners following miscarriage. I recognize that I hold biases based on my background, upbringing, and knowledge of the research literature.

I also have scholarly experiences. I am an advanced doctoral student in counseling psychology who has studied grief and loss with my advisor and in my research team for over three years. I was familiar with the three theories (i.e., attachment, patterns of grief, and meaning reconstruction) outlined in Chapter II through my coursework and participation in my research team. From the team, I also learned about other prominent grief theories and specific student research topics including suicide, college student grief, international student grief, and death notification. I am also a counseling psychologist-in-training with five years of clinical experience counseling adults of various ages, from college students to older adults, with diverse presenting issues. I have also co-facilitated an adult grief support group for families and conducted intakes with grieving children and adults. I am comfortable talking to men, discussing difficult issues with people, and observing others' silence or expressions of emotions I realize that my roles as interviewer, observer, and researcher entail personal involvement. I acknowledge my background and biases as a researcher, and I outlined

these features. Presenting my personal experiences and scholarly knowledge in the present study are ways that I examine my background and biases. Consistent with IPA, I acknowledge my unique background and biases.

CHAPTER IV RESULTS

In this chapter, I provide the results that I determined through my analysis of the interview and measure data. In IPA, findings are generally presented in the form of both superordinate and subordinate themes. Superordinate themes are the primary themes that were found in the data from each of the nine participants. Subordinate themes consist of smaller and supportive themes and are a part of and considered "under" one of the superordinate themes. The five superordinate themes I organized were as follows: (a) men's emotional and behavioral expressions following miscarriage; (b) men's views of their partner's emotional and cognitive expressions following miscarriage; (c) men's coping following the miscarriage; (d) men's meaning-making activities following the miscarriage; and (e) men's perspective of gender roles and masculinity.

I have ordered the five superordinate themes that I organized from my data in alignment with the order of my research questions to promote flow and foster consistency across chapters. For example, my primary research question was focused on men's overall experience following miscarriage, which fits with three of the five superordinate themes. It is important to note that two of my superordinate themes (i.e., men's view of their partner's responses to miscarriage and men's perspective of gender roles and masculinity) were not associated with my initial research questions. My first sub-question

involved men's expressions following miscarriage, and the first superordinate theme I address below is men's emotional and behavioral expressions to miscarriage. My second sub-question explored men's coping, and there was an accompanying superordinate theme focused on coping. My final sub-question examined how men made sense of the miscarriage, and I chose a supportive superordinate theme related to this topic. I begin each section with a general introduction to the superordinate theme and subordinate themes, followed by an expansion of each subordinate theme with supporting quotes from the interview transcripts. See Tables 2, 3, 4, 5, and 6 for information on which participants exhibited which subordinate themes. As noted earlier, all men exhibited the five superordinate themes.

Table 2

Participant's Emotional and Behavioral Expressions Superordinate Theme with Accompanying Subordinate Themes

Participants experienced emotional expressions/psychological distress and behavioral/physical expressions:

Duration of emotional expressions	Primarily initial expressions with short duration (Time length: Weeks): 4 men: Frank, Nathan, Ken, Terry	Emotional expressions of longer duration (Time length: Months to years) 4 men: Eugene, Larry, Dale, Wade	
Nature of emotional expressions	Sadness, as demonstrated by self-reported feelings, crying, and withdrawal: All 9 men	Shock/Disbelief: 4 men: Frank, Ken, Dale, Wade	Anger/Irritability: 4 men: Frank, Larry, Dale, Wade
Nature of behavioral expressions	Recuperative activities: All 9 men	Rituals: 3 men: Frank, Terry, Eugene	
Important Unique Expressions (2 men)	Complicated, diverse emotions for one participant: 1 man: Chris	Complicated emotional response for one participant, following wife's two miscarriages and resulting medical problems: 1 man: Dale	

Table 3

Participant Views of Partners' Emotional and Cognitive Expressions Superordinate Theme with Accompanying Subordinate Themes

Partners experienced emotional and cognitive expressions/psychological distress:

Duration of emotional expressions	Primarily initial expressions with short duration (Time limit: weeks): 3 partners: Frank, Nathan, Terry	Emotional expressions of longer duration (Time limit: Months to years): 6 partners: Chris, Eugene, Ken, Dale, Larry, Wade	
The nature of partner's expressions	Emotional Expressions: Sadness, Crying, Withdrawal: All 9 women Anger (1 woman): Chris Anxiety/Panic (1 woman): Eugene	Cognitions (Guilt, Self-blame, Sense of inadequacy): 4 partners: Larry, Wade, Ken, Dale)	

Table 4

Coping Superordinate Theme Accompanying Subordinate Themes

Many participants coped in many ways including:

Supporting their partners	All 9 men indicated offering support	2 men reported that they felt supported when their partners received support from others: Nathan, Terry	1 man stated that he actively sought out female support figures for his wife in the form of family members and medical professionals: Terry	
Viewing the loss as a challenge to work through	4 men viewed the miscarriage as a challenge to work through and overcome: Ken, Nathan, Dale, Wade	2 men viewed previous miscarriages and life difficulties as helping prepare them to healthily cope: Wade, Dale		
Staying busy/Following a routine	Busyness and routine helped 3 men in limited ways: Nathan, Dale, Larry	Busyness and routine hindered the same 3 men in some ways: Nathan, Dale, Larry		
Holding hope for future fertility/family expansion	6 men held hope for future family expansion: Ken, Nathan, Terry, Eugene, Larry, Wade	2 men placed their losses in perspective: Nathan, Ken	1 man demonstrated an optimistic perspective for a healthy, viable future pregnancy: Ken	
Relying on social support	6 men reported adequate social support from family, friends, and employer:	2 men wished they had received more social support and had sought counseling:		

	Wade, Frank, Ken, Terry, Nathan, Eugene	Dale, Larry		
Expressing thankfulness for an existing child	4 men indicated that having a child helped them cope with the miscarriage: Terry, Frank, Dale, Eugene	2 men indicated that their child helped bring a sense of purpose: Larry, Terry		
Understanding medical knowledge about the possible causes and frequent occurrence of miscarriage	4 men indicated that they appreciated processing medical information rationally: Wade, Nathan, Ken, Frank	4 men were reassured to learn that miscarriages are common: Wade, Nathan, Ken, Frank	1 man was reassured to learn that miscarriages are not typically caused by people: Ken	2 men were reassured to learn that miscarriages typically do not indicate infertility: Nathan, Ken

Table 5

Meaning-making Superordinate Theme Accompanying Subordinate Themes

Participants constructed meaning in various ways:

Gratefulness for an early gestational loss	3 men related that they were grateful that the pregnancy loss occurred earlier, rather than later: Frank, Eugene, Terry	2 men believed that their unborn child died due to congenital defects, and so they preferred that the child did not "suffer" (Eugene): Eugene, Frank	
Belief in a reason for the miscarriage	3 men believed there was a "reason" and purpose for the miscarriage: Frank, Eugene, Dale	2 men believed that their families were meant to grow in other ways (i.e., new pregnancy or adoption): Frank, Eugene	3 men shared that they believed that God had a plan for their lives: Frank, Eugene, Dale
Enhanced value for life	3 men have learned to value fertility and life more since the miscarriage: Nathan, Frank, Terry	Terry reported that his wife's miscarriage, along with fertility difficulties increased the value he placed on fertility and life in general.	
Strengthened family relationships	3 participants viewed their partner's miscarriage as helping to strengthen family relationships: Eugene, Chris, Dale	2 men reported that the miscarriage experience created a rift between them and their wives: Larry, Dale	

Table 6

Relationship Role/Masculinity Superordinate Theme Accompanying Subordinate Themes

Participants described their gender role and masculinity:

Held traditional gender roles (Frank, Terry, Eugene)	"Head and "Leader"	"Provider" & Care-taking Responsibilities	"Control"	
Held non-traditional gender roles (Larry, Dale, Nathan)	Equality	Partnership	Flexible Roles	
Held a combination (Ken, Wade, Chris)	Provider	Flexible Roles	Traditional Values	Equality

Men's Emotional and Behavioral Expressions Following Miscarriage

The first superordinate theme that I selected was that all participants experienced emotional responses/psychological distress and physical/behavioral responses following their partner's miscarriage(s). This theme is associated with my primary research question: What are men's responses to miscarriage? This superordinate theme had four subordinate themes. One subordinate theme was focused on duration in that some participants indicated primarily initial emotional expressions with short duration, whereas others indicated emotional responses of longer duration. Another subordinate theme that I found was that the nature of the men's emotional expressions varied, from sadness demonstrated by crying, shock and disbelief to anger and irritability. In addition, many men exhibited another subordinate theme of behavioral expressions including

recuperative activities (e.g., taking time off work, spending time with family), and participating in rituals. Finally, two participants displayed and described unique expressions that stood out as unique.

Duration of Participant Expressions

With regard to duration, all participants reported an initial emotional expression following miscarriage, with approximately half reporting a response of longer duration. Frank, Ken, and Larry described the experience following the miscarriage as "hard," and Larry described his experience as "tough." Frank shared that he was "upset," and "shaken up" immediately following the miscarriage. Frank rushed from an out-of-town business trip to be with his wife during the miscarriage. He reflected about that time, "The next couple of days, it just (sigh…pause) I mean, she wasn't that far along, so she didn't have like a huge attachment. We didn't know what the baby was, but it was still *hard.*" Frank related that he was initially "upset" following the miscarriage and that he had difficulty focusing on his work responsibilities. Terry shared that he experienced a "mourning period" and described the loss by stating, "It impacted us as losing a baby."

Four men primarily experienced emotional expressions that were of short duration, with a lack of apparent long-term emotional expressions (Terry, Ken, Nathan, Frank). These men did not specifically quantify the length of these responses, but they indicated that their distress lasted a matter of weeks. They described their distress beginning after the initial concern and news of the miscarriage and ending shortly after the miscarriage took place. Terry and Frank reported minimal initial emotional expressions, and they spoke of their expressions in the past tense. Terry explained, "We had a mourning period but it was fairly, uh, quick. I think we processed the miscarriage

and moved on." He shared that he had become focused on conceiving again. Terry also described himself as "a fairly even-keeled guy, and I don't know that I get overly emotional or stressed." Frank revealed, "I tend to hold in my emotions." Frank spoke of his response to his wife's miscarriage as occurring in the past-tense. He indicated at the time of the interview that he did not think about the miscarriage and did not view himself as needing to cope. However, Frank also disclosed that he initially cried following the loss. Interestingly, he became tearful during the interview when discussing his response to the miscarriage. He reported at the time of the interview that he seldom thought about or discussed the miscarriage and told himself to "move on." Similarly, Nathan described his expressions following his wife's three miscarriages in the past-tense, and he summarized his experiences as "relatively simple," and not "a very complex issue emotionally or psychologically." He also apparently handled the miscarriages as "just something that happened that we had to work through."

In contrast to the four men who reported minimal and short-term emotional expressions to the miscarriage(s), four reported longer, more intense, emotional expressions (Eugene, Larry, Wade, Dale). These men did not specifically quantify the length of these expressions, but they indicated that their distress lasted a matter of months or years. A few (Eugene, Larry, Dale) appeared to still be affected by the miscarriage(s), as evidenced by self-report and crying during the interview. Wade described his wife's second miscarriage as a time of "emotional upheaval" connected with it being their second loss and because of the medical necessity for a dilation and curettage (D&C) procedure to protect his wife's health. Larry described his wife's first miscarriage as

"disappointing," but he reported experiencing a more substantive response following his wife's second miscarriage, which he described as "far more traumatic."

Nature of Participant Emotional Expressions

The nature of the participant's emotional expressions was diverse (e.g., sadness, shock/disbelief, and irritability/anger). All men disclosed feelings of sadness following the miscarriage, half indicated shock/disbelief, and half reported irritability/anger.

Some men reported that they responded to the miscarriage with sadness and withdrawal (Larry) and also demonstrated their sadness through crying during the interview (Frank, Eugene, Dale, Larry). Larry described withdrawing from friends, becoming less talkative and outgoing, and spending less time at work. Eugene appeared to have experienced great sorrow. He cried as he shared about his and his wife's responses, "We were *devastated*. It's like, *man.* (short pause) I was holding my wife and I mean, sobbing. It was *pretty horrible."* Larry described his wife's two miscarriages as "hard" and "tough" to handle for both of them.

Also related to sadness, Frank, Eugene, Dale, and Chris cried throughout the interview when discussing the miscarriage experience. Frank cried as he reflected,

> I was upset, I mean (sigh) I tend to hold in my emotions as well. I was upset. My dad was watching my little girl so we could go to the doctor's appointment, and we got back, and my dad then asked me, 'How is everything?' And I was like, 'Ahh, you know, I started crying…Even now, I thought that I would be able to talk about it just fine (tearful), and it's kind of coming back a little bit. I mean, I can get through the interview just fine. But it was a *loss.*

Eugene, Frank, and Larry revealed that they cried *with* their wives. Larry shared, "When we were in the hospital, the doctor comes out, says, you know, 'You lost the baby.' You're crying; they're crying." Eugene disclosed, "I mean, I cried with her, but there were times that I would just do it by myself for a little while."

Four men experienced initial shock and disbelief at the news of an impending miscarriage, and they held hope for a healthy pregnancy. Frank, Ken, Dale, and Wade indicated that they experienced disbelief and denial about the reality of the miscarriage(s). These participants described remaining hopeful for a healthy pregnancy even following the news from the doctor that a miscarriage was imminent. Frank described, "At that time, I didn't really want to believe it either. I'm like, aahhh, it'll be okay. Maybe [the medical professionals] were wrong. It hadn't sunk in at that point." Ken shared,

> When we first heard that there might be a problem, we were kind of scared; we weren't sure what was going to happen. We were trying to hold out hope that maybe it was just smaller than normal, or that there was something wrong, but it wasn't the end.

Wade reported that he experienced "a little bit of shock and disbelief" upon hearing the news of his wife's second miscarriage, and he described himself as "emotionally numb" at times. He appeared to be surprised that the incident happened a second time, and he did not initially know how to process the loss. He disclosed,

> I've been through this situation the first time, and so I didn't know what to think as it kind of set in what was really going on, you know the gravity of the situation (short pause). I don't know. I think my natural tendency is to kind of shut down

> from prior experiences in life, so. I don't know. It was just kind of a state of disbelief, and my wife's crying, and I was trying to console her.

Dale revealed that he was surprised that his wife suffered a second traumatic miscarriage and health complications from a blood-clotting disorder. He shared that he had previously been relieved and grateful that his wife and family had survived her first miscarriage, health complications, and recovery, and that they were able to settle back into ordinary life. He did not expect his wife's second miscarriage and life-threatening health complications. Frank related that he initially doubted his wife's diagnosis of impending miscarriage, but he eventually realized the reality of the loss:

> At that point (after the doctor's news of the impending miscarriage), though, it didn't really feel real because it hadn't happened yet. It was just like, we *know* something's going to happen. So I'm thinking in the back of my mind, 'Maybe they were wrong.' I've heard stories of that happening, so. But I think the worst was after it actually happened because it was a reality. At that point, we're like, 'We're not having this baby, there's no chance. It's gone.

Other participants experienced irritability and anger (Frank, Larry, Wade, and Dale). Frank and Larry pondered possible reasons why their wives' miscarriages occurred. They also reflected on the perceived unfairness of the situation. When Frank was asked about the important aspects of the miscarriage that stand out to him, he recalled, "I was upset. I was angry. I was like, why does this happen to us?" Larry also questioned the reason for his wife's miscarriage (her second one): "The second one was sort of like, anger and blaming. Why let us even get pregnant, if this was going to happen? So the second one was hard to justify or kind of rationalize." Larry also

wondered if the miscarriage was “sort of like karma” for his wife’s previous abortion, her first pregnancy. Like Larry, Wade also expressed anger following his wife’s second miscarriage. He disclosed that he was, “a little bit angry” and “upset that it happened again.” However, he reported feeling “a little bit relieved to find out exactly what was going on” medically with the second miscarriage because “the first miscarriage was kind of unexplained.” Dale admitted frustration and anger “to some extent” toward his wife because he viewed the second miscarriage/health complications as “preventable” since his wife had, by his report, conceived without his knowledge or consent. He reported that he and his wife had originally planned on having three children, and his wife broke that agreement by becoming pregnant with a fourth child. He described being supportive of her during her recovery, but offered that he was also angry at her. He viewed her decision as “selfish,” “dumb,” and “mostly for her sake.” Dale began to question his wife’s loyalty and “commitment” to the family.

Frank and Larry’s irritability and anger were demonstrated in various ways, including their interactions with their wives. Frank shared that his irritability and anger were manifested when he “yelled” at his wife for leaving their bedroom door open in the morning after his daughter was “screaming” when he was sleeping in. He recounted,

> I mean, it’s like I was angry, and I guess I was just taking it out on her. I still feel bad about that, I mean, she’s going through a tough time, and then I yelled at her over [leaving the door open].

Larry disclosed that he “blamed” his wife for the miscarriage. He described,

> Because I was angry, my wife would probably say that that was not a good few months. Because again, we were excited when we got the news, and then it was

> like, 'Oh wow.' So I'd say angry and probably on the side of sort of blaming… I think the second one was hard on the relationship for a while.

Larry indicated that he eventually processed the loss and resumed his typical functioning, "And then you realize, you know what, it happened. It's time to move on, and you learn to cope."

Nature of Behavioral Expressions

In addition to emotional expressions, participants also reported the subordinate theme of behavioral expressions. These behavioral expressions included restorative activities (e.g., taking time off of work, spending time with family) and rituals including donating money to a college alma mater, attending a religious memorial service for unborn babies, and displaying the ultrasound picture.

All of the participants reported participation in the behavioral expressions of restorative activities. Some participants, Frank, Terry, Eugene, and Dale reported taking time off of work with the time varying from one day to one week. Frank revealed that he could not focus on work, so he held his two-year-old daughter and watched television, and he and his family "just spent time together." All participants indicated that they spent time with their family throughout the miscarriage process.

Some participants participated in rituals to remember and honor their unborn child. Rando (1985) described ritual as either a one-time action or a reoccurring behavior "which gives symbolic expression to certain feelings and thoughts of the actor(s) individually or as a group" (p. 236). Grief rituals serve the purpose of remembering a person and also honoring one's relationship with the deceased (Castle & Phillips, 2003). Ritual activities can include visiting the gravesite, displaying pictures, attending

memorial services and cultural celebrations, burning candles, and many other actions. Frank shared that he and his wife donated money to their university alma mater "In Honor of Baby (Last Name)." Terry related that he, his wife, and his three children considered the unborn child a member of their family, and they discussed and memorialized that child. He and his family attended a Catholic mass to honor unborn children. After attending the mass, Terry realized that many babies had names, so he, his wife, and his children discussed possible names for the unborn baby. Eugene demonstrated the ritual of displaying the ultrasound picture of his unborn child at his office, next to a picture of his adopted daughter. He sobbed intensely, with tears streaming down his face and his voice raised to a higher pitch, as he shared, "And it's like, there's my other kid. It doesn't really keep me sad, it's just a part of me. Sometimes when I talk about it like this (cries more intensely…pause)…we were *devastated."* He reported that his wife "has a little shoebox memory box" where she keeps ultrasound pictures. He viewed the unborn child as part of his family and believed that he will see the child in heaven. He offered, "I mean, I'm glad we had the kid. We'll see it again in heaven someday. But it still hurts (sobbing). So when people lose a kid, I feel pain for them (sobbing)."

Although many participants reported ritual activities, Dale appeared to express regret over his lack of remembrance activities for his two unborn children. He reported believing that miscarriage loss is not recognized by society, and he described feeling isolated in his experience. He shared that he did not know of anyone else who had been affected by miscarriage. He expressed gratitude for current pregnancy loss awareness initiatives and brought a newspaper article about a local pregnancy loss memorial. He

stated, “I’m glad to see that someone’s doing something to help people who have lost infants.” He shared that he did not know the sex of the first baby lost, but he knew the second one was a boy. Dale disclosed, “We never had any kind of service, there was no casket, no burial, no nothing really.”

Important Unique Expressions

Two participants’ experiences (Chris and Dale) were unique and differed from the other participants’ expressions and also from each other’s expressions. Chris’ response was unique because he was the only participant who reported experiencing “mixed emotions” of “relief” along with sadness for the loss, followed by “guilt” for feeling partly relieved. He was the only participant to report that he experienced relief following the miscarriage. Chris related that his girlfriend’s pregnancy had been unplanned, and that he had originally not desired to have children. He reported experiencing relief when the future possibility of baby preparations and child-rearing responsibilities ended. He described his response as,

> A big mix of emotions…so, (tearful) finding out that (sigh) one day she had been bleeding and went to the hospital, and eventually having through the scan the doctor saying that there was no heartbeat, was, it was a mix of…(short pause) sadness. Because by that point I had come to accept and almost be excited about the thought of having a child, as well as almost a bit of relief because I hadn’t originally wanted to have a child. And then because of those two conflicting, almost a little bit of guilt from feeling the relief.

He further described,

> From what I can remember, there were all sorts of thoughts of, 'Well, I'll never get to teach this child how to ride a bike. 'If it's a girl, I'll never get to send her to prom, or if it's a boy, never get to play catch, or whatever. But then the relief of I'm still in college, and at least I don't have to have that added stress while trying to finish school.

Dale's experience differed from those of the other participants, including Chris, because he reported multiple stressors stemming from his wife's two miscarriages and her resulting health complications from a blood clotting disorder. His perspective of his wife's issues apparently contributed to a complicated emotional response. He related that the miscarriages and his wife's health "created emotional, physical, and financial problems," and "affected my kids as well." Dale shared that he lacked time to process his reactions. He described the two miscarriages: "There was so much activity; there was no grieving involved there. So both times, the situation itself kind of precluded any kind of finalization of what had happened to us." He explained that, following the second miscarriage, he did not believe that he was able to process his emotions and fully grieve (i.e., his own spontaneous use of term). According to Dale, "Emotions kind of got put over on the shelf because of the practicality of taking care of the family and fixing the bill situation and then work. There was no time for grieving, really, it just got pushed farther and farther down the list." He asserted that he had not fully "grieved" the losses after 30 years, and that he has not experienced "resolution." Dale also shared, "I think there's still some loss there." However, he revealed that he has been able to "grieve" more "over time." Dale described the lack of "finalization" from the miscarriages and health

complications as one stressor on his marriage. In summary, Chris and Dale described responses that differed from the other participants.

Participant Views of Partner's Emotional and Cognitive Expressions

A second superordinate theme that I selected for all nine participants and does not fit with one of my research question was men's view of their partners' emotional and cognitive expressions/psychological distress following the miscarriage(s). This superordinate theme had three subordinate themes. The first subordinate theme I found was that most men reported that their partners experienced greater psychological distress than they did. The second subordinate theme I selected was that some partners experienced primarily initial emotional expressions with short duration, and others experienced emotional expressions of longer duration. A final subordinate theme was that, according to the men, the nature of women's emotional and cognitive expressions varied and included emotional responses including sadness, demonstrated through crying and withdrawing, as well as anger, anxiety, and negative cognitions of guilt and a sense of inadequacy as a woman.

Greater level of Psychological Distress for Partners

Most participants (Chris, Nathan, Ken, Eugene, Wade, Terry) indicated that their partners experienced more intense emotional expressions and greater psychological distress than they themselves experienced. Eugene described his wife's experience as "really horrible." He elaborated, "She was panicking and was weak for days. We got through it, but (pause) it was horrible." These participants shared that they were concerned about their partner's well-being and tried to support them. Terry described his reaction, "I would say most of it was sharing, dealing with her pain." Ken wondered

aloud whether he would have been as focused on supporting his wife if he had been grieving and more “upset” than she was. He asserted that he believed that he was better able to assist her because he was grieving less than she was. However, he remarked that perhaps she would have been helping to support him if he was the one “grieving more.” Ken disclosed that the three miscarriages for his wife “really hit her a lot harder” than it affected him, and he attributed her response to her demonstrating “a lot stronger of an attachment” where she was “really, really connected” to the child, “obviously, being the person carrying it.” He described his wife as “really depressed for a little while.”

Duration of Partner Expressions

According to the men, their partners experienced the subordinate theme of varied duration of expressions, from short-term to long-term. Three men (Frank, Nathan, Terry) indicated that their partners experienced initial short-term sadness and distress primarily during and immediately following the miscarriage. The participants indicated that these expressions lasted a matter of weeks. Frank revealed that his wife was initially “upset” and “shaken up” following her miscarriage, but that her intense emotional response was short-lived. He attributed her less severe response to her reported lack of attachment to the unborn child. Similarly, Nathan related that his wife “didn’t experience great amounts of sadness. It was more of a trial kind-of-thing: something to get over, get through.” Terry also reported that he and his wife “moved on fairly quickly” and focused on conceiving again. Although he described his wife’s expression as short-lived, he highlighted the intense initial emotional and physical effects of the miscarriage on her:

> I know that it was pretty emotional when it happened so there certainly were tears shed. It is rough when your body is rejecting something, so when you’re passing

> blood or passing tissue. I know that that was probably the most real- 'This is happening to me.' There's no denying that it's a miscarriage, and it's happening. So that was probably the hardest part.

Most participants (Ken, Chris, Eugene, Wade, Larry, Dale) reported that their partners experienced intense emotional expressions of a longer duration, lasting months to years. Larry, Eugene, Wade, Dale, and Chris revealed that their partners were "devastated," Wade described his wife's two miscarriages as "hard," Eugene repeatedly referred to his wife's miscarriage as "horrible," and Dale summarized, "Well, there was definitely loss there." Wade reported that his wife experienced "emotional upheaval" following her second miscarriage and needed a D&C procedure. Chris described the intense response that his then-girlfriend experienced, "There's no word that could possibly describe how much sorrow was on her face (pause…sigh). It was almost as if part of her *had* died." He further disclosed, "All-in-all for me, yes, I lost a child, but it was never a truly tangible, independent person for me. Whereas for her, I felt like she truly felt as if her child had died." In sum and according to the participants, many of their partners experienced intense, long-term emotional expressions following miscarriage.

Nature of Partner Expressions

According to the participants, many of their partners experienced the subordinate theme of diverse nature of responses, including emotional expressions, behavioral expressions, and negative cognitions. Many women (as reported by Eugene, Chris, Dale, Larry, Frank, Wade, Terry) experienced intense emotional expressions including sadness (i.e., demonstrated by the behaviors of crying and withdrawing), anger, and anxiety. Chris related that his girlfriend experienced "anger," irritability, withdrawal, and sadness." He

elaborated, “I mean, she was sad. She’s normally an incredibly optimistic, outgoing, social butterfly person. She’s so much fun to be around. She didn’t want to see anyone; she just was in her room crying for a while.” Chris continued to describe her withdrawal, irritability, and anger:

> She pushed me away. She would tell me to come over because she wanted to see me and then lock the door and wouldn’t open it so that I couldn’t actually come to see her. There were periods of anger, and she never meant it, but she would yell at me and blame me for whatever reason. She would blame me in the sense of, ‘Well, you got me pregnant in the first place, so this is all your fault that I have to go through this now’ - that kind of stuff.

Similar to Chris’ partner, Larry revealed that his wife demonstrated the behaviors of withdrawal and decreased talkativeness following her second miscarriage. Eugene described his wife’s experiences of emotional and physical pain and distress (e.g. anxiety, panic, and intense sadness). He disclosed,

> She was kind of panicky, thinking she was dying a lot, and it’s like, ‘No, you’re not dying, you’re having a panic attack. You’re working yourself up into a frenzy. You’re about to pass out.’ She turned as white as a sheet. She doesn’t deal well with stress, and this was pretty horrible. She went to the ER and they gave her an IV, and she kind of panicked and passed out. She turned as white as a sheet like that (he showed me a piece of white paper) and just passed out. It was a horrible experience.

Four participants (Wade, Ken, Larry, Dale**)** reported that their partners seemed to experience negative thoughts of guilt, self-blame, and a sense of inadequacy as women.

These men described how their wives felt like their bodies had betrayed them. Larry shared that his wife had felt “hurt and disappointed,” following her second miscarriage and “probably thought, ‘I’m older now, my body’s more stable. I should be able to do this.’” Though Wade reported that she never expressed it, he thought that his wife held the “irrational thought” that the miscarriages were “her fault.” He speculated that she “logically” knew “that she didn’t do anything to cause this.” Wade conjectured that this irrational thought was perhaps a deeper “feeling of inadequacy in some sense…that she was inadequate as a woman in some way.” Dale also speculated that his wife may have experienced guilt following her two miscarriages and health complications from a blood-clotting disorder. He explained:

> She might have felt some guilt by omission. Like, ‘What could I have done differently?’ And the fact that she didn’t even know that she was a hemophiliac, getting those two things at the same time - that was a huge hit to her. Because now she’s less of a person because she has something wrong with her.

In sum, four partners appeared to experience negative thoughts related to guilt, self-blame, and a sense of inadequacy as women. Some of these women felt guilty for the miscarriage and blamed themselves. Some women also experienced a sense of inadequacy because they were not able to carry a healthy unborn child full-term.

Men’s Coping

The third superordinate theme that I chose from the data, and that was represented by all of the participants, was coping. This superordinate theme is affiliated with the research question: “What approaches do men use in coping with miscarriage?” Men reported a number of ways that they attempted to cope with the miscarriage including

seven subordinate themes of supporting their partners, relying on social support, viewing the loss as a challenge to work through, staying busy/following a routine, holding hope for future fertility/family expansion, expressing thankfulness for an existing child, and understanding medical knowledge about the possible causes and frequent occurrence of miscarriage.

Offering Support to Partners

Five participants (Chris, Larry, Dale, Nathan, Ken) reported the subordinate theme that offering support for their wives helped them to cope. Some men addressed the prompt, 'Tell me about how you are coping with the miscarriage,' by describing how they were caring for and supporting their partners. Ken related that he coped by "mostly focusing on my wife and making sure that she was okay, and that she had the support that she needed." Throughout the interview, Ken reiterated his concern for and support of his wife during her three miscarriages. He also wondered aloud whether he would have been as focused on supporting her if he had been grieving and more "upset" than she was. Ken asserted that he believed that he was better able to assist her because he was grieving less than she was. He shared, "I was very concerned with how my wife was feeling." Eugene remarked that he believed that men's coping depended on how their partners were coping. He urged men in similar situations to consider that, "You're not going to feel any better until she feels better." Eugene encouraged men to "lean into your wife. I mean, she needs the help…pour what you can into your wife, and it makes a world of difference." He suggested specific ways to be supportive including,

> Cry with her. If she wants to talk, talk. I don't know how I did it, but somehow I was able to get my wife to laugh- I joked about stuff. It helped. Take the time; be there. Pour what you can into your wife, and it makes a world of difference.

Eugene also reported that he and his wife developed a closer bond through his support of her during the miscarriage experience; a bond he considered to be a benefit of the experience.

Two men (Nathan, Terry) related that they felt supported when their partners were supported by others. These men reported that they were more affected by their partners' responses to the miscarriage than their own personal responses. The men indicated that they coped better when they believed their partners were coping effectively, often in connection with social support offered to their wives by others. Nathan reported that his wife shared "a lot" about her three miscarriages with her main social support, friends via Facebook, and received "a lot of support that helped her." Nathan elaborated,

> And I think the thing that affected me the most was actually the way that the miscarriages affected her. So I thought her sharing that and getting the support from her friends, that actually helped me as well, knowing that she had that support out there.

Similarly, Terry reported that he was reassured and helped by knowing that his wife was supported by others. He indicated that his wife's needs were in the forefront of his mind, and he focused on her response more than on his. He shared, "At least for me, knowing that she was getting help and was processing it, I was more her-centered, I think, than feeling that I needed to be the one that reached out or had help." He further reflected,

> I would say that the amount of support that she was able to get was valuable for me, knowing that she had friends, knowing that she could talk with her mom, her sisters, and my sister-in-law who had just gone through a miscarriage. Those kinds of things were very helpful.

Terry indicated that he also felt supported by others but preferred that his wife receive more support. He shared, “In general, I would say that I was supported. And most people asked *more* about my wife and how she was dealing with the miscarriage more than how I was dealing with it.” When asked if it bothered him that people asked more about his wife, he responded, “Not really. I would say that my main concern was more for her and her emotions. She certainly is more emotional than I am. I would say her having this support was much better.” He described himself as “fairly even-keeled,” and one who is not “overly emotional or stressed.”

Additionally, Terry stated that he actively sought out female support figures for his wife in the form of family members and medical professionals throughout the miscarriage process. He asserted that female support was “important” for his wife. He also described that because he is not a woman, he has “learned that women provide a different relationship level, so her having two sisters helped tremendously, her having her mother, and to some extent my mom… and having a sister-in-law that could share that kind of scenario.” Terry reported that he also encouraged his wife’s interactions with female medical professionals because “both her physicians were men- her OB and our main fertility person. I think she bonded with the nurses at the hospital.” He related that his wife benefitted from interacting with female medical professionals, because it was

"always helpful for her to hear the nurse's version, not just the male physicians, medical-only version."

Not only did these participants appear to place their partner's needs before their own, many of them reported that they benefitted from supporting their partners, and their partners being supported by other people. These men did not indicate that they ignored or internalized their responses, but they described the supportive behaviors toward their partners as *helpful* to them. Their support of their partners appeared to help *facilitate* their own grief responses and processing of the loss rather than *hindering* their responses.

Relying on Social Support

A fifth subordinate theme under the superordinate theme of coping that stood out from the data, and was reported by six men (Wade, Frank, Ken, Terry, Nathan, and Eugene) was coping by relying on social support from family, friends, and employers. Some men described their social support as adequate (Terry, Eugene, Wade), but some men wished that they had received or reached out for more support (Larry, Dale). Terry described his family as "very supportive," and reported that he frequently communicated with them during the miscarriage. Eugene described his wife's side of the family as supportive, and he reported that his in-laws cared for his daughter during the week of his wife's miscarriage and recovery. Wade appeared to respond emotionally. He was proactive in expressing himself to many family members and friends in order to express his emotions in "healthy ways" and not "internalize" his emotions like he reported he has a tendency. Nathan shared a unique experience where he described his parents as offering support and "*very* concerned." He described, "It was a little more difficult with them because I felt like they thought I should be feeling more sad than I probably was… I was

like, 'Hey, it's not that bad overall.'" He disclosed that he did not find their support helpful, and he "didn't really rely on them for support."

Wade appeared intentional in his attempts to cope with his wife's two miscarriages by effectively sharing with people and being aware of and accepting of his emotions. He coped with his wife's miscarriages by "just talking about it with people in general. I talk to a lot of different men, mainly men, about what's going on in my life." He also expressed that although he communicated with his wife, he also benefited from talking to others,

> Although it's nice to talk to my wife and partner about the issue, it's also comforting to talk to someone else about what's going on. Especially when things are difficult to talk about, and I don't want to say the wrong thing. I don't want to upset her, and I don't want to seem insensitive about how I may or may not be feeling.

Wade expressed that talking with others provided mental clarity, a sense of connection to others, and a realization of the common occurrence of miscarriage. He reflected, "I think there's a lot to be said with talking about it with other people, and just saying things in general out loud. Sometimes working through my own thoughts is different when I just say them aloud." Wade stated,

> Just expressing the stuff out loud really seems to help, and through that process I've actually been related to a lot more than I expected. It's just not something I hear about often- women having miscarriages. A lot of people told me about their own experiences.

He related that one of his "close" friends with whom he confided recently experienced health complications with his baby, and that he and Wade supported each other. Wade shared, "It seems like when I talk to a lot of people they have recently had something going on maybe similar or maybe different. But yeah, it is nice to be able to reach out and talk to other people."

Certain participants found support from their places of employment. Dale described his employers as supportive and reported that they offered him coveted day-time shifts during his three daughter's daycare and school hours while his wife was recovering from miscarriage and health complications. Nathan and Terry coped by confiding in their graduate student co-workers with whom they frequently interacted and who were similar in age and relationship/family status. Frank reported that his supervisor and father-in-law encouraged him to take some time off to spend with his wife and daughter.

In contrast, some men reported that they wished that they had been able to share their experiences with others and receive more social support. Dale and Larry reported that they wished they had sought counseling to better cope with their wives' two miscarriages. Larry shared, "I wish I had done therapy the second time. I think the first time, I was just too young to even understand what that might have done." Larry also related that he wished he had received more social support. He reported that only a handful of his friends knew about his wife's two miscarriages, and he wished that he had discussed the topic with other friends and reached out for support. He reflected,

> And I think again, I wish *then* that I'd had the communication skills with my friends, beyond my two close friends, neighbors, to have said, 'Well, something

> pretty bad happened this month. I just need to tell you. I don't want you to do anything; I don't want you to fix it. I just need to tell you.' And I didn't do that. And because you don't do that, it probably didn't give us the opportunity to find out that maybe other families that were friends of ours had gone through it, because nobody else had said.

Additionally, Larry disclosed that he wished that he had talked with his daughter about his wife's two miscarriages, like his wife has. He offered, "I've *never* had a conversation with my daughter about this; I think that's a male thing." He also reflected on the role of race in asking for support,

> African-American men tend to be far more private than the majority of the population. So you go to church and talk about getting married and having kids and being a good father, and that type of stuff. I don't think for all the times I've ever been in a church, I've ever heard a minister talk about, 'Well, here's how a man oughtta deal with this.' Now I suspect, my wife has gone to church, and they probably as women have talked about, 'Now this may happen, and here's how you might cope with this.' So I think that's something that hasn't changed in my lifetime, other than maybe the support group stuff. And so because of that, I don't think it's like this weight that you carry by yourself, but it *does* require you to have a dependent spouse or friend or best friend.

Larry expressed that he thinks men still need better communication and "coping" skills to tell their families and friends about this difficult subject,

> I still can't imagine, even in 2014 that most men have the coping skills necessary to tell their best friends and families about what's going on in their lives. I mean,

> this is bad. And how do you go about communicating that? Especially if it's beyond the trimester when you announced it and grandparents think they're going to have a grandchild. And you've gotta call and say, 'Oh no, something happened.' Oof.

In summary, many men reported receiving adequate social support, whereas some wished that they had received more social support.

Viewing the Miscarriage as a Challenge

A third subordinate theme of how participants (Ken, Nathan, Dale, Wade) coped was by viewing the miscarriage as a life challenge that they could overcome. Some men used metaphors and likened the miscarriage to "a bump in the road," (Ken and Terry) and "a stumbling block" (Nathan). Ken stated, "It's sad that it happened, but it happened." Nathan appeared to view the miscarriage as similar to other challenges and trials of life and coped with it similarly. He shared, "I didn't see the miscarriage as different than any other trying time…this sucks, but we'll get over it." Nathan also described the miscarriages as, "relatively simple; it wasn't a very complex issue emotionally or psychologically for me. It was more of just something that happened that we had to work through." He held onto the belief that "This too shall pass." Dale described his wife's two miscarriages as a "challenge" that he sought to work through and overcome. He explained, "You have to just keep plugging ahead, and probably the best realization I had is, hey, this is the challenge we've been given, and we'll have to deal with it." He reported that he was determined to make it through the "challenges," and realized that, "You can't fail, and you have to just keep plugging ahead." Dale reflected later on in the interview, "I could have lived without the challenges, but I think the challenges also

made me a little better, a little stronger, mentally if not emotionally." These men demonstrated appeared to cope by facing the miscarriage challenges head-on and attempting to work through the difficulties.

Two participants, Wade and Dale, described their development of effective coping skills and determination through difficulties. These men reported that previous difficulties prepared them to more effectively cope with their wives' two miscarriages. Wade reported that he had learned to cope in "healthy ways" through previous difficulties, and he "definitely" coped with the miscarriages in "a positive, healthy manner." He repeated the phrase, "the past is prologue for the future," a couple of times throughout the interview, and he indicated that the coping strategies (e.g., talking to other men, becoming aware of his emotions) he learned through previous challenges assisted him during the miscarriage experiences. Dale reported that his wife's first miscarriage and resulting health complications, from a diagnosis of a blood-clotting disorder at that time, helped prepare him to cope more effectively with his wife's second miscarriage, health problems, and year-long recovery. He offered, "I'm a lot more resilient than I thought I was." Similar to Wade, he stated that he believed that his "challenges" made him "a little better, a little stronger mentally, if not emotionally."

Wade was able to situate the miscarriage events within the framework of his life. He appeared well-acquainted with loss and "adversity, and he viewed previous losses as helping to equip and strengthen him for the miscarriages as well as future possible losses. Wade stated, "I mean, I've had a lot of losses in my life, but I don't think that I typically deal with them in a healthy way." He described a previous traumatic event where he almost drowned while trying to save a friend who ended up drowning. Wade believed he

did not know how to cope effectively. He explained, “I didn’t talk about it, and I didn’t know how to deal with it.” He reported handling the loss by “compartmentalizing, shutting down, and internalizing.” He reflected, “I have a tendency not to express things with other people, and kind of shut down, which is not a healthy coping mechanism. And that’s something that I already know about, so I talk to a lot of different people.” Wade elaborated,

> I’ve made some mistakes, and I’ve had some adversity that I’ve faced earlier in life that I consciously try to work on some of my weaknesses and such. I guess it has been a better time in my life for this kind of thing to occur because I am able to try and deal with it, or cope with it in a healthy manner, and be present with my wife.

Overall, Wade described the previous traumatic event and other difficulties as opportunities to learn and implement healthier coping skills such as talking to people, which he believed he was able to implement following his wife’s miscarriages.

Dale reported that the first miscarriage and health challenges, and likewise, the high-risk pregnancy with his third daughter, helped prepare him for his wife’s second miscarriage, and “made the second one a little easier in a way.” Similarly, he stated that he believed that his “challenges” made him “a little better, a little stronger mentally, if not emotionally.” He described the second miscarriage as “even tougher because it was worse- quadruple, quintuple - because of all the bad things that were going on. Struggle, struggle, struggle.” Dale also viewed the difficulties as an opportunity to model character traits of perseverance and responsibility to his children and to outside observers. “It would have been easy to make other choices, but that would have been a very bad lesson

for my three daughters and any family and friends watching. So it wasn't feasible to do anything else *but* forge ahead."

Staying Busy/Following a Routine

The fourth subordinate theme that I determined under the superordinate theme of coping was reported by three participants (Nathan, Dale and Larry) and involved coping through busyness and by following a normal routine. However, coping in this manner appeared to only help to a certain extent or at certain times. Nathan, Dale, and Larry each indicated doubt about whether this style of coping was healthy and beneficial. Nathan appeared to question whether the approach was positive when he prefaced his description with, "Fortunately, well maybe not fortunately…" Dale shared that busyness and routine helped him cope, but he asserted that busyness did not allow him to fully grieve his wife's two miscarriages. Larry reported that busyness and routine helped him cope after his wife's first miscarriage, but it did not help following his wife's second miscarriage. Nathan reported he and his wife appeared to benefit to some extent by staying busy with their jobs. More specifically he offered,

> We were both very busy at the time, so I think it was relatively easy for us to put it aside and focus on what we needed to focus on. I think if one of us hadn't been working, she or I would have had a lot more time maybe to dwell on the miscarriages. I think at the time it was more of just, we had a lot to do (laugh). So it kind of helped us to move on in that situation.

Nathan admitted that he believed overall that busyness helped him and his wife to "put [the miscarriage] aside" and to "move on."

The routine and responsibilities of family life and work appeared to help Dale and Larry cope to a certain extent. Dale shared that he was "resilient" and was focused on the caregiving responsibilities for his three young daughters. He indicated that busyness was how he coped, although he reported that it hindered him from processing the losses.

> Emotions kind of got put over on the shelf because of the practicality of taking care of the family and fixing that bill situation, and then work. There was no time for grieving, really, it just got pushed farther and farther down the list.

He believed, at the time of the interview, that he had never fully grieved and found "resolution." He reflected that he had grieved "over time," but believed "there's still some loss there… it's been 30 years."

Larry related that continuing his work and family routine helped him cope following his wife's first miscarriage, but not her second. He shared,

> I think the first one was relatively pretty easy because we were going to work, we had the child, she was going to law school, and so Monday got to be Tuesday, Tuesday got to be Wednesday, and so you went about your day-to-day stuff. You went about your routine, and that was it.

However, Larry related that after his wife's second miscarriage, he withdrew and wished that he had taken time off of work to help him better cope. He shared that he had been more excited about the baby and found that miscarriage more difficult to handle. He shared,

> I think with the second one, I didn't know that I *knew* that you could take time off, so I couldn't wait 'til like the weekend. And you had a five-year-old, so there were things that you had to do, but when you didn't have to do stuff you know,

> you were pretty quiet, a little more withdrawn. And then finally again, like everything else, one day got through to the next, and you got into your routine.

Larry appeared to question whether he should have stayed busy and regular in his routine following the second miscarriage, but he indicated that he was able to make it through that difficult time and return to his everyday tasks and normal functioning.

Hope for Future Fertility or Family Planning/Expansion

Another subordinate theme under the superordinate theme of coping was holding hope for future fertility and family planning/expansion. Ken, Nathan, Terry, Eugene, Larry, and Wade spoke of holding hope for future family expansion through pregnancy or adoption. These men indicated that having children was a goal for them and their partners, and they did not allow themselves to feel defeated or give up following encumbrances to their plans. Instead, these participants chose to hold hope that their goal would be realized in the future through future conception or adoption. Nathan acknowledged the difficult circumstances of his wife's three miscarriages, but he also expressed hope. He offered, "This is a terrible situation, but we can try again." Nathan also noted that it was "the most helpful thing" to realize "that there is a way forward." Larry related, "I kept thinking we'll adopt…that'll take care of the miscarriages. It will take care of sort of having more kids." Ken expressed throughout his interview that during his wife's three miscarriages, he held hope for future viable pregnancies. He explained, "We knew that we would be able to try again, and with the doctor's help, make sure that everything went better the next time." Terry reported a desire to try and expand his family following his wife's miscarriage. He noted that he and his wife coped by "moving on fairly quickly…for us to become pregnant relatively soon was a good

thing." Terry and his wife experienced fertility problems, and they had discussed adopting if they were not able to give birth to a second child. Eugene spoke passionately throughout the interview about his plan to expand his family through adoption, something that he and his wife had already experienced when welcoming their nine-year-old daughter two years ago through adoption. He stated, "we're ready to bring in more foster children that we hope to adopt…we want to expand our family." Eugene discussed specific preparations that they had been making including moving to a bigger house, earning income that was additional to his and his wife's full-time jobs, and saving money. These participants appeared hopeful through the miscarriage difficulties, and they were motivated to make efforts to expand their families.

Ken and Nathan were able to place the miscarriage in a broader perspective which appeared to help them cope and reinforce their hope for future fertility. Nathan used a metaphor: "I kind of knew that even if this didn't work out, we would be able to try again, and it wasn't the end of the world." Similarly, Ken reported that placing the miscarriage in perspective helped him and his wife cope; "knowing that this wasn't the end-all. There was still hope for another pregnancy." Additionally, when asked what advice he would offer to other men in similar situations, the only suggestion he gave was to "just keep trying."

Ken demonstrated an optimistic perspective and was able to identify a positive outcome of the miscarriage such as his wife's ability to initially conceive, to become pregnancy.

> And the miscarriage was good in some ways because it was like, well this didn't work out, but we didn't have any problem getting pregnant before, so we

> shouldn't have too much of a problem getting pregnant again. So we know it can happen.

Ken channeled his optimism about his wife's apparent fertility into anticipation that she would conceive a viable pregnancy that would be "successful in the future." When asked what he had learned from the miscarriage experience, Ken replied, "we've got two beautiful kids now. So it doesn't always work out, but when it does work out, it works out great." Additionally, he reflected,

> It's sad that it happened, but it happened, and now we successfully got pregnant and have two wonderful, beautiful daughters and might be trying for a third one at some point in the future. I'm sad that it happened, but I guess it was meant to be.

In summary, some men indicated hope for future family expansion that helped them cope with the miscarriage.

Appreciating the Existence of a Living Child

A sixth subordinate theme that I highlighted in the data under the superordinate theme of coping is that four participants (Terry, Larry, Frank, Dale) coped by appreciating the existence of a living child. These men related that the existence of a child helped calm them and brought joy to their lives. Terry related, "Our main coping mechanism was having a healthy one-year-old. Having that child allowed us to move on fairly quickly." Terry shared that his wife felt similarly that having their son, "was the easiest coping mechanism or her main ability to focus on him as our existing miracle, our existing child. So that made it *much* easier for a stressful situation…to be able to move on." He reflected, "We had a healthy one-year-old child, and so that *really* was probably our biggest stress-reliever, our biggest miracle."

A couple of men (Larry, Terry) also indicated that they experienced a sense of meaning and purpose because of their existing child. Larry related, “With the first miscarriage, it made sense because we had a daughter.” Terry reflected on his wife’s miscarriage and their fertility struggles, “But I think having a child made it easier for both of us to move on, having a child that we weren’t sure we would have.”

A couple of men (Frank, Terry) reported that they believed that the miscarriage would have been more difficult if they had not already previously experienced a successful pregnancy and healthy child. Frank shared, “Having another child, you know, if we didn’t have any kids at all, and we kept trying and trying, it’d be devastating. But we do have another child already, and she easily got pregnant the next time.” Frank indicated that his wife stated that she would have felt similarly as he did and “would have been devastated” if their first child had been miscarried. Terry shared,

> I don’t think the miscarriage was as impactful as it could have been. Had it been miscarriage first where we’d gone through all the infertility challenges, *finally* we’re pregnant, and then lost our first pregnancy. I think it *could* have been more devastating and could have been a much bigger impact than it was.

He summarized, “so in the grand scheme of things, the miscarriage was difficult, but we viewed it as less of a challenge since we already had a child.” In summary, some men coped by appreciating the child that they already had.

Learning Medical Information

The final subordinate theme that I selected under the superordinate them of coping was that learning factual medical information about the common occurrence and potential causes of miscarriage aided some men in their coping with the loss. Four

participants (Ken, Frank, Nathan, Wade) learned information from the doctor and also discovered information on their own. Wade and Nathan disclosed that they appreciated miscarriage information delivered "factually" (Nathan) and "in a logical or rational sense" (Wade). Wade explained, "As a man, I think dealing with it in a more logical or rational sense was somewhat comforting in the beginning, not that I didn't want to deal with it emotionally at all."

Some men were reassured to learn that miscarriages are common, are not typically caused by people, and do not generally signal infertility problems. These participants related that their doctors also indicated hope for future fertility. Wade related, "The doctor explained that this is more common, and these things happen." Nathan reported that the doctor stated, "This happens sometimes." Ken related, "It helped knowing that it was a fairly common thing; it wasn't completely unexpected." He reported that learning medical information about the common occurrence of miscarriage was reassuring; "It wasn't like we were the only people this had ever happened to." Ken also expressed relief in realizing that the miscarriage was not caused by he or his wife; "It's not like it was our fault." Nathan expressed similar sentiments and appreciated that the doctor offered hope for future fertility,

> I think the doctor was very good at putting our mind at ease, that there's not necessarily anything wrong with you… And it's very unlikely at this point that it would be that you're infertile. That helped a little bit.

Nathan described that the doctor also "gave us some advice on how to move forward if this is an issue…that there are ways to help someone who has tendencies to miscarry."

The participants were reassured from learning about the causes and frequent occurrence of miscarriage.

Meaning Reconstruction

The fourth superordinate theme that I perceived from the data was that many participants engaged in meaning-making activities following the miscarriage. This superordinate theme is coincides with the following of my research questions: "How do men make sense of their miscarriage experience?" I asked about meaning-making through questions such as, 'Tell me about any ways that you may have made sense of the miscarriage,' 'What advice would you give to another man going through a similar experience?' and 'What have you learned, if anything, from the experience?' The participant's meaning-making activities fell into four subordinate themes: gratefulness for an early (rather than late) gestational loss, belief in a reason for the miscarriage, enhanced value for life, and strengthened family relationships.

Gratefulness for an Early Gestational Loss

The first subordinate theme that I selected was that three men (Frank, Eugene, Terry) considered the 'worst case scenario' with regard to their losses, and they appeared grateful that their losses were early in gestation. Eugene and Frank's perspectives were colored by their interactions with sisters who lost babies from congenital health conditions, and Terry's perspective was influenced by "friends that had later miscarriages and stillbirths." Terry expressed gratitude that his wife's experience "with passing tissue and things" was not "quite as difficult" as friends who had miscarried later pregnancies or who had delivered babies who were stillborn. Frank reported that his sister and other acquaintances had "been through a lot worse" with his sister's loss of a child 16 days

following birth and acquaintances whose babies were stillborn. Frank believed that for him, a miscarriage was significantly easier to deal with than a pregnancy that was further along, or the death of a child following birth. He explained, "So I think, at least, this wasn't as bad as it could have been. I mean, the further along you are, the worse it makes it." Eugene and Frank both assumed that their wives' miscarriages were due to congenital defects, for example, Eugene stated, "We knew our child had died because something was wrong with it. It's better that it died then. Time gives perspective." Frank shared Eugene's sentiments,

> Obviously something wasn't right with the baby. It makes it far better to have a miscarriage early than to have a child that's going to need constant attention for medical purposes for their entire life, and then they die when they're three or four. That would just be so much more difficult to handle than a miscarriage.

Eugene shared that as time passes since his wife's miscarriage, he is thankful that the loss occurred early so that his child did not "suffer." He sobbed (i.e., cried intensely as tears streamed down his face and his vocal pitch heightened) as he related the experience of his niece who suffered with a heart condition and lived 81 days in a hospital. Eugene went on to explain:

> I mean, when she died her chest was split open, and I mean, that's how my sister and brother-in-law saw their kid before she died. And it's like, you know, I know it's selfish to say, but I'm glad our kid didn't suffer like that (sobbing harder). That gives perspective, but it still hurts. I mean, you just walk up-and-down the halls of the hospital, and there's a lot of suffering out there. I'm glad our kid didn't suffer because there's a lot of kids that are out there that are suffering.

Belief in a Reason/Purpose for the Miscarriage

The second subordinate theme that I exposed under the meaning-making superordinate theme was that three participants believed that there was a "reason" and purpose for the miscarriage, and two men suggested that a possible reason for their wives' miscarriages was that their families were meant to grow in other ways (i.e., new pregnancy and adoption). Three men (Eugene, Frank, Dale) shared that they believed that "God has/had a plan" for their lives and for the miscarriage. Eugene related, "God has a plan, and you just wait and see what He puts in your life." Frank shared that his faith in God and his belief that there's a "reason" for why events happen helped him find meaning from his wife's miscarriage. More specifically he offered:

> Knowing that God is sovereign and that everything happens for some reason, and that He controls everything. That really does help. God gives, and God takes away. I can't always understand why, but just know that He's in control, and He allowed it. So there's gotta be some reason for it.

Dale also shared, "There's a lot to be said for faith, family, and friends," and he referenced a Bible verse "that says we're not given challenges that we can't handle." The three men referenced a higher power who they believed was involved in their lives and in the miscarriages.

Additionally, Frank and Eugene suggested that one possible reason for their wives' miscarriages was that their families were meant to be expanded by another pregnancy (Frank) and by adoption (Eugene). Frank made reference to his wife's 13-week pregnancy at the time of the interview, "If we didn't have the miscarriage, we wouldn't have this baby. Maybe this was the one we were meant to have." Eugene

reported that the preparations that he and his wife had made for a baby would aid their future adoption plans as they had previously adopted a daughter. He stated, “We want to expand our family. If the miscarriage hadn’t happened, we probably wouldn’t be ready to adopt again. I mean, we probably wouldn’t have moved- we’re in a bigger house.” Both Eugene and Frank appeared willing to conjecture about possible reasons for their losses.

Enhanced Value for Fertility and Life

The third subordinate theme that I chose under the superordinate theme of meaning-making was that three participants (Nathan, Terry, Frank) reported that they learned to value fertility and life because of the miscarriage experience. Frank urged, “I mean, don’t take anything for granted. I assumed that everything was going to be okay.” Terry revealed he and his wife’s appreciation for life, “We don’t take our children for granted. None of them were mistakes; none of them were accidents. We tried for a long time to have them.”

Terry reported that his wife’s miscarriage, along with fertility difficulties, served to bolster the value he placed on fertility and life in general. He referred to fertility as a “miracle,” a “blessing,” and as “pretty valuable.” He expressed a great appreciation for his children, noting that “We’re incredibly blessed to have them.” He twice referred to his family’s value on fertility and life as “part of our family heritage.”

Terry reported that he had talked about the miscarriage that occurred many years ago and about his and his wife’s fertility problems with his children. More specifically, he stated that

> We have shared with our kids so they’re aware that there could be four in the family, instead of three. So that’s been part of our family heritage. That helps

> them understand that we value them individually, each of them as our children…none of them were mistakes; none of them were accidents.

He shared that he desires for his children to know how much they were wanted and planned, which he believes is demonstrated by his and his wife's fertility efforts and miscarriage. He viewed communication about family planning and difficulties as an important aspect of their "family heritage." Terry asserted that speaking of the child who died imparts the importance of life, "and even just having conversations about a miscarriage, I think that conveys that to them and the value of children and the value of family."

Strengthened Family Relationships

The fourth subordinate theme that I determined from the superordinate theme of meaning-making was that three participants viewed their partner's miscarriage as helping to strengthen family relationships. Eugene reported that he and his wife grew closer to each other through the miscarriage experience. Chris related that he and his girlfriend's relationship continued to develop following the miscarriage and resulted in engagement. Dale reported a closer attachment with his daughters through his wife's miscarriage and health complications.

Eugene described ways that he supported his wife and reported that a stronger bond resulted. He remarked, "Ideally, that's really not how you want to get closer to your wife, having a miscarriage, but I mean, fire tempers your relationship and makes you stronger." Eugene described taking one week off of work to be with his wife during the miscarriage and recovery. He explained that he held her, cried with her, encouraged her that she was not "dying," tried to calm her, told jokes to make her laugh, and even re-

arranged their bedroom (i.e., place of miscarriage) so that his wife's negative memories from the miscarriage would be decreased. He related that his wife told him he was "amazing" throughout the miscarriage experience. Eugene also shared that his wife had told him about instances of friends of hers whose husbands were not supportive of their wives. Eugene referred to those husbands as "dipshits" in the interview and repeatedly urged other men going through a similar experience to "Be there for your wife."

Chris reported that he and his girlfriend's relationship survived the challenge of the miscarriage and continued to grow. He explained that they attended couples counseling to work through the loss and learned effective communication and implemented healthy coping skills. Chris indicated that they became engaged after the miscarriage and, at the time of the interview, were beginning to plan a wedding.

Dale reported that his wife's two miscarriages, health complications from a resulting blood-clotting disorder, and extended recovery resulted in her being "out of commission" to assist with childcare or household responsibilities. He shared that his increased time and childcare responsibilities with his three young daughters resulted in a closer bond with his daughters. He related that his daughters began to rely on him more at that time, and that they still turn to him as adults. He expounded, "One of my kids would fall and get hurt, and they would run to me, not to their mother. Because they'd learned I was their go-to guy." He reported that he took responsibility for all of the childcare responsibilities and realized that his wife might die. He cried as he explained that, "I knew I had to take care of the three kids. There was a chance I might be taking care of the three kids (without his wife). So I think that's why they came to me, and they still do. They still do." He spoke about the positive outcome (i.e., "the cherry on top") of the

strengthening of his attachment with his daughters as a result of the miscarriages and his wife's health complications. Dale described continuing to enjoy a close bond to his now-adult daughters and grandchildren and that they frequently communicate on the phone and through visits.

While many men grew closer to their partners and family members, two men (Dale, Larry) reported that the miscarriage experience created a rift between them and their wives. Dale credited his wife's decision to pursue a risky pregnancy, without his knowledge or consent, as the cause of her life-threatening, extended health complications. He indicated that her decision caused "a little distrust" that eventually contributed to their divorce 13 years later. He admitted that he was "angry to some extent" about his then-wife's "selfish" and "dumb" decision. Dale disclosed, that "she wanted another baby, and that decision almost ended up killing her, ironically." He shared that her decision was "stressful" for the family and "created a little bit of a rift that never really got addressed." Larry reported that he withdrew from his wife following her second miscarriage because he was "angry" and "blamed" her. He admitted, "I think the second one was hard on the relationship for a while." Larry related that he eventually "learned to cope" and "move on" and reported a close relationship with his wife at the time of the interview.

Men's Perspectives of Gender Roles and Masculinity

I chose the superordinate theme of men's perspectives on gender roles and masculinity through my analysis of the interview data. All of the participants were given multiple opportunities to discuss their views on masculinity and gender roles throughout the data collection process by answering an open-ended interview prompt (i.e., "Tell me about your role in the relationship.").

Gender Roles

When asked the question, 'Tell me about your role in your relationship,' their responses fell into one of three subordinate themes. Approximately one-third reported employing traditional gender roles (i.e., emphasis on male as provider, leader; Perrone et al, 2009); Eugene, Frank, Terry), one-third reported practicing non-traditional gender roles (i.e., focus on equality and flexible roles; Perrone et al.; Dale, Larry, Nathan), and one-third reported implementing a combination of the two (Perrone et al; Chris, Ken, Wade). With regard to the open-ended masculinity measures, most men indicated valuing the role of partner and father. Many men also indicated valuing responsibility, hard work, and being a good citizen by caring for and helping others.

Traditional views. Three participants (Eugene, Frank, Terry) ascribed to the subordinate theme of traditional views. They viewed themselves as the "head" and leader of their families, and they viewed their wives as supportive and more family-centered. They shared that they believed that their responsibility was to provide for the physical, financial, and emotional needs of their family. Eugene explained:

> I am the head of the family, so (big sigh) (Laugh). It's a lot of responsibility, it's like (sigh, sigh). My wife worries about the little day-to-day things; I think about the big picture. She was widowed once before, so things can happen. I plan for the worst. And sometimes my wife and kid forget that- I'm preparing for the worst, hoping for the best. And it's working out pretty well. And God-forbid something happens, I know they'll be well taken care of.

Similarly, Terry disclosed, "It's important for me to have a more traditional role as husband and father, breadwinner, leader of the household." He related that initially, "it

was a challenge" because his wife was "the breadwinner for a couple years helping [him] in school." At the time of the interview, he reported being an educator for many years and being able to come "home as a dad," and his wife worked part-time and worked as a homemaker at the same time. He explained, "We have made financial decisions that have allowed her to stay home." He described that his wife was/is "able to be home, even with a job. She's home when the kids are home, and she has, I would say, a fairly traditional gender role as a home provider, as a mother for the children." Similar to Eugene and Terry, Frank valued traditional gender roles and desired to "be the leader in everything." Along with leadership, he desired to "take care" of his wife and daughter because "that's my responsibility." He expounded:

> I feel like I take good care of my wife. She stays home, and essentially I stay home too. I have a job, and I work from home, so I'm always home…So when my daughter's crying, I can go find out what's wrong. If my wife needs help for a minute, I can step away from my desk and do what I need to.

In summary, Eugene, Terry, and Frank all described traits of traditional gender roles in their marriages. More specifically, they all emphasized leadership and provision for their families.

Non-traditional views. One-third of participants (Dale, Larry, Nathan) reported ascribing to the subordinate theme of non-traditional gender roles with an emphasis on equality and more flexible roles. Nathan described his relationship as "companionship-oriented," and indicated that he viewed his that his "primary role is to be her companion and friend." He also reported flexible gender roles within his marriage. He explained:

> We really don't have very traditional gender roles as far as what's required of us. I think recently we've kind of assumed more traditional gender roles, but it was more of just how life took us. Most of our marriage we both worked, now I'm working and she's staying home. She's pregnant, and she's getting ready to have the baby.

Larry described his marriage and family as "non-traditional" and a mutual "partnership." He indicated that he and his wife are close and supportive of each other. He elaborated:

> I think we're a pretty non-traditional family. Like I do the grocery shopping; I'm the coupon-clipper. She has no desire for that sort of stuff. Because we lived on the East coast and we were commuters, the rule always was, whoever got home first started dinner. I'm proud of the fact that when we had our child, we agreed that this wasn't, 'you get up at night and I sleep.' This was, we both sort of share this. And again a part of that was because we didn't have family. There was no grandmother there and stuff. And so I think our relationship is the same way, it's more of a partnership.

Dale reported a previous "equal" relationship with his ex-wife where they operated as a "team." He related that they shared child-rearing and financial responsibilities. He described:

> Well, we were both working and raising our kids on an equal basis. And to me it didn't matter that I made a little bit more. But that wasn't really an issue or a question because we were working as a team in all phases of our lives from 'I do',

> (well, we're not anymore). But that was it for me, we were joined at the hip and at the head. So we discussed things; we planned things.

Dale expressed frustration when he explained that his wife planned her last pregnancy without his consent, and he described questioning her loyalty to their marital partnership and "commitment" to the family. His wife's last pregnancy was her third high-risk pregnancy and eventually resulted in her second miscarriage. Due to her "dumb" decision, he reported that he and his family experienced emotional and financial stressors, and he was left to sacrifice for his family in order to provide for their welfare and wellbeing. He disclosed that the distrust that he experienced toward her eventually contributed to the dissolution of their marriage years later. In summary, Nathan, Larry, and Dale all described characteristics of non-traditional gender roles. More specifically, they all demonstrated views of equality and flexible gender roles.

Combination of traditional and non-traditional views. One-third of participants reported the subordinate theme of implementing a combination of traditional and non-traditional gender roles (desire for male to be provider; focus on flexible gender roles, demonstrating traditional values), and an emphasis on equality (Chris, Ken, Wade).

Ken reported that he and his wife have assumed traditional gender roles, with his role as the financial provider and his wife working as a "stay-at-home mom." Despite the traditional gender roles in Ken's marriage, he reported certain flexibility within gender roles, such as his assisting with childcare responsibilities. He explained:

> My wife is able to be a stay-at-home mom, which is great. So I go to work and earn the money, and she stays home and takes care of the kids. But she also has a lot of medical issues which make it difficult for her to take care of the kids more

> than she has to. So I take care of them as much as I'm able to when I'm not at work or asleep, and she does a great job taking care of them when I am at work.

Similar to Ken, Wade also reported flexible gender roles with his wife as the primary financial provider, yet he reported holding to traditional values in the relationship (i.e., protection). He explained that he "felt like the roles were reversed" when he began school and his wife's income was primary. Wade disclosed that the change "was hard for me because I didn't feel in a traditional role, you know, not bringing in as much money." At the time of the interview, he stated that he is "a little bit more comfortable now, although still a little bit uncomfortable at times." He asserted that he still tries to practice values that are "traditional in the sense that I try to provide and protect, and things like that."

Chris reported that the relationship with his fiancée was based on the non-traditional concept of equality, along with traditional views of polite behavior. When asked about how he viewed his role in his relationship, he displayed initial hesitation. He paused and replied, "Um, (short pause) I don't know. I've never really thought about that." He paused again and reflected:

> I like to think that we're equal I guess. It's a bit odd because she's the older one. She's the one who has a full-time job now while I'm still a student. But at the same time, I try to somewhat adhere to traditional masculinity roles of picking her up, opening doors, and being the supporting one, things like that.

In summary, Ken, Wade, and Chris reported a combination of both traditional and non-traditional gender role and masculinity views. They demonstrated an emphasis on providing for their families, flexible gender roles, holding traditional values, and a focus on equality.

CHAPTER V DISCUSSION

In this chapter, I provide ideas and possible explanations, along with interpretation, related to the results I organized in the qualitative data. I follow the organization from the results section, in that I have ordered the information by the superordinate themes and in connection with my research questions. I conclude the discussion chapter by providing implications for therapy and limitations of the study.

As done throughout this document, I followed recommendations from IPA regarding how to write a discussion section (Smith et al., 2009). More specifically, I offer explanations and interpretations of the data. I set my specific findings within the broader framework of existing research literature. Consistent with IPA (Smith et al., 2009), I implemented my research knowledge and skills in analyzing and offering possible interpretations for participant experiences. IPA recommends researchers to integrate their research skills with their knowledge of the data in order to make plausible interpretations. Additionally, I describe limitations of the present study and implications for counseling, as recommended by Smith et al. As a note, I intentionally attempted to avoid use of the term "grief" during the interview/data collection, analysis, interpretation, and writing processes. I did not want to assume that the participants experienced grief. However, I

found that many men organically used the terms “grief” or “loss” to describe their experience.

As a review, the superordinate themes I organized were as follows: (a) men’s emotional and behavioral expressions to miscarriage, as affiliated with research sub-question of men’s responses to miscarriage; (b) men’s views of their partners’ emotional and cognitive expressions to miscarriage, not affiliated with a research question; (c) men’s coping following the miscarriage, as affiliated with research sub-question of men’s coping; (d) men’s meaning-making activities following the miscarriage, as affiliated with research sub-question of meaning-making; and (e) men’s perspective of gender roles and masculinity, not affiliated with a research question. My primary research question was focused on men’s overall experience following miscarriage, and all of the superordinate themes supported this question.

Although saturation was reached with full participant support for the superordinate themes, the data reflects the diversity of men’s experiences. Men demonstrated diverse responses to miscarriage, and men coped and made sense of the experience in various ways. Men also indicated that their partners experienced diverse responses and coped in various ways. They also revealed diverse perspectives in terms of gender roles and masculinity. More specifically, I examined the diverse experiences of the only African-American participant, Larry.

Men’s Emotional and Behavioral Expressions Following Miscarriage

As indicated in the results section, all participants reported expressions following miscarriage that were both emotional and behavioral in nature. Men experienced *initial* emotional and behavioral expressions, while some experienced expressions of *longer*

duration and intensity. Below I describe the nature and duration of the expressions and offer explanations and connections. As a reminder, I intentionally attempted to avoid use of the term "grief" during the interview/data collection, analysis, and writing processes.

Nature of Expressions

Men's expressions revealed insights into the emotional and behavioral nature of their experiences following miscarriage. Some men indicated emotional experiences of shock/disbelief and irritability/anger, and some reported the behavioral expression of creating rituals following miscarriage. The participants' experiences in the present study highlight the need for further study on men's emotional and behavioral expressions following miscarriage.

Emotional expressions. The fact that the current participants reported a variety of emotional expressions fits with previous research that suggests similar findings and the present study contributes to the research literature by offering insight into the under-studied emotions of shock/disbelief and irritability/anger (Beutel, 1995; Murphy, 1998; Puddifoot & Johnson, 1997; Stinson et al., 1992). Certain emotional expressions of men (e.g., sadness/grief/depression, anxiety) following miscarriage have been examined to a greater extent in the existing research than have the expressions of shock/disbelief and irritability/anger (Puddifoot & Johnson, 1999; McCreight, 2004; Murphy, 1998). Little research exists on men's experiences of these later emotions (Murphy, 1998). Half of the participants in the present study experienced shock and disbelief, and half disclosed irritability and anger. Men may experience shock and disbelief because they do not sense that the pregnancy and resulting miscarriage were real because they were not the ones carrying the unborn child (Johnson & Puddifoot, 1998). Men may experience anger and

irritability in part to a lack of focus on their needs and a sense of isolation (Conway, 1995). The participants' experiences in the present study highlight the need for further study on men's emotional expressions following miscarriage. More specifically, further research is needed on men's emotional expressions including shock/disbelief and irritability/anger. Further examination is needed to provide further validation and understanding of these emotions.

Behavioral expressions. Some men in the present study implemented rituals and indicated that the rituals aided their expressions by helping to decrease avoidance, isolation, and anxiety regarding the loss, and that ritual participation increased a sense of calm, finality, and family harmony. These men described ways that they channeled their focus and energy into creating activities that helped them and their partners/families to acknowledge the existence of the unborn child. Some men described the behavioral response of creating rituals following miscarriage, and some men disclosed that they wished they had implemented rituals. In the present study, a few participants implemented rituals. Frank related that he and his wife made a donation to their college alma mater in honor of their unborn child. Terry reported that he and his wife and three children attended a memorial service for unborn children at their church (many years post-loss), as a way to acknowledge and honor their unborn child. He described the ritual activity as a special family bonding activity that promoted family unity and harmony. His experience fits with previous research that suggested that rituals can promote harmony and decrease stress and anxiety in families (Markson & Fiese, 2000).

No participant in the present study reported holding or participating in funeral or memorial service immediately following miscarriage. For example, Dale shared that he

did not hold services following his wife's two miscarriages approximately 30 years ago. He indicated that he wished that he had participated in a ritual, such as holding a memorial service. He expounded, "We never had any kind of service. There was no casket, no burial-no nothing, really." He prefaced the preceding quote by disclosing, "I think there's still some loss there." Dale appeared to wish that there had been memorial services following his wife's two miscarriages. He brought a newspaper clipping about a memorial service for unborn children to the interview, and he related, "I'm really glad to see somebody's doing something, locally at least. I'm sure people have gotten more thoughtful and aware of those situations." Perhaps the lack of funeral/memorial service rituals contributed to some men's emotions of shock and disbelief, along with a lack of sense of closure like in Dale's case.

The present study contributes to the research literature on ritual activities as very little research exists on rituals following miscarriage, particularly on *men's* use of rituals (Kobler, Limbo, & Kavanaugh, 2007; McCreight, 2004; Rajan & Oakley, 1993). Performing rituals following other types of death losses can help people cope and adjust to loss, as well as strengthen the attachment between grievers and the deceased (Castle & Phillips, 2003; Rando, 1985). A certain type of ritual, funerals, can aid grievers in accepting the reality of the death and help decrease shock and disbelief (Hoy, 2013; Rando, 1988). Miscarriage is a unique type of loss that often lacks social norms and grief rituals such as funerals, which may contribute to a lack of acknowledgement of loss and a sense of isolation in women (Jaffe & Diamond, 2011; McCreight, 2004; Rajan & Oakley, 1993).

Overall, very little is known about rituals implemented following miscarriage. The results of the present study contribute to better understanding men's implementation of rituals. Men's implementation of rituals following loss, death loss, broadly, and miscarriage, specifically, deserves further examination.

Duration of Expressions

The participants reported emotional and behavioral expressions of different durations. Some men reported primarily initial expressions (Nathan, Frank, Terry, Ken) following the miscarriage, and some indicated long-term expressions(Wade, Eugene, Dale, Chris). There are possible explanations for the differences demonstrated between the two groups of men including level of attachment to the unborn child, the type of coping used, the investment in the pregnancy, the number of miscarriages experienced, and the extent of disenfranchisement of their experiences.

Attachment. One potential reason for the difference in duration may be that some men described greater attachment to the unborn child than others. Four of the five men who experienced expressions of long duration indicated attachment to the unborn child. The four men who described little to no attachment to the unborn child appeared to experience expressions of short duration. One of these participants, Chris, indicated "relief" following the miscarriage, along with sadness. Additionally, most men indicated that their partners demonstrated greater attachment to the unborn child than they did.

Type of coping. One potential reason for the difference in duration may be that all four of the men who demonstrated an initial, short-term emotional expression, and did not indicate a long-term expression, implemented problem-focused coping skills and exhibited instrumental grief. Problem-focused coping strategies aim to lessen the impact

of stressful situations by cognitive reframing and emphasizing active ways to address and manage the problem (Lazarus & Folkman, 1983). Similarly, instrumental grief is a cognitive and physical approach to grief that is part of Doka's and Martin's (2010) theory of patterns of grief. More detailed information on coping is presented later on in the coping superordinate theme.

Investment in pregnancy. Another possible reason for the difference in duration and intensity for men's emotional and behavioral expressions may be a greater investment in and desire for the pregnancy. All of the men who indicated responses of longer duration and greater intensity reported more significant investment in and greater desire for the pregnancy than did their peers who reported primarily initial response. For example, Larry related that he had been excited about his wife's unexpected pregnancy that resulted in a second miscarriage, because of their advanced ages. He reported experiences of disappointment, sadness, irritability, anger, and withdrawal following the loss. This finding mostly corresponds to limited, prior research on planned versus unplanned miscarriage with female participants (Beutel et al., 1995, Simmons et al., 2006). Beutel et al. and Simmons et al. found that women whose pregnancies were unplanned and undesired reported less psychological distress and less intense expressions than women whose pregnancies were planned and desired. The current findings primarily fit with this past research except with regard to one participant, Dale, whose wife's pregnancy was unplanned and initially undesired by him. His experience stood out as unique because his response was not short-lived. At the time of the interview, he expressed that he still experienced "grief," 30 years following the miscarriage. Similarly, Chris disclosed that his girlfriend's pregnancy was unplanned, and he initially did not

desire it. He was also the only unmarried participant in the sample. He was in a dating relationship at the time of the miscarriage and was engaged at the time of the interview. In response, Chris disclosed "mixed emotions" of "relief" along with sadness for the loss, followed by "guilt" for feeling partly relieved. The participants' experiences in the present study highlight the need for further study on factors that influence men's reaction to miscarriage, including unplanned and initially undesired pregnancy.

Number of miscarriages. Additionally, a possible reason for the difference in duration for men's emotional and behavioral expressions is the number of miscarriages in that two men reported intense distress following multiple miscarriages. Little research on the effect of multiple miscarriages on men exists. However, this finding fits with some research studies conducted with women (Friedman & Gath, 1985; Swanson, 1999; Swanson, Kieckhefer, Powers, & Carr, 1990). More specifically, these researchers found that some women experienced increased distress following multiple miscarriages in contrast to their counterparts who had experienced only one miscarriage. Some women also placed high significance on subsequent pregnancies. Nathan and Larry reported that they experienced greater distress of longer duration following their wives' second miscarriages than they did after the first miscarriage. They both wondered and worried about whether their family would be able to grow from possible future pregnancies. The finding on some men's greater distress following multiple miscarriages contributes to the paucity of research on how multiple miscarriages may affect men.

Lack of disenfranchisement of responses. A final possible reason for the difference in duration in men's emotional and behavioral expressions is that two men who experienced longer and more intense expressions disclosed disenfranchised grief

experiences. I did not find disenfranchisement to be a major theme among the participants in the present study, which differs from prior research (Doka, 2002). The two men who described disenfranchisement disclosed that they did not believe that their grief experience was validated by other people or by society in general, which is consistent with prior research (Doka, 2002). Both of their losses occurred over 10 years prior to the interview. They disclosed experiences of isolation and lack of social support, and they both wished they had reached out for increased social support. Both of them expressed regret that they did not pursue counseling to help them to cope following their wife's miscarriages. They did not feel comfortable expressing their grief, and one man (Dale) reported that he was still grieving the miscarriage 30 years later. Dale was the participant who brought the newspaper clipping to the interview about a local memorial service for unborn children. Interestingly, these men were two of three participants who expressed irritability and anger following the loss. Perhaps their experience of disenfranchisement contributed to their anger. Their loss and initial grief responses were not acknowledged, which appeared to have contributed to their sense of isolation and anger. They may have experienced greater disenfranchisement than the participants in the study who experienced more recent losses, due to society's previous lack of awareness of miscarriage responses. Dale and Larry lacked social support and did not have an outlet to express their emotions such as sadness, disappointment, loneliness, irritability, anger, etc. Additionally, over time, the emotions which were not expressed (i.e., sadness) may have turned into irritability and anger.

Men's Views of Partner Emotional and Cognitive Expressions

The second superordinate theme was men's view of their partners' emotional and cognitive expressions following miscarriage. Men's responses revealed insights into the nature and duration of their partners' responses. Their reports demonstrated a diversity of responses from their partners. According to study participants, their partners experienced initial emotional expressions, while some partners experienced emotional expressions of longer duration. According to the participants, some of their partners experienced negative cognitive expressions as well. In this section, I describe the nature and duration of partners' expressions (i.e., as described by participants) and offer explanations and connections and also integrate my understanding of the results with the concept of differential grief.

Nature of Partner Expressions

One significant finding was that, overall, the participants demonstrated an apparent accurate awareness of their partners' emotional and cognitive expressions. The male participants' accounts of their partners' experiences were consistent with findings from previous research studies conducted with women (Adolfsson, 2011; Adolfsson et al., 2004; Hughes & Page-Lieberman, 2005; Murphy & Merrell, 2009; Nikčević, et al., 2007; Shreffler et al., 2011; Swanson et al., 2007). More specifically, the men reported that their partners experienced sadness, anxiety, panic, anger, guilt, self-blame, crying, and withdrawal, which fits with women's accounts from existing research.

Duration and Intensity of Partners' Expressions

One subordinate theme I selected was that, according to my participants, all of their partners experienced more intense expressions of longer duration than they

themselves had experienced. No participant reported that his expression was more intense or longer than his partner's expression. This finding fits with the findings of several research studies with couples (Abboud & Liamputtong, 2003; Beutel et al., 1996; Conway & Russell, 2003; Hamama-Raz et al., 2010; Hughes & Page-Lieberman, 2005; Serrano & Lima, 2006; Stinson, et al., 1992). More specifically, in all of these past studies, women experienced greater distress of longer duration than their partners. Additionally, according to the participants, the women tended to rely on their male partners for support. There are possible explanations for the differences demonstrated between men and women's expressions including the female partner's attachment to the unborn child, desire for pregnancy, physical response to miscarriage, and emotional sensitivity. Interestingly, these findings are consistent across varied methods (i.e., qualitative, quantitative) and self-report. This finding cannot be tied back to the use of quantitative measure that best captures the more traditional feminine approach to grief.

Attachment to unborn child. Some participants attributed the difference in the intensity of their expressions to their partner's responses to the physical and emotional attachment to the unborn child (Ken, Wade, Terry, Eugene). For example, Ken implied that his wife's physical connection to the child contributed to her emotional attachment. Chris disclosed that his girlfriend was very attached to the unborn child and intensely affected by the miscarriage. When the loss occurred, "It was like a part of her died too." Most participants indicated that their partners were attached to the unborn child.

Desire for pregnancy. An additional possible explanation for the difference in duration and intensity of partner's expressions is that a couple of men indicated that their partner desired the pregnancy more than they did (Chris, Dale). Dale disclosed that his

wife conceived without his knowledge or consent, and he indicated that he initially did not desire the pregnancy.

Physical response of miscarriage. Furthermore, several men (Wade, Ken, Terry, Eugene) indicated that their partners' physical response from the miscarriage process/medical procedures affected their partners' emotional expressions, which could have contributed to a longer duration or greater intensity. Eugene repeatedly described the physical and emotional pain from his wife's miscarriage as "horrible." He described his wife as "panicky" due to sight of blood from the miscarriage induced by a pill. Wade described the medical necessity for a D&C procedure to protect his wife's health following miscarriage as contributing to her emotional distress. Terry disclosed that his wife was "pretty emotional" during the miscarriage, with "tears shed." In sum, it appeared that the participants' viewed the physical symptoms of miscarriage as being related to the intensity and duration of some women's emotional expressions.

Emotional sensitivity. Another possible reason for the difference in duration and intensity of partners' expressions is that some men (Terry, Wade, Dale, Chris, Larry, Ken) described their partners as more emotional and sensitive in personality than they were themselves. These men indicated that their partners expressed their emotions more following the miscarriage. Terry described himself as "fairly even-keeled," and one who does not "get over-emotional or stressed." He described his wife as "more emotional than I am." Wade described his wife as more pessimistic than himself and more prone to depression. He related that she experienced thoughts "in the back of her head that weren't very positive." These men indicated that their partner's personality feature of emotional sensitivity affected their response.

Differential Grief

It is not unusual, but rather common, for family members to demonstrate diverse responses following loss, particularly the loss of a child (Gilbert, 1996). Diverse grief responses, known as differential grief, often occur within couples and families (Gilbert, 1996). Grief is often studied and viewed by society on an individual level, even though grief often occurs in the context of a partnership or family (Walsh & McGoldrick, 2004). Overall, the partners and participants appeared to have implemented the recommendations from Jordan (1990), Walsh and McGoldrick (2004), and Gilbert (1996), regarding how best to approach situations of differential grief. More specifically, these authors recommend that family members acknowledge the loss and the impact on the other family members, which the men in the present study appeared to have done. Many participants (Chris, Eugene, Ken, Wade, Terry) indicated discussing the miscarriage and acknowledging the different responses they each had with their partners and other family members. Most men attempted to reorganize their family lives by implementing activities focused on strengthening their family unit. At the same time, they acknowledged the loss and integrated it into their forward motion. Most men also demonstrated reinvestment in their family by holding hope for future family expansion.

Overall, unlike findings connected to prior research (Gilbert, 1996), the majority of participants did not report relationship conflict with their partners related to miscarriage. For example, unlike prior research that suggested that bereaved parents can hold expectations for how their partner should grieve or respond to miscarriage (Peppers & Knapp, 1980), most of the participants in the present study did not appear to hold expectations for their partners. Instead, most participants expressed understanding,

sensitivity, and compassion towards their partners' experiences. The experience of differential grievers can cause misunderstanding and conflict within a partnership and family. Partners may not understand each other's different styles of grief, and they may not know how to support each other (Gilbert, 1996).

Men's Coping

The third superordinate theme is that of participants' coping strategies following miscarriage. Participants' responses revealed insights into the types of coping strategies used. One primary way that men coped was by relying on social support themselves. They also coped by offering support to their partners and by accepting others' support of their partners. Additionally, a handful of men appeared to demonstrate the personality characteristic of hardiness that assisted with their coping, and a couple of men described their development of hardiness. Below I describe men's types of coping and offer explanations and connections.

Type of Coping

As I noted above, one potential reason for the difference in men's response duration and intensity after miscarriage may have been that all four of the men who demonstrated an initial, short-term emotional response, and did not indicate a long-term response, implemented problem-focused coping skills. I describe problem-focused, emotion-focused, and avoidant coping strategies below.

Problem-focused, avoidant, and emotion-focused coping. Participants in the present study utilized various coping strategies. Problem-focused coping strategies aim to lessen the impact of stressful situations by concentrating directly on challenges in order to work through and overcome them (Lazarus & Folkman, 1983). Participants (Nathan,

Wade, Ken, Terry) in the present study implemented problem-focused coping by viewing the loss as a challenge to work through and overcome and holding hope for future fertility/family expansion. Certain benefits have been linked to problem-focused coping (e.g., effective adjustment, emotional self-control; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Johnson & Baker, 2004).

Problem-focused coping has been viewed as more effective than emotion-focused coping (Carver, Scheier, & Weintraub, 1989; Folkman & Lazarus, 1985; Johnson & Baker, 2004; Lazarus & Folkman, 1984). Some men who appeared to experience long-term responses implemented emotion-focused and avoidant coping strategies. Avoidant coping behaviors are focused on denial of the stressor or loss, isolation, and lack of cognitive and social activities regarding the stressor. Avoidant approaches reported by participants in the present study included isolation from partner, family, and friends, lack of a self-reported needed sharing about the loss, strictly focusing on busyness and routine to the neglect of considering emotional and behavioral responses, and lack of implementation of a self-reported need of self-care activities. Emotion-focused coping strategies are activities (e.g., prayer/meditation, substance use, writing in a journal) thought to reduce the impact of negative emotions (Lazarus & Folkman, 1983). Emotion-focused approaches reported by participants it he present study included prayer, spiritual activities, and talking to friends. Research findings seem to suggest that those who used emotion-focused and avoidant coping reported more intense and longer responses.

Social Support

One primary way that men coped was by offering, promoting, and relying on social support. Three significant findings regarding social support and men's coping

stood out from the data and differed from previous research: most men coped by offering support to their partners, some men actually felt supported when others supported their partners, and the majority of men received adequate social support.

Support for partner. One finding of the present study that clearly differs from previous research is that most participants found that offering support to their partners helped them to personally cope. Their support of their partners appeared to help *facilitate* their own grief responses and processing of the loss instead of *hindering* their responses. The findings from previous research indicated that some men tended to recognize their partners' need for support and attempted to provide appropriate support, even to the extent of possibly neglecting their own need to grieve (Beutel et al., 1996; Hamama-Raz et al., 2010; McCreight, 1996; Murphy, 2004). Some men in past studies reported that supporting their partner interfered with their responses following miscarriage (Hamama-Raz et al., 2010; Johnson & Puddifoot, 1996; McCreight, 2004; Murphy, 1998). The men in these prior studies disclosed a heavy burden connected with supporting their partners, and they indicated that they had difficulty focusing on their own responses. Men in these past studies appeared to delineate two separate tasks: caring for their grieving partners and caring for themselves. The former appeared to take precedence for many men, with the latter often being overlooked. However, most participants in the present study did not view these two tasks/roles as opposing. In fact, they viewed the role of caring for their partner as actually helping them to care for themselves.

During the interviews, I did not fully explore the possible reasons for men's perspective on their support provision to their partners. However, I offer tentative explanations. One possibility is that men's support for their partners reflected their

overall closeness and attachment to their partners. These men appeared to view their relationship with their wives/girlfriend as a partnership where they supported one another when in need. Each participant viewed his partner as more in need and requiring more support than he did. When the partner grieved, the man desired to help. By helping his partner, he helped their relational unit and in the process helped himself. Eugene offered advice to other men in similar situations, “You’re not going to feel any better until she feels better.” Men may view supporting their partners as aiding their relationships and ultimately their own wellbeing.

The support the current participants offered to their partners fits with research on helping behavior that suggests that aiding others benefits one’s own well-being (Brown, Brown, House, & Smith, 2008; Morelli, Lee, Arnn, & Zaki, 2015). Morelli et al. (2015) found that friends’ provision of emotional support (i.e., demonstrating empathy) predicted the well-being of the giver. The researchers also found that implementation of instrumental support (i.e., helping fix a problem, giving money) aided the well-being of both the giver and receiver, when combined with emotional support. In their study of widows and widowers, Brown et al. (2008) found that the provision of instrumental support to others was associated with decreased depressive symptoms in givers.

Additionally, Yalom’s (1995) ideas on the presence and benefits of altruism demonstrated within group therapy may help explain men’s cooping through supportive behaviors. Yalom outlined many benefits of group membership including the opportunity for catharsis, installation of hope, and improved social skills. Group members can benefit from getting outside of their own experiences and hearing other people’s experiences. They may feel inadequate and wonder if they can help others. Group members can gain

improved self-esteem from listening and supporting others. Similar to Yalom, it appeared that the participants in the present study generally appreciated the opportunity to try to help their partners feel better, and in turn, they themselves ended up feeling better.

Others' support of partner. Another significant finding that differs from prior research was that some participants in the present study reported feeling satisfaction when others inquired about and supported their partners. This finding differs from past research that suggested that some men did not appreciate when family and friends would ask about their partner and focus on their partner's wellbeing (Conway & Russell, 2005). In the present study, some men directly encouraged their partner's receipt of social support from others (Nathan, Terry, Eugene). One man actively orchestrated social support for his wife. No participants reported feeling like their response and grief was overlooked or undermined by others' emphasis on their partners. Perhaps one reason this finding differs from previous research is that men who volunteered for the study happened to be exceptionally supportive of their partners. The majority of men in the present study described psychologically healthy, supportive relationships with their partners, along with most describing supportive family and friends.

Support for self. All of the men indicated that they relied on social support to some extent. The majority of men reported adequate social support from family, friends, and places of employment. For example, Wade especially valued social support as a "healthier way" to cope with his wife's two miscarriages than how he previously coped in "unhealthy ways" (e.g., avoidance). This finding is in contrast somewhat to prior research that indicated that men may receive less social support in miscarriage grief situations than do their female counterparts (Conway & Russell, 2005; McCreight 2004). This contrast

may be due in part to a recent increased societal awareness of the impact of miscarriage (Rinehart & Kiselica, 2010). Men who experienced prior losses may have experienced less social support and acknowledgement of their responses than men who experienced more recent losses.

Although the majority of participants received desirable social support, one man received undesirable social support. This one participants' experience is consistent with some previous research (Gilbert, 1996; Hughes & Page-Lieberman, 1989). Research suggests that some family members and friends can assume that men were experiencing or should have experienced more intense responses. In the present study, Nathan disclosed that his parents were "very concerned" about his well-being, and he perceived that they were overly invested in expressing their concern. Nathan perceived that his response was minor and was accepting of that. As a result, he withdrew and attempted to avoid contact with them. However, Nathan was the exception in the present study. Overall, those close to men (and women) following miscarriage should not assume an "appropriate" or "necessary" nature and/or duration of response. Others should also refrain from assuming that all men do not receive sufficient support.

In fact, in the present study, only two men disclosed that they did not receive adequate social support. Although Larry and Dale reported relying on social support to some extent, they disclosed that they wished that he had sought further support from friends and counseling. Larry appeared to take responsibility for his lack of social support. He described that he lacked the "communication skills" to disclose the miscarriage to family and friends, and he mentioned several times throughout the

interview that he was not intentional in garnering support. He expressed regret over not telling family, friends, and his daughter about his wife's two miscarriages.

Hardiness

The coping results from some of the participants can be viewed through the personality characteristic/concept of hardiness. Below I define the term and relate the three components of hardiness (i.e., challenge, commitment, and control) to the data from the present study**.** I also describe the development of hardiness in two of the men.

Definition of hardiness. Maddi, (2011) defined hardiness as "the existential courage needed in turning life's ongoing stresses from potential disasters into growth opportunities" (2011, p. 370). Hardiness involves an openness to new experiences and the opportunity to continue to "construct and appreciate the meaning of experience rather than just holding on to old, preconceived ways of understanding life" (2011, p. 370). Maddi noted that hardiness is "the pathway to resilience under stress" and can aid people during challenges (p. 370). Maddi (2011; 2013) identified three components of hardiness (the 3Cs): challenge, commitment, and control.

Challenge. Two of the subordinate themes under the superordinate theme of coping (i.e., viewing the miscarriage as a challenge to work through and relying on social support) fit the hardiness facet of challenge. Hardiness may have enabled some men in the present study to cope with the challenge of miscarriage and view it as temporary (Eschleman & Bowling, 2010). Some of these men used metaphors and likened the miscarriage to "a bump in the road" and "a stumbling block." In addition, people who are hardy are more likely than non-hardy individuals to rely on social support, which many men in the present study demonstrated (Eschleman & Bowling, 2010). Hardiness is

grounded in existentialism, which views stress and life challenges as normal and developmental, occurring throughout the life span (Maddi, 1998). Miscarriage and the resulting emotional and behavioral expressions fit the type of developmental life challenge described by existentialists.

Commitment. The second aspect of hardiness is commitment, and most men demonstrated commitment through the subordinate theme of actively supporting their partners. These men indicated a commitment to actively coping with the miscarriage by engaging with their partners and considering their needs. Most men also revealed commitment to their relationship. Some men could have chosen to avoid and ignore their partners' responses, but most did not. These men reported that supporting their partners helped them process their own responses following the miscarriage. The men chose to engage and be actively involved in their own and their partners' experiences.

Control. The final aspect of hardiness is control and the men in the present study experienced a greater sense of control when they were able to obtain and understand medical information and hold hope for future fertility/family expansion. One contribution of the present study to the research literature is that it expands the little known information about ways that men cope following miscarriage, which includes the apparent helpfulness of relying on medical knowledge and holding hope for future family expansion. Prior research has examined how medical information aided women's coping following miscarriage. More specifically, researchers have found that women who lacked knowledge about an identified cause of miscarriage experienced increased anxiety than those who knew the cause (Nikčević et al., 2000; Simmons et al., 2006). Similarly, some men in the present study indicated that they experienced decreased anxiety and a sense of

calm when they learned medical information regarding miscarriage. Previous research has suggested that women blamed themselves when a cause was unknown, and they pondered possible causes (Nikčević et al., 2000; Simmons et al., 2006). Additionally, many men coped by holding hope for future family expansion via future fertility or adoption.

Meaning Reconstruction

Consistent with the superordinate theme and research question involving meaning-making, every participant reported meaning-making activities. Many of these activities were consistent with elements of meaning reconstruction theory (Neimeyer, 2001). More specifically, participants' responses can be connected with the meaning reconstruction elements of benefit finding, sense-making, and identity reconstruction. In addition, I connected the extent of and investment in meaning-making activities with participants' post-miscarriage responses.

Definition of Meaning-making

Neimeyer (2001) developed the meaning reconstruction theory of loss. The theory asserts that individuals need to integrate loss into their sense of self and alter the way they view the world and themselves in order to grief and mourn (Neimeyer et al., 2009). Individuals create a narrative for their lives, and losses require re-writing of that narrative. Major losses can warrant substantial re-structuring of the self (Neimeyer, Prigerson, & Davies, 2002). Grief can be associated with positive outcomes such as compassion, but also with negative outcomes such as loneliness. Many of the participants in the present study attempted to organize their losses within a meaningful framework, and their meaning-making activities fit with the meaning reconstruction theory (Keesee et

al. 2008; Neimeyer et al., 2009; Neimeyer, 2001). Specifically, men reported activities including gratefulness for an early gestational loss, belief in a reason for the miscarriage, enhanced value for life, and strengthened family relationships. The participants also demonstrated specific elements of the theory including benefit finding, sense-making, and identity reconstruction.

Benefit finding. All participants in the present study were able to find positive outcomes from the miscarriage that can be organized into two categories: benefit involving the miscarriage loss (i.e., gratefulness for an early gestational loss), and benefits involving existing children/family (i.e., enhanced value for life; strengthened family relationships) (Neimeyer & Anderson, 2002). Three men disclosed they were grateful for an early, rather than late perinatal loss. Frank expressed, “So I think, at least, this wasn’t as bad as it could have been. I mean, the further along you are, the worse it makes it.” Two men believed that their unborn child died due to congenital defects, and so they were grateful that the child did not “suffer” as Eugene described. Three men indicated that they viewed life as precious because of their miscarriage experience. Terry disclosed that he and his wife “don’t take our children for granted.” Three men reported strengthened family relationships with partners and/or children. Eugene described, “Ideally, that’s really not how you want to get closer to your wife, having a miscarriage, but I mean, fire tempers your relationship and makes you stronger.” These meaning-making activities from the present study are consistent with prior research on meaning-making with bereaved parents (Lichtenthal et al., 2011; Lichtenthal et al., 2013). Lichenthal and colleagues have found that bereaved parent noted benefits such as greater compassion towards others and greater self-awareness following loss. Perhaps the

participants were able to find benefits from the loss over time. None of the participants were interviewed immediately following miscarriage, and a few were interviewed years later.

Sense-making. Some participants were able to make sense of the miscarriage. Sense-making involves processing the loss and considering how it may fit with one's view of the world (Janoff-Bulman, 1992). Sense-making may involve individuals shifting and reorganizing their perspective of the world following the loss (Attig, 1992). In the present study, men made sense of the miscarriage in various ways. Some men's religious/spiritual beliefs aided them in making sense of the miscarriage. For example, some men (Eugene, Frank, Terry) implemented religion/spirituality by believing that the unborn child was in heaven and that they would see the child in the future. Eugene, Frank, and Terry indicated that they gained a more personal perspective on death, grief, and pain in the world. These men obtained this view following their wives' miscarriages, as well as knowing of other perinatal/infant losses of family and friends. Additionally, three men (Frank, Terry, Eugene) fit their miscarriage losses with their spiritual belief that God was in control and had a plan for their lives. They believed there was a "reason" for the loss and that it was part of the plan for their lives. These men's experiences are consistent with prior research (Keesee et al., 2008; Keesee et al., 2013; Lichtenthal et al., 2010; Lichtenthal et al., 2013; Murphy et al., 2003) that indicated an association between religious faith/spiritual beliefs and meaning-making. Keesee et al. and Lichtenthal et al. found that religion and spirituality contributed to less severe grief responses among bereaved parents. Religion and spiritual beliefs may have provided grounding for the participants in the present study. Their spiritual faith and beliefs may have helped provide

answers to any questions about why the miscarriage occurred. The participants' experiences in the present study highlight the need for further study on the spiritual effects of meaning-making activities on men following miscarriage.

Additional ways that men appeared to make sense of the miscarriage included the belief that their families were meant to expand in other ways, and the view of the world as an unfair place. Two men (Frank, Eugene) believed that their families were meant to expand in other ways. Frank disclosed that his wife was approximately 13 weeks pregnant (at the time of the interview). Eugene disclosed he and his wife's future adoption plans. Alternatively, some men reconstructed their view of the world as an unfair place. Frank, Eugene and Larry considered justice and fairness and appeared to begin to view the world negatively. They perceived life as unfair because their unborn children did not survive.

Identity reconstruction. Some men in the present study appeared to engage in the meaning reconstruction element of identity reconstruction. Identity reconstruction involves processing who an individual is following loss and re-establishing one's sense of self (Neimeyer & Anderson, 2002) People may reorganize their view of themselves and may benefit in areas such as maturity, compassion, and hardiness. In the present study, some men worked to reconstruct aspects of their identity. For example, some men (Eugene, Terry, Frank) considered themselves fathers of the unborn children. Identity reconstruction activities that some men participated in included family rituals to remember and honor their unborn children. Terry shared that he and his family attended a memorial mass, and related that the mass strengthened family bonds and helped his family consider the unborn child as a member of their family. Eugene disclosed that he

considered his unborn child a member of his family, and he believed he would see the child in heaven. Eugene kept an ultrasound picture of his unborn child at his desk, next to the picture of his adopted daughter. These men not only reconstructed their own identities following miscarriage, but they also aided in reconstructing the identity of their families.

Association Between Meaning-Making Activities and Functioning

The extent of meaning activities implemented and the level of investment in those activities appeared to be associated with the intensity and duration of some participant's post-miscarriage responses. Some participants (Larry, Dale) who indicated less investment in meaning-making activities than other participants described responses of greater intensity and duration. Many participants who actively participated in meaning-making activities (Terry, Nathan, Ken, Frank, Wade) described responses of shorter intensity and duration. Overall, the participant's level of involvement in meaning-making activities appeared related to their outcomes, with the exception of one man (Eugene) who actively participated in meaning-making yet conveyed a response of great intensity and long duration.

Few studies have examined men's implementation of meaning-making activities following miscarriage (Gray, 2001; Maker & Ogen 2003; Wenzel, 2014). Most existing studies have examined women's meaning-making experiences (Nikčević & Nicolaides, 2014) and meaning-making following stillbirth, infant death, or child loss (Corbet-Owen & Kruger, 2001; Gray, 2001; Wenzel, 2014). Alves, Mendes, Alves, & Neimeyer (2012) conducted a case study on a woman who experienced complicated grief following a stillbirth. They examined the participant's meaning reconstruction processes throughout six sessions of constructivist grief therapy. The researchers discovered that the woman's

complicated grief symptoms decreased so much by the end of therapy that she no longer met the diagnostic criteria for complicated grief. In their study of 127 women who experienced miscarriage, Nikčević and Nicolaides (2014) found that most women indicated finding meaning, and that meaning-making was positively associated with psychological adjustment. Women who stopped searching for meaning within seven weeks after the miscarriage experienced greater distress at 16 weeks post-miscarriage than women who continued meaning-making activities long-term. Keesee et al. (2008) examined risk factors for complicated grief among bereaved parents following a variety of child loss including causes of death such as miscarriage, stillbirth, accident, suicide, homicide, and cancer. They found that meaning-making was "the most salient predictor of grief severity," as well as a significant predictor of adjustment (p. 1145). In their study, parents who incorporated meaning-making activities experienced less intense grief responses. In the present study, all participants implemented meaning-making activities to some extent, whether their responses were mild or intense or short or long in duration. Overall, the level of investment in meaning-making activities appeared to affect some men's outcomes, with more investment resulting in less intensity and shorter duration.

Men's Perspectives on Gender Roles and Masculinity

The final superordinate theme that I chose was men's perspectives on masculinity and gender roles. Research on men's experiences after miscarriage rarely emphasizes this topic, so this finding offers a unique contribution to the field. The focus on masculinity and gender roles also contributes to the field of thanatology in terms of the current paucity of research available on men's grief experiences. In this section, I

offer my ideas regarding the possible connections between men's views of masculinity/gender roles and their experience following miscarriage.

As a review, I organized the interview results regarding masculinity and gender role views (i.e., primarily from their responses to the question: "Tell me about your role in the relations") into three categories: traditional, non-traditional, and a combination of both, with one-third of the participants in each category (Perrone et al., 2009). Overall, participants' quantitative scores on the ISME and SMSS (located in the participant demographic section) were consistent with their qualitative responses regarding their role in their relationship.

Men's Overall Traditional Viewpoint

Regardless of whether men espoused traditional, non-traditional, or a combination of views on masculinity and gender roles, most men indicated facets of traditional viewpoints. For example, most men reported the more traditional desire to protect and provide for their families. The majority of participants also indicated underlying traditional masculinity/gender role themes of: (a) desiring to be a good partner, and (b) desiring to be a good father. In contrast, more traditional men indicated a desire to lead their families.

The majority of participants indicated strong emphasis on prioritizing family expansion, which may have contributed to most men's investment in the pregnancy and resulting miscarriage. For example, most men reported planning and desiring the pregnancy. This masculine belief of prioritizing family may also have contributed to all men demonstrating emotional and behavioral responses following the loss. All men were apparently affected by their partner's miscarriage. If some of the men did not hold these

more specific traditional masculine ideas, perhaps they would not have been as invested in and affected by the miscarriage.

Men's Perspectives on Masculinity/Gender Roles on Support of Partner

Men's perspectives on masculinity and gender roles may have been related to their provision of support to their partner. More specifically, the nature of their perspective (i.e., traditional, non-traditional, blend) seems related to how they perceived and interacted with their partner.

Participants with a traditional view of men as the "head" of the household and the "provider" appeared more likely to report actively supporting their partners (e.g., promoting social support, re-arranging furniture in bedroom (site of miscarriage). These men indicated they believed that it was their responsibility as leader and head to support their partners and ensure that they coped effectively. They also were very concerned about their partners' wellbeing and believed that they had satisfactorily supported their partners.

Conversely, the three men in the non-traditional category (Larry, Dale, Nathan) who emphasized equality in the partner relationship appeared to place less emphasis on supporting their partners. All three of them indicated that their support was variable. Nathan wondered aloud about whether the support he provided his wife was sufficient. Perhaps their non-traditional gender role views of equality contributed to the variability in their support. One area of difference of their views from the traditional viewpoint was that they did not indicate a strong sense of personal responsibility for the recovery and well-being of their partners. These men in the non-traditional category indicated caring about and providing support for their wives to an extent. Their views on equality and

partnership appeared related to their acknowledgement of their partners' autonomy. These men indicated that their partners appeared to adequately cope with miscarriage and that their partners relied on them as needed. With the non-traditional viewpoint, the onus of recovery following miscarriage appeared to be on each member of the couple. Men with these views did not appear to assert ultimate responsibility for their partners, and vice versa.

The men who exhibited a blend of traditional and non-traditional views indicated mixed provision and view of the support they offered to their partners. Two of the three men in the blended group (Wade and Ken) reported offering ample support for their wives. One man (Chris) indicated attempting to offer support to his girlfriend, but explained that she refused, withdrew, and pushed him away at times. All three indicated concern for their partners, and Wade and Ken appeared to offer acceptable support. However, they did not appear to take responsibility for their wives' recovery and well-being, unlike men in the traditional group.

Men, Miscarriage, and Diversity

One man's experiences stood out from the other participants due to his description of his experiences and diversity. Larry was the only African- American participant, along with the second oldest one. His wife's two miscarriages occurred approximately 22 and 32 years prior to the interview. His response on the SMSS was an outlier compared to the other participants and indicated that he experienced stress related to his masculine identity and roles. The intersection of his identities of race, age, and gender may have contributed to a complicated response.

Larry was one of two participants who described experiences of disenfranchised grief. The other participant, Dale, also experienced miscarriages approximately three decades prior. Both Larry and Dale described miscarriage as not as acknowledged in society at that time as it has been during recent years, which fits with research (Rinehart & Kiselica, 2010). Larry wished that miscarriage would have been discussed among his friends and the environments he interacted in, including church. Larry shared that he did not feel comfortable disclosing his response to the miscarriage. He disclosed that he did not feel comfortable confiding in and reaching out for support from friends and family. He expressed regret that he did not participate in counseling to help him cope with the loss. He indicated that he lacked an outlet for his thoughts and emotions, and he became avoidant. He reported a range of responses including sadness, tearfulness, irritability, anger, and avoidance. His disenfranchised response may have contributed to his avoidance and irritability/anger/blame towards his wife. Larry's experiences are consistent with prior research on disenfranchised grief (Attig, 2004; Doka, 2002).

Larry's disenfranchised grief response and reported subjective experience of masculinity stress may be related to his race, age, and non-traditional perspective on masculinity/gender role. Unfortunately, an extreme paucity of miscarriage research focused on race and ethnicity exists; however, research on African-American men and masculinity exists (Rinehart & Kiselica, 2010; Rogers, Sperry, & Levant, 2015; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Larry disclosed that he believed some African-American men are more private than other men and do not openly discuss problems. His experience fits with prior research and could have contributed to his complicated grief experience (Hunger & Davis, 1992; Rogers et al., 2015). Research also

indicates that some African-American men report that experiences of racism limit provide barriers to their success and well-being (Rogers et al., 2015). Larry did not directly disclose experiences of racism, but he may have experienced threats to his well-being as a member of a minority group. Both Larry and Dale related that they believed miscarriage was not as acknowledged in society at the time of their wives' losses. This assertion is supported by research that suggests that an increased focus on miscarriage has occurred in society, psychology, and thanatology in recent years (Rinehart & Kiselica, 2010). Perhaps part of Larry's stress related to masculinity experiences is due to his ascription to non-traditional masculinity/gender role values which does not fit with traditional masculine ideas/traditional gender roles that some African-American men hold (Rogers et al., 2015; Vogel et al., 2011). He indicated value for family, which is consistent with prior research (Hunter & Davis, 1992; Rogers et al., 2015). Additionally, Larry's hesitance to seek professional help is consistent with research that suggests that some men are not as open to seek counseling as women (Gonzalez, Alegria, & Prihoda, 2005; Pederson & Vogel, 2007).

Implications for Therapy

Men's experiences after miscarriage are idiosyncratic, highly individual, and appear to cover a wide range of emotional, cognitive and social elements. Therefore, it is important to keep in mind that there is no one correct way to clinically interact with a man who presents for therapy following a miscarriage. Counseling psychologists cannot use a one-size-fits-all approach with people recovering from miscarriage. Counseling psychologists need to recognize and appreciate the possible diversity of responses, even within one couple and family. The present findings support prior research in many ways

including that counseling psychologists can reassure men and their partners that if grief is present, it is normative and an existential part of life. In addition, counseling psychologists can help normalize and enfranchise men's expressions and provide reassurance. Counseling psychologists can play a vital role in assisting men and their partners by providing psycho-education and support through a variety of modalities such as individual, couple, and family therapy as well as outreach.

Counseling psychologists also need to be aware of not assuming that men and their partners will experience severe grief responses following a miscarriage, and yet some men may experience significant and long-term grief. The results of the present study revealed that approximately half of participants experienced responses of fairly mild intensity and short duration, whereas approximately half experienced more severe responses of longer duration.

In addition to these findings that confirm prior research, I offer unique and significant clinical implications from the present study including the recognition that some men may perceive their supportive actions toward their partners as helpful, not hurtful, to their own coping. I also assert that men's perspectives on masculinity and gender roles may affect their responses and perception of and interactions with their partners. Furthermore, I discuss ways that counseling psychologists can aid people in meaning reconstruction activities and ritual implementation.

First, counseling psychologists need to recognize that men's support of their partners may be perceived by themselves as helpful, rather than hurtful to their own coping. Past research has indicated that some men perceived supporting their partners as burdensome and distracting from their own coping and responses. However, most men in

the present study offered that they were concerned about their partners, and that assisting their partners actually helped facilitate rather than detract from their own coping and functioning. Many of the men in the present study demonstrated altruism and found that supporting their partners actually benefitted themselves and their relationship with their partner. Specific benefits that men reported included providing opportunities to communicate with their partner about the loss, a sense of fulfillment, increasing their focus, and allowing them to channel any extra energy from their emotions/responses into their partner. Counseling psychologists need to be aware that while some men may find offering support for their partners as burdensome or tiring, others may feel invigorated, fulfilled, and more closely connected to their partner.

Second, counseling psychologists can explore men's perspectives on masculinity and gender roles. Results from the present study revealed that men's views may have affected how they perceived and interacted with their partners. Men's views on masculinity and gender roles may affect their expectations for how they should respond to their partner, and it may affect their level of support they provide and receive. Men's perspectives on masculinity and gender roles may also affect their responses and possible grieving. Counseling psychologists can uncover ways that men's views affect their coping and response to partner.

Next, counseling psychologists can help men make sense of the miscarriage and create meaning from the loss. Counseling psychologists can explore the meaning that individuals, including men, place on the pregnancy, the unborn child, and the resulting miscarriage. Counseling psychologists can gently guide individuals in meaning-making activities including benefit finding, sense-making, and identity reconstruction.

Counseling psychologists can help men process the miscarriage loss and integrate it into their perspective on the world. Counseling psychologists can gently guide men to identify benefits from the miscarriage.

Finally, counseling psychologists can help men create and participate in the unique meaning reconstruction activity of rituals. Rituals can aid people to remember and (in some cases) mourn their unborn child. Men can participate in rituals with other people, such as a memorial service, or, they can participate in individual or family rituals. Since miscarriage is often unacknowledged by society, traditional grief rituals may not be implemented. Ritual creation and implementation often requires creativity and resourcefulness, which the counseling psychologist can aid in. In the present study, three men (Terry, Eugene, Frank) described how they found comfort in ritual, and one man (Dale) disclosed how he wished he had participated in rituals following his wife's miscarriage approximately 30 years before the interview.

Limitations/Future Research

Like all research investigations, the present study involved certain limitations. These limitations can be categorized based on sampling, paradigm, and design.

Sampling

The current sample was biased, and findings cannot be generalized beyond those who are similar to the individuals included in the present sample. Although the participants were heterogeneous in some ways and demonstrated diverse characteristics in terms of age, time since miscarriage, geographic regions, they were all similar with regard to being affected to some extent by miscarriage. In addition, the sample was also homogenous with regard to race a (e.g., Caucasian/European-American), with one

African-American man. The sample may not be characteristic of other men in the U.S. in terms of demographic information such as ethnicity, age, experience, etc. In addition, four of the nine participants did not live in the Midwest area during the time of the miscarriage. Participant locations included New Jersey, Colorado, North Carolina and Oregon. With regard to time since miscarriage, most of the participant's partner's miscarriages occurred more than two years before the interview, with three of the men who had experienced losses many years prior.

Additionally, the sample size was larger than typically used in IPA (Smith et al., 2009). The large sample size prohibited implementation of an in-depth, narrative approach. Detailed information on participants was provided, but a holistic description of individual participants was not possible. For example, I offered a brief summary of the unique factors that likely contributed to Larry's experiences (i.e., race, age, and non-traditional view of masculinity/gender roles), but I did not provide an in-depth description or deeper examination of his unique story and the possible intersection of his identities. Researchers using a narrative approach would have been able to provide a more in-depth, holistic approach that would have contributed to the present study.

The sample was self-selected and may, therefore, have differed in significant ways from those who did not volunteer. It is possible that the participants may have experienced more distress and difficulties following their partner's miscarriage than their counterparts who did not volunteer. Their experience may have been more severe than average, which may have contributed to their view of the miscarriage as a loss and to their spontaneous use of the term "grief." Participants may also have been closer to their families and more family-oriented than their peers who did not volunteer.

Future research should be conducted with two sizes of samples: larger, more diverse samples than the present study, as well as smaller samples. Specifically, samples including diversity with regard to race/ethnicity, age, geographic location, marital status, and time since miscarriage are needed for research studies. Ideally, the sample would be purposive and stratified, and perhaps be achieved by recruiting from one type of agency or program. The sample would represent data from each region of the United States and accurately reflect the latest census. Furthermore, future research with smaller samples would provide in-depth descriptions of participant uniqueness. A narrative approach to individual participants would provide a holistic approach to future studies.

Additionally, future research is needed with men who did not initially desire the pregnancy. All but two men in the present study reported that they initially desired the pregnancy. The responses of men who did not desire their partners' pregnancy may differ from men who desired the pregnancy.

Paradigm

Another limitation is that certain steps of my research process are not consistent with the constructivist paradigm and I made certain modifications in my consideration of the paradigm. The present study is a dissertation project, and as such certain procedures were used to enhance the educational nature of the research process. For example, I wrote the literature review prior to data collection. Constructivist researchers would not explore the research literature in depth prior to data collection in an attempt to let the data unfold naturally and minimize the potential for the researcher bias (Ponterotto, 2005).

Future research could involve pure constructivist approaches that are not conducted as part of a thesis or dissertation project. This type of approach would allow

the researcher to collect data prior to reviewing the research literature, thereby minimizing researcher bias.

Design

In addition to sampling and paradigm limitations, the present study demonstrated design limitations. Unlike quantitative research, when using a qualitative and phenomenological design there is not a standard interview protocol for all participants. I offer each participant a minimum of four broad prompts and then I asked follow-up questions as needed. Lack of standardization may affect the reliability of the measure, which is an important feature of quantitative research. Standardization is less emphasized and appropriate for qualitative research, however.

Another limitation related to design is that qualitative research does not allow for the clear examination of associations among variables and hypothesis testing as does quantitative research. However, qualitative research allows for the exploration of a phenomenon and the development of hypotheses (Neimeyer & Hogan, 2001). The present study attempted to explore the understudied phenomenon of men's response to miscarriage and to provide information that could lead to better understanding for researchers and practitioners.

Quantitative studies that establish and test theories are recommended. For example, an ideal study could be a mixed-methods approach that tests hypotheses and also incorporates qualitative data. Surveys could be completed that examine men's experiences following miscarriage (i.e., responses, coping, meaning-making, views of masculinity/gender role). Measures that examine psychological distress, grief, and coping could also be given. Qualitative data such as interviews would provide useful, in-depth,

and individualized information. The participants could also be studied longitudinally. For instance, a cohort of men who participate in initial prenatal appointments with their partners could be selected. Participants could then complete a survey at regular increments, such as every five years. The men whose partners ended up experiencing a miscarriage could be compared and contrasted to the men whose partners' pregnancies resulted in healthy babies. Later factors that could be examined include possible effects that future children have on participant functioning/well-being, the effects of possible future perinatal losses, and any complicated grief experiences. Research would continue throughout the participants' and partners' child-bearing years, and perhaps even after.

Conclusion

In the present study I examined men's experiences after miscarriage. This topic has been understudied, and little is known. Through a qualitative approach, I was able to organize detailed data about men's unique and diverse emotional and behavioral expressions, their views of their partners' diverse emotional and cognitive expressions, men's ways of coping, men's participation in meaning reconstruction activities, and about how men's perspectives on masculinity and gender roles appeared to be related to their own responses and their support of their partners. The present findings support previous research, but also offer unique, new insights. The results contribute to the paucity of research on men's grief, broadly, and men's experience following miscarriage, specifically. More specifically, the present study contributes to the limited information regarding men's emotional and behavioral expressions, coping, meaning-making, and perspectives on masculinity and gender roles.

The present study revealed certain significant and unique insights into men's experience following miscarriage. First, men demonstrated diverse expressions following miscarriage, with about half experiencing more severe expressions of longer duration than the other half. Men coped and made sense of their experiences in diverse ways. Men also held diverse perspectives of gender roles and masculinity, which appeared related their perception of and interactions with their partners. Second, most men found that supporting their partners helped, rather than hindered, their own responses and coping. Unlike the results of some previous research studies, the majority of participants did not report miscarriage-related relationship conflict with their partners. All of the participants indicated concern for their partners, and most men demonstrated sensitivity and acceptance towards their partners' experiences. In addition, most men indicated that they were concerned about their partners' wellbeing and perceived their supportive actions as helping both their partners and themselves cope. Next, all participants participated in meaning-making activities to help make sense of, find benefit from, and reconstruct themselves and their worlds. For example, some men found that rituals related to the miscarriage helped them to cope, create meaning from loss, and increase family bonds. Finally, most participants appeared accurately attuned to their partners' experiences. More specifically, participants demonstrated an awareness of their partners' emotional and cognitive expressions; an awareness that was consistent with previous research focused on examining women's experiences following miscarriage.

The results of the present study offer implications for the fields of thanatology and counseling psychology, including the recognition of the unique and diverse responses that men experience, factors that may affect men's emotional and behavioral expressions

(e.g., views on masculinity and gender roles), men’s interactions with their partners, ways that men cope, and types of meaning reconstruction activities.

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APPENDICES

Appendix A

RESEARCH PARTICIPANT CONSENT FORM
The Experience of Men After Miscarriage
Heather Servaty-Seib, Ph.D.
Stephanie Rose
Purdue University
Department of Educational Studies

The purpose of this study is to explore the experience of men whose partners have experienced miscarriage. The study is titled *The Experience of Men After Miscarriage***.**

Specific Procedures
If you agree to participate in the study, you will meet with me for an individual interview. Each interview will be audio-taped so I can capture your experiences the best way possible. I will transcribe the interview. Afterwards, I will schedule a follow-up meeting with you to give you a chance to read the interview transcript, check the accuracy, and make comments.

Duration of Participation
The interview will last approximately 60-90 minutes. You can also agree to take part in a follow-up meeting where you can read the interview transcript and make comments; this meeting will last approximately 20 minutes. The interview(s) will occur at a private office at Purdue University.

Risks
Breach to confidentiality is a risk, and several safeguards will be used to minimize this risk. Neither your name nor any identifying material will be used. The audio recordings of the interviews will only be used for the purpose of this study and will be kept in a secure place until the study is completed, and then they will be destroyed. Another potential risk of participating in this study is that you may have had difficult experiences that you may feel uncomfortable sharing during the interview. For instance, you will be asked "Tell me about your miscarriage experience," and "Tell me about the details of the pregnancy." This question may remind you of any uncomfortable experiences you have had. However, participation in this study poses minimal risk to the participant; no more than experienced in daily life. Also, by my asking questions in an open manner, you can decide how much you want to share with me. You are free to decline to answer any

question asked. Additionally, I will provide a list of mental health clinics in the Midwest area if you are interested in counseling.

Benefits

There are no direct benefits to participating in this study. However, the resulting research may benefit society indirectly by furthering our understanding about how miscarriage affects men. Men have often been overlooked in research and treatment, and increased understanding is needed. Results of this study may increase the body of knowledge about miscarriage which may benefit medical and mental health professionals' awareness and treatment.

Compensation

Participants will be compensated for their time after the interview. You will have the choice to receive a $10 Target gift card, or have $10 donated to the March of Dimes organization.

Confidentiality

All information received will be kept confidential and will be seen only by authorized members of our staff. To minimize the risk of a breach to confidentiality, the audio tape recordings of the interview will be kept in a locked file cabinet in Beering Hall Room 5164. Only the Principal Investigator and the Co-Principal Investigator listed above will have access to the recordings.
I will transcribe the tape from our interview and assign a pseudonym to your responses so your actual name will be kept separate from your responses. After transcribing the audio recordings, two other graduate student researchers will serve as coders and will help analyze the data to ensure validity. However, the coders will not have access to the recordings themselves; they will only have access to the transcribed data, which will have no identifying information attached to them. The recordings and transcribed data will only be used for the purpose of the study and will be maintained for a minimum of three years after your initial interview. All recordings and other identifying data will be destroyed after three years. A data file with no identifying information will be kept for seven years after publication of any article(s) developed from the research. All findings from the study will be reported in aggregate form and no identifiable information will be used.

The researchers will have no contact with you after the follow-up meeting (where the transcription of the interview will be discussed) and completion of the study, unless you would like to contact sdfireba@purdue.edu with questions. The project's research records may be reviewed by departments at Purdue University responsible for regulatory and

research oversight. The present study has been partially funded by a Purdue Research Foundation Grant.

Voluntary Nature of Participation

Your participation is strictly voluntary. You do not have to participate in this research project. You may refuse to participate or discontinue participation at any time without penalty. You may contact our office at any time, if you have questions about the research project. Also, you may contact me, Stephanie Rose, after the study is completed to hear about the results. Also, I will contact you after the interview to receive your feedback and make sure the results reflect your experience.

Contact Information:

If you have any questions about the project you may contact Dr. Heather Servaty-Seib at servaty@purdue.edu or Stephanie Rose at sdfireba@purdue.edu. Members of the research team can be contacted through calling (765) 494-9748. If you have concerns about the treatment of research participants, you can contact the Institutional Review Board at Purdue University, Ernest C. Young Hall, 10th Floor- Room 1032, 155 S. Grant Street, West Lafayette, IN 47907-2114. The phone number for the Board is (765) 494-5942. The email address is irb@purdue.edu.

Documentation of Informed Consent

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research project and my questions have been answered. I am prepared to participate in the research project described above.

_____ I agree to give permission to be contacted at a later date for checking the accuracy of the research findings.

_____ I do not agree to give permission to be contacted at a later date for checking the accuracy of the research findings.

____ ________________________
Participant's Signature Date

____
Participant's Name

____ ________________________
Researcher's Signature Date

Appendix B: DEMOGRAPHIC INFORMATION SHEET

(Feel free to use additional space as needed.)

Name:____

Contact Information (Phone, e-mail, address):

____

____

____

Age: _____________

Race/Ethnicity:

___African-American/Black

___Asian American

___Caucasian/White

___Hispanic American

___Native American or Eskimo

___Pacific Islander

___Multi-racial
(Specify:____
_____)

___International
(Specify:____
____)

___Other____
____

Educational Level (Please indicate highest attained):

___Grade school

___Middle/junior high school

___High school

___GED

___Some college

___College graduate

___Graduate study

Employment Status (If Employed):

___Unemployed

___Part-time

___Full-time

___Temporary

Has your employment status changed since the miscarriage? If yes, how so? :

____

____

What is your sex?

___Male

___Female

___Intersex

What is your gender?

___Man

___Woman

___Transgendered

Current Relationship Status:

___Single

___Married

___Partnered

___Separated

___Divorced

___Widowed

___Other____

Was the pregnancy planned?

____

____

How did you feel about the pregnancy (i.e., happy, excited, fearful, anxious, etc.)?

____

____

Did you view ultrasound images?

____

____

Relationship Status at Time of
Miscarriage:____

____

Date of
Miscarriage:____

Time since Miscarriage
Occurred:____

How far along in the Pregnancy did the Miscarriage
Occur?____

____

What support resources have you accessed (if any?):

___Physician or Healthcare Professional

___Counselor

___Support Group

___Workshop on Miscarriage

___Religious/Spiritual Leader

What was the interview like for you?

____

____

Appendix C: INTERVIEW PROTOCOL

Review consent form and confidentiality

1. Tell me about yourself.
2. Tell me about your miscarriage experience.
3. How did you respond when you first heard the news? (How did you feel? What were you thinking? How did you act?)
4. What are some of the most important aspects of the experience that stood out to you?
5. Tell me about how you are coping with the miscarriage.
6. What helped or hindered you through this experience?
7. Tell me about your social support system? (Who was helpful, and who got in the way?)
8. How much have you interacted with medical professionals? (How was that experience?)
9. Tell me about ways that you may have made sense of the miscarriage experience.
10. What have you learned, if anything, from the experience?
11. If there was another man going through a similar experience, what would you tell him?
12. Tell me about your role in your relationship.
13. Tell me about how the miscarriage was for your partner.
14. How did your partner respond? (How did she think, feel, and act?)
15. Have you provided support for your partner? (If yes, in what ways?)
16. What else would you like to tell me about your experience?

Appendix D: LETTER OF INTRODUCTION TO POTENTIAL GATEKEEPERS

Dear Health Care Provider,

I am a Ph.D. student in the Counseling Psychology program at Purdue University. I am currently conducting a research study focused on the experiences of men whose partners have had a miscarriage, and it is titled *The Experience of Men After Miscarriage*. My goal is to learn more about how men respond to miscarriage, explore men's grief reactions, and discover men's thoughts, emotions, and behaviors related to the miscarriage. My hope is that the results of this study will provide valuable information to physical and mental health professionals regarding the nature of men's experiences. Little research has been conducted on men's responses to miscarriage, and further inquiry is needed so that men do not continue to be overlooked by the research literature.

I would appreciate it if you would consider posting the attached flyer and distributing the letters to potential participants. The primary criteria for participants in this study are that they (a) are men and (b) their partner has experienced one or more miscarriages (one within the last two years). Please note that participation in the study is not intended to be therapeutic or to be used as a supplement for therapy. Interview data will only be accessible to me, Stephanie Rose, my research advisor, Dr. Heather Servaty-Seib, and two other graduate student researchers.

Participation in the research consists of the following:

(a) 60 to 90 minutes of an in-depth, open-ended, semi-structured interview. The interview will occur in a private office at Purdue University. A consent form will be filled out and signed during this process. The interviews will be audio-taped and later transcribed. The tapes will be accessible only to me and my supervisor, Heather Servaty-Seib, Ph.D.

(b) Participants will be contacted at a later date about checking the accuracy of their interview transcription. They will also be given the opportunity to provide additional information.

This study has been approved by the Institutional Review Board at Purdue University, Ernest C. Young Hall, 10th Floor- Room 1032, 155 S. Grant Street, West Lafayette, IN 47907-2114. The phone number for the Board is (765) 494-5942. The email address is irb@purdue.edu. I will be under the supervision of Heather Servaty-Seib, Ph.D. (765) 494-0837; servaty@purdue.edu).

All participation in this research study is voluntary, and the participants may withdraw at any time. Information offered by participants will contribute to the understanding of men's experiences and responses following a miscarriage. This information will provide valuable and informative perspectives to both practitioners and researchers. A

community mental health resource list will be provided to participants, should the participants desire counseling after participation.

Please feel free to contact me at sdfireba@purdue.edu or (937) 532-4914 with any questions or to obtain more information.

Sincerely,

Stephanie Rose

Appendix E: LETTER OF INTRODUCITON TO POTENTIAL PARTICIPANTS

Dear Potential Participant,

I am a Ph.D. student in the Counseling Psychology program at Purdue University. I am currently conducting a research study focused on the experiences of men whose partners have had a miscarriage, and it is titled *The Experience of Men After Miscarriage*. My goal is to learn more about how men respond to miscarriage, explore men's grief reactions, and discover men's thoughts, emotions, and behaviors related to the miscarriage. My hope is that the results of this study will provide valuable information to physical and mental health professionals regarding the nature of men's experiences. Little research has been conducted on men's responses to miscarriage, and further inquiry is needed so that men do not continue to be overlooked by the research literature.

I will conduct an interview with you and the interview will consist of several open-ended questions about your experiences related to the miscarriage. I will audiotape our interview. I will be the only person who will hear the tapes, and precautions will be taken to keep all materials confidential, including keeping them in a locked file. Information which might identify you will not be included in any publications based on the research. Interview data will only be accessible to me, Stephanie Rose, my research advisor, Dr. Heather Servaty-Seib, and two other graduate student researchers.

Participation in the research consists of the following:

(a) 60 to 90 minutes of an in-depth, open-ended, semi-structured interview. The interview will occur at either the participant's residence or a private office at Purdue University. A consent form will be filled out and signed during this process. The interviews will be audio-taped and later transcribed. The tapes will be accessible only to me and my supervisor, Heather Servaty-Seib, Ph.D.

(b) You will be contacted at a later date about checking the accuracy of your interview transcription. You will also be given the opportunity to make any comments and provide additional information.

This study has been approved by the Institutional Review Board at Purdue University, Ernest C. Young Hall, 10th Floor- Room 1032, 155 S. Grant Street, West Lafayette, IN 47907-2114. The phone number for the Board is (765) 494-5942. The email address is irb@purdue.edu. I will be under the supervision of Heather Servaty-Seib, Ph.D. (765) 494-0837; servaty@purdue.edu).

All participation in this research study is voluntary, and you may withdraw at any time. Information offered will contribute to the understanding of men's experiences and responses following a miscarriage. This information will provide valuable and

informative perspectives to both practitioners and researchers. A community mental health resource list will be provided, should you desire counseling after participation.

Please feel free to contact me at sdfireba@purdue.edu or (937) 532-4914 to obtain more information or if you are interested in participating.

Sincerely,

Stephanie Rose

Appendix F. RESEARCH FLYER

Men Needed for Study on Experience After Miscarriage

Little is actually known about men's experiences after miscarriage. Most of the research on miscarriage has been done with women. The title of this project is: *The Experience of Men After Miscarriage.*

Volunteering for this study could help:

- Increase public awareness of men's experiences
- Give men a voice in research
- Aid healthcare and mental health professionals in how to provide effective services to men

Please contact me if you are willing to take part in an interview (60-90 minutes) about your experiences after miscarriage. **I am looking to interview men who participated in a committed romantic relationship at the time of the miscarriage. The interview will occur at a private office at Purdue University.** Participants can choose to receive a $10 gift card or have $10 donated to the March of Dimes.

Contact Stephanie Rose, Counseling Psychology doctoral student at Purdue University, for more information: sdfireba@purdue.edu or (937) 532-4914. Dr. Heather Servaty-Seib is the faculty advisor for this project. Privacy is ensured, and information will be kept confidential.

Appendix G: LIST OF MENTAL HEALTH PROFESSIONALS

Alpine Clinic
3660 Rome Drive
Lafayette, IN 47905
(765) 446-9394

Bauer Family Resources Counseling Office
100 Saw Mill Road, Suite 3200
Lafayette, IN 47905
(765) 742-4848

Counseling Partners/Child and Family Partners
115 Farabee Dr. North, Suite B-2
Lafayette, IN 47905
(765) 274-0874

Heartland Clinic
2201 Ferry Street
Lafayette, IN 47904
(765) 446-9898

Purdue Counseling and Guidance Center
Beering Hall, College of Education
Purdue University, Room 3202
West Lafayette, IN 47907-2098
(765) 494-9738
pcgc@purdue.edu

Center Point Counseling
7700 N. Meridian Street
Indianapolis, Indiana
(317) 252-5518

Family Tree Counseling Associates
11350 North Meridian Street, Suite 110
Carmel IN 46032
(317) 844-2442

Lotus Group Counseling
11950 Fishers Crossing Drive
Fishers, IN 46038
(317) 595-5555

Center for Grief Recovery & Therapeutic Services
Institute for Creativity & Development
1263 W. Loyola
Chicago, IL 60626
(773) 274-4664

Appendix H. MASCULINITY/GENDER ROLE MEASURES

INVENTORY OF SUBJECTIVE MASCULINITY EXPERIENCES

& SUBJECTIVE MASCULINITY STRESS SCALE

Important note: The Inventory of Subjective Masculinity Experiences (ISME) and the Subjective Masculinity Stress Scale (SMSS) are copyrighted material. It may not be sold, circulated for general reading, published in a journal, or posted on the Internet without the expressed approval of one of its authors (Joel Wong, Ph.D. and Munyi Shea, Ph.D.). When using the ISME for research purposes, please do not modify the instructions or wording of the ISME and SMSS in any way without the permission of the authors. Permission is granted for the ISME and SMSS to be used in research and clinical practice, subject to the above conditions.

Scoring Instructions for the SMSS:

Compute the average score based on scores from the 10 items on stress. No reverse-scoring.

The following questions are about gender issues. Please describe your personal experience of what it means to be a man by completing the following sentence, "As a man…" 10 times. Just give 10 different responses. Respond as if you were giving the answers to yourself, not to somebody else. There are no right or wrong responses. Don't worry about logic or importance, and don't over-analyze your responses. Simply write down the first thoughts that come to your mind.

1. As a man…
2. As a man…
3. As a man…
4. As a man…
5. As a man…

6. As a man…
7. As a man…
8. As a man…
9. As a man…
10. As a man…

Please refer to your responses above. For each "As a man..." response, indicate how OFTEN this experience is STRESSFUL for you.

1 Never/Almost

2 Rarely

3 Sometimes

4 Often

5 Always/Almost Always

	Never/Almost	**Rarely**	**Sometimes**	**Often**	**Always/ Almost Always**
"As a man..." Response 1					
"As a man..." Response 2					
"As a man..." Response 3					
"As a man..." Response 4					
"As a man..." Response 5					
"As a man..." Response 6					
"As a man..." Response 7					
"As a man..." Response 8					

	Never/Almost	Rarely	Sometimes	Often	Always/ Almost Always
"As a man..." Response 9					
"As a man..." Response 10					

Appendix I: IPA TABLES OF RESULTS

Table 1

Participant's Emotional and Behavioral Expressions Superordinate Theme with Accompanying Subordinate Themes

Participants experienced emotional expressions/psychological distress and behavioral expressions:

Duration of emotional expressions	Primarily initial expressions with short duration (Time length: Weeks) (4 men: Frank, Nathan, Ken, Terry): Frank reflected, "The next couple of days, it just (sigh…pause) I mean, she wasn't that far along, so she didn't have like a huge attachment. We didn't know what the baby was, but it was still *hard.*"	Emotional expressions of longer duration (Time length: Months to years) (4 men: Eugene, Larry, Dale, Wade): Eugene cried as he shared about his and his wife's responses, "We were *devastated*. It's like, *man.* (short pause) I was holding my wife and I mean, sobbing. It was *pretty horrible."*	
Nature of emotional expressions	Sadness, as demonstrated by self-reported feelings, crying, and withdrawal (All men): Eugene described, "We were *devastated*. It's like, *man.* Frank shared, "I was upset, I mean (sigh) I tend to hold in my emotions as well." Larry shared, "When we were in the hospital, the doctor comes out, says, you know, 'You lost the	Shock/Disbelief (4 men: Frank, Ken, Dale, Wade): Frank described, "At that time, I didn't really want to believe it either. I'm like, aahhh, it'll be okay. Maybe [the medical professionals] were wrong. It hadn't sunk in at that point."	Anger/Irritability (4 men: Frank, Larry, Dale, Wade): Frank, "I was upset. I was angry. I was like, why does this happen to us?" Larry also questioned the reason for his wife's second miscarriage: "The second one was sort of like, anger and blaming. Why let us even get pregnant, if this was going to happen? So the

	baby.' You're crying; they're crying."		second one was hard to justify or kind of rationalize."
Nature of behavioral expressions	Recuperative activities (All 9 men): Frank, Terry, Eugene, and Dale reported taking time off of work, with the time varying from one day to one week. All participants indicated that they spent time with their family throughout the miscarriage process.	Rituals (3 men: Frank, Terry, Eugene): Frank shared that he and his wife donated money to their university alma mater "In Honor of Baby (Last Name)." Terry related that he and his family attended a Catholic mass to honor unborn children.	
Important Unique Expressions (2 men)	Complicated, diverse emotions for one participant (Chris): "A big mix of emotions… So, (tearful) finding out that (sigh) one day she had been bleeding and went to the hospital, and eventually having through the scan the doctor saying that there was no heartbeat, was, it was a mix of… (short pause) sadness. Because by that point I had come to accept and almost be excited about the thought of having a child, as well as almost a bit of relief because I hadn't originally wanted to have a child. And then	Complicated emotional response for one participant, following wife's two miscarriages and resulting medical problems (Dale): According to Dale, "Emotions kind of got put over on the shelf because of the practicality of taking care of the family and fixing the bill situation and then work. There was no time for grieving, really, it just got pushed farther and farther down the list."	

	because of those two conflicting, almost a little bit of guilt from feeling the relief."		

Table 2

Participant Views of Partners' Emotional and Cognitive Expressions Superordinate Theme with Accompanying Subordinate Themes

Partners experienced emotional and cognitive expressions/psychological distress:

Duration of emotional expressions	Primarily initial expressions with short duration (Time limit: weeks) (3 partners: Frank, Nathan, Terry): Frank revealed that his wife was initially "upset" and "shaken up" following her miscarriage, but that her intense emotional response was short-lived. Similarly, Nathan related that his wife "didn't experience great amounts of sadness. It was more of a trial kind-of-thing: something to get over, get through." Terry also reported that his wife "moved on fairly quickly."	Emotional expressions of longer duration (Time limit: Months to years) (6 partners): Larry, Eugene, Wade, Dale, Ken, and Chris revealed that their partners were "devastated," Wade described his wife's two miscarriages as "hard," Eugene repeatedly referred to his wife's miscarriage as "horrible," and Dale summarized, "Well, there was definitely loss there." Chris described, "There's no word that could possibly describe how much sorrow was on her face (pause) (sigh). It was almost as if part of her *had* died."	
The nature of partner's expressions	Emotional Expressions: Sadness (All women), (Crying, Withdrawal):	Cognitions (4 partners: Larry, Wade, Ken, Dale) (Guilt, Self-Blame,	

	Chris disclosed about his girlfriend, "I mean, she was sad. She's normally an incredibly optimistic, outgoing, social butterfly person. She's so much fun to be around. She didn't want to see anyone; she just was in her room crying for a while." Anger (one woman): Chris shared, "There were periods of anger, and she never meant it, but she would yell at me and blame me for whatever reason." Anxiety/Panic (one woman): Eugene described his wife, saying, "She was kind of panicky, thinking she was dying a lot."	Sense of Inadequacy): Larry shared that his wife had felt "hurt and disappointed," following her second miscarriage and "probably thought, 'I'm older now, my body's more stable. I should be able to do this.'" Wade believed that his wife experienced a "feeling of inadequacy in some sense…that she was inadequate as a woman in some way."	

Table 3

Coping Superordinate Theme Accompanying Subordinate Themes

Many participants coped in many ways including:

Supporting their partners	All men indicated offering support "You're not going to feel any better until she feels better…	Two men reported that they felt supported when their partners received support from others (two	One man stated that he actively sought out female support figures for his wife in the form of family members and	

	lean into your wife. I mean, she needs the help…pour what you can into your wife, and it makes a world of difference." (Eugene)	men: Nathan, Terry): "So I thought her sharing that and getting the support from her friends, that actually helped me as well, knowing that she had that support out there." (Nathan)	medical professionals: Terry reported that he encouraged his wife's interactions with female family members and medical professionals because it was "always helpful for her to hear the nurse's version, not just the male physicians, medical-only version."	
Viewing the loss as a challenge to work through	Four men viewed the miscarriage as a challenge to work through and overcome (four men: Ken, Nathan, Dale, Wade): "You have to just keep plugging ahead, and probably the best realization I had is, hey, this is the challenge we've been given, and we'll have to deal with it." (Dale)	Two men (Wade,, Dale) viewed previous miscarriages and life difficulties as helping prepare them to healthily cope: "I've made some mistakes, and I've had some adversity that I've faced earlier in life that I consciously try to work on some of my weaknesses and such. I guess it has been a better time in my life for this kind of thing to occur because I am able to try and deal with it, or cope with it in a healthy manner,		

		and be present with my wife." (Wade)		
Staying busy/Following a routine	Busyness and routine helped three men in limited ways (Nathan, Dale, Larry): "We were both very busy at the time, so I think it was relatively easy for us to put it aside and focus on what we needed to focus on. I think if one of us hadn't been working, she or I would have had a lot more time maybe to dwell on the miscarriages. I think at the time it was more of just, we had a lot to do. (laugh) So it kind of helped us to move on in that situation." (Nathan)	Busyness and routine hindered the same three men in some ways (Nathan, Dale, Larry): "There was no time for grieving, really, it just got pushed farther and farther down the list." (Dale) "I think with the second {miscarriage}, I didn't know that I *knew* that you could take time off, so I couldn't wait 'til like the weekend… when you didn't have to do stuff you know, you were pretty quiet, a little more withdrawn." (Larry)		
Holding hope for future fertility/family expansion	Many men did not allow the miscarriage to diminish their hope for future family expansion (6 men: Ken, Nathan, Terry,	Two men (Nathan, Ken) were able to place their losses in perspective which appeared to help them cope and reinforce their	One man (Ken) demonstrated an optimistic perspective and was able to identify one positive outcome of the	

	Eugene, Larry, Wade): "We knew that we would be able to try again, and with the doctor's help, make sure that everything went better the next time." (Ken) "We're ready to bring in more foster children that we hope to adopt…we want to expand our family." (Eugene)	hope for future fertility: "I kind of knew that even if this didn't work out, we would be able to try again, and it wasn't the end of the world." (Nathan)	miscarriage which was his wife's ability to initially conceive. He channeled his optimism about fertility into anticipation for a healthy, viable future pregnancy: "And the miscarriage was good in some ways because it was like, well this didn't work out, but we didn't have any problem getting pregnant before, so we shouldn't have too much of a problem getting pregnant again. So we know it can happen." (Ken)	
Relying on social support	Some men reported adequate social support from family, friends, and employer (6 men: Wade, Frank, Ken, Terry, Nathan, Eugene): "Although it's nice to talk to my wife and partner about the issue, it's also comforting to talk to someone	A couple of men wished they had received more social support and had sought counseling (2 men: Dale, Larry): "I wish *then* that I'd had the communication skills with my friends… to have said, 'Well, something pretty bad happened this month. I just need to tell you. I don't		

	else about what's going on. Especially when things are difficult to talk about, and I don't want to say the wrong thing. I don't want to upset her, and I don't want to seem insensitive about how I may or may not be feeling (Wade)."	want you to do anything… And because you don't do that, it probably didn't give us the opportunity to find out that maybe other families that were friends of ours had gone through it, because nobody else had said." (Larry)		
Expressing thankfulness for an existing child	Four men (Terry, Frank, Dale, Eugene) indicated that having a child helped them cope with the miscarriage: "Our main coping mechanism was having a healthy one-year-old. Having that child allowed us to move on fairly quickly." (Terry)	Two men (Larry, Terry) indicated that their child helped bring a sense of purpose: "With the first miscarriage, it made sense because we had a daughter." (Larry)		
Understanding medical knowledge about the possible causes and frequent occurrence of miscarriage	Four men (Wade, Nathan, Ken, Frank) indicated that they appreciated processing medical information rationally:	Four men (Wade, Nathan, Ken, Frank) were reassured to learn that miscarriages are common: "The doctor explained that this is more common,	One man was reassured to learn that miscarriages are not typically caused by people: "It's not like it was our fault." (Ken)	Some men (Nathan, Ken) were reassured to learn that miscarriages typically do not indicate infertility:

	Wade explained, "As a man, I think dealing with it in a more logical or rational sense was somewhat comforting in the beginning, not that I didn't want to deal with it emotionally at all."	and these things happen." (Wade) "It helped knowing that it was a fairly common thing; it wasn't completely unexpected." (Ken)		"I think the doctor was very good at putting our mind at ease, that there's not necessarily anything wrong with you… And it's very unlikely at this point that it would be that you're infertile. That helped a little bit." (Nathan)

Table 4

Meaning-making Superordinate Theme Accompanying Subordinate Themes

Participants constructed meaning in various ways:

Gratefulness for an early gestational loss	Three men (Frank, Eugene, Terry) related that they were grateful that the pregnancy loss occurred earlier, rather than later: "So I think, at least, this wasn't as bad as it could have been. I mean, the further along you are, the worse it makes it." (Frank)	Two men (Eugene, Frank) believed that their unborn child died due to congenital defects, and so they preferred that the child did not "suffer" (Eugene): "We knew our child had died because something was wrong with it. It's better that it died then. Time gives perspective." (Eugene)	

Belief in a reason for the miscarriage	Three men (Eugene, Frank, Dale) believed there was a "reason" and purpose for the miscarriage: "There's a lot to be said for faith, family, and friends," and he referenced a Bible verse "that says we're not given challenges that we can't handle." (Dale)	Two men (Frank, Eugene) believed that their families were meant to grow in other ways (i.e., new pregnancy or adoption): "If we didn't have the miscarriage, we wouldn't have this baby. Maybe this was the one we were meant to have." (Frank) "We want to expand our family. If the miscarriage hadn't happened, we probably wouldn't be ready to adopt again. (Eugene)	Three men (Frank, Eugene, Dale) shared that they believed that God had a plan for their lives: "Knowing that God is sovereign and that everything happens for some reason, and that He controls everything- that really does help. God gives, and God takes away. I can't always understand why, but just know that He's in control, and He allowed it. So there's gotta be some reason for it." (Frank)
Enhanced value for life	Three men (Nathan, Frank, Terry,) shared that they have learned to value fertility and life more since the miscarriage: "I mean, don't take anything for granted. I assumed that everything was going to be okay." (Frank) "We don't take our children for granted. None of them were mistakes; none of them were accidents. We tried for a long time to have them." (Terry)	Terry reported that his wife's miscarriage, along with fertility difficulties, served to bolster the value he placed on fertility and life in general: He expressed a great appreciation for his children, noting that "We're incredibly blessed to have them." (Terry)	
Strengthened family relationships	Three participants (Eugene, Chris, Dale)	While many men grew closer to their	

	viewed their partner's miscarriage as helping to strengthen family relationships: "Ideally, that's really not how you want to get closer to your wife, having a miscarriage, but I mean, fire tempers your relationship and makes you stronger." (Eugene)	partners and family members, two men (Dale, Larry) reported that the miscarriage experience created a rift between them and their wives: Larry reported that he was "angry," "blamed" his wife, and withdrew. "I think the second {miscarriage} was hard on the relationship for a while." Dale credited his wife's "selfish" and "dumb" decision to pursue a risky pregnancy, (without his knowledge or consent), as the cause of her life-threatening, extended health complications. He indicated that her decision caused "a little distrust" that eventually contributed to their divorce 13 years later.	

Table 5

Relationship Role/Masculinity Superordinate Theme Accompanying Subordinate Themes

Participants described their gender role and masculinity:

Held traditional gender roles (Frank, Terry, Eugene)	“Head and “Leader” “It’s important for me to have a more traditional role as husband and father, breadwinner, leader of the household.” (Terry) “I think my vote should supersede my wife’s.” (Frank) “I am the head of the family, so (Big sigh) (Laugh). It’s a lot of responsibility.”	“Provider” & Care-taking Responsibilities “[My wife and I] have made financial decisions that have allowed her to stay home… She’s home when the kids are home, and she has, I would say, a fairly traditional gender role as a home provider, as a mother for the children.” (Terry) “I want to provide for my family.” (Frank) “I feel like I take good care of my wife. She stays home… and I work from home. So when my daughter’s crying, I can go find out what’s wrong. If my wife needs help for a minute, I can step away from my desk and do what I need to do.”	“Control” “I want to be in control, no matter what the situation.” (Frank)	
Held non-traditional gender roles (Larry, Dale, Nathan)	Equality “Well, we were both working and raising our kids on an equal basis. And to me it didn’t matter that I made a little bit more. But that wasn’t	Partnership Nathan described his relationship as “companionship-oriented,” and he views his “primary role is to be her companion and friend.”	Flexible Roles “We really don’t have very traditional gender roles as far as what’s required of us.” (Nathan)	

	really an issue or a question because we were working as a team in all phases of our lives from 'I do', (well, we're not anymore). But that was it for me, we were joined at the hip and at the head. So we discussed things, we planned things." (Dale)		"I think we're a pretty non-traditional family. Like I do the grocery shopping; I'm the coupon-clipper. She has no desire for that sort of stuff. Because we lived on the East coast and we were commuters, the rule always was, whoever got home first started dinner. I'm proud of the fact that when we had our child, we agreed that this wasn't, 'you get up at night and I sleep.' This was, we both sort of share this." (Larry)	
Held a combination (Ken, Wade, Chris)	Provider "My wife is able to be a stay-at-home mom, which is great. So I go to work and earn the money, and she stays home and takes care of the kids." (Ken)	Flexible Roles "{My wife} has a lot of medical issues which make it difficult for her to take care of the kids more than she has to. So I take care of them as much as I'm able to when I'm not at work or asleep, and she does a great job taking care of them	Traditional Values Wade asserted that he tries to practice values that are "traditional in the sense that I try to provide and protect, and things like that."	Equality "I like to think that we're equal." (Chris referring to the relationship between him and his fiancée).

		when I am at work." (Ken)		

VITA

VITA

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EDUCATION

Ph.D.		December 2015 (exp.) Purdue University Counseling Psychology (APA-accredited) *Advisor:* Heather Servaty-Seib, Ph.D.
M.S.Ed.	2013	Purdue University *Advisor:* Heather Servaty-Seib, Ph.D.
B.A.	2005	Cedarville University Psychology; Minors: Music, Bible *Advisor:* Michael Firmin, Ph.D. *Cum laude*

CLINICAL EXPERIENCE

Pre-Practicum Student	Counseling Techniques Lab, C&D Program, Purdue University
08/25/2008 – 12/19/2008	*Activities:* Learn basic micro skills, including attending behaviors, empathic listening responses, and intake interviewing/question-asking strategies. Also, perform supervised (and video-taped) role-plays with peers.
	Instructor/Supervisor: Carrie L. Wachter, Ph.D.
Practicum Student	BRIDGe (By Remembering I Develop and Grow) support group
03/2009- 04/2010	for bereaved families
	Activities: Co-facilitated the adult group and received supervision.
	Supervisor: Heather Servaty-Seib, Ph.D.
Practicum Student	Purdue Counseling and Guidance Center
08/31/2009- 12/20/2010	*Activities:* Conduct intakes and counseling sessions with clients, receive individual, group, and peer supervision, and viewed DVD footage of sessions
	Instructor/Supervisor: Kevin Kelly, Ph.D., Ayse Ciftci, Ph.D., William Hanson, Ph.D.
Therapeutic Assessment	*Activities:* Administer personality & career assessments including
Practicum Student	MMPI-2, Strong Interest Inventory, and Rokeach Values
01/2010- 05/2010	Inventory. I also conducted intakes and feedback sessions with
	first-generation college students at-risk for attrition or retention.

Instructor/Supervisor: William Hanson, Ph.D.

Practicum Student

08/2011-05/2012

Richard L. Roudebush VA Medical Center, Indianapolis, IN

Activities: Conduct individual and group counseling sessions with clients utilizing theories including CBT, DBT, ACT. I administered and scored assessments including the MMPI-2, MCMI-III, BDI, BAI, and Shipley-2. I also received group, individual, and peer supervision.

Supervisor: Carol Wright-Buckley, Ph.D.

Practicum Student

01/2013-03/2013

01/2014-03/2014

BRIDGe (By Remembering I Develop and Grow) support group for bereaved families

Activities: Conduct intakes with children and adults interested in participating in the group; Administer assessments

Supervisor: Heather Servaty-Seib, Ph.D.

Practicum Student

08/2013- Present

River Bend Hospital, West Lafayette, IN

Activities: Conduct individual therapy, co-facilitate groups including cognitive therapy group and a support group for family members of people with severe mental illness.

Supervisor: Brian Primeau, Ph.D.

Pre-doctoral Psychology Intern

07/2014- 07-2015

Family Medicine Residency Center, Muncie, IN

Madison County Community Health Center, Anderson, IN

Alexandria Care Center, Alexandria, IN

(Integrated Behavioral Health Consortium of Indiana)

Supervisors: Linda Daniel, Ph.D. & Sharon McNeany, Ph.D.

Activities: Provide behavioral health consultations, individual, couples, family, dementia/Alzheimer's, and group therapy. I also conduct personality, intellectual, career, & neuropsychological assessment and lead small group discussions with medical residents. I also attend didactic training and conferences. I supervise a doctoral student in clinical training and receive individual and group supervision.

<u>Therapist</u> — Wabash Valley Alliance, Inc., Crawfordsville, IN

08/31- Present — *Supervisor:* Dale Crowder, Ph.D.

Activities: Provide individual and group therapy to patients with various needs, including diagnoses of depression, anxiety, PTSD, behavior disorders, etc. I also work with students in school settings. I also participate in staffing meetings and consult with fellow therapists and case managers.

PROFESSIONAL CREDENTIALS & AFFILIATIONS

Student Affiliate, APA, Division 17, Society of Counseling Psychology

Student Member, Association for Death Education and Counseling (ADEC) (12/13-12/14)

RELEVANT WORK EXPERIENCE

<u>Research Assistant</u>	Department of Educational Studies, Purdue University
08/1/08 – 07/31/10	*Activities:* Conducted literature searches, wrote research papers, participated in meetings
	Supervisor: Aman Yadav, Ph.D.
<u>Teaching Assistant</u>	Career Counseling, Department of Educational Studies, Purdue University
08/1/10- 12/10	Activities: Participated in meetings, planning, assigned homework
	Supervisor: Carrie Wachter, Ph.D.
<u>Research Assistant</u>	Discovery Learning Research Center (DLRC), Purdue University
06/11- 08/11	Activities: Conducted literature searches, coded interviews, analyzed data, and wrote final research papers
	Supervisor: Omolola Adedokun, Ph.D.
<u>Instructor</u>	EDPS 10500: Academic and Career Planning
08/11- 12/11	Department of Educational Studies, Purdue University
	Activities: Created lesson plans and class activities, lectured, and graded student assignments.
	Supervisor: Sheila Hurt

Graduate Assistant	Department of Educational Studies, Purdue University
01/12- 05/12	Assistant organizer of the Great Lakes Conference
	Activities: Managed conference e-mail account, oversaw conference proposal submissions, obtained faculty contact information, organized information, and attended meetings.
	Supervisors: Ayse Ciftci, Ph.D. & M. Carole Pistole, Ph.D.
Research Assistant	Purdue Research Foundation, Purdue University
08/01/12- 07/31/13	*Activities:* Plan dissertation research, conduct literature searches, Write dissertation proposal
	Supervisor: Heather Servaty-Seib, Ph.D.
Research Assistant	Science Learning through Engineering Design (SLED),
08/2013- 05/2014	Purdue University
	Activities: I conduct teacher interviews and classroom observations involving the implementation of engineering design activities in science teaching. I also transcribe and code interviews and observations and participate in research team meetings.
	Supervisor: Brenda Capobianco, Ph.D.

SCHOLARSHIP

Dissertation

The Experience of Men After Miscarriage (Proposed December 2013; Defended November 2015)

Articles in Peer-Reviewed Journals

Firebaugh Rose, S. D., & Firmin, M. W. (2013). African-American students on a predominantly white university campus: Qualitative research findings. *Psychological Studies, 57(4),* doi: 10.1007/s12646-012-0175-5.

Firebaugh Rose, S.D., & Firmin, M.W. (2013). A Qualitative Study of Interracial Dating Among College Students. *International Journal of Sociology of Education, 2(1),* doi: 10.4471/rise.

Firmin, M. W., Warner, S. C., **Firebaugh Rose, S. D.,** Johnson, C. B., & Firmin, R. L. (2012). A learning community's potential academic impact: A qualitative analysis. *Journal of Research in Education, 22(1),* 2-13.

Firmin, M. W., Warner, S. C., Johnson, C. B., **Firebaugh, S. D.,** & Firmin, R. L. (2010). A learning community's potential social impact: A qualitative analysis. *Learning Communities Journal, 2(1),* 73-94.

Firmin, M. W., Warner, S. C., Johnson, C.B., **Firebaugh, S. D**., & Firmin, R. L. (2009). Attitudinal outcomes of a multicultural learning community experience: A qualitative analysis. *Journal of Learning Communities Research 4(3),* pp. 1-25.

Firmin, M. W., & **Firebaugh, S.** (2008). Historical analysis of college campus interracial dating. *College Student Journal, 42*, 782-788.

Firmin, M. W., & **Firebaugh, S**. (2007). The discussion of politics in general psychology textbooks. *American Association of Behavioral and Social Sciences Journal*, *10*, 64-77.

Tse, L., Firmin, M. W., Hwang, C., & **Firebaugh, S**. (2006). Generational perspectives on interracial relationships: A comparison of parent and child views. *National Social Science Perspectives Journal*, *32,* 190-201.

Presentations at Peer-Reviewed Local, Regional, & National/International Conferences

Rose, S. (2014, April) *The Grief Experience of Men After Miscarriage.* Poster session presented at the 36th Annual conference of the Association of Death Education and Counseling (ADEC), Baltimore, Maryland.

Firebaugh, S., & Hanson, W. E. (2011, August) *Measurement error of CRIS scale scores: An rg study.* Poster session presented at the annual conference of the American Psychological Association (APA), Washington, D.C.

Firmin, M., Warner, S., Johnson, C., **Firebaugh, S.,** Firmin, R. (2009, April). *Academic outcomes of learning community experience.* Paper presented at the 37th Annual National Association for Ethnic Studies Annual Conference, San Diego, CA.

Firmin, M., Warner, S., Johnson, C., **Firebaugh, S.,** Firmin, R. (2008, November). *Attitudinal outcomes of a student learning community experience: A qualitative Analysis.* Paper presented at the 28th International Lilly Conference on College Teaching, Oxford, OH.

Firmin, M., Warner, S., Johnson, C., **Firebaugh, S**., & Firmin, R. (2008, April*). Learning community's potential social impact: A qualitative analysis*. Paper presented at 5th Annual Black Atlantic Community Conference, Wilberforce, OH.

Firmin, M., **Firebaugh, S.,** & Wantz, R. (2007, February). *The discussion of politics in general psychology textbooks.* Paper presented at the 10th Annual Conference of the American Association of Behavioral and Social Sciences, Las Vegas, NV.

Firmin, M., & **Firebaugh, S.** (2007, February). *A qualitative study of interracial dating among college students.* Paper presented at the 55th Annual Convention of the North American Association of Christians in Social Work, Dallas, TX.

Firebaugh, S., & Firmin, M. (2007, March). *Racism in interracial dating: A case study.* Paper presented at the 55th Annual Convention of the North American Association of Christians in Social Work, Dallas, TX.

Firebaugh, S., & Firmin, M. (2006, April). *Minority student experiences on a predominately Caucasian university campus: A qualitative research analysis.* Paper presented at the 3rd Annual Black Atlantic Community Conference, Wilberforce, OH.

Tse, L., Firmin, M., Hwang, C., & **Firebaugh, S**. (2006, April). *Parent and child views of interracial relationships.* Paper presented at the 22nd Annual Conference of the National Social Science Association, Las Vegas, NV.

Firmin, M., & **Firebaugh, S.** (2005, December). *Historical analysis of campus interracial dating.* Paper presented at the 2nd Annual International Conference on Social Science Research, Orlando, FL.

HONORS & AWARDS

ADEC Student Initiative Conference Scholarship, Association for Death Education and Counseling (ADEC), 01/14

The Bruce Shertzer Graduate Scholarship in Counseling, Purdue University, 03/12

Purdue Research Foundation Year-long Research Grant, Purdue University, 08/12- 08/13

Ross Fellowship Recipient (4-years of funding), College of Education, Purdue University, 08/08-07/12

National Dean's List inductee, 2005

Who's Who Among America's College Students inductee, 2005

PEO Sisterhood Academic Scholarship recipient, 2004

Academic Scholarship recipient*,* Cedarville University, 2002-2005

President's Scholarship recipient, Cedarville University, 2001-2005

USA Education/USA Funds academic scholarship recipient, 2001-2003

Leadership Scholarship recipient, Cedarville University, 2001

SERVICE & ENGAGEMENT

Program interview housing coordinator, Counseling Psychology Program, 01/13-02/13

Student Representative to the Faculty, Counseling Psychology Program, 01/12- 04/12

Big Sister, Big Brothers & Big Sisters program, 03/10-07/11

Program applicant interview coordinator, Counseling Psychology Program, 01/10- 02/12

Mentor to new students, 08/09- 05/11

Vice President, C &D Student Group, 08/09-08/10

Student recruiter, Counseling Psychology Program, 11/08-12/09

Member, Multicultural Group, Counseling Psychology Program, 09/08-08/09

Tutor for an international student, 09/08-02/09

Treasurer, C & D Student Group, 08/08 – 08/09

Member, C & D Student Group, 8/08 – present

Volunteer for Adopt-A-Grandparent program, 06/02-present

Nanny for professional household, 04/06-07/08

Youth Mentor for Greene County Juvenile Court, 10/05-10/07

REFERENCES

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