Kate Louise Obst and Clemence Due

Men's grief and support following pregnancy loss: A qualitative investigation of service providers' perspectives

Death Studies, 2021; 45(10):772-780

Men's grief and support following pregnancy loss: A qualitative investigation of service providers' perspectives

Kate Obst[*1] and Clemence Due[1]

[1]*School of Psychology, University of Adelaide, Adelaide, Australia*

* Corresponding author: kate.obst@adelaide.edu.au

The version record of this manuscript has been published and is available in *Death Studies* (10 Nov, 2019) http://www.tandfonline.com/10.1080/07481187.2019.1688430

Abstract

This study explores service providers' experiences of supporting men following a miscarriage or stillbirth in Australia. In-depth, semi-structured interviews were completed with seven service providers including midwives, grief counselors and social workers. Participants highlighted that, despite the individual nature of men's grief, there is a need to recognize and address the additional expectations and responsibilities that may compound their experience. Within an environment focused on women-centered care, participants described creative strategies and inclusive language to promote engagement of men. Further research exploring men's grief is needed to inform training and guidelines for healthcare professionals who work with bereaved families.

Keywords: men; pregnancy loss; miscarriage; stillbirth; grief

Introduction

Pregnancy loss, including miscarriage and stillbirth, affect millions of families worldwide. Definitions of loss by gestational age vary considerably across countries, making determining precise prevalence difficult. However, approximately 2.6 million stillbirths (defined as a loss occurring at or over 28 completed weeks of gestation) occur each year (Lawn et al., 2016), while miscarriage occurs in approximately 15-20% of all recognized pregnancies (Brier, 2008). International research has recognized the potential for high levels of psychological distress immediately following pregnancy loss at any gestational age, with significant distress occurring in approximately one in five parents (Cacciatore, 2013; Flenady et al., 2014; Murphy et al., 2014).

In countries including Australia, the United States (US), Canada, and the United Kingdom (UK), a number of guidelines have been developed to inform quality bereavement care practices and assist services providers in supporting families experiencing pregnancy loss (e.g., Flenady et al., 2018; Hendson & Davies, 2018; Hunter, 2016; Sands Australia, 2018; Queensland Clinical Guidelines, 2018). Sections within these guidelines that deal with psychological support consistently emphasize key themes including the importance of open and honest communication with both parents; using sensitive language; the need for empathetic and compassionate emotional care; and creating memories (e.g., seeing/holding the baby, providing mementos) that are in line with parents' individual wishes. However, despite the availability of supportive care guidelines, parents continue to report mixed experiences of support from the healthcare system, particularly in relation to a lack of sensitivity and compassion, appropriate information, and follow-up care (Bellhouse et al., 2018; Due et al., 2018; Downe et al., 2013; Gellar et al., 2010; Rowlands & Lee, 2010). The majority of guidelines also focus primarily on the experiences of heterosexual women, with few to no recommendations pertaining specifically to the experiences of bereaved men.

Similarly, early research into the psychological experience and grief of pregnancy loss focused almost exclusively on women, and concluded that women grieved more deeply than men (e.g., Peppers and Knapp, 1980). More recent quantitative studies comparing mothers' and fathers' grief have also typically found men to experience less intense and enduring emotional responses; thus potentially requiring less support (Beutel et al., 1996; Kong et al., 2010; Murphy et al., 2014; Rinehart & Kiselica, 2010). However, qualitative research involving men provides a more nuanced perspective, suggesting that men's grief experiences and support needs following pregnancy loss may differ in style – rather than intensity – to those of women (Armstrong, 2001; Bonnette & Broom, 2011; McCreight, 2004; Miller et al., 2019; Miron & Chapman, 1994; Murphy, 1998; Obst & Due, 2019; Wagner et al., 2018). For example, normative gendered expectations may lead men to actively suppress their grief, or to assume the role of 'supporter' and 'protector' to their female partners when in heterosexual relationships. These expectations can lead to expressions of grief which may therefore be more hidden or private, but do not necessarily require less support (Bonnette & Broom, 2011; Miller et al., 2019; Miron & Chapman, 1994; Obst & Due, 2019; Wagner et al., 2018). Such gendered expectations and subsequent hidden expressions of grief may also be exacerbated by, or lead to, a lack of recognition for men's grief from their social networks, including family, friends, and the wider community. Overall, a widespread lack of social recognition for men's roles in pregnancy and childbirth more generally have been found to lead others to downplay their position as a grieving father, in need of support (Bonnette & Broom, 2011; McCreight, 2004; Miller et al., 2019; Obst & Due, 2019).

While there is emerging evidence from men's perspectives with regard to their grief and support needs (e.g. Bonnette & Broom, 2011; McCreight, 2004; Miller et al., 2019; Obst & Due, 2019; Wagner et al., 2018) following pregnancy loss, it is essential to also explore the experiences of service providers including midwives, nurses, social workers, and grief

counselors. These health professionals play a crucial role in providing sensitive care and emotional support to bereaved parents, particularly as they are typically the first healthcare staff that parents will engage with if the loss occurs in a hospital (Bellhouse et al., 2018; Downe et al., 2013; Due et al., 2018; Edmond et al., 2019; Flenady et al., 2018; Martínez-Serrano et al., 2018; Nash et al., 2018). Previous research concerning healthcare professionals' experiences has identified a number of barriers to providing effective care to parents following pregnancy loss, including: lack of confidence, knowledge, training, and resources to deal with parents' needs; compassion fatigue; and systemic issues such as staff shortages and over-crowded hospital environments (Boyle et al., 2015; Edmond et al., 2019; Engel & Rempel, 2016; Kelley & Trinidad, 2012; Jensen et al., 2018; Modiba, 2008). Again, however, the vast majority of this research has focused on experiences of supporting women and not men, with only one other study to the authors' knowledge looking at service providers' perspectives and attitudes toward supporting men following pregnancy loss (McCreight, 2004).

Given the potential differences in grief and the lack of specific guidelines, then, it is perhaps unsurprising that men have frequently reported feeling forgotten or overlooked by both healthcare professionals as well as family members and friends following a pregnancy loss (Bonnette & Broom, 2011; McCreight, 2004; Miller et al., 2019; Murphy & Hunt, 1997; Obst & Due, 2019; Puddifoot & Johnson, 1997). However, there remains very little research exploring service providers' perspectives of providing support for bereaved parents following miscarriage and stillbirth, and working with bereaved men in particular (e.g., Boyle et al., 2000; Downe et al., 2013; Evans et al., 2002; Jensen et al., 2018). To address this gap, the present study aimed to explore service providers' experiences of supporting men following pregnancy loss, with a view to consider current and potential future practices when working with men whose female partners have experienced pregnancy loss. As such, this article

focuses particularly on two research questions: (1) how do service providers currently support men following pregnancy loss, and (2) what do service providers see as future support options?

Method

Participants

This study is part of a larger program of research involving men who have experienced pregnancy loss, with the findings from interviews with Australian men whose female partners have experienced pregnancy loss published previously elsewhere (see Obst & Due, 2019). Participants for the present study were seven service providers from Australian pregnancy loss support organizations and a large maternity hospital. Inclusion criteria were: 18 years of age or older, fluency in English, and experience providing formal care and/or support to men following a pregnancy loss in the last five years. Participants were two social workers, a parent supporter, a grief counselor, a nurse, a midwife, and an art therapist. They had an average of 12 years of experience working in grief and loss (range 2-20 years). One participant declined to provide her exact age, with the remaining participants aged between 35 and 57 (M = 48 years). All but one of the participants were Caucasian, and each had tertiary-level qualifications.

Procedure

Ethical approval was obtained by the University of Adelaide Human Research Ethics Committee on 13th of April, 2017, and by the Women's and Children's Health Network Human Research Ethics Committee on the 5th of July, 2017. Participants were recruited via advertisements distributed through local pregnancy loss support organizations, and relevant midwifery and obstetric units at the maternity hospital. Potential participants were asked to

contact the researchers to express their interest in the research, and each participant provided written informed consent.

Individual interviews were completed between April and August 2017. A semi-structured approach was used, with open-ended questions developed based upon previous literature as noted in the introduction, as well as initial coding of prior interviews completed with men as part of the wider program of research (Obst & Due, 2019). Example questions included: Can you tell me about your experiences of supporting men following pregnancy loss at your hospital/organization? What types of supports do you think have been most effective in supporting men following pregnancy loss? Are there any supports you think would be useful to men that currently aren't available? Interviews were an average of 38 minutes (range 20-55 mins) with recruitment continuing until data saturation was reached. This was determined at the seventh interview, as no new themes were identified – this is also in line with Braun & Clarke's (2013) suggestion that six to 10 interviews is sufficient for 'small' qualitative projects. Each interview was audio-recorded and transcribed verbatim by the first author using an orthographic method (Braun & Clarke, 2006; 2013). To maintain confidentiality, each participant was allocated a pseudonym, and all names and identifying features were removed from the interview transcripts.

Methodological rigor was enhanced through the use of Tracy's (2010) "Big-Tent" criteria for excellence in qualitative research. The first author kept an Audit Trail to facilitate data analysis and reflect on the quality of the interview process. All participants were also given the opportunity to engage in member reflections of their interview transcripts. Two participants accepted this offer, and did not request any changes. Finally, to promote the sincerity of the research, the process of self-reflexivity was engaged throughout the research process (Tracy, 2010). The first author does not have personal experience of pregnancy loss, and has no children of her own, which may have influenced the ways participants interacted

with, and responded to her questions. However, all participants expressed their enthusiasm toward being involved in the research, and their desire to contribute their experiences and expertise. The second author has experienced pregnancy loss and has three children. Given this, data analysis was approached from the authors' positions and perspectives as women both with and without experiences of pregnancy loss and children.

Data Analysis

Given the exploratory nature of the research aims, Thematic Analysis (TA) from a realist ontological position, which assumes reality to be independent from human knowledge and understanding, was used to analyze the data (Braun & Clarke, 2006; 2013). Interpretation and analysis of participants' interview data was thus perceived to be a direct reflection of their lived experiences, without attempting to apply further meaning beyond this. Analysis was conducted in two stages. The first involved a deductive approach in order to examine the data according to the research questions, with coding specifically conducted in relation to current practice in relation to providing support and potential future support options. Following this, the complete data set was analyzed using an inductive approach where additional themes were identified that sat outside these two research questions. All interviews were transcribed by the first author, who also completed the initial coding. This initial analysis was cross-checked by the second author, and the final thematic structure was developed and agreed upon through a collaborative process of discussions and refinement.

Results

In total, three themes were identified from the interviews, outlined below.

Gender, Grief and Support for Men: Tensions in Providing Bereavement Care

Participants indicated that having an understanding of potentially gendered expressions of grief was useful when offering services for men compared to women.

However, they also emphasized that grief is typically an individual experience, with reactions "dependent […] on many things" (Nicole, social worker), and therefore not always dictated by gender. Importantly, this variability meant that gender-specific stereotypes concerning how mothers and fathers might grieve, and their subsequent support needs, could be unhelpful when considering what support to provide:

> I try to say, look, it's not gender-specific, you know, these are styles of grieving […] I've got a father coming in later this morning and he's – well the wife is more the stoic [type] and he's more the expressive [type], and he's coming in for one-on-one counselling sessions. (Elise, grief counselor)

With this in mind, the importance of taking the time to understand men as individuals, with unique styles of grieving and subsequent support needs, was an essential consideration among participants' work with bereaved parents, and the resulting support that they offered.

However, despite noting that gendered expectations of men's reactions to pregnancy loss may be unhelpful when providing support, participants also highlighted that, generally, men do often face responsibilities and societal pressures that may conform to gendered expectations. For example, men may be responsible for caring for their (female) partner or other family members, as well as managing practical tasks associated with the pregnancy loss, or returning to daily life. In addition, many men have to return to work soon after a pregnancy loss, given the lack of leave available within most workplaces. Participants felt that these often gendered expectations can lead both the community and healthcare professionals to overlook men's grief and subsequent support needs:

> I think you still have the […] image of the men, the male being the protector. And so you often get a lot of people saying to the wife, "how are you?" But not many people

> say it to the husband, "how are you?" […] but the fathers do grieve as well, in their own way. (Jennifer, parent supporter)

As such, participants felt that there were common (and gendered) patterns in the support than many men do receive following pregnancy loss. However, participants who had been working in the bereavement space for many years also indicated that they had seen a slow shift in perceptions over time, towards recognition of the potential effect of pregnancy loss on men and their subsequent grief. For participants, this movement was particularly evident among younger people, who are more "capable of sticking up for themselves" (Ashley, nurse) and likely to voice their needs and actively seek support.

Overall, then, participants felt that while gendered expectations concerning grief for men were still prevalent amongst healthcare professionals, there was a trend towards greater recognition of the need to support men affected by pregnancy loss, as well as their female partners (in heterosexual couples).

Engaging Men in Services: The Importance of Inclusivity and Recognition in the Hospital Environment

Participants in this study focused much of their responses on hospital settings, noting that when staff are empathetic and engaged with parents' individual experiences and needs, "they develop a special bond" which remains "with them during the admission and in the delivery" (in the case of stillbirth; Rachel, social worker), and the time following the loss. However, participants also highlighted a number of challenges to providing effective support for bereaved fathers specifically in the hospital environment. For example, sometimes, "people are just not ready to open up" (Rachel, social worker) so soon after a miscarriage or stillbirth, and it can be difficult to build rapport in the often short time frame of a hospital stay:

> People don't allow just anybody into their lives when they're going through such a crisis like that. Like, sometimes they don't even have their family members there, and then we kind of present ourselves – [but we] don't know the client, we're total strangers. And so we do have to kind of be quite creative in how we engage them. (Nicole, social worker)

In relation to this theme of inclusivity, a key point raised by participants that of language use and the inclusion of both mothers and fathers in heterosexual couples in medical settings right from the start of the pregnancy. For example, as Ashley (nurse) stated:

> I think we have to change midwifery and obstetrics. We have to change, because [we] all just talk about 'the women'. The women this, the women that. You know […] when a woman suffers miscarriage – well actually, a couple suffers miscarriage […] until we change that language and actually acknowledge the loss at the coalface – well, we have to learn to do that.

Similarly, participants indicated that it was essential that hospital staff actively engage with fathers, since "the man is standing there, and they need to address both of them [parents]" (Elise, grief counselor). This includes taking the time to engage with men separately and individually, ensuring their grief and needs are validated, and that ongoing support options are clearly explained to them:

> …not just, 'oh here's a couple of brochures give them a call if you want'. But actually us being able to say, 'look this is what they provide […] this might be good for you, and this is the feedback that we've had from these services' and so forth. Whereas, if it's just kind of, 'here's a bit of a pack' […] you find that people just won't access those services on their own. (Nicole, social worker)

Overall, participants indicated that care following pregnancy loss – both inside and outside the hospital – is currently women-centric, given "the woman is the patient [who] delivers" (Rachel, social worker). In this environment, participants indicated that men can often be left feeling isolated, leading to a perceived lack of support options for themselves. For example:

> Initially you know, a lot of the men were like […] "oh, speak to [partner], this is happening to her" […] And, it's kind of like, no, no, we want to speak to both of you […] it's just about educating them as well, I think, to say, you know what? This is actually just as difficult for you as it is for your partner, it's still a loss for you […] I think they have this general thing about, you know, I don't want to take away from her, like feeling bad to make it about them. (Nicole, social worker)

In addition, and as noted by Nicole above, participants felt that men may feel as though they should focus on their female partners rather than seek support for themselves, further limiting the support that might be provided to men.

Finally, participants also noted that there were differences in support provided by the hospital for miscarriages compared to stillbirth. In particular, participants acknowledged that miscarriages receive less attention and follow-up:

> There's a lot more around the stillbirths or a genetic termination of pregnancy than miscarriage I would say […] they've got a great system here at this hospital where if it is a stillbirth or a termination of pregnancy they get lots of follow-up really, they come back for appointments to see us. Whereas if it's a miscarriage, just like a, you know, eight or ten week miscarriage, they get nothing. (Michelle, midwife)

Overall, then, participants felt that providing adequate support immediately in the hospital setting was important for men – although there is a need to do this with respect and

consideration for individual needs. Further consideration of how to support those who have experienced miscarriages rather than stillbirths in the hospital setting (if applicable) was also raised by participants.

Supports Tailored to Men: Rethinking Support Groups and Counselling

Outside the hospital environment, participants described a range of difficulties in engaging men in service access. In particular, participants noted that it could be "very threatening to sit in a group" (Elise, counselor), and felt that it was more common for women to attend support groups, which could be alienating for men. As such, participants felt that many men might be "very opposed to counseling" (Rachel, social worker), leading to the need to consider a range of support options to support individual needs, as also noted in the first theme above.

In particular, service providers highlighted that, since many men may focus on the question of "what can I do?" (Nicole, social worker), and may face a range of societal expectations concerning their role following pregnancy loss, a potential support option was to provide men with practical roles that also addressed their own support needs. For example, Laura (art therapist), who worked with bereaved parents to create mementos of their babies, often encouraged fathers to be actively involved in this process where they are present and comfortable to do so. She explained that allowing men to "take charge of [the baby's] hand and foot prints" provided them with both a tangible role and an essential space to connect with their baby following stillbirth. Participants also described a number of other strategies which they had used successfully, including male-specific "beer and pizza" support groups, providing counseling while going for a walk rather than face-to-face, and activity-based group supports (such as archery, camping, or go-karting). Many explained how the use of activity takes away some of the discomfort of a formal group or counseling setting, as "it's

the doing that then leads to conversation […] if they want to talk, they can" (Laura, art therapist).

In addition to considering diverse support options to support individual needs for bereaved fathers, and while also acknowledging that "not everybody needs counseling" (Elise, grief counselor), participants did highlight the importance of simply knowing that support was available following pregnancy loss. Follow-up efforts were identified as essential for men to realize that they hadn't been forgotten or overlooked. This could either be from the hospital, a support organization, or a general practitioner (GP), but needed to be directed specifically at fathers to ensure they feel affirmed and recognized:

> I think some sort of [follow-up] that is part of a checklist - that there is a way of engaging the father even if the father's not at the appointment […] the question is asked anyway, or their number is sought out and they are actually called to say 'how are you doing with this?' […] I actually think GPs don't know enough about grief and loss, and often the follow-up appointment is just the mother […] In actual fact, it should be seen as an appointment that's meant to be for the two of them, together. (Ashley, nurse)

Finally, and to facilitate the process of transition from the hospital to the community, strong relationships between hospital staff and support organizations were also identified as vital for supporting men. Elise (grief counselor) described how she had worked closely with hospitals over many years to establish close relationships with staff, while Jennifer (parent supporter) also described how she had delivered multiple educational sessions to hospital staff to raise awareness of bereaved parents' needs.

Discussion

This study explored Australian service providers experiences of working with men bereaved to pregnancy loss. Consistent with mixed findings on men's grief in previous

literature (e.g., Kong et al., 2010; Rinehart & Kiselica, 2010; Obst & Due, 2019; Puddifoot & Johnson, 1997; Conway & Russell, 2000), participants emphasized the need to work with bereaved men on a case-by-case basis, although they also noted tensions given the often gendered nature of expectations concerning grief following pregnancy loss. Research suggests that rather than subscribing to stereotypically 'masculine' or 'feminine' grieving styles, grief for each individual exists on a continuum between intuitive (emotion-focused) and instrumental (problem-focused; Martin & Doka, 2011). This study suggests that service providers typically felt that men's grief was more towards the instrumental side of the continuum (i.e., cognitive, problem-solving grief management), but that they nevertheless indicated that it was important not to assume grieving styles according to gender. Rather, service providers should tailor approaches according to individual need.

Previous studies from service providers' perspectives have identified a range of challenges relating to supporting bereaved parents in general in the hospital environment (e.g., Boyle et al., 2015; Engel & Rempel, 2016; Kelley & Trinidad, 2012; Jensen et al., 2018). This study confirmed similar difficulties, including the challenge of building rapport with bereaved men in the limited time frame of a hospital stay, and differences between supports following miscarriage (where hospital procedures are involved) as compared to stillbirth. However, participants also highlighted additional challenges in the hospital environment that were specific to supporting men. For example, some service providers noted that because men are not the primary 'patient' in the case of pregnancy loss, there are systemic barriers to providing services specifically to them in the hospital environment. This is an issue also noted in the wider palliative care literature, where although policies emphasize the need to support family members, a lack of 'patient' status limits the types of services which can be provided (e.g., Sealey et al., 2015; Breen et al., 2014). Nevertheless, the findings of this study suggest that – at the very least – men bereaved by pregnancy loss

that occurs in a hospital should be included in memorials and provided with details of appropriate support services.

Similarly to previous research on men's experiences following pregnancy loss (e.g., Bonnette & Broom, 2011; McCreight, 2004; Miller et al., 2019; Obst & Due, 2019; Puddifoot & Johnson, 1997), participants also identified that men often experience a lack of recognition for their own support needs. In this case, participants had to work harder to advocate for men's needs and promote engagement in available support services. Helpful strategies service providers employed in this space included providing men with tangible roles so that they could be supported, while also recognizing the likelihood of gender-specific expectations, such as that of organizing practical requirements associated with the stillbirth or miscarriage (e.g., assisting in memory-making activities). Participants also highlighted the importance of working in multi-disciplinary teams to facilitate the transition of support services from hospital to community. In that regard, participants also noted that any follow up appointments with GPs may only be with women – presumably because this visit is geared towards physical health checks. One possible support avenue for men may be GPs who are trained in grief support, with follow up visits possible for men as well as women.

In general, this research with service providers supports previous research concerning male help-seeking for stressful life events. This is particularly in relation to the tensions between normative expectations of masculine ideals and individual emotional responses, which can have negative implications for men's help-seeking behavior and engagement in health services (Addis & Mahalik, 2003; Galdas et al., 2005; Yousaf et al., 2013, 2015). For example, service providers noted that men can often be opposed to available support services, particularly grief counseling, a format of support which previous research indicates is also usually favored by women (Breen et al., 2019). Importantly, however, previous research has also shown that encouragement from others and discussion of grief or psychological distress

as a "normal" response to loss, can lead men to engage in support (Addis & Mahalik, 2003). Participants in this study similarly identified the essential need for ongoing efforts to validate men's grief and their need for support following pregnancy loss, given the current landscape of women-centered care which contributes to a lack of recognition for men's roles in maternity services. Along with the development of specific support options tailored to men, training programs for service providers are needed to facilitate this process, and promote understanding of the unique needs of men following loss. Importantly, previous studies have also acknowledged the emotional impact of caring for bereaved families on service providers, particularly on midwives and social workers (e.g., see Jonas-Simpson 2010; McCreight 2005; Nash et al., 2018; Wallbank & Robinson 2008). As such, any training programs should consider the impact of pregnancy loss on service providers themselves, including strategies for self-care.

It is important to note that this sample of service providers is limited in relation to diversity; they were all female and recruited from local pregnancy loss support organizations and only one public South Australian hospital. Nevertheless, data saturation appeared to be reached at the theme level and, as such, the results can be seen as representative of the experiences of this cohort of service providers. However, given the importance of research in this area, further research among support staff from a range of public and private hospitals and clinics is needed, along with generalized staff members who do not specialize in grief and bereavement, but provide support when required. In relation to miscarriage support more specifically, it would also be useful to explore the experiences of general emergency department staff, obstetricians, and general practitioners. Given the lack of specialized support identified by participants following miscarriage, these groups of professionals may be parents' only point of contact during their pregnancy loss. Overall, there remains a lack of comprehensive understanding of men's grief following pregnancy loss (Bonnette & Broom,

2011; McCreight, 2004; Obst & Due, 2019). Continued research in this area is required, including the experiences of under-represented populations such as culturally and linguistically diverse fathers, gay and transgender men, and other non-pregnant partners, such as in lesbian couples (Cacciatore & Raffo, 2011; Ellis et al., 2015; Peel, 2010; Roberts et al., 2017; Ziv & Freund-Eschar, 2014).

This study provides a contribution to the limited body of literature on service providers' perspectives of working with men following pregnancy loss, including suggestions for potential future support options. Findings highlight the ongoing need to further service providers' understandings of bereaved men's unique needs in the aftermath of loss, as well as developing male-specific support services. Services could potentially involve: including men in service provision concerning pregnancy from the beginning (where possible) so that where losses do occur they are already 'linked in' to services; using inclusive language that recognizes the central role of men as fathers in heterosexual couples; and considering alternative support options that may appeal to a broader range of men, including activity-based supports. As such, rather than completely reinventing the wheel in terms of support, it is essential to promote strategies that ensure men are actively engaged throughout the process of pregnancy, and early in their grief following subsequent loss. The study also points to the tensions men may face in societal expectations of their grief following pregnancy loss and expectations that they undertake practical tasks, support their partner, and return to work. Supporting men bereaved by stillbirth or miscarriage requires both challenging these expectations, as well as engaging with them so that men can be fully supported as individuals.

Acknowledgements: The authors would like to sincerely thank participants for their time given to complete the interviews.

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14. doi:10.1037/0003-066X.58.1.5

Armstrong, D. (2001). Exploring fathers' experiences of pregnancy after a prior perinatal loss. *MCN American Journal of Maternal and Child Nursing, 26*(3), 147–153. doi:10.1097/00005721200105000000012

Bellhouse, C., Temple-Smith, M., Watson, S., & Bilardi, J. (2019). "The loss was traumatic… some healthcare providers added to that": Women's experiences of miscarriage. *Women and Birth, 32*(2), 137-146. doi:10.1016/j.wombi.2018.06.006

Beutel, M., Willner, H., Deckardt, R., Von Rad, M., & Weiner, H. (1996). Similarities and differences in couples' grief reactions following a miscarriage: results from a longitudinal study. *Journal of Psychosomatic Research, 40*(3), 245-253. doi:10.1016/0022-3999(95)00520-X

Bonnette, S., & Broom, A. (2011). On grief, fathering and the male role in men's accounts of stillbirth. *Journal of Sociology, 48*(3), 248–265. doi:10.1177/1440783311413485

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

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

Breen, L. J., Aoun, S. M., O'Connor, M., & Rumbold, B. (2014). Bridging the gap in palliative care bereavement support: An international perspective. *Death Studies, 38*, 54-61.

Breen, L. J., Croucamp, C. J., & Rees, C. S. (2019). What do people really think about grief counseling? Examining community attitudes. *Death Studies.*

Brier, N. (2008). Grief following miscarriage: A comprehensive review of the literature. *Journal of Women's Health, 17*(3), 451–464. doi:10.1089/jwh.2007.0505

Boyle, F., Chapman, R., & Hancox, J. (2000). General practice care following miscarriage. *Australian Family Physician, 29*(3), 197.

Boyle, F. M., Mutch, A. J., Barber, E. A., Carroll, C., & Dean, J. H. (2015). Supporting parents following pregnancy loss: a cross-sectional study of telephone peer supporters. *BMC Pregnancy & Childbirth*, *15*(292), 1-10. doi:10.1186/s12884-015-0713-y

Cacciatore, J. (2013). Psychological effects of stillbirth. *Seminars in Fetal and Neonatal Medicine*, *18*(2), 76–82. doi:10.1016/j.siny.2012.09.001

Cacciatore, J., & Raffo, Z. (2011). An exploration of lesbian maternal bereavement. *Social Work*, *56*(2), 169-177.

Conway, K., & Russell, G. (2000). Couples' grief and experience of support in the aftermath of miscarriage. *British Journal of Medical Psychology*, *73*(4), 531–545. doi:10.1348/0 0 071120 0160714

Downe, S., Schmidt, E., Kingdon, C., & Heazell, A. E. P. (2013). Bereaved parents' experience of stillbirth in UK hospitals: a qualitative interview study. *BMJ Open*, *3*(2), e002237. doi:10.1136/bmjopen2012- 002237

Due, C., Obst, K., Riggs, D. W., & Collins, C. (2018). Australian heterosexual women's experiences of healthcare provision following a pregnancy loss. *Women and Birth*, *31*(4), 331–338. doi:10.1016/j.wombi.2017.11.002

Ellis, S. A., Wojnar, D. M., & Pettinato, M. (2015). Conception, pregnancy, and birth experiences of male and gender variant gestational parents: It's how we could have a family. *Journal of Midwifery and Women's Health*, *60*(1), 62–69. doi:10.1111/jmwh.12213

Edmond, T., De Montigny, F., & Guillaumie, L. (2019). Exploring the needs of parents who experience miscarriage in the emergency department: A qualitative study with parents and nurses. *Journal of Clinical Nursing*, *28*(9-10), 1952-1965. doi:10.1111/jocn.14780

Engel, J., & Rempel, L. (2012). Health professionals' practices and attitudes about miscarriage. *MCN: American Journal of Maternal and Child Nursing, 41*(1), 51-57.

Evans, L., Lloyd, D., Considine, R., & Hancock, L. (2002). Contrasting views of staff and patients regarding psychosocial care for Australian women who miscarry: A hospital

based study. *Australian and New Zealand Journal of Obstetrics & Gynaecology*, *42*(2), 155–160.

Flenady, V., Boyle, F., Koopmans, L., Wilson, T., Stones, W., & Cacciatore, J. (2014). Meeting the needs of parents after a stillbirth or neonatal death. *BJOG: An International Journal of Obstetrics and Gynaecology*, *121*, 137–140. doi:10.1111/1471-0528.13009

Flenady, V., Oats, J., Gardener, G., Masson, V., McCowan, L., Kent, A., & Khong, Y. (2018). *Perinatal Society of Australia and New Zealand clinical practice guideline for care around stillbirth and neonatal death. 3rd ed.* Perinatal Society of Australia and New Zealand.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, *49*(6), 616–623. doi:10.1111/j.1365-2648.2004.03331.x

Hendson, L., & Davies, D. (2018). Supporting and communicating with families experiencing perinatal loss. *Journal of Paediatrics and Child Health*, *23*(8), 549. doi:10.1093/pch/pxy134

Hunter, A. (2016). *Pregnancy loss and the death of a baby: Guidelines for professionals. 4th ed.* Coventry: Sands.

Jensen, K. L. B., Temple-Smith, M. J., & Bilardi, J. E. (2018). Health professionals' roles and practices in supporting women experiencing miscarriage: A qualitative study. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 1-6.

Kelley, M. C., & Trinidad, S. B. (2012). Silent loss and the clinical encounter: Parents' and physicians' experiences of stillbirth–a qualitative analysis. *BMC Pregnancy & Childbirth*, *12*(1), 137.

Kong, G. W. S., Chung, T. K. H., Lai, B. P. Y., & Lok, I. H. (2010). Gender comparison of psychological reaction after miscarriage—a 1-year longitudinal study. *BJOG: An International Journal of Obstetrics and Gynaecology*, *117*(10), 1211–1219.

Lawn, J. E., Blencowe, H., Waiswa, P., Amouzou, A., Mathers, C., Hogan, D., et al. (2016). Stillbirths: Rates, risk factors and potential for progress towards 2030. *The Lancet*, *387*, 587– 603. doi:10.1016/S0140-6736(15)00837-5

Martin, T. L., & Doka, K. J. (2011). Grieving styles: gender and grief. *Grief Matters, 14*(2), 42-45.

Martínez-Serrano, P., Palmar-Santos, A. M., Solís-Muñoz, M., Álvarez-Plaza, C., & Pedraz-Marcos, A. (2018). Midwives' experience of delivery care in late foetal death: A qualitative study. *Midwifery, 66,* 127-133. doi:10.1016/j.midw.2018.08.010

McCreight, B. S. (2004). A grief ignored: Narratives of pregnancy loss from a male perspective. *Sociology of Health and Illness, 26*(3), 326–350. doi:10.1111/j.1467-9566.2004. 00393.x

Miller, E. J., Temple-Smith, M. J., & Bilardi, J. (2019). 'There was just no-one there to acknowledge that it happened to me as well': A qualitative study of male partner's experience of miscarriage. *Plos One, 14*(5), e0217395.

Miron, J., & Chapman, J. S. (1994). Supporting: Men's experiences with the event of their partners' miscarriage. *Canadian Journal of Nursing Research, 26*(2), 61–72.

Modiba, L. M. (2008). Experiences and perceptions of midwives and doctors when caring for mothers with pregnancy loss in a Gauteng hospital. *Journal of Interdisciplinary Health Science, 13*(4), 29-40.

Murphy, F. A. (1998). The experience of early miscarriage from a male perspective. *Journal of Clinical Nursing, 7*(4), 325–332. doi:10.1046/j.1365-2702.1998.00153.x

Murphy, F. A., & Hunt, S. C. (1997). Early pregnancy loss: Men have feelings too. *Family Issues, 5*(2), 87-90. doi:10.12968/bjom.1997.5.2.87

Murphy, S., Shelvin, M., & Elkilt, A. (2014). Psychological consequences of pregnancy loss and infant death in a sample of bereaved parents. *Journal of Loss and Trauma, 19*(1), 56–59. doi:10.1080/15325024.2012.735531

Nash, M., Barry, M., & Bradshaw, C. (2018). Midwives' experiences of caring for women with early pregnancy loss in an Irish maternity hospital. *British Journal of Midwifery, 26*(12), 796-805.

Obst, K. L., & Due, C. (2019). Australian men's experiences of support following pregnancy loss: A qualitative study. *Midwifery, 70,* 1-6.

Peel, E. (2010). Pregnancy loss in lesbian and bisexual women: An online survey of experiences. *Human Reproduction, 25*(3), 721-727. doi:10.1093/humrep/dep441

Peppers, L. G., & Knapp, R. J. (1980). *Motherhood and mourning: Perinatal death*. New York: Praeger.

Puddifoot, J. E., & Johnson, M. P. (1997). The legitimacy of grieving: The partner's experience at miscarriage. *Social Science and Medicine, 45*(6), 837–845. doi:10.1016/ S0277- 9536(96)00424-8

Queensland Clinical Guidelines. (2018). *Queensland clinical guideline: Early pregnancy loss.* Queensland Clinical Health; May. Document No.: MN17.29-V5-R22.

Rinehart, M. S., & Kiselica, M. S. (2010). Helping men with the trauma of miscarriage. *Psychotherapy, 47*(3), 288–295. doi:10.1037/a0021160

Roberts, L., Montgomery, S., Ganesh, G., Kaur, H., & Singh, R. (2017). Addressing stillbirth in India must include men. *Issues in Mental Health Nursing, 38*(7), 590-599.

Rowlands, I. J., & Lee, C. (2010). "The silence was deafening": Social and health service support after miscarriage. *Journal of Reproductive and Infant Psychology, 28*(3), 274–86. doi:10.1080/02646831003587346

Sands Australia. (2018). *Sands Australian principles of bereavement care. 1st ed.* Box Hill: Victoria.

Sealey, M., O'Connor, M., Aoun, S. M., & Breen, L. J. (2015). Exploring barriers to assessment of bereavement risk in palliative care: Perspectives of key stakeholders. *BMC Palliative Care, 14*, 49.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837–851. doi:10.1177/1077800410383121

Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2013). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review, 9*(2), 264-276. doi:10.1080/17437199.2013.840954

Yousaf, O., Popat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men and Masculinities, 16*(2), 234-237. doi:10.1037/a0036241

Ziv, I., & Freund-Eschar, Y. (2014). The pregnancy experience of gay couples expecting a child through overseas surrogacy. *Family Journal, 23*(2), 158–166. doi:10.1177/ 1066480714565107