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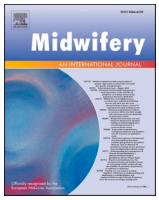

Encountering the health and social environment after a pregnancy loss: A grounded theory study from male perspective

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ABSTRACT

Aim: To develop an empirical model that explores and explains the social process of the encounters of men who suffered pregnancy loss with health and social environments.
Methods: A constructivist grounded theory method was performed, whereby 23 couples were interviewed using a semi-structured interview. Men that suffered pregnancy loss were analysed iteratively, with line-by-line and incident-to-incident coding, focused coding and axial coding, until data saturation and the emergence of theory.
Results: The theory *Behind bars that hide and mask them* illustrates the social process of the encounters of men who suffered pregnancy loss with the health and social environment. Social taboo and gender stereotypes could repress, marginalize, and hide men's feelings. This transposed into the healthcare setting, which focused on the physical aspects of the woman, and lacked an emotional approach, follow-up, and sensitivity. Men reported a lack of recognition or family and social support.
Conclusion: Many men report not feeling involved in the care process after pregnancy loss, in addition to the prioritisation of medicalised care, which can be explained by a medical paternalism approach. These results provide a basis to reflect and plan the inclusion of men for the provision of comprehensive and couple-centred care.
Implications for practice: Communication strategies and emotional management, self-reflection of health professionals, theoretical-practical content with a gender perspective in the training of nurses and midwives, involvement of the organisation and leadership, and further research is required.

Statement of significance

Problem or Issue

Lack of emotional care for men in pregnancy loss.

What is Already Known

Research has mainly focused on how pregnancy loss affects heterosexual women. But there hasn't been much research on how men experience it.

What this Paper Adds

An empirical model that explores and explains the social process of encounters between men who have suffered pregnancy loss in their encounters with the health and social environment has been developed.

Introduction

Involuntary pregnancy losses or voluntary losses after a foetal anomaly diagnosis leads to different, dynamic, and highly individualised responses, in which it is difficult to predict the significance of loss for any parent (Dias et al., 2017; Hutti et al., 2017). Evidence reports that such losses involve more than the *loss of a pregnancy*, and include the loss of a projected child, aspects of themselves, stage of life, a dream, and creation (Dallay, 2013). Parents may experience sadness, relief, or ambivalent feelings, and their expression or behaviour may be conditioned by factors and societal expectations, such as cultural, religious, or spiritual (Dallay, 2013; Fenstermacher and Hupcey, 2013; Worden,

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2018). Research has focused mainly on the pregnancy loss experience of heterosexual women; however, little research has focused on the experience of men, eventually transferring the experience of women over them (Due et al., 2017). However, current literature highlights the impact of gender expectations on the expression and behaviour of men, encouraging them to maintain a façade of stoicism or a strong and protective role, not enabling them to express themselves emotionally. Consequently, men are inclined to cry less, avoid talking about the loss, and to express increased anger (Due et al., 2017; Meaney et al., 2017). Therefore, feelings derived from the loss are supplementary to those caused by the struggle between expressing or suppressing their suffering to assume the role of 'supporter' for their partner and family (Armstrong, 2001).

In the development context of this study, previous literature demonstrated that physical loss suffering was added to the frustration of the idea of parenthood and the physical and emotional suffering of women (Fernández-Basanta et al., 2021a; Martínez-Serrano et al., 2019). Men were especially affected by the loss of a wanted pregnancy; however, when the pregnancy presented problems, the loss was a relief by exonerating them from making future difficult decisions. This suffering was often concealed within the social context. To cope, men incorporated the loss into their lives, turning it into pseudo-rational emotions. When interacting with others, they typically avoided or belittled their feelings and made light of the loss. This contributed to emotional outbursts and feelings of frustration, somatisation, emotional distance from the partner, and caused tension in their relationship (Fernández-Basanta et al., 2022).

These losses remain taboo and may be made invisible or unacknowledged by social and health environments, leading to insufficient health and social support (France et al., 2013; Heazell, 2016; Martínez-Serrano et al., 2019). However, emotional support beyond the moment of loss to bereaved parents is important and can have long-term implications for their well-being, especially in the absence of social support (Crawley et al., 2013; Downe et al., 2013). Due to their proximity to parents, nurses and midwives are key professionals in their care (Ellis et al., 2016). Further, statistics demonstrate a high probability that these professionals encounter a significant number of families who have experienced pregnancy loss (Heazell et al., 2019). However, these health professionals report that care remains a challenge due to the unsupportive organisational culture, lack of preparation or knowledge, and an emotionally demanding care. In particular, nurses and midwives report that connection with men is difficult. Moreover, physical care for women is detailed generally in clinical guidelines; however, the emotional approach depends usually on the involvement of health professionals (Fernández-Basanta et al., 2021b).

Accordingly, the question of how pregnancy loss experienced by men is relates to their health and social environment remain unanswered. The present study developed an empirical model exploring and explaining the social process of these encounters.

Methods

Research design

This qualitative study is part of a larger research project that investigated the experiences of women and men, as well as midwives and nurses after pregnancy loss. A constructivist grounded theory methodology developed by Charmaz (2006) was applied. It facilitates processes and new understandings of social interaction, based on empirical data and expressed in the form of a theory, to be explored (Glaser and Strauss, 2017). Using this approach, the unavoidable impact of personal experience and social network activity on the co-construction of shared realities was examined, in addition to providing a reflective framework to maintain awareness of these effects throughout the research process. Data collection, and data analysis and theory are kept in reciprocal relationships with each other, and an iterative process of constant comparison is followed within and between data cases, field notes, and memoranda of theory and researchers (Charmaz, 2011). This study complies with the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014).

The research team comprised trained qualitative researchers with experience in researching pregnancy loss from the perspective of parents, nursing, and midwifery. There was no previous relationship with the sample participants.

Sampling and participants

Sampling involved a purposive theoretical sampling strategy, where gynaecologists and midwives from the Gynaecology and Obstetrics Service initially collaborated in sample recruitment. They gave the parents an information flyer after the loss, with which they gave their consent for the researcher to contact them by telephone. During the first contact, the researcher and the couples set up appointments at times and places convenient to them. Subsequently, primary care midwives from Health Area in northwest Spain recruited women with a history of pregnancy loss following a process like that described previously. Eligibility criteria included female or male identity, couple or single status, pregnancy loss including miscarriage, pregnancy termination due to foetal anomalies, or stillbirth, and have been assigned to a specific healthcare area. Although for this study, only the results of the analysis of the experiences of men who suffered pregnancy loss are presented. Twenty-three experiences were obtained from twenty-two cisgender and white heterosexual men, since one participant experienced two losses during the study. Table 1 details the sociodemographic characteristics of the participants.

Data collection

Twenty-three in-depth interviews were performed (by SFB or MJMF) with couples using a semi-structured interview schedule that focused on both individual and shared experiences, facilitating the elucidation of tacit knowledge of their experiences (Table 2). Data were collected between 2015 and 2019, and interviews were performed primarily in the participants homes, or in an office workplace of the authors. Interviews were in Spanish or Galician. The average duration was 90 min, with interviews tape-recorded and transcribed by SFB. Anonymity was

Table 1
Sociodemographic characteristics of the participants.

Characteristic	Value
Sociodemographic Characteristics	
Age, mean (SD), years	37.45 (6.13)
Educational level, n (%)	
Lower secondary education	6 (27.3 %)
Upper secondary education	2 (9.1 %)
Post-secondary non-tertiary education	6 (27.3 %)
Short-cycle tertiary education	4 (18.2 %)
Higher Education (Bachelor's or master's level)	4 (18.2 %)
Full-time employment, n (%)	18 (81.8 %)
Nationality	
Spanish	22 (100 %)
Pregnancy loss Characteristics	
Type of loss, n (%)	
Miscarriage	17 (73.9 %)
Stillbirth	5 (21.7 %)
ToPFA	1 (4.3 %)
Previous loss, n (%)	4 (18.2 %)
Previous children, n (%)	7 (31.8 %)
Other information	
Included in an artificial insemination program	1 (4.3 %)
Ovarian stimulation prior treatment	1 (4.3 %)
Pregnant during the interview	2 (8.7 %)
Child and miscarriage after the stillbirth	1 (4.3 %)
Time between loss and interview, mean (SD), weeks	15.8 (35.7)

Abbreviations: Termination of pregnancy for foetal anomaly (ToPFA).

Table 2
Semi-structured interview script.

Thematic field	Examples of questions
Contextualisation of pregnancy loss	How has it happened? What did you feel? What has this loss meant for you?
Health support	What role did healthcare professionals play?
Family and social support	What role did your family play at that time? And your social environment? And now?
Returning home	How was the return home? Has your routine and family life changed?
Dealing with loss	How do you deal with the loss? Have you sought help on your own? What type?
Experience for the couple	What has this experience meant for the couple?
Experience at the time of the interview	How do you feel now? Do you keep any memento? Have you performed any act of farewell?

guaranteed, and audio recordings were destroyed using acceptable industry procedures. After the interviews, field notes were prepared and integrated into the transcripts to enrich data.

Ethics

The study obtained the approval of the Committee of Research Ethics of Galicia (registration code 2015/232) and access permission by the health area of Ferrol. All participants were informed orally and in writing about the voluntary nature of participation and the assurance of confidentiality during the research. All participants consented in writing to participate prior to the interviews. No participant withdrew their consent from the study.

Data analysis

Following interview transcription, coding line-by-line and incident-to-incident transpired. Initial codes were termed gerunds, and kept short, precise, analytical, and close to the data. Subsequently, and through constant comparison, the focused code was developed. Memos were produced during data collection and analysis to record analytical thoughts and ideas. Next, axial coding involved grouping codes with similar content into concepts with a higher level of abstraction, invoking provisional analytical categories. After the first 15 interviews, an initial framework was developed to organise the emerging categories. Theoretical sampling enabled deepening of the development of category properties, incorporating participants whose experience was not limited to the first weeks after pregnancy loss. Accordingly, this facilitated the testing and saturation of the categories. Coding was based on an abductive reasoning process. Categories were considered saturated when the collection of further data no longer provided new theoretical insights or revealed additional properties. This aspect involved a conceptual framework comprising three main topics.

The criteria outlined by Charmaz (2006) included credibility, originality, resonance, and usefulness. During the different analytical phases, periodic meetings were held between the authors (SFB, CC, and MJMF) to review coding, discuss the emerging analysis, and resolve inconsistencies, until consensus was reached. The iterative decision-making process during the research was collected through memos. The emerging theory was presented to clinical midwives before publishing, aiding in the verification of resonance and recognisability.

Results

The theory of *Behind bars that hide and mask them* (Fig. 1) explains the behaviour patterns of men in their encounters with health professionals and their social and family environment. This theory emerged from the results presented shows a man who is an intermediary between the woman who suffers the physical pregnancy loss and the social and health environment. In the metaphorical dialogue among these figures, the experience of women predominates, while the man's experience is imprisoned within it, represented in the form of a spring. The social taboo, represented in *the silence surrounding pregnancy loss*, contributed to the loss not being normalised, remaining secret or not discussed openly and deeply. In contrast, gender stereotypes conditioned the way in which men expressed their suffering and behaved with others. Given this, men found themselves oppressed and their suffering hidden and belittled.

Care not-centred on the suffering men reveals how the care of men that suffered a pregnancy loss is approached. In general, care prioritised the physical aspects of the loss over a comprehensive approach, excluding men from care. Furthermore, attention focused on the acute moment of loss, with the process and protocols largely insensitive. An

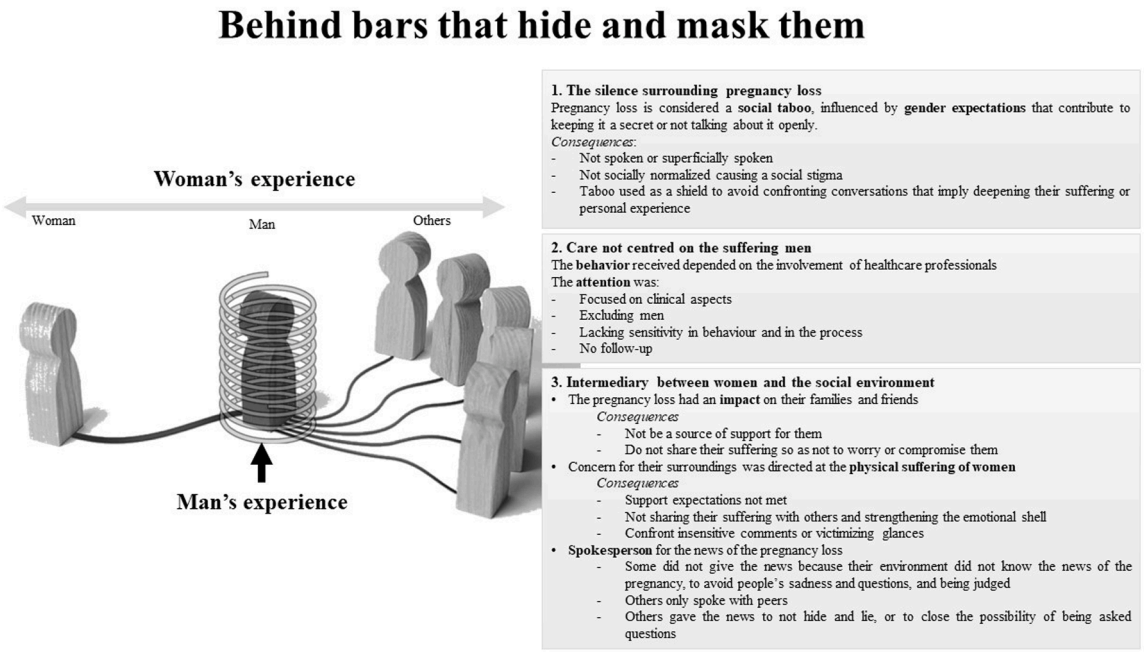

Fig. 1. Behind bars that hide and mask them.

individualised approach depended on healthcare professional involvement. Socially, the encounters with family and friends potentially contribute to the man being devoid of a space to express himself or share his suffering. *Intermediary between women and the social environment* presents the man's role in this environment. The impact of the loss on the family and close environment, or the lack of recognition of the man's suffering could mean that he did not receive the expected support, or that it was not shared in an attempt to prevent further hurt, in addition to facing insensitive comments or victimising glances. Informing those around them about the loss depended on whether individuals were informed of the pregnancy, to avoid their sadness, questions, or judgement, to be understood and their suffering to be acknowledged, to avoid hiding or lying about the loss, or to prevent potential questions.

The silence surrounding pregnancy loss

Men who have suffered pregnancy loss reported the silence surrounding it, referring to the social taboo and impact of gender expectations when communicating and expressing the loss. They recognised that their social environment avoided talking about the loss under the notion of not harming them through mention of the topic, which they considered as perpetuating the taboo towards these losses. Further, men expressed that gender expectations also contributed to not being deeply talked to about the loss, in particular regarding with how they were coping with it.

> *What I mean is that with my friends, the issue* [pregnancy loss] *was not discussed. That topic was never touched, you know? […] I believe that among men, there is no such thing as "What's up? What…?"* (H5_PL6)

This contributed to the fact that pregnancy losses were not socially normalized, and, therefore, that men were unaware of other cases of loss within their environment. In turn, feelings of loneliness and unfamiliarity arose in their personal experience, as this participant mentions:

> *At the hospital, they told us that this was more normal than what was known. In other words, there was noticeably more than known. What happens is that people try not to advertise it; that it is not something to celebrate and advertise, right? But hey … that is why less is known about it, and it appears as if it is rare in your own case and " impossible that you are affected." There is much more than you can imagine.* (H13_PL14)

However, for many, it was perceived as positive that they did not have to discuss and even reveal the loss to close people. Even when informing their family, the men avoided explaining or engaging in conversations that involved delving into their suffering or personal experience.

> *Let's see, starting from the basis that I think we can understand that, not only for us, but also globally, it is a somewhat taboo issue. I would even say that the fact of … well, thinking about that communication strategy, so to speak … It allows you not to have to face uncomfortable moments and conversations. […] I see it as relatively positive … I mean, I don't know if it is positive, but well, let's say that it would be a positive consequence the fact it being a taboo issue.* (H9_PL15)

Care not centred on the suffering men

The participants stated that the attention to the physical aspects of pregnancy loss was adequate, positively evaluating the rapid clinical attention, which reduced their concern. In many cases, they valued the attention received, emphasising the concern, humanity, and involvement of health professionals, and the opportunity of having moments alone and intimacy. This led to their expectations being exceeded and the participants rejected the initial idea of contracting private health insurance that would increasingly monitor the pregnancy or attend to any future pregnancy. Some participants highlighted that this depended on their assigned healthcare professional and was the consequence of a fortuitous circumstance, as stated by this participant:

> *It depends on the person you are assigned with. There are some who are very good, whereas there are others who required a kick in the teeth. But hey, I think we generally were quite lucky in this respect* (H14_PL18).

Essentially, participants highlighted the care provided by the midwives and gynaecologists who demonstrated their feelings and were emotionally involved, concerned about their emotional state, careful, and resolved their doubts. For some participants, these professionals helped deliver meaning to the loss, alleviating their suffering. They highlighted that when the health professionals were young and female, their involvement was greater, as this participant mentions:

> *I equate it to the attention you would have undergone if you had broken an ankle, right? They explain what you have and it's over. For example, "Look, you've broken your foot, rest for a month and that's it." With the exception… you see that the women* [women and young health professionals] *are younger, the excitement… I don't know, they are more involved. With the staff that are older or of seniority… they are a little more […] less involved, let's say* (H10_PL6).

Although the attention depended on the involvement of health professionals, attention was primarily focused on caring for the pregnancy and on the physical aspects of the loss. Consequently, the woman was prioritized or cared for exclusively. Many participants reported that emotional care during pregnancy and at the acute time of pregnancy loss was generally not prioritised. Therefore, the participants were relegated to the background, since the pregnancy loss only implied an emotional impact for them, unlike the woman.

> *But I notice that lack (of emotional care), not only when I get out of there. I notice it in the whole process. There is no one at no point in the process asking you "Do you have doubts? Do you want to talk more?" They don't.* (H7_PL7)

Especially in early pregnancy losses, some participants were not present at the time of the news of the pregnancy loss, feeling excluded from the attention, as this participant verbalises:

> *I was basically a companion. When I sat down, they didn't even look at me. In this case, I think it is leaving a little aside. I understand it in a way, because the one who really suffers is you* (women). *But we also have our little heart* (suffering)*, and from time to time…*(H4_PL10)

Care focused on clinical aspects was also evident in the follow-up, which, in most cases, was based on the ultrasound. In advanced losses, an emotional follow-up was performed especially by health professionals who were involved, highlighting primary care midwives.

The male participants believe that the cause of the more pronounced emotional detachment of health professionals in early losses, may be due to their accustoming to miscarriages and a protection mechanism. In addition to the false belief that having a previous child was able to shield health professionals from not offering that emotional support. In addition, in some cases, participants felt dehumanising attention towards their child or a lack of sensitivity in the medical reports, as this participant expresses:

> *The male midwife went with the bedpan, and besides, you could see how big it* [the foetus] *was, that it was something like that, and the male midwife went with his hand like that. The shape* [of the foetus] *could be seen. It was what I told her, they threw it in a garbage can […] The way the baby was carried out, I said "It* [the foetus] *was thrown in the garbage"* (H3_PL19)

Accordingly, many couples decided on a private gynaecologist for answers, to resolve doubts or receive increased attention, which they were not experienced in the public health system. Other health professionals were highlighted, such as psychologists or acupuncturists, who contributed to the emotional approach lacking in the public health system and aided in providing meaning to the loss.

Couples requiring hospitalization were mostly admitted to the delivery ward. This implied being in the close vicinity to pregnant women and audible babies, potentially leading to further suffering. The alternative was an admission to other services, such as gynaecology or surgery. This location steered the couples clear of the palpable memory of the loss but implied losing privacy by having to share a room with other patients or being away from the health professionals most suited to providing care in such situations.

> *For example, between being in that ward and with other professionals, I would rather stay in the ward with the professionals who attended me.* (H6_PL6)

Male participants demanded greater sensitivity by health professionals and other staff when accessing the room, for example, identifying the door with a symbol facilitating identification of rooms with a couple suffering pregnancy loss.

Intermediary between women and the social environment

Pregnancy loss not only impacted the couple but the entire family when the pregnancy was known and desired. In many cases, the loss resulted in the men being unable to vent or rely on their family and friends, as the loss was also difficult for them. As the following participant reported, relying on others meant posing a delicate and compromising situation to those who were helping them:

> *This also happened to me, being with someone, maybe not talking and, what you just said, putting them into a commitment. Not in a commitment but in a situation that is unpleasant. Because I put myself in the shoes of that person and would try to comfort him/her.* (H21_PL35)

In addition, participants reported being in the background in terms of the interest of family and friends for their well-being. Many accepted this position, as the family's concerns were primarily directed at the physical suffering of the woman. As a result, some participants did not observe that their expectations regarding family support were met, causing them to refrain from opening emotionally with others. In some cases, the participants only shared their suffering with their partner. Moreover, they had to face unsympathetic comments, which potentially belittled or minimised their loss, or glances and attitudes victimising. Meeting friends with children sometimes reminded participants of the loss and their longed-for parenthood:

> *Let's see, they always give you support, but, hey, sometimes listening to certain things is also worse than the encouragement they can provide you.* (H17_PL7)

Specifically, in advanced losses where it was visible to the social environment, the couple could receive a high number of home visits, forcing them to continuously explain and remember the loss, which increased the need to remain secretive regarding emotional details, making it difficult to manage their emotions:

> *And retelling and reliving it* [the pregnancy loss] *again and going back to… Maybe that also makes you put on an armour: "I'm going to retell how my son died." You have put on the armour to talk about this, that… So, it is to remember and reinforce that armour further. I realise that every time I retell the loss, it is an additional layer of an onion to reinforce, so that I cannot burst.* (H15_PL35)

The role of the men within their family and social environment was mainly as a communication link between the woman and others. The men announced the loss and were initially confronted with their environment. In early losses, couples could decide not to reveal the pregnancy loss. Among the causes, participants highlighted the ignorance of the news of the pregnancy by their environment, to avoid disappointment and sadness in their surroundings and questions with emotional involvement, and to avoid comments or judgement, although they highlighted that social pressure was worse for women, as this participant reported:

> *I told my boss, because, well, I ran out and explained, "Look, this happened." But I hear little groups, comments from other people, right? When they start talking about other people. Sure, I don't want that they talk about me, so no. They* [people at work] *comment that "It was difficult for her to get pregnant", "[…] Where is she going?" Sure, but they don't say "The husband, why not…"*(H10_PL6)

Others spoke of the loss only with individuals with the same experience because they felt understood and that their loss was not undervalued. Participants that told others of the loss made the decision so as not to conceal or lie, and to prevent the potential of being asked questions personally or to their partner:

> *I went to class on Tuesday mostly to warn them not to ask anything about stillbirth, that if we wanted to talk about it, we would have already. But they never asked.* (H18_PL20)

Discussion

The theory *Behind bars that hide and mask them* emerged as an explanation of the social process of the encounters of men who suffered pregnancy loss with the health and social environment. Our findings suggest that the taboo and gender stereotypes regarding these losses oppress, hide, and marginalise men. In this scenario, the physical aspects of women could be prioritised, whereas men were usually excluded, with insufficient sensitive care, and a general lack of emotional approach or follow-up. In social encounters, men tend to act as intermediaries between the family and the woman. They did not usually find support in others, which prevented them from sharing their suffering.

Our results highlight the existing taboo on pregnancy loss, as people did not generally know what to say and avoided talking about the loss. Most men expressed having felt supported by their social environment, but even so their child may not have been recognized nor their experience understood (Miller et al., 2019; Obst and Due, 2019). According to the literature and the findings of this study, it presumes the emergence of feelings of loneliness or misunderstanding (Due et al., 2017; Fernández-Basanta et al., 2020). Therefore, it is necessary that men are able to express themselves or obtain recognition, especially when this is not possible within their social environments, and professionals are required to provide this opportunity.

Furthermore, the results of the present study suggest the consideration of gender stereotypes by healthcare professionals in their encounters with men. Western gender norms promote unemotional, emotionally impaired, or stoic attitudes (Cacciatore et al., 2013; Reeser and Gottzén, 2018). Although hegemonic masculinity may be currently gradually changing, the essence of the old image still remains and impacts both men and social expectations (Johansson and Klinth, 2008; Premberg et al., 2011). In the transition to fatherhood, men may find themselves in the dilemma of dismissing hegemonic masculinity to becoming an emotionally committed father, versus the display of a typically hegemonic masculine stoicism to being a supportive partner and advocate (Draper and Ives, 2013). Therefore, some men were able to maintain emotional balance by not perceiving themselves in the fatherly role upon occurrence of the loss, while others deflected the emotional discomfort by considering the loss in biological terms, or not directing attention to themselves. However, others were able to recognise the suffering of loss and the end of their hopes and dreams (Fernández-Basanta et al., 2023; Williams et al., 2020).

Healthcare professionals need to be aware of men and their own attitudes towards gender stereotypes to avoid their repression. Furthermore, the existence of a hierarchy in terms of the recognition of suffering based on gender and gestational week in which the loss occurs is noted (Fernández-Basanta et al., 2020; Kofod and Brinkmann, 2017). For instance, assuming that those whose emotional manifestations are

more expressive, considering the woman as the suffering the most or assuming that advanced losses entail greater suffering, may exclude those who are not in those circumstances from care. It is vital that health professionals are aware of their prejudices and individualise care in each situation.

According to the literature, the preparation and attachment of men to the fatherhood role and connection with the baby begins during pregnancy (Aydin and Kabukcuoğlu, 2021; Wagner et al., 2018). Involving men in prenatal and maternity consultations and classes contributes to the generation of a bond with the future baby, and to begin to think and behave like a father (Burgess, 2008). However, with the current design of maternity services, the participation of men is promoted in the abstract and many men do not feel involved in the health aspect of the pregnancy. Little room remains for men to express their own concerns or fears, or to negotiate the terms and scope of their involvement in parenthood. Male participation medicalises their experience; however, without a health commitment, similar to that of women in terms of protecting their own health and well-being (Draper and Ives, 2013; Ives, 2014). Our results emphasise that this is transferred to pregnancy losses, in many cases perceived as guests but not as participants. Some healthcare professionals have been reported to recognise only women as the legitimate recipients of support in early losses and identified men as observers or even outsiders by default, (Williams et al., 2020). This could be explained by the predominant medical paternalism approach in Western medicine and obstetrics, which prioritizes the obstetric approach to the foetus over the women, and to a greater extent towards men (Newnham and Kirkham, 2019). Without any biological or pathological claim on the man's condition, they could feel excluded and lack recognition by health professionals and the process itself, as people whose paternity had been truncated. Accordingly, family-centred care that considers and supports couples in a comprehensive and individual manner is required, and should not be only limited to pregnancy losses, but from the first contact. However, this inclusion requires caution, as it can have a debilitating effect on men who may perceive the healthcare professional as an authoritative figure that cannot be challenged or negotiated (Draper and Ives, 2013).

Implications for practice

According to the above, establishing a bond with men needs to be reinforced, provides them with the security and confidence to express themselves with health professionals. Furthermore, involvement of the organisation and leadership is required that favours comprehensive care and provides resources to handle the emotional demands that this care implies.

Pregnancy losses are poorly addressed in childbirth education classes (Layne, 2003), perpetuating their concealment and not naturalization. This would justify the inclusion of pregnancy losses in childbearing education, although a balance between accuracy, realism, and not being an alarmist is imperative. Strategies, such as male facilitators in antenatal care programmes, can be successful in engaging other men.

In addition, reflecting one's own attitudes and prejudices that favour holistic care is required. Communication and emotional management skills must be strengthened from the university and continuing education of health professionals, especially registered nurses and midwives due to their close contact with these men. The transversal incorporation of theoretical-practical content with a gender perspective in the training of these professionals will facilitate developing gender sensitivity, making it possible to recognise, visualise, and address gender differences and inequalities.

Limitations and future research

The limitations of this study are in the sample and data collection. Data collection through couple interviews are a limitation due to the potential conditioning of the responses, although the wealth of data through favouring participation and the emergence of shared experiences would not be captured in individual interviews. However, the sample incorporates a participant who decided to have an abortion. Although there was a decision-making process, it was made based on a diagnosis of foetal anomalies that were incompatible with life and a certain failure of progress of the pregnancy. In addition, the sample is homogeneous in terms of cultural context, sexual orientation, and relationship status. Therefore, future research is required to provide greater heterogeneity regarding these aspects. Given the importance of the social context, deepening experiences in other cultural contexts to facilitate a broader vision of the phenomenon and, therefore, contribute to the practice and education of midwives and nurses, is imperative.

Conclusion

The theory *Behind bars that hide and mask them* provides an empirical model that explores and explains the social process of the encounters of men who have suffered pregnancy loss in their encounters with health and social environments. Men were faced with a scenario that did not enable the normalisation and visibility of these losses, and that their response to the loss was strongly oppressed and reviled by gender stereotypes. Therefore, healthcare was directed mainly to the physical aspects of women, whereas the man was excluded, care was insufficiently sensitive, and there was no emotional approach or follow-up. On a social level, the suffering of men was barely acknowledged, which perpetuated shielding behaviours when sharing or expressing themselves with others.

Accordingly, the involvement of health professionals, especially nurses and midwives, in approaching men is necessary, even prior to the loss, and in comprehensive support beyond women and clinical aspects. Undergraduate education for midwives and nurses should also strengthen the non-medicalisation of care during pregnancy or pregnancy loss.

These results provide a basis for reflecting and initiating the dialogue of the incorporation of men in caregiving, as well as providing the basis for future research, facilitating results in other cultural contexts and types of losses.

CRediT authorship contribution statement

Sara Fernández-Basanta: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Carmen Coronado:** Writing – review & editing, Validation, Supervision, Funding acquisition, Formal analysis. **María-Jesús Movilla-Fernández:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary materials

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