

**Adding More Layers to Loss: LGBTQ+ People's Experiences of Pregnancy Loss**

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## Conference Presentations

Rose, A (2020, September). “*Like dropping from a huge height*”: *LGBQ+ experiences of pregnancy loss*. [rapid oral presentation]. Annual SA Gender, Sex and Sexualities Postgraduate and ECR Conference, South Australia.

## Abstract

While reproductive technologies are facilitating the expansion of kinship possibilities for LGBTQ+ people, psychological supports are lagging for key aspects of reproduction such as pregnancy loss, which occurs in one-quarter of pregnancies in Australia. More knowledge about LGBTQ+ people's pregnancy loss experiences must be gained before effective support can be provided. This qualitative study contributes to such knowledge by exploring experiences of pregnancy loss and support through semi-structured interviews with 14 LGBTQ+ people, including gestational and non-gestational parents. Using thematic analysis four themes were generated to describe the factors that shape experiences of pregnancy loss for LGBTQ+ people: (1) pregnancy loss can only be fully understood in context; (2) the role of compassionate healthcare; (3) lack of identity recognition and discrimination compounds distress; and (4) seeking psychological safety and understanding in times of distress. Across themes, participants described multilayered experiences reflective of existing research on common aspects of pregnancy loss and added layers that, for LGBTQ+ people, travel alongside the more widely reported aspects. The additional challenges experienced throughout the journey of conception, pregnancy, and loss, compounded the distress experienced and highlighted the need for tailored resources and supports for LGBTQ+ people. This research illustrates how pregnancy losses can be experienced differently by different cohorts, particularly when normative reproductive practices are challenged. These findings have implications for how pregnancy loss can be understood in theory and addressed in practice. There are many avenues for future research, including the development of professional education programs relating to LGBTQ+ pregnancy loss.



## **Declaration**

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Signature

Alice Rose

September, 2020

### **Contribution Statement**

In writing this thesis, my supervisor conceived the initial idea and aims for this research project. My supervisor and I collaborated on the research question, ethics application, interview schedule and recruitment materials. I conducted a literature search and consulted with LGBTQ+ advocacy agencies and peer support groups to ensure appropriate language and consideration of any aspects pertaining to conducting research relating to marginalised populations. My supervisor promoted the study for recruitment purposes within their professional network and supervised the pilot interview to ensure the interview schedule was appropriate and to enable discussion about any necessary changes. I was otherwise responsible for the recruitment of participants, scheduling and conducting interviews and the transcription of those interviews. I conducted data analysis of the data with discussion with my supervisor regarding the final themes as is standard in qualitative research. I selected the participant extracts to be included, and I wrote up all aspects of this thesis.

Signature

Alice Rose

28<sup>th</sup> September, 2020

## Acknowledgements

Dedicated to the children I will never know and the courageous parents who mourn them.

*I daydreamed about our son and Hazel long before they were even conceived. With my son, I live my daydreams, and with Hazel my daydreams continue. She's older now. She's—she's—she understands what I say to her. Um because I talk to her all the time. I feel that she's definitely, definitely the one that is, um, it's like she's got this big hug over us. And she needs me to be her dad, but also, I get comfort from that too, so.... So, in that sense, our relationship has evolved, and I understand it. And it's my job to make sure people in my life that are important to me, understand it as well. (David, Lines 430-436)*

I would first and foremost like to thank my supervisor, Dr Melissa Oxlad, for their enthusiasm and guidance throughout this project.

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## CHAPTER 1

### Introduction

#### 1.1 Overview

Families are formed in diverse ways, and advances in reproductive technology are facilitating an accelerated rate of change (Dempsey, 2013a). Increasingly, families are being formed by sexuality and gender diverse people (Australian Bureau of Statistics, 2018; Power et al., 2010; Riggs et al. 2016). In Australia, approximately one-third of lesbians and 11% of gay men have children (Dempsey, 2013a, 2013b), and lesbian engagement in assisted reproductive technology (ART) services has increased by 15-20% annually since 2009 in the United Kingdom (UK) (Darwin & Greenfield, 2019). While family diversity is increasing, there is a paucity of psychological research into LGBTQ+ reproductive experiences including pregnancy loss (Darwin & Greenfield, 2019; Obst & Due, 2019) and there is no disaggregated data on LGBTQ+ pregnancy loss prevalence. However, pregnancy loss is common, with one in four pregnancies ending in miscarriage, and six babies stillborn each day in Australia (Australian Institute of Health and Welfare [AIHW], 2019).

Pregnancy loss is a devastating experience, as illustrated through research with cisgender heterosexual parents (Brier, 2008; Cacciatore, 2013; Obst & Due, 2019). The medicalisation of reproduction gives healthcare systems and professionals a significant role in heterosexual experiences of pregnancy loss (Due et al., 2018). For cisgender heterosexual women, healthcare professionals can have positive impacts by providing empathy and agency (Due et al., 2018; Redshaw et al., 2014) or adverse effects when emotional needs are overlooked alongside a focus on the physical process of loss (Basile & Thorsteinsson, 2015; Due et al., 2018).

Despite its high prevalence, pregnancy loss is rarely discussed, which creates barriers to support (Bellhouse et al., 2018; Rowlands & Lee, 2010). Heterosexual parents report

disparity between their intense grief and social expectations of grief after loss (Obst et al., 2020). The general lack of understanding, validation, and support following pregnancy loss can increase distress and reduce help-seeking (Bellhouse et al., 2018; Obst et al., 2020).

So far, just four psychological studies have been published on LGBTQ+ experiences of pregnancy loss; an international survey of non-heterosexual women (Peel, 2010), thematic analyses of interviews with lesbians (Wojnar, 2007), gay men (Riggs et al., 2015), and trans men (Riggs, 2020). These reveal that pregnancy loss has a significant impact on LGBTQ+ people's lives, and that conception investment and context may amplify grief (Peel, 2010; Riggs, 2020; Riggs et al., 2015).

Enhancing knowledge of LGBTQ+ people's experiences is vital to enable healthcare professionals to provide more effective services and support. The current research begins to address the knowledge gap by using inductive qualitative methodology to explore the experiences and support needs of LGBTQ+ people who experience pregnancy loss.

## **1.2 Definitions and Scope**

### ***1.2.1 Inclusive language***

Definitions and terminology are particularly important in this area of research because, historically, LGBTQ+ identities have been pathologised or rendered invisible through cisgenderism, heteronormativity, mislabelling and homogenising (Darwin & Greenfield, 2019). Distinctions between types of parents are contentious and often value-laden (Craven & Peel, 2017). Accordingly, this research used inclusive language and prioritised how individuals wished to define themselves throughout the research. The definitions of key terms are outlined in Table 1. Although there is no ideal, or even agreed, terminology in many cases (Craven & Peel, 2017; Strauss et al., 2017), care was taken to identify the most appropriate terms available where no unified terms exist. For more detailed information about key terms relating to sexuality and gender diverse individuals, please see

the scholarly works of Damien Riggs (2020) and Elizabeth Peel (2001, 2010), and The Safe Zone Project's (2018) glossary.

### ***1.2.2 Scope***

A person's LGBTQ+ status is only one aspect of their identity. This research acknowledged the intersectional nature of identities and how they influence experiences in different contexts (Chan & Howard, 2020; Rosenthal, 2016; Vaccaro & Koob, 2019). For example, ethnicity, ability, socio-economic status, citizenship, and age may also influence experiences of pregnancy loss and support (Turan et al., 2019). This research sought to investigate LGBTQ+ people's experiences of pregnancy loss using an experiential approach. However, unless intersecting identities were generated as a theme in the data, it would be beyond the scope of this thesis to report on how other aspects of participants' identities shaped their pregnancy loss experiences.

**Table 1***Definition of Key Terms Used*

Key term	Definition
Cisgender	Cisgender is a term used to describe people whose gender is consistent with their assigned sex at birth (National LGBTQIA+ Health Education Centre, 2020; Strauss et al., 2017).
Cisgenderism	Cisgenderism or cisnormativity refers to the assumption by individuals or institutions that everyone is cisgender, and assumes there are only two genders. Research that treats cisgender identities as the default and not needing to be explicitly acknowledged, marginalises and stigmatises trans and gender diverse people (The Safe Zone Project, 2018).
Heterosexual	Heterosexuals are people who consider themselves as being solely or primarily romantically or sexually attracted to members of another gender (The Safe Zone Project, 2018).
Heteronormativity	Heteronormativity is when heterosexuality is assumed and not required to be explicitly stated (National LGBTQIA+ Health Education Centre, 2020). This presumption leads to structural discrimination which privileges heterosexuals and marginalises and stigmatises people who do <i>not</i> consider themselves heterosexual (The Safe Zone Project, 2018).
Kinship norms	Kinship norms refers to socially shared understandings of what constitutes family. Kinship norms change across time and place (Peel & Riggs, 2016). Specific types of families or kin are represented as natural in contrast to other types of kin which may be contested, or wholly unrecognised by society (Riggs, 2020). As ways of forming families expand, heterosexual reproduction continues to retain its default status as “real”, “natural” and “normal”, leaving alternative forms of kinship as “other” or “illegitimate” (Riggs, 2020: p. 5).
LGBTQQIAPP+	A diverse range of identities short for lesbian, gay, bisexual, trans, queer, questioning, intersex, asexual, a-romantic, pansexual, polysexual (sometimes abbreviated to LGBT or LGBTQ+) but is an umbrella term intended to encompass gender diversity and sexual diversity. Sometimes this acronym is replaced with “queer.” Note that “ally” is not included in this acronym (National LGBTQIA+ Health Education Centre, 2020)

LGBTQ+	LGBTQ+ reflects the participants recruited for this research. The acronym includes gender diverse, an umbrella term that encompasses a range of genders including, but not limited to, gender nonbinary, gender non-identifying, gender fluid, genderqueer, transmasculine and transfeminine people who may or may not have had any gender-affirming surgery, commenced or be planning to commence a course of hormone replacement therapy (Strauss et al., 2017). In addition to gender diversity the acronym also includes sexual diversity including, but not limited to, cisgender people who are attracted to members of the same gender, attracted to more than one gender, people who identify as “queer”. People who feel unaccounted for by the definitions and identities represented in LGBTQ are also acknowledged through “+”.
Baby	The term "baby" is used in this study regardless of gestational age unless quoting a participant who chooses to use a different term (The Stillbirth Centre for Research Excellence, 2018). This reflects recommendations that healthcare professionals take a client-centred approach to language and recognise the parenthood of people who have lost a baby in pregnancy (Redshaw et al., 2014).
Parents	Individuals who have identified themselves as having familial bonds with their baby, through cultural, gestational and/or biological connections, including intended parents (Craven & Peel, 2014).
Gestational parent	For this research "gestational parent" will be used to describe any person whose body carried the pregnancy. <i>Synonyms: pregnant individuals</i> (Riggs, 2020), <i>gestational carrier</i> (Craven & Peel, 2017).
Gametes	This thesis uses the word gametes to refer to eggs or sperm. A conscious choice was made to avoid the term “biological parent” and to refer to biological contributions in terms of gestation or gametes. While existing literature often uses "biological parent" to exclusively describe the contribution of gametes, the term is fraught, not only because of the cultural value placed on biological kinship, with biological being culturally equated with "real" (Riggs & Peel, 2016), but also because of the inaccuracy of its assumed meaning when gestational carriers contribute biologically regardless of gametes, and the potentially distressing nature of referring to gender diverse gametes in gendered ways (Riggs, 2020).
Non-gestational parent	Parents who may or may not have contributed their gametes, and either have a partner who carried the pregnancy or engaged a woman to act as a surrogate (Collins et al., 2014). <i>Synonyms: social parent</i> (Demspey, 2013), <i>other mother</i> (McKelvey, 2014), <i>partner</i> (Craven & Peel, 2017).



Surrogate	Surrogacy is a collaborative form of reproduction, where a gestational carrier carries a pregnancy for intended, non-gestational parents. While surrogates are gestational carriers, they are not defined as parents (Gunnarsson-Payne et al., 2020).
Surrogacy	Surrogacy arrangements vary. Surrogates may contribute their own eggs in the case of “traditional surrogacy”, however, it is becoming increasingly common to use eggs from a donor, who may be anonymous or known to the intended parents, this is commonly known as “gestational surrogacy” (Gunnarsson- Payne et al., 2020). In altruistic surrogacy arrangements, legal in Australia, surrogates receive limited compensation for some expenses relating to pregnancy and birth (Everingham et al., 2014). Commercial surrogacy, illegal in Australia, involves compensation for expenses as well as additional payment (Gunnarsson-Payne et al., 2020). Commercial surrogacy may involve a third party such as a surrogacy agency who acts as a liaison between surrogates and intended parents. “Independent” or “private” surrogacy arrangements refer to agreements that do not involve surrogacy agencies.
Multi-parent families	A “multi-parent family” refers in this study to families formed between two sets of couples, for example, two gay cismen and two gay ciswomen conceive a child together. Multi-parent families have shared care arrangements so that children spend time with all four parents.
Pregnancy loss	Pregnancy loss refers to "the death of a baby at any stage in utero" (Obst et al., 2020: p. 3). The most common types of pregnancy loss are miscarriages (the death of a baby less than 20 weeks gestation, estimated to occur in one in every four pregnancies (Hure et al., 2012)), stillbirths (babies who die at 20+ weeks gestation or weigh more than 399 grams (AIHW, 2019)), and medically indicated terminations (Korenromp et al., 2005). The distinction between miscarriages and stillbirths varies widely internationally (for example, the World Health Organisation (WHO) defines stillbirth as pregnancy loss from 28 weeks gestation onwards and 1000 grams or above (WHO, 2020)).

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### 1.3 LGBTQ+ Families

LGBTQ+ people tend to experience daily stressors resulting from their non-normative gender or sexual diversity (Ali & Barden, 2015; Leblanc et al., 2015; Meyer, 2003; Nadal et al., 2016; Peel, 2001). These stressors relate to navigating issues of visibility, conflict, policy and employment-related discrimination, physical and verbal assaults/threats, internal conflict or internalised heteronormativity, and microaggressions and misunderstandings (Nadal et al., 2016). Consequently, LGBTQ+ people face increased risk of mental health issues, including greater severity of anxiety and affective disorders (e.g., Ehlke et al., 2020; National LGBTI Health Alliance, 2020; Keating & Muller, 2020). Overlaid upon these individual experiences of gender and sexuality, the sphere of kinship holds additional challenges for LGBTQ+ people.

As fertility barriers decrease, reproductive health decisions made by LGBTQ+ people are challenging long-held Western-societal norms regarding families and kinship (Allen & Goldberg, 2020; Riggs & Peel, 2016), but heteronormative models of family persist (Perales et al., 2020; Riggs et al., 2016; Webb et al., 2018, 2020). The perceived legitimacy of LGBTQ+ families in Western countries varies, and an emphasis on the importance of biology in the context of family is negatively correlated with community support for LGBTQ+ families (Riggs & Due, 2018). Beyond individually directed attacks, same-sex parents experience *added* discrimination when the “family” aspect of their identity is salient, likely evoked by perceived illegitimacy of LGBTQ+ families (Haines et al., 2018; Nadal et al., 2016).

Internalised kinship norms and biological limitations can make family formation decisions more difficult for LGBTQ+ people (Riggs, 2020). Non-normative reproduction often requires the reconsideration of what constitutes a “real family” (Chapman et al., 2012; Riggs, 2020, Walks, 2004). Same-sex couples must navigate complex decision making such as who will

contribute gametes, who will carry the pregnancy, and whether future siblings will be biologically related (Dempsey, 2013b; Lindheim et al., 2019). The number and complexity of these choices are often unacknowledged (Holley & Pasch, 2015; Peel, 2010).

Multi-faceted decisions regarding altruistic or commercial surrogacy arrangements are complex (Everingham, et al., 2014; Gunnarsson-Payne et al., 2020; Lindheim et al., 2019; Navarro, 2020). In Australia, it is currently illegal to engage in overseas surrogacy in the states of Queensland, New South Wales (NSW), and the Australian Capital Territory (ACT) (Department of Home Affairs, 2020). Despite a 277% increase in overseas surrogacy between 2009 and 2011 and a stable number of altruistic Australian surrogacies, research on Australian experiences is limited (Commonwealth of Australia, 2016; Dempsey, 2013b; Riggs & Due, 2010; Riggs et al., 2015).

The legitimacy of LGBTQ+ family formation can often be contested at the reproductive stage. Assisted Reproductive Technology (ART) clinics and maternity contexts increase the need for gender and sexuality disclosure, and as such, LGBTQ+ people are often more vulnerable to discrimination (Ali & Barden, 2015; Baldwin et al., 2017; Bejakovich & Flett, 2018; Doan et al. 2019; Holley & Pasch, 2015). Though LGBTQ+ access to ART is increasing (VARTA, 2019), Western Australia, Queensland, NSW and the ACT – still allow clinics to refuse same-sex couples treatment, and feminist bio-ethnography on women's miscarriage experiences in the UK found that heteronormativity pervades reproductive healthcare (Peel & Cain, 2012).

In sum, LGBTQ+ people face challenges of individual and family-based discrimination (Haines et al., 2018), complex reproductive decisions (Lindheim et al., 2019), and variability of community and legislative support for family diversity (Riggs & Due, 2018; Webb et al., 2020).

These challenges may increase the stressful context in which LGBTQ+ people then experience pregnancy loss, potentially compounding distress.

## **1.4 LGBTQ+ Experiences of Pregnancy Loss**

### ***1.4.1 Lesbian and bisexual ciswomen's pregnancy loss***

A literature search into lesbian and bisexual ciswomen's experiences identified two papers (Peel, 2010; Wojnar, 2007). A qualitative study of 10 American lesbian couples' miscarriage experiences identified that grief could only be fully understood when considering the substantial efforts that lesbians undertake to conceive (Wojnar, 2007). Following this, an international mixed methods study of lesbian and bisexual women's experiences of pregnancy loss found amplification of loss due to the "work" involved in conception and the level of investment in their unborn baby (Peel, 2010).

### ***1.4.2 Gay cismen and pregnancy loss***

Australian research into gay men's surrogacy experiences (Riggs et al., 2015) found that offshore surrogacy arrangements had particular impacts on gay men, who in general needed support and involvement in all aspects of the process. Surrogacy agencies provided services without adequate emotional support for parents (Riggs et al., 2015). This gap between the needs of intended parents, and offshore agency services, increased parents' distress when pregnancies were lost (Riggs et al., 2015).

### ***1.4.3 Transmasculine, transfeminine and non-binary pregnancy loss***

Transgender parents are at higher risk of discrimination and minority stress than sexually diverse cisgender people (Ellis et al., 2015). Some transmasculine people experience a sense of possibilities and efficacy of their bodies through the act of conception (Hoffkling et al., 2017; Riggs et al., 2020). However, other transmasculine people may experience loss as a betrayal of

their bodies for not “successfully” carrying a pregnancy to term (Ellis et al., 2015; Riggs et al., 2020). Research into transmasculine experiences highlights the importance of friends due to a lack of both formal and family supports following transmasculine pregnancy loss (Riggs et al., 2020). No research into transfeminine or non-binary experiences was identified.

## **1.5 Emotional and Psychological Support Following Pregnancy Loss: How Cultural Norms**

### **Shape Support**

Kenneth Doka's (2002, 2008) theory of disenfranchised grief has influenced psychological understandings of pregnancy loss and support. Normative expectations of grief and grieving can significantly impact people experiencing pregnancy loss (Obst et al., 2020). Cultural “rules” that dictate who should grieve, when and how, are often internalised so that people try to regulate their thoughts and feelings (Doka, 2008; Kauffman, 2002).

Disenfranchised grief occurs when grief falls outside social “rules” and lacks acknowledgement or social validation (Doka, 2002). With pregnancy loss, this disenfranchisement can lead to increased distress (Bellhouse et al., 2018). Grieving rules extend beyond intrapersonal experiences to shape interactions, support structures and workplace policies (Doka, 2002).

Psychological research into grief and disenfranchisement following pregnancy loss has thus far focused on heterosexual, cisgender people (Lisy et al., 2016; Peters et al., 2016). For example, a systematic review of men’s experiences of pregnancy loss found that their grief does not exist in isolation, but is impacted by interpersonal, community, and public policy factors (Obst et al., 2020). Factors impacting grief experiences include cultural expectations of men’s emotional displays, and their assumed role as a supporter of their pregnancy carrying partner (Obst et al., 2020). Along with limiting social recognition, these cultural expectations are often

internalised, leading to a double disenfranchisement from grief (Due et al., 2017; Obst et al., 2020; Redshaw et al., 2014; Riggs et al., 2018; Story-Chavez et al., 2019).

The limited support reported by heterosexual people experiencing pregnancy loss due to grieving norms may be limited further for LGBTQ+ people due to family norms, leading to a “double taboo” (Collins et al., 2014) and the further erosion of support for LGBTQ+ people following pregnancy loss (Collins et al., 2014; Doka, 2008). Experiences of discrimination, by healthcare professionals who have the *potential* to provide support, further compound distress (Riggs et al., 2014; Saxby et al., 2020). However, healthcare professionals who engage with LGBTQ+ people with compassion can have a positive impact (Riggs et al., 2014, 2015). This has led to a call for specific LGBTQ+ services and for increased education regarding assisting LGBTQ+ people within existing services (Bethel, 2010; Holley et al., 2015; Nash, 2014; Walks, 2004).

Current support services and clinical care guidelines for people experiencing pregnancy loss draw on psychological literature to inform best practice (Commonwealth of Australia, 2018; Queensland Health, 2018; SA Health, 2019; SANDS, 2018). Psychological researcher’s focus on heterosexual relationships limits healthcare professionals’ ability to support LGBTQ+ people. For example, while Australian guidelines for care following stillbirth and neonatal death have been revised (Flenady et al., 2020), they fail to acknowledge LGBTQ+ people and their care needs.

Psychology, as a respected discipline, has a responsibility to be inclusive in research and the application of research (Australian Psychological Society [APS], n/d). Without investigating LGBTQ+ people’s experiences of pregnancy loss, psychology cannot make recommendations of best practice for LGBTQ+ needs, and organisations and healthcare professionals who draw on

psychological research remain limited in their capacity to support LGBTQ+ people following pregnancy loss.

### **1.6 Aims and Research Question**

For LGBTQ+ people, the distress caused by pregnancy loss could be exacerbated by many factors. Individual stressors, kinship norms and family legitimacy, and discriminating surrogacy and ART legislation may add to LGBTQ+ people's experiences of pregnancy loss. These factors may also provide barriers to effective support for LGBTQ+ people following loss. Together these factors underscore the urgent need to learn more about LGBTQ+ people's experiences of pregnancy loss and identify opportunities for optimal support.

This thesis aimed to bring LGBTQ+ voices to the fore to fill an important gap in the understanding of the experiences and needs of LGBTQ+ people following pregnancy loss. Accordingly, this research addressed the question: What are the experiences of pregnancy loss and support for LGBTQ+ people? This question was investigated using a qualitative inductive approach, allowing for the exploration of lived experiences of LGBTQ+ people. This research may inform healthcare guidelines, resources, and professional development programs about the support needs of LGBTQ+ people following pregnancy loss.

## CHAPTER 2

### Method

#### 2.1 Participants

People aged 18 years or older, fluent in English, who did not consider themselves cisgender *and* heterosexual were eligible to participate. Individuals who had experienced pregnancy loss less than six months ago or pregnant during study recruitment were excluded to minimise distress. Individuals who experienced pregnancy loss more than ten years ago were excluded as LGBTQ+ conception laws and technologies have changed considerably over time.

Pregnancy loss could include ectopic pregnancies, miscarriage, medically indicated termination and stillbirth. Participants could be gestational or non-gestational parents, including those engaging in surrogacy. While invited, no intersex or asexual people participated.

Participants were 14 LGTBQ+ people who had experienced pregnancy loss (see Table 2). Participants ranged from 30 to 60 years of age ( $M = 40$  years), residing in metropolitan areas of NSW, Victoria, Queensland, South Australia, and England. All participants were in long-term relationships. Two participants were a married couple in the same household. Five participants had experienced pregnancy losses while engaging in altruistic or commercial surrogacy, which occurred in Australia, Canada, the United States of America, India, Cambodia, and Thailand. One participant also experienced pregnancy loss as part of a multi-parent family. The time since pregnancy loss ranged between eight months and ten years ( $M = 3.5$  years). Some participants experienced multiple losses within one year.



**Table 2***Participant Information*

Pseudonym	Age	Gender	Sexuality	Ethnicity <sup>a</sup>	Religion	Types of loss	Time since loss	Living children
Edward	54	Cis-male	Gay	Caucasian/ Indigenous	Anglo	Miscarriages	8 & 10 years	5
Cate <sup>b</sup>	36	Cis-female	Non- identifying.	Anglo-Celtic	None	Miscarriage	3 years	0
Emma	37	Cis-female	Lesbian /Gay	White	Catholic	Miscarriages	2 & 4 years	3
Mark	36	Cis-male	Gay	White	-	Miscarriage	4 years	2
Elizabeth	30	Cis-female	Queer	White	Christian	Miscarriage & ectopic	2 & 3 years	0
Isabella	35	Cis-female	Bisexual	-	None	Miscarriages	4 & 2 years	2
James	60	Cis-male	Gay	-	Agnostic Non-practicing	Miscarriage & stillbirth	8 & 9 years	2
Maryanne	34	Cis-female	Non- identifying	Aboriginal- Mixed	-	Miscarriages	5 & 6 years	2

Pseudonym	Age	Gender	Sexuality	Ethnicity	Religion	Types of loss	Time since loss	Living children
Tom	56	Cis-male	Gay	Anglo-Celtic	Presbyterian	Miscarriage & ectopic	2 years	1
Elanor	39	Cis-female	Queer	Anglo-Australian	-	Miscarriages	2, 3 & 4 years	0
Alex	34	Trans/non-binary	Queer	Greek-Australian	Catholic	Miscarriages	8 months & 1 year	0
Charlotte	30	Cisgender female	Gay	English	Agnostic	Miscarriages	8 months & 1 year	0
David	47	Cisgender male	Gay	4 <sup>th</sup> generation Australian	Non-practicing Catholic	Ectopic & stillbirth	2 & 4 years	1
Gillian	41	Cisgender female	Gay	Irish	Atheist	Miscarriages	8 months & 1 year	0

Note. <sup>a</sup> With the intention to empower participants to decide their own identities (Flanders et al., 2017), and people's varying preference of language used, this table reflects the specific cultural identities nominated by participants.

<sup>b</sup> This participant did not identify with any of the *specific* LGBTQ+ categories but was in a relationship with a cisgender woman. It is important that each participant is identified in the way in which they choose, rather than assigning them an identity.

## 2.2 Theoretical and Methodological Background

Historically, positivist informed research has erased and pathologised LGBTQ+ identities (Clarke & Peel, 2007; Darwin & Greenfield, 2019). This century psychological researchers have begun to undertake LGBTQ+ inclusive research across psychological domains (Callaghan et al., 2015; Clarke et al., 2002; Clarke & Peel, 2007; Peel 2010; Riggs, 2007, 2020; Riggs & Coleman, 2014; Riggs & Due, 2018) and have extended their collaborations to include sociologists (Nash, 2014) and anthropologists (Craven & Peel, 2014). The current study draws upon these critical psychological perspectives.

Clarke and colleagues' (2002) critique of sameness and difference research on lesbian parenting is relevant to the research. Rather than creating a dichotomy which homogenises LGBTQ+ people's experiences, the current study adopted an experiential and inductive qualitative approach. All data about LGBTQ+ people's experiences of pregnancy loss, *including* comments found in heterosexual, cisgender literature, were coded for analysis.

## 2.3 Procedure

The University of Adelaide Human Research Ethics Committee approved this research (Approval Number: H-2020-025). This study sought to be as inclusive as possible; participants from across LGBTQ+ communities were invited to participate. The APS's (2014a, 2014b) ethical guidelines for working with gender and, or sex diverse clients, and lesbian, gay and bisexual clients, The National LGBTI Health Alliance, AIDS Council of NSW (ACON), Intersex Human Rights Australia, and Intersex Peer Support organisations were consulted regarding language and inclusivity (see Appendix A).

To recruit participants, flyers (Appendix B) were emailed to local and national support organisations including those relating to LGBTQ+ conception, surrogacy and parenting, LGBTQ+ mental health, pregnancy loss support and perinatal mental health. From the organisations approached Benson Radiology, Bfriend, Domestic Violence Resources and Self Care Hub, Family Fertility Centre, Infertility Support Group Australia, Lifeline, Perinatal Anxiety and Depressions Australia, Pink Parenting, Pride Club of the University of Australia, Pride Infertility Support Group, Rainbow Email Network (SA Health), Rainbow Families Australia, Red Nose, SANDS, Still Aware, Stillbirth Foundation Australia, Surrogacy Australia & Growing Families all promoted the study through their networks. Additionally, fertility specialists and infertility clinics throughout Australia, and members of the Australian and New Zealand Infertility Counsellors Association were contacted to aid with recruitment.

Potential participants were invited to contact the researcher, who then sent them the Information Sheet (Appendix C) and Consent Form (Appendix D). No direct approaches were made to potential participants; however, passive snowball sampling was employed.

Interviews were arranged with eligible participants, who were informed that their participation was voluntary, they could choose not to answer particular questions and were free to withdraw from the research until data analysis began. Consent was obtained in writing or read verbatim and audio-recorded immediately before the interview.

To appropriately address the research question, an inductive qualitative approach to data collection was adopted. Semi-structured interviews allowed participants to share information they felt relevant, rather than being directed by the researcher. The interview schedule (Appendix E) was developed by adapting existing questions relating to pregnancy loss (Peel, 2010; Obst &

Due, 2019). Interviews commenced with demographic questions, and the AIDS Council of NSW (ACON) gender and sexuality question template (Appendix F). After demographic data were collected, the interview schedule continued with the question: “Could you please tell me a little about your experience of pregnancy loss?”. Follow-up prompts were used where appropriate.

All interviews were conducted between March 13<sup>th</sup> and July 2<sup>nd</sup> 2020. One interview was held face-to-face on March 19<sup>th</sup>, and all subsequent interviews were conducted via telephone or Zoom. A pilot interview was conducted on March 13<sup>th</sup>, with the research supervisor present, to assess the interview schedule and prompts. Following the interview, one prompt was added, and slight adjustments were made to how demographic questions were asked. As no other changes were made, this interview was included in the final analysis. All interviews were audio-recorded and ranged between 47 minutes and 127 minutes in length (M= 87 minutes).

As per Tracy’s (2010) ‘Big Tent’ criteria for excellence in qualitative research, an audit trail was established to document the research process, including communication with participants and noting researcher reflections throughout the research. An iterative approach to data analysis was taken, with sequential analysis and comparisons made between each interview and previous interviews to identify when saturation, that is, no new information relating to the research question was identified within the new data (Guest et al., 2006), was reached. Saturation was reached after 12 interviews. However, given the diversity of the sample, two additional interviews were conducted; no new themes were identified. Despite sample diversity, data were similar; the final themes appear representative.

Interviews were transcribed by the researcher using orthographic transcription to assist with immersion in the data (Braun & Clarke, 2013). Each participant was then allocated a pseudonym, and transcripts were deidentified with one exception: a participant who expressly wished their deceased daughter to be named to honour them.

To ensure credible research (Tracy, 2010), each participant was emailed a copy of their transcript for feedback; all 14 participants verified their transcript, and no changes were required. Following initial data analysis, candidate themes were sent to six self-nominated participants for “member reflections” (Tracy, 2010), which enhanced the credibility of the findings by allowing participants to collaborate. Three participants responded; all were happy with the candidate themes. All participants elected to receive a summary of the findings.

As sincere research occurs from the process of self-reflexivity (Tracy, 2010), the researcher was conscious to reflect throughout the research. As a queer parent with two children surrogacy, or gender dysphoria, the researcher was mindful to avoid disclosure to limit influences on participant responses. Understanding that one’s experiences can also influence data analysis (Braun & Clarke, 2013) the researcher reflected on the issues of power and vulnerability inherent in both the data content and between researcher and participant (Ryan-Flood, 2010). The researcher’s ontological understandings of reproductive biomedicine and perinatal mental health have been influenced by critical psychology, as well as authors beyond the psychological community, such as Adrienne Rich (1986). These understandings may have influenced the researcher’s perspective of the context in which participants’ accounts took place.

## 2.4 Data Analysis

Data were analysed using thematic analysis (Braun & Clark, 2006, 2013, 2019). The researcher treated participant accounts as providing access to information while also allowing for underlying and latent patterns to be identified (Braun & Clarke, 2013). Data analysis occurred via six steps (Braun & Clarke, 2013). Each transcript was read several times by the researcher to assist with familiarisation and immersion. A systematic, complete-coding approach was adopted. Initial codes generated were semantic, reflecting an experiential approach to participant accounts. Additional coding “sweeps” of the data were completed to capture any underlying, implicit meanings with latent codes (Braun & Clarke, 2013). Consideration was given to unexpected and unprompted codes, and to avoiding unacknowledged assumptions. Once all data were coded, the researcher synthesised the initial codes to identify potential themes across the data set. These candidate themes were reviewed for their boundary clarity, presence of central organising concept, quality of meaning in relation to the research aim and question, then edited accordingly before being collapsed into higher-level themes which were then discussed with the research supervisor to enhance reliability. The themes were refined and labelled, and a thematic map was constructed to illustrate the relationships between the themes and sub-themes (see Figure 1). Finally, compelling extracts were selected to represent each theme.

## CHAPTER 3

### Results

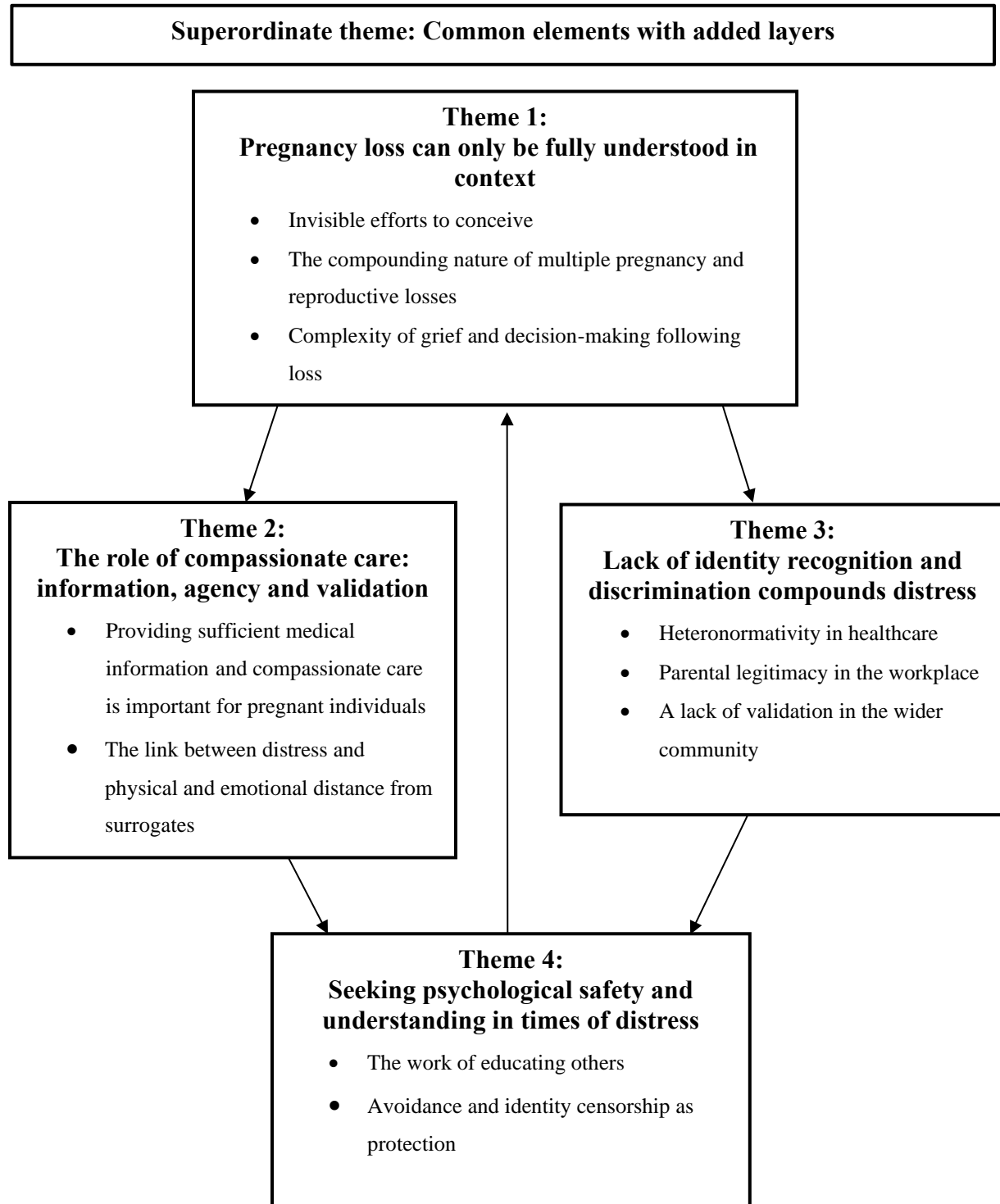
#### 3.1 Overview

Thematic analysis resulted in the identification of one overarching superordinate theme and four themes: *‘Pregnancy loss can only be fully understood in context’*, *‘The role of compassionate care: information, agency and validation’*, *‘Lack of identity recognition and discrimination compounds distress’*, and *‘Seeking psychological safety and understanding in times of distress’*. Each theme comprises two to three subthemes, as shown in Figure 1.



**Figure 1**

*Thematic Map of Results*



### **3.2 Superordinate Theme: Common Elements with Added Layers**

When discussing pregnancy loss and support, participants described some elements indicating fundamental aspects of the experience, as well as added layers specific to LGBTQ+ people. For example, the gestational complexity unique to LGBTQ+ people manifested itself in different ways, such as decision making about conception, parental identity, and the legitimacy of loss which shaped access to supports such as workplace leave and emotional supports including empathetic family or healthcare professionals. Experiences of discrimination, and anticipated discrimination, from conception to recovery, added heightened fear and distress throughout participants' experiences.

Participants were adversely impacted at interpersonal and societal levels by a lack of awareness about the added complexities for LGBTQ+ people experiencing pregnancy loss. Limited empathy of potential supports and a lack of service specificity added to the challenges faced by LGBTQ+ people. Further, the marginalisation of LGBTQ+ people increased their distress and disenfranchisement and created barriers to support. In the case of multiple losses, these experiences were compounded, leading to increased erosion of emotional, biological, financial, and social resources, and imbuing subsequent pregnancies with fear and foreboding.

### **3.3 Theme 1: Pregnancy Loss Can Only Be Fully Understood in Context**

LGBTQ+ people described their devastation following pregnancy loss within the context of their conception efforts, and experiences of antenatal care, including previous pregnancy and reproductive losses. In the lead up to pregnancy loss, time planning and sacrificing other aspects of life increased participants' attachment to their unborn babies. The drain on resources, along with early attachment, was inextricably linked to participants' experiences of loss.

### 3.3.1 Invisible efforts to conceive

Engaging in ART was taxing. Without alternatives, LGBTQ+ people often invested significant financial resources into conception, sacrificing other aspects of their lives to do so, such as purchasing a home or getting married. The increased energy focused on conception added to a sense of isolation and pressure:

*“Work took a back burner and we just didn’t – we knew where we wanted our priorities and so work – we have chosen our work according to that. Everything! Everything! We didn’t buy a house because we knew this is what we wanted. So instead of using this money on a deposit, we kept any money to save for having children.” (Isabella, Lines 159-162)*

Likewise, for participants engaging in surrogacy, the required investment was described as enormous and unrecognised. Investing so much time, effort, and money into conception left cisgender participants feeling emotionally and financially extended:

*“...that is an added factor that goes over gay men who do surrogacy, it’s that in order to get to pregnant in the first place, the hurdles you have to jump over, the money you have to spend, the travel you have to undertake, the invading into your private life that you have to um engage, is enormous. It’s not something – it doesn’t occur because you had sex in the back of a car after a party. These things are huge, huge investments of emotion, time, and money just to find a surrogate, just to find an egg donor, just to get the process to work. So when you do get pregnant, you’ve already invested huge amounts of emotion um, er, on this you*

*know on this idea of becoming a father. And when something fails, you're dropping from a huge height.” (Edward, Lines 412-419)*

The acute awareness of limited options compared to heterosexual people added layers of tension and frustration to the experience of loss for LGBTQ+ people:

*“I have this deep constant anger that IVF is one of the only ways same-sex couples can start a family. The effort involved, not to mention the exorbitant cost. It seems unfair, though I know that it's no one's fault. It makes me angry that heterosexual couples at least have the choice to try naturally for a while and every month before they resort to fertility treatment.” (Cate, Lines 515-519)*

LGBTQ+ people were frustrated by a lack of acknowledgement that their experiences came with added challenges around decision making, a lack of alternatives, discriminatory legislation and the invalidation of services presuming heterosexual orientation:

*“I think there are times that it would've been nice to have a bit more acknowledgement about how an IVF journey for a same-sex couple is very different to an IVF journey for a couple doing it for other reasons. Um, you know like, all of the forms you have to fill in, all of our forms that we still have to fill in, all still ask about sperm and the male fertility factor.” (Charlotte, Lines 607-611)*

Reproductive medicine required LGBTQ+ disclosure which participants described as a perpetual “coming out” to healthcare professionals. Disclosure of sexual diversity was particularly stressful for participants accessing ART in NSW, the ACT, and Queensland as clinics in those states are exempt from Australian anti-discrimination laws and can refuse same-sex couples treatment.

*“And it can kind of get a bit weird. Um and so absolutely it’s there with people. And I am like, I’m very confident, and I don’t really care what other people think or if they have a problem with my sexuality. Like I’m not doing anything offensive so – I’m like that, and I’m still nervous. So, I can imagine what it’s like for people who aren’t as confident. It must be really daunting, and maybe lots of them don’t even bother trying because it’s too overwhelming for them. So, I think that that general kicking off as a same-sex couple is hard work”. (Emma, Lines 599-606)*

Many participants anticipated discrimination and described their strategies for managing this, including extensive online detective work to identify services that were inclusive and welcoming of LGBTQ+ people and delaying disclosure while they assessed the language used on intake forms and waiting room signage looking for signals of inclusivity. Not knowing how they would be received, participants often had proactive disclosure scripts prepared in advance:

*“That’s what we do now. We learnt that that’s what we need to do because of all of our hospital experiences. I’m not the support person, I am [name]’s wife, I am the other parent. This is how you can refer to me [...] I feel it’s important, so we don’t waste precious time talking about like who we are and miscommunications.” (Isabella, Lines 283-285, 288-289)*

Time spent engaging with heteronormative reproductive services before loss eroded the social, financial and psychological resources of LGBTQ+ people.

### **3.3.2 The compounding nature of multiple pregnancy and reproductive losses**

Collectively, the 14 participants had lost 33 babies, with 12 participants having experienced multiple pregnancy losses. Additionally, many participants had experienced other

reproductive losses, including unsuccessful egg insemination or embryo transfers. These experiences of reproductive losses were highly distressing for many participants. The extended time planning for a child, and the growing sense of finite biological resources meant that embryos became increasingly precious. Cate describes how lost embryos were experienced as the loss of family:

*“Ah I’d describe it as losing a family member. Yeah especially because it was something that you worked so hard for[...] Yeah, it felt like a death. Yeah. But so do the failed embryo transfers. It’s like a similar feeling. The grieving is the same.[...]You’ve had embryos transfers into you which- they have fertilised. I mean they’re called little potentials. And so for us, we’ve lost about thirteen of them, so that’s thirteen potential children. And that’s a lot of effort, a lot of money, a lot of grieving.” (Cate, Lines 131-137, 146-148)*

Participants experienced increasingly complex emotions following multiple losses. Multiple losses left many participants concerned that their dream of a family was becoming increasingly unlikely as their options and resources diminished. Many began to lose hope and were impacted by intense emotions:

*“...by the time the ninth one had um, was coming up, I was um, I was done. I was – I just couldn’t put myself through it again. So we kind of, if the ninth – if it didn’t work that time, I think we needed to walk away from it. Because it was over three years, the transfers, with you know two separate egg donors [...] But the general toll on me was enormous. So, it affected me, every fail affected me deeply,*

*deeply, and I just—I was running out of hope. You know what I mean. I was running out of hope. Nine transfers.” (David, Lines 169-172, 185-187)*

Multiple losses, including reproductive losses, equated to an extension of the invisible efforts and unacknowledged challenges faced by LGBTQ+ people. Participants often described themselves as starting conception with more limited biological resources than heterosexuals. Multiple losses increased the salience of the finite nature of their biological resources, as well as shrinking the overall conception possibilities. Maryanne described how pregnancy losses not only involved grief, but increasing uncertainty as to whether there would be another opportunity to attempt conception, or if they had exhausted their reproductive options:

*“So yeah, that’s a big commitment [from the donor], and I guess the question then becomes, you know, will he agree to another six cycles? Will he agree – I guess there’s a lot more of a time pressure on it, and that wasn’t recognised.”*  
(Maryanne, Lines 326-328)

For participants who were recipients of altruistic gamete donations or surrogacy the generosity and uncertainty involved, added complexity to their pregnancy loss experiences. Following multiple pregnancy losses, cisfemale participants expressed a growing tension between their desire for children and their concerns for placing surrogates at further risk of emotional or physical harm:

*“What I thought after the second one [pregnancy loss] was how’s our surrogate going to be because it wouldn’t have surprised me if she’d said after the second one “That’s it”. I couldn’t blame her. You know, she’d been through – had a miscarriage, and had to have urgent surgery to save her life in effect, or well*

*prevent her life being lost. [...] And if she had said, “Sorry guys, I’m out of here”,  
um we sort of half expected that.” (Tom, Lines 572-579)*

Multiple pregnancy losses, while not unique to LGBTQ+ people, had an additional impact on participants. Along with added grief, multiple losses reduced the reproductive resources of participants and prolonged the work of conception described in Section 3.2.1, leaving participants feeling exposed to more discrimination in healthcare settings.

### ***3.3.3 The complexity of grief and decision-making following loss***

Participants described complexity in their reproductive decision making, unique to LGBTQ+ people. The options available to participants were often not as broad as they had initially imagined. For participants engaging in surrogacy, decisions also included whether to move to locations where undertaking commercial surrogacy overseas was legal, whether engaging in altruistic surrogacy was worth risking their existing relationship with the surrogate and potential custody issues that could arise. The context of conception and the impact of multiple reproductive losses often led participants to re-examine decision making and conception priorities. Most participants described re-evaluating the importance of biological relationships and the identity of gamete contributors as the concepts of family and parent came to the fore:

*“It’s heartbreaking. Yeah it’s – they’re all lives. Our babies that I’ve been talking about, they were a huge loss. But these other losses, they were losses in their own right. And they led up to the biggest loss. And that’s how you realise the lack of importance about who was the biological parent and who wasn’t. It didn’t matter. We just wanted to be pregnant. We wanted a child. I mean maybe it’s the same for all same-sex couples, you imagine yourself as the proud biological parent in the*



*beginning when you're making decisions. But in the end, it just didn't matter."*

*(James, Lines 317-322)*

Gestational and biological options, when available, were often experienced as “trade-offs”. Some participants chose between altruistic surrogacy in Australia, commercial surrogacy overseas or multi-parent families. Such decisions required weighing up having a relationship with and being in proximity to surrogates and the healthcare available during pregnancy, or possible complications of long-term custody entitlements if engaging in altruistic surrogacy in Australia.

One participant described the dire consequences:

*“...we didn't want to do that with a friend because does the friend become a co-parent. Does the friend – there was too much risk in that for us, you know what I mean. Not that she was risky, not that she was risky, but there was just too much risk for us to put ourselves in that situation – we felt more at risk going with that option than doing commercial surrogacy. It was clearer. It was clinical, it was, um, clear, it was clinical, and if we were lucky enough to have a baby, then that baby was ours. No one else's, just my partner and mine. And that's why we did commercial surrogacy. [...] and let's jump forward to Hazel. If that pregnancy were here, Hazel would be alive. So, we paid the ultimate price for the vulnerability, I think.” (David, Lines 104-116)*

In many cases, ciswomen and gender diverse participants' experiences of multiple pregnancy losses led to reconsideration of gestational options. Some participants were the sole member of the couple who could be the gestational carrier. For others, plans for each member of the couple

to conceive had not eventuated. One participant described her decision to change tack due to the physical and emotional toll several losses had taken:

*“So, I made the decision myself, and my partner has supported it obviously, for me to stop. So the next stage, um, will be for my partner to carry – to have a crack at carrying, which she’s very happy to do. So I’m very lucky. Not all same-sex couples both want to carry. But that was a lot. And I did seek counselling through the fertility clinic in that period because it was two losses and then a decision to stop. You know? It was really hard. It was a tough time.” (Gillian, Lines 210-214)*

Some participants could carry to term while their partners’ experienced multiple losses. One participant described how supporting their partner through four miscarriages raised mixed emotions, including guilt about being about to carry a pregnancy when their partner could not:

*“You’ve got my partner who is going through this process, and I guess potentially grieving and not knowing whether she is grieving the fact that she may not be able to carry a child. And then I’m feeling guilty that I’ve been able to, I guess to have that privilege knowing that that’s something that she desperately wanted to do and, yeah. So I think it was quite a confusing process, and I think there were times that like my partner was feeling guilty, but that was the last thing that I wanted her to feel – like I don’t want, you know? I know that this is out of her control, the stuff going on, and so yeah it was a bit of a difficult process with a lot of different emotions and thoughts and everything I guess going on.” (Maryanne, Lines 100-107)*

Accounts of multiple losses and decision-making highlight how the context and limitations of conception, emotional attachment, and experiences of prior pregnancy loss all had a compounding impact on participants.

### **3.4 Theme 2: The Role of Compassionate Care: Information, Agency, and Validation.**

Interactions with healthcare professionals and surrogacy agencies following pregnancy loss significantly impacted participants. Most participants reported inadequate information and a lack of agency which was linked to higher levels of distress. Additionally, the absence of LGBTQ+ inclusivity and competency, and a lack of warmth and validation of emotions also increased distress. The quality of care received following pregnancy loss had a long-term impact on participants' distress and resilience.

#### ***3.4.1 Providing sufficient medical information and compassionate care is important for pregnant individuals***

Information and concern extended to participants had the power to reduce or increase distress. While not consistently offered, warm demeanour, adequate information and inclusivity were highly regarded by participants:

*“...when one of those things happens it’s sort of our fears are materialised, and it’s how we can cope with that pain and then where do we go from there? It’s like being in a bottle. It all just echoes in on you, and you just can’t escape. So I think care from the medical professionals, and that includes their – the person at the front desk, as well as if you deal with the scientist or the nurse coordinator within the IVF clinic, and then care within the hospital, that helps. That really does help. It makes it, um, a lot easier to deal with.” (Tom, Lines 899-905)*

Many participants expressed surprise at the lack of information provided and the rushed manner in which they were asked to make decisions in hospital settings. More than half of the gestational parents in the sample described incidents where a lack of adequate information about pregnancy loss left them afraid for their lives:

*“...so it was like the emotional stuff, and there was all this physical stuff on top of it where, because I hadn’t been told that there was this possible complication and what it would be like, and I’d been told that the pain would be like a bad period, so I thought I must be dying.” (Elizabeth, Lines 116-120)*

Following distressing experiences at their local hospital during previous pregnancy loss, Isabella described her gratitude at receiving more inclusive, compassionate care as a non-gestational parent:

*“... in the last miscarriage was – I was treated as an equal, and we were both valued.[...] and that made a big difference to feeling valid and like the grief that we feel and the loss that we feel and the pain and like that this is legitimate to feel like this, that it’s not imagined. It’s nice to be treated like the loss was big enough.” (Isabella, Lines 179-187)*

Continuity of care in hospitals was often associated with feeling validated and consequently reduced participants’ distress. Emma described how feeling visible and validated by her specialist at the time of loss had helped reduce distress and enable coping:

*“...that’s the thing that really stands out because I could have just woken up and cried to myself. But you know it just really, so significantly changed my experience, because after that I was okay. I felt so supported. [...] That aided in*

*me just being able to move on and keep moving forward and be okay. And I think that was the significant event that actually made me okay". (Emma, Lines 368-375)*

Continuity of care did not always ensure support following loss, however. Several participants described healthcare professionals' warm manner experienced during the pregnancy coming to an unexpected end during pregnancy loss. What was described by participants as a very personal, life-changing event, was often treated impersonally by healthcare professionals. Several participants were notified that they were miscarrying via text message:

*"We went back in on Monday and then we said in the appointment "can you please call us?" and we left, and three hours later we got a text message saying that we were having a miscarriage. They sent a fucking text message. They told us that we had lost our baby on a fucking text message and that for us, we were just absolutely floored. We could not believe it.[...] The next contact we had was a message on the portal saying "don't forget your early pregnancy scan next week". So, we had a reminder to come in for a fucking scan for a baby that had died! Like for a pregnancy that we had already lost; that they had notified us of!"*  
(Alex, Lines 659-673)

Without acknowledgment of loss, participants' distress increased. Participants spoke of their shock at the lack of consideration for psychological wellbeing and procedures to follow up people at risk of self-harm:

*“Particularly after the first and the second pregnancy I was pretty suicidal so um, there was active suicidality, so I think yeah, no one to catch that isn’t great! It’s just dangerous.” (Elanor, Lines 556-558)*

Healthcare professionals’ demeanour and their consideration for the emotional distress of loss influenced participants’ distress and resilience.

### ***3.4.2 The link between distress and the physical and emotional distance from surrogates***

In addition to a lack of information, increased geographical distance disempowered fathers when they sought to support their surrogate, increasing their distress. Increased physical distance, cultural differences and surrogacy agencies created barriers of silence and disconnection between intended parents and surrogates. Fathers who had engaged in altruistic surrogacy were physically close and had established relationships with their surrogates. Being present with a surrogate and being able to support them through both pregnancy and loss reduced participants’ distress as Tom describes below:

*“... to have a close family member, living just down the road, that we could take to appointments, um, you know just you can’t bottle that stuff, it’s just wonderful, just absolutely wonderful. And just being there whenever she needed um, we’re here. And picking her up at her work, and either I or my husband or both of us, um would go. And there were lots of appointments at the hospital because she was a public patient, my husband went to most of the meetings.” (Tom, Lines 321-326)*

However, even those nearby described how unprepared they had been for pregnancy loss:

*“It's a business thing, I think. Because if they told people the truth, I think people may reconsider it. [...] I think just knowing that it's not always going to be perfect. Um, it just needs to be more clear.” (Mark, Lines 197-200)*

The high levels of investment required of intended parents were at odds with the sparse information surrogacy agencies provided them, which was focused on the physical aspects of pregnancy:

*“The communication around that was – from the agency was deplorable! It was just — we didn't know what was going on, we were in limbo. Is this something – we just, we were just so confused you know what I mean? We were just at the mercy of these – of people that were trying to keep us happy but at the same time not giving us the information we needed, I think. So one day – I was at the gym, I was in the changeroom. And my partner got the text, and I got the text, saying “surrogate going for curette”.” (David, Lines 56-61)*

Along with poor communication style, a lack of information and involvement led, in some cases, to vicarious trauma:

*“We were in a situation of being disassociated with the situation. We had no power, no control and we were grieving for the loss and feeling a connection to those babies. [...] And we couldn't reach out to her [the surrogate]. I don't even know physiologically what happened to her or emotionally. I don't know how she might have felt. But it can't have been good for her and we weren't there with her. We couldn't be there. [...] We didn't have – we didn't have a chance to say goodbye to the kids, there was no funeral, there was you know as a nurse, all I*

*could think of was how they would be disposed of as waste, my little kids would be burnt out the back of a hospital. It was all I could think of was my little kids just burned, as waste. It was really hard. It was bloody tremendously hard.” (James, Lines 90-98, 103-106)*

One father described his contrasting experiences of pregnancy loss. A miscarriage with a friend in Australia, as part of a multi-parent family, did not prepare him for pregnancy loss while undertaking commercial surrogacy overseas:

*“Distance is a problem. In differe—as I’ve mentioned before our friend was here. We could talk about it. We could not talk about it. When this happened [the pregnancy loss in Australia] she told us. [...] her telling us what she wanted was enough, so we just did what she wanted in that sense. And we could just be there. That felt right. Doing nothing, just being there was actually doing something. We felt, uh do we, it wasn’t going to be pleasant, but we could come closer, and feel the situation, and get through it all together. But when it uh happened to us [overseas], it, you know the surrogate so far away, we couldn’t do that [...] So, you know even that was difficult because of who she was, you know.” (Edward, Lines 337-346)*

The ability to be informed and physically present with a surrogate appears valuable. However, surrogacy agencies created an extra layer of distance and disenfranchisement that increased distress following loss.



### 3.5 Theme 3: Lack of Identity Recognition and Discrimination Compounds Distress

Heterosexual kinship norms around conception and families, bio-medical norms around reproduction and attitudes towards grief following pregnancy loss shaped the way others, including family, friends and healthcare professionals, understood and responded to participants' losses.

In addition to a lack of acknowledgment of *what* had been lost, participants described a lack of acknowledgement or confusion about *who* they were, across healthcare, workplaces and social circles due to their LGBTQ+ status. As described below, LGBTQ+ discrimination and exclusion contributed to participants' increased distress and disenfranchisement from their grief following pregnancy loss.

#### 3.5.1 Heteronormativity in healthcare

Healthcare understandings of what constitutes a parent or child were at odds with participant's emotional responses to loss. Other significant non-reproductive losses did not prepare participants for the level of emotional attachment and grief:

*“Ah, I'll tell you, my parents have both died, my best friend committed suicide in two thousand and eleven, and nothing could have prepared me for the loss of [baby].*

*None of that grieving process for those other people could even begin to prepare me for the loss of [baby].” (David, Lines 639-641)*

Participants expressed frustration that others did not recognise pregnancy loss as the loss of their child. Additionally, some participants described their identity as parents also lacked social recognition. For gender diverse parents, recognition of parental status can be complex. Alex described their longing for others to understand who they were:

*“I’m very – um, have a lot of kind of what would typically be called masculine traits, and I’m very – I fucking haven’t worn a dress since I, I don’t even remember. Like none of that. And that’s why it’s all bullshit from society and none of it really fits. But I don’t identify one hundred per cent as female, but I do identify one hundred per cent as a mother. I’m a mother. And I love children. I’m so comfortable with a baby that’s an hour old. I just feel as comfortable with them as I do with an eighteen-year old that I’m working with. I love children, I love working with them, and I love being with them. And I can’t wait to be a mum. But I’m a mum without children and people often forget that. That that’s the situation. It’s not just that we’re childless, it’s just not childless by choice. That it’s childless through a horrific fucking series of events that have left us without our babies.” (Alex, Lines 718-730)*

Healthcare professionals often considered what was lost in terms of gestational age, rather than the meaning participants had attributed. One participant’s discussion with their General Practitioner cemented the idea that their loss may be invalidated or judged harshly elsewhere:

*“That then puts you in a position where like we were feeling that “well who do we talk to about this and are we just going to either be dismissed, or you know, what’s the response?”? I guess it’s kind of just a sense of I guess uncertainty on how it’s gonna be responded to. It’s not just—it didn’t alleviate obviously any of the anxiety, but it also I guess created that layer and being quite cautious in who we would talk to you about it because, yeah, because you don’t want that invalidation again.” (Maryanne, Lines 261-267)*

Invalidation of emotional responses to pregnancy loss, inappropriate language, misidentifying partners, and explaining their families to healthcare professionals added to a sense of illegitimacy for participants. Elizabeth discussed the complexity of this when a midwife was noting her medical history during a subsequent pregnancy.

*“...she kept on saying “Oh, but those weren’t your pregnancies. They were your wife’s pregnancies, because they were your wife’s eggs.” [...] I had the miscarriage. My wife also lost a potential child in that situation, but it’s very invalidating to say that that wasn’t my pregnancy because it was someone else’s egg. [...] And she did other weird things like she wrote—in the front of the orange book, she wrote in the part where it says “relationship issues” to specify if there’s a domestic violence relationship or something, she wrote in that box that we were in a legal same-sex marriage.” (Elizabeth, Lines 227-232, Lines 236-239)*

Microaggressions and invalidation in healthcare were common amongst participants, and these interactions were described as both frustrating and hurtful. Participants found themselves having to explain and re-educate healthcare professionals when seeking medical care following pregnancy loss. The language in healthcare was often coded for heterosexual reproduction (parental legitimacy was a significant issue, refer to 3.5.2), with some participants citing a need for customised resources:

*“All of your leaflets and information, it’s quite often the mother and the father and yeah, even like the little paper leaflet that we got from the hospital when we left after Alex having her surgery, it was like don’t have unprotected sex for two*

*weeks because you don't want to fall pregnant again. And it's like, well, we know that's not going to be an issue.” (Charlotte, Lines 610-615)*

### **3.5.2 Parental legitimacy in the workplace**

Grief and identity were often contested at work. Normative understandings of parental and bereavement leave in some workplace policies hindered participants' ability to take leave following pregnancy loss. Participants described having to “come out” to workplaces. James found themselves denied parental status and appropriate leave by a queer co-worker, invalidating their identity as a parent and engendering a sense of betrayal:

*“...they wouldn't give it to me. She said “You were never pregnant; your partner was never pregnant. You can't have it.” I had kids in intensive care in India. I was trying to work our leave out. I tried to fight her on it, but I thought “I can't do this while my kids are in intensive care”. I just had to get over there. So, I just had to use my savings. And um she wrote to the department of health and tried to get a ruling to say that we didn't get to have leave, but because they weren't our children. And this was one of our own.” (James, Lines 240-246)*

While this decision was subsequently overturned, it illustrates experiences of invalidation and the added layers of difficulty for LGBTQ+ people in accessing workplace entitlements.

Work was noted as a potential source of comfort and distraction for some participants. However, for several participants, returning to work served to suppress grief, rather than allow them to process it. Some participants pushed themselves so far that they had to take significant time off work months later to address their complete exhaustion of resources.

*“And I’m absolutely a case in point, where I tried to begin with to suppress that; to return to work, to pretend that everything was okay. To carry on as normal. And I ended up literally having a breakdown. I could not function. I could not go to work. I couldn’t – I love cooking, and I do all of the cooking in that house, and I couldn’t prepare meals. I couldn’t go for walks, you know, exercise. Nothing! I could do nothing because I was a shell of who I was.” (Alex, Lines 351-356)*

While negotiating leave entitlements following pregnancy loss may not be unique to LGBTQ+ people, heteronormative leave policies and a lack of acknowledgement of non-gestational parents’ needs may further deplete the resources of LGBTQ+ people following pregnancy loss.

### ***3.5.3 A lack of validation in the wider community***

Participants experienced variable levels of support from family, friends and LGBTQ+ peers. Some participants made a conscious effort to override the normative silence around pregnancy loss, seeking support from friends and family. Participants described the courage it took to open up about pregnancy loss and the vulnerability they experienced in doing so. However, rather than allowing participants’ sense of loss to govern offers of support, societal norms often governed whether informal support was offered to bereaved parents. Gillian expressed how people in the wider community regularly minimised their loss and their emotional response to it:

*“...it’s hard to hear, you know, other women would say “oh, well two miscarriages is NOTHING”! If I had a dollar for every doctor or person that’s told me that “it’s actually – that it’s a drop in the ocean”. “Oh, well I had seven,*

*or I had...”. But they also have sperm on tap so they can try every month and have an orgasm while they’re at it.” (Gillian, Lines 247-250)*

Adding another layer to disenfranchised grief, several participants described internalising heteronormative understandings of family legitimacy that left them feeling they did not deserve to grieve or receive support:

*“I think that it’s easy to feel like that you know. “Oh straight people didn’t choose it, they tried to get pregnant themselves, and then they had to get medical help,” and you know. Whereas I suppose we choose to go down this path and so we don’t deserve to feel sad, um but that’s just not true. [...] I mean I felt that way for a little while, that I should – almost like I couldn’t take up that grief space. Like that, I had to leave that for heterosexual people because I’d made the choice to try and get pregnant, whereas other people, it was their birthright I suppose. That’s probably just a cultural norm that I absorbed.” (Elizabeth, Lines 343-351)*

Even when people expected to receive support, wider social norms around reproduction created a lack of understanding from others. Men described how their desire to be fathers was not widely understood, making them “*freaks*” (James, Line 214) or dubious in the eyes of others. Cis-male participants expressed frustration at the lack of social acceptability or normalcy of men’s desire to be parents. Edward recalled how his endeavours to become a father through surrogacy were not supported:

*“The scrutiny was really quite intense. Everybody feels they have a right to comment on, you know, your right to have children, your ability to parent, um*

*how much damage you'll do to the children, all those – everybody's got an opinion.” (Edward, Lines 251-253)*

Already experiencing variable community support, LGBTQ+ people described how it was then more difficult to find acknowledgement and emotional validation following pregnancy loss. The privileging of gestational and biological kinship in wider society created a further barrier to support for gay men engaging in surrogacy in particular, as those around them did not consider the pregnancy “theirs” to lose. Instances where support was needed, sought, and denied, were devastating for participants. The lack of psychological safety experienced in those moments had long-term impacts on participants, increasing their distress and discouraging them from seeking support in the future:

*“Ah, we did have a few comments from people saying “it doesn't really impact you” or “it's the surrogate who had the loss and has to deal with it. It's not really your thing – you can just try again”. I think those sort of comments don't help.” (Mark, Lines 214-216)*

While participants such as Mark, struggled to find support, other participants had established informal surrogacy support networks and still found themselves isolated, and in one case, attacked by a peer for choosing commercial surrogacy:

*“We were really alone in our grief. And I think, when we spoke to people or talked to people, it was hard. Because they don't understand, particularly because we're two males, it was like “oh well, this is what women have to put up with. Get over it”. Um, I don't think that we got the understanding that other people would have had. [...] we put it up that we'd lost our babies in the group chat and we*

*expected to get support. And one of the guys on there said “Stop worrying about yourselves. You should be worrying about the surrogate”. I mean we were doing everything we could for the surrogate after the miscarriage.” (James, Lines 40-43, 63-66)*

### **3.6 Theme 4: Seeking psychological safety and understanding in times of distress**

Emotional and psychological support following pregnancy loss was particularly warranted for LGBTQ+ people, whose experiences were amplified by contextual and social factors. However, participants were often cautious about accessing support services as they anticipated, often correctly, that the non-normative aspects of their endeavours to have children would not be understood or validated.

Participants who accessed LGBTQ+ inclusive and *informed* formal supports described the relief they experienced at feeling psychologically safe and adequately supported. However, without appropriate referrals, most participants struggled to find LGBTQ+-competent support. Participants, often highly distressed, were left to choose between accessing heteronormative supports that left them vulnerable to discrimination and microaggressions or avoiding supports in order to maintain psychological safety.

#### **3.6.1 The work of educating others**

Many participants described needing to educate healthcare professionals about LGBTQ+ reproduction and related challenges before receiving support. The anticipation of needing to do this was an exhausting prospect. Amid emotional distress, many participants were not willing to further expose themselves in seeking supports that may not already be educated about LGBTQ+ issues and surrogacy:



*“...she was lacking so much information [about surrogacy] that I felt like I was educating her. Which, which becomes a role, I think, I feel, I sometimes feel, I at times I would have to educate someone before I can talk about something, that I might be feeling, to someone. Um, and that education role at times can be very draining. Very draining. To the point where sometimes, it’s easier not to say anything. Because with education comes questions.” (David, Lines 359-364)*

LGBTQ+ people experienced a distinct difference between services that were *accepting* and services that had experience or training in working with LGBTQ+ communities. While offering a degree of psychological safety, participants were still marginalised by many well-meaning healthcare professionals’ microaggressions, such as cisgenderist and heteronormative language. In these incidences, participants, already distressed and needing support, lost confidence in a service’s ability to effectively support them:

*“If you are in a relationship which is queer and diverse, that it’s not blinked at [by support services], I will be led by you, and if I [as a healthcare professional] don’t know about your lived experience and experience of your communities – that’s not going to be your job to educate me. I will go and do that education on my own. I think that really important. So the burden is not on the client or the patient or the person who has experienced the loss.” (Elanor, Lines 585-602)*

### **3.6.2 Avoidance and identity censorship as protection**

The proactive strategies used to access healthcare were less likely to be enacted to seek emotional support. Instead, many participants avoided services. The heteronormativity of

available supports was raised by many participants, who often felt invisible or excluded by heteronormative language through the conception process.

Several participants expressed frustration at a lack of clear referral pathways for LGBTQ+ supports. Some had searched unsuccessfully for appropriate LGBTQ+-competent services. Others, were given cues by healthcare professionals and informal networks that support was not warranted, adding another barrier to seeking help and furthering disenfranchisement from grief:

*“I mean we never really processed the emotions we were feeling at the time because neither of us knew what to do. Neither of us knew who to speak to. Neither of us knew how – what even to speak about. Um, even talking to you today, um I’m surprised at the level of emotion. It’s still welling up in me, thinking about it. I’m still surprised about that”.* (Edward, Lines 406-410)

With a lack of appropriate resources, many participants used adaptive strategies to make the most out of existing resources. Some participants censored their identities to receive support, while one participant described their strategy of avoiding disclosure while sounding out supports:

*“I sort of avoid disclosure, but I sort of almost give people the clues that they need. [...] It’s that stuff around using gender-neutral pronouns and things like that to describe my partner, and then knowing almost having that sense of okay they’re using gender-neutral pronouns back, and I kind of read that as okay you’re safe...”* (Maryanne, Lines 458-464)

The lack of LGBTQ+ specific supports and feeling at risk of judgement and discrimination when accessing other support, led participants to turn towards their partners for support rather than search for safe services in times of distress. The norms surrounding pregnancy loss and the lack

of understanding of the added complexities of LGBTQ+ people's experiences had a galvanising effect on some relationships. As grief was largely relegated to private spaces, supporting each other in moments of fear and learning about each other's needs following losses, brought many couples closer together:

*“And there is a physical understanding that we have with each other that um, I don't think either of us could effectively explain. There's a grief that we now share, there's – you know we've been on an incredible journey together. And I think that will be different again when we have a live birth; there will be another incredible journey, another chapter. We're still kind of very much feel like we're in the miscarriage chapter at the moment because even with this next one we're still anticipating a miscarriage. [...] But yeah, there's a strength, the depth, yeah if we thought that we were a strong, tight unit before, again we've just reached a different level. Absolutely.” (Alex, Lines 840-848)*

## **CHAPTER 4**

### **Discussion**

#### **4.1 Overview**

The purpose of this study was to gain a better understanding of LGBTQ+ peoples' experiences of pregnancy loss. Using qualitative methods four themes were developed to describe the factors that shape those experiences: (1) pregnancy loss can only be fully understood in context; (2) the role of compassionate healthcare; (3) lack of identity recognition and discrimination compounds distress; and (4) seeking psychological safety and understanding in times of distress. The overall picture, reviewing the themes individually and collectively, is that of a multi-layered experience for LGBTQ+ people. At the core, LGBTQ+ people describe experiences reflective of and consistent with existing research on common aspects of pregnancy loss. The novel contribution of this research is, however, the identification of added layers that, for LGBTQ+ people, travel alongside the common aspects. These layers result in the need for sustained effort throughout conception, pregnancy, and loss, compounding the distress experienced and highlighting the need for tailored resources and supports if a loss occurs. This research illustrates that experiences of pregnancy loss vary for different cohorts, particularly when normative reproductive practices are challenged. These findings have implications for how LGBTQ+ people's pregnancy losses can be understood in theory and addressed in practice.

#### **4.2 Contribution to knowledge**

Pregnancy loss is, understandably, a devastating event for parents. A key discovery of the present study is that LGBTQ+ people's experiences of pregnancy loss involve additional

complexity not reported in research on heterosexual people (Bellhouse et al., 2018; Lisy et al., 2016). These added challenges not only directly exacerbate distress, grief and disenfranchisement, but failure to recognise these challenges, together with a lack of services equipped to validate and support LGBTQ+ people can have a further compounding negative effect.

Rather than existing in isolation, grief is influenced by socio-ecological contexts that often compound disenfranchisement (Obst et al., 2020). Considering LGBTQ+ people's grief in this manner points to a socio-ecological hierarchy of disenfranchisement, with multiple intersecting challenges to kinship and gender norms potentially leading to triple or quadruple disenfranchisement. Coping with disenfranchisement of this magnitude necessitates an ongoing investment of resources, which gradually deplete, placing LGBTQ+ people in a vulnerable position for managing additional stressors such as pregnancy loss (cf. Hobfoll, 1989). When resources are depleted, it is more difficult to mobilise additional resources to cope with new events, causing distress (Hobfoll, 1989). In other words, the energy and social resources expended in coping with disenfranchisement contribute to the elevated distress of LGBTQ+ people experiencing pregnancy loss.

#### ***4.2.1 LGBTQ+ loss experiences***

Several findings of the current study are consistent with literature reporting cisgender, heterosexual people's experiences of pregnancy loss, including gestational age not being a key predictor of emotional distress (Aldofsson, 2010; Obst & Due, 2019; Riggs et al., 2018). Findings also support the positive impact of early emotional validation from healthcare professionals (Due et al., 2018; Redshaw et al., 2014), whilst a lack of adequate recognition of

pregnancy loss compounds grief (Mulvihill & Walsh, 2014; Obst et al., 2020). In line with previous research, ciswomen and non-binary mothers regularly experienced disempowerment, lack of information, and clinical language in healthcare settings leading to increased distress and trauma (Cacciatore, 2013; Due et al., 2018; Lee, 2012; Lisy et al., 2016; Redshaw et al., 2014). The commonality of these experiences indicates a need to consider whether the expansion of existing care guidelines following stillbirth (Flenady et al., 2020) to include other forms of pregnancy loss could improve psychological outcomes.

The current findings on LGBTQ+ people's grief experiences expand on factors reported by heterosexual parents, such as the silence surrounding pregnancy loss and gendered norms around grief (Adolfsson, 2010; Obst et al., 2020), by identifying added challenges relating to the non-normative status of LGBTQ+ families. Policy-level factors identified for LGBTQ+ people's experiences included limited access to ART and commercial surrogacy, a lack of healthcare training on LGBTQ+ people's needs, and varied access to appropriate workplace leave. Varying levels of community acceptance of LGBTQ+ individuals and families may impact the informal support options of LGBTQ+ people compared to the already limited informal supports available to heterosexual people (Bellhouse et al., 2018; Obst et al., 2020). These policy and community-level factors create an environment in which LGBTQ+ people experience discrimination, exclusion and microaggressions at the interpersonal level and contribute to self-invalidation and distress.

The present results indicate that healthcare professionals largely failed to acknowledge the emotional impact and added stressors faced by LGBTQ+ people following pregnancy loss. The negative experiences involving IVF clinics and emergency departments described in this

study are consistent with existing LGBTQ+ research (Peel & Cain, 2012; Riggs et al., 2015). The present study supported and expanded upon LGBTQ+ research involving the formation of very early emotional attachments to unborn babies (Peel, 2010; Riggs et al., 2015), suggesting that more significant conception efforts foster perceptions of embryos as potential children. In addition to a lack of recognition of what has been lost, the present study illustrates how LGBTQ+ people also face a lack of recognition as parents, with the legitimacy of LGBTQ+ parental identities contested in healthcare, workplaces and informal settings (Doan et al., 2019; Ehlke et al., 2020; Haines et al., 2018; Riggs, 2020). These findings reflect the continued gap between personal meaning and social legitimacy (McKelvey, 2015; Riggs, 2020).

Notably, the present study indicates that reproductive healthcare experiences are amplified – positively and negatively – for LGBTQ+ people, due to anticipation of discrimination and exclusion. As Riggs and colleagues (2015) also found, when LGBTQ+ people experiencing pregnancy loss received a basic standard of care, their appraisals of care were disproportionately positive. This amplification may result from an anchoring effect whereby LGBTQ+ peoples' experiences of exclusion and discrimination create an expectation of future discrimination, and any care above this is experienced as exceptional. As well as positive care experiences being amplified, LGBTQ+ people experiencing pregnancy loss found discriminatory and dismissive care highly distressing. Previous LGBTQ+ research indicates that experiences of discrimination and microaggressions relating to heteronormativity and cisgenderism (Haines et al., 2018) can lead to insidious trauma (Szymanski et al., 2011), post-traumatic stress disorder (PTSD) symptoms (Keating & Muller, 2020), and internalised homophobia (Newcomb & Mustanski, 2010). The amplification of quality of care is one

manifestation of the added layers that LGBTQ+ people experience following pregnancy loss identified in this study. The present findings indicate that experiences of pregnancy loss could be significantly more distressing for LGBTQ+ people who have experienced microaggressions or discrimination, against a backdrop of added layers of complexity including gestational decision making, erosion of resources and lack of appropriate services.

#### ***4.2.2 LGBTQ+ experiences of support***

Findings regarding help-seeking behaviours extend knowledge garnered from existing LGBTQ+ pregnancy loss literature (Craven & Peel, 2017). Despite previous recommendations from the Australian Psychological Society (2014a, 2014b) that professionals take LGBTQ+ people's conception efforts into account when offering support, the present findings indicate that this does not routinely occur and that support still appears governed by factors such as gestational age at the time of loss and normative understandings of families.

The current study highlights the additional difficulties in finding appropriate bereavement support; the heteronormativity prevalent in service provision requires LGBTQ+ people to educate others before being able to access supports. With eroded resources, some parents avoid supports altogether. As a result of anticipated, subtle, and overt discrimination and marginalisation, distressed LGBTQ+ people may choose to avoid identity-disclosure, which is associated with poorer health outcomes (Bejakovich & Flett, 2018). The findings also indicate that societal invalidation led some LGBTQ+ people to internalise kinship norms and experience self-invalidation, feeling undeserving of support.

The present study identified that navigating workplaces following pregnancy loss involved additional challenges specific to LGBTQ+ people. The need to “come out” in



workplaces during times of distress creates anticipatory stress and, in some cases, experiences of explicit discrimination. Findings that workplace policies often include microaggressions, further marginalising LGBTQ+ people in times of distress, support American data regarding LGBT workplace discrimination (James et al., 2016). Current findings relating to increased levels of attachment to unborn babies in early gestation, along with the impact of distance on parents who have engaged a surrogate, are at odds with many workplace policies (Porschitz, & Siler, 2017; Resnick & Galupo, 2019), contributing to experiences of marginalisation and increased distress of LGBTQ+ people following pregnancy loss. Indeed, the need to deprioritise biological ties and the emphasis on gestational length in workplace policies is especially relevant for LGBTQ+ people.

Whereas previous research into stigma and intersectional identities theorised that unification through shared identity could provide a buffer against experiences of marginalisation in healthcare (Benkert et al., 2019; Turan et al., 2019), the current research indicates that LGBTQ+ peer support is variable and precarious. The subject of pregnancy loss has likely influenced this finding in several ways. The intersecting experiences of LGBTQ+ sub-community membership *and* pregnancy loss may be too small for people to identify peer supports with shared experience. Additionally, Doka (2002) has argued that support groups often retain broader societal norms. Findings that gay cismen engaging in commercial surrogacy were particularly unlikely to garner peer support could indicate that norms inhibiting the discussion of pregnancy loss (Bellhouse et al., 2018; Peel & Cain, 2012), and what constitutes a legitimate family (Riggs, 2020) are further reducing LGBTQ+ peer support.

### 4.3 Strengths

The findings of this research are made more robust by the adherence to methodological rigour, guided by Tracy's (2010) "Big Tent" criteria for excellent qualitative research. Specifically, it is timely to focus on issues concerning family diversity, and the research makes a moral and practical contribution to LGBTQ+ psychological research and pregnancy loss literature by addressing a significant gap in knowledge regarding the experiences of a marginalised population (Australian Psychological Society, n/d; Tracy, 2010). The data collection and analysis are rich in rigour, marked by the additional credibility of participant verification of transcripts and candidate themes (Tracy, 2010). Additionally, careful consideration was given to the ethical aspects of conducting research relating to marginalised populations, and the researcher consulted multiple representative organisations to ensure inclusive, culturally sensitive promotion materials, data collection and analysis. The criteria for meaningful coherence was met in conjunction with ethical considerations by adopting a method that allowed for LGBTQ+ voices to be included (Tracy, 2010). The sample included diversity in conception contexts, varied locations, and range of pregnancy loss experiences. The researcher used reflexive practice throughout the research (Tracy, 2010).

This research contributes several new findings to the pregnancy loss literature, which furthers the understandings of LGBTQ+ people's experiences. To the best of the researcher's knowledge, this was the first Australian psychological study investigating ciswomen and nonbinary experiences of pregnancy loss, offering new insights into the complexities of hope, grief and shared decision making for ciswomen in same-sex relationships, particularly regarding multiple losses, as well as providing insight into experiences of gender diversity and parental

identity. The findings support those of heterosexual ciswomen's care needs in healthcare settings, indicating that non-binary and gay cismen also have similar requirements for adequate information and compassionate care. This research also identified additional associated needs for LGBTQ+ people experiencing pregnancy loss. Sexuality and gender diverse people benefit from acknowledgement of the added challenges they face in their efforts to grow a family. While some experiences may be shared with heterosexual people, LGBTQ+ people benefit from LGBTQ+ specific supports following pregnancy loss. Additionally, as they are often anticipating discrimination, LGBTQ+ people benefit from signs of inclusion that signal psychological safety in healthcare settings.

Findings extend the previously limited knowledge on gay Australian fathers' experiences of pregnancy loss through surrogacy in India (Riggs & Due, 2010; Riggs et al., 2015) to include a range of contexts such as multi-parent families, altruistic surrogacy, independent surrogacy, and commercial surrogacy across six countries. This diversity has offered the ability to identify factors that contribute to and reduce distress following pregnancy loss.

The current findings build on the generalised experiences of LGBTQ+ discrimination and microaggressions in the workplace (Resnick & Galupo, 2019). Specifically, experiences of discrimination and microaggressions relating to leave entitlements, and workplace expectations not allowing for employee emotional attachment were identified as added challenges for LGBTQ+ people. This study illustrates the need for broader policy concerning leave entitlements that explicitly include LGBTQ+ people and apply not just to stillbirth but all forms of pregnancy loss and family dynamics.

#### 4.4 Limitations and future research

Following recommendations and the spirit of inclusivity, the current study sought to include a broad range of LGBTQ+ participants. Despite consultation with relevant representative organisations, the extensive attempts to recruit intersex and asexual participants were unsuccessful. Gaps in knowledge about intersex, asexual, and transfeminine pregnancy loss experiences remain important to investigate in future research.

All participants in this study were in long-term relationships, and many described the strengthening of their relationships through pregnancy loss. However, this is not necessarily the case for all couples (Hanna & Gough, 2017). This sample did not capture how the stressors of conception and loss may impact single LGBTQ+ people or breakdown long-term relationships, and what their support needs may be. Future research could investigate how different family constellations may create hierarchies of exclusion and disenfranchisement.

The sample reflected some cultural diversity, including two Indigenous Australian participants, one Greek-Australian, and two participants whose partners spoke English as a second language. However, future research could investigate the experiences of intersectionality relating to ethnicity, citizenship, sexual and gender diversity, and stigmatised events such as pregnancy loss. Based on the varying experiences of a range of LGBTQ+ people engaging in the healthcare system, intersectionality is a flexible framework that may be useful in understanding LGBTQ+ people's experiences of pregnancy loss (Chan & Howard, 2020; Turan et al., 2019).

While it was beyond the scope of the present study, future research could also triangulate the findings to understand LGBTQ+ pregnancy loss experiences from a healthcare perspective. Future research could also investigate the development of a professional development LGBTQ+

cultural competency program, or specific workplace accreditation to assist in both the education of healthcare professionals and the ability of LGBTQ+ individuals to find and access informed inclusive services.

Participants regularly referred to feeling traumatised and described their experiences of pregnancy loss as traumatic. This finding is particularly interesting given changes to the criteria for PTSD diagnosis, whereby most medical events are no longer considered a traumatic stressor under Criterion A of the Diagnostic and Statistical Manual-V (American Psychiatric Association, 2013). Given the levels of distress and trauma reported by participants, future research could investigate under what circumstances pregnancy loss may result in PTSD symptomatology.

#### **4.5 Implications**

Though the latest guidelines for care following stillbirth and neonatal death include references to and consideration of fathers and first nations peoples, they do not acknowledge LGBTQ+ people's experiences or needs (Flenady et al., 2020). While they do not speak directly to the clinical guidelines, the current findings indicate that small adjustments by healthcare professionals and organisations are likely to reduce the distress of LGBTQ+ people (see Figure 2). In addition to LGBTQ+ specific inclusive care suggestions, other general care suggestions that may reduce the distress of all individuals experiencing pregnancy loss are offered (see Figure 3). These general care suggestions could be applied in conjunction with relevant recommendations from the clinical practice guidelines for care around stillbirth and neonatal death (Flenady et al., 2020).

**Figure 2***Practical Suggestions for Inclusive Care Following Pregnancy***Suggestions for LGBTQ+ inclusive care**

- Be mindful that all pregnancy losses are NOT the same: LGBTQ+ people experience added layers of complexity.
- Ensure medical forms and communication use inclusive language.
- Signposting safety:
  - Use inclusive representation online: to avoid discriminatory experiences LGBTQ+ people go online to search for inclusivity/safety clues (for example, rainbow flag icons and images of same sex couples).
  - In LGBTQ+ educated settings, signpost windows and waiting rooms with pride flags or images representing LGBTQ+ diversity.
  - Mirror language of individuals, and do not assume heterosexuality.
- Healthcare professionals should educate themselves on relevant aspects of same-sex, trans, non-binary and surrogacy conception and families so that support of LGBTQ+ people is effective, and LGBTQ+ people are relieved from the role of educator.
- Understand that gay cismen engaged in surrogacy may experience *increased* distress due to distance from gestational carrier.
- Be aware that the variation in definitions of miscarriage and stillbirth internationally may cause confusion and distress for people engaging in surrogacy overseas.
- Continuity of care reduces stress relating to perpetually “coming out” in healthcare settings.
- Where continuity of care is not available, healthcare professionals can reduce distress by appropriately signposting their acceptance of sexual and gender diversity as soon as possible.
- Identify and provide LGBTQ+ referral pathways where appropriate (this will validate emotions, promote support-seeking and reduce barriers to receiving support).
- Engage in self-reflection: assumptions about what it means to be family, the importance of biology and gendered language.

**Figure 3***Care Suggestions For All Individuals Experiencing Pregnancy Loss***Care suggestions for all individuals experiencing pregnancy loss**

- Validating grief reduces distress and improves resilience.
- Assumptions about distress or support needs following pregnancy loss should not be made based on gestational age.
- Be aware that individuals engaging in ART have added layers of distress and grief.
- Individuals should be screened for suicide risk, and all parents should be followed up (by telephone) by a healthcare professional within 48 hours of notification of loss.
- Adequate information about pregnancy loss and aftercare, including what to expect physically and emotionally empowers (rather than frightens) people and can reduce overall experiences of distress and trauma.

From this research, it is clear that LGBTQ+ people face additional challenges, which need to be recognised, over and above those experienced by heterosexual people. Additionally, healthcare professionals should be made aware of their ability to offset experiences of marginalisation through compassionate, inclusive care, and encouraged to normalise help-seeking and provide appropriate referral pathways. In this way, healthcare professionals can validate emotional responses to loss and reduce the workload of LGBTQ+ people seeking appropriate supports.

Particularly in settings such as reproductive healthcare, professionals should be aware that LGBTQ+ people anticipating discrimination look closely for signs of inclusivity. While current clinical guidelines for care following stillbirth (Flenady et al., 2020) include the intention to be culturally sensitive, LGBTQ+ people do not see themselves represented in the care recommendations. The present study highlights the importance of affirming the legitimacy of LGBTQ+ people and their efforts to grow a family. Even where needs are similar, guidelines must be revised to include LGBTQ+ people, so they are at the very least acknowledged. For example, through the inclusion of a statement such as “these guidelines apply to all people seeking to become parents, regardless of gender and sexual diversity”.

#### **4.6 Conclusion**

This research highlights how LGBTQ+ people contend with extra layers of difficulty following pregnancy loss. LGBTQ+ people experience a lack of acknowledgement of their efforts to conceive, and an invalidation of their significant relationships and status as “real parents” through heteronormative language, policies and services. Healthcare professionals should be made aware of their opportunity to positively impact the experiences of LGBTQ+



individuals through minor acts of compassion and inclusive care following pregnancy loss. LGBTQ+ people would benefit from broader social awareness and understanding of the added layers of their pregnancy loss experiences. The lack of societal acknowledgement and legitimisation of LGBTQ+ individuals' reproductive efforts compounds distress. Kinship norms, heteronormative services, a lack of validation and experiences of discrimination both increase the need for, and create barriers to, support following pregnancy loss. Despite the added layers of complexity, LGBTQ+ people without easy access to appropriate services are likely to avoid supports, further compounding and extending distress.

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## Appendix A

### Evidence of Consultation with LGBTQ+ Organisations



18 June 2020

Ms Alice Rose, School of Psychology, The University of Adelaide, North Terrace Campus  
ADELAIDE SA 5005

RERC Reference Number 202011

Dear Ms Rose

I am writing in regard to your recent application to the ACON Research Ethics Review Committee (RERC) titled: **LGBTIQA+ Experiences of Pregnancy Loss: Perceptions of Formal and Informal Support and the Impact on Mental Health**

The Committee moved to provide full ethical support to this application.

The following points of consideration were raised by the Committee for the research team, although don't affect the approval decision:

- The Committee suggest changing the language on one poster from "LGBTQIA+ or non-binary" to sexuality and gender diverse, or LGBTQIA+, as per rest of the project, noting that there is no reason to single out non-binary people in that poster.
- The Committee recommends that if no participants from sex and gender diverse (e.g. intersex or transgender people) or asexual communities are recruited for the project, they should be removed from the purported cohort of the research.
- The Committee suggests not using the phrase 'Australians who identify as LGBTQIA+'. A more appropriate identifier may be 'People from LGBTQIA+ communities, living in Australia who are fluent in English'.

The Committee, and ACON itself, welcome research on this topic and we wish you the very best with this project. Please do not hesitate to be in touch so we may best support you in this work, correspondence addressing the above can be directed to Brandon Bear, Manager, Policy Strategy Research at [bbear@acon.org.au](mailto:bbear@acon.org.au)

Kind regards,  
Brandon Bear Manager,  
Policy Strategy Research

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**Authority to Fundraise**  
CFN/21473

## Appendix B

### Recruitment Flyer



## School of Psychology The University of Adelaide

### PARTICIPANTS INVITED

We are seeking participants to take part in a research study of **LGBTQIA+ Experiences of Pregnancy Loss: Perceptions of Formal and Informal Support and the Impact on Mental Health**

**As a participant** in this study, you will be asked to take part in an interview with the researcher, at your convenience, to describe your experiences of pregnancy loss.

**To be eligible**, you must be sexuality or gender diverse and have experienced pregnancy loss more than 6 months and less than 10 years ago. This includes many types of pregnancy loss such as miscarriage, stillbirth, the loss of a pregnancy being carried by your surrogate, and medically-indicated termination of pregnancy. We are interested in speaking with the person who carried a pregnancy and/or partners of the person who carried a pregnancy, and/or people who have sought to become parents through the use of a surrogate.

**Your participation** would involve one session, lasting approximately one hour. All data will be de-identified prior to analysis and publication.

You may not receive a direct benefit from this study, but your participation may help discover ways to best support other LGBTQIA+ identifying individuals who experience pregnancy loss in the future.

For more information about this study, or to volunteer, please contact:

**Alice Rose**

**School of Psychology**

**The study has been reviewed and approved by the Human Research Ethics Committee, H-2020-025, The University of Adelaide.**

## Appendix C

### Participant Information Sheet



## PARTICIPANT INFORMATION SHEET

**PROJECT TITLE:** LGBTQIA+ Experiences of Pregnancy Loss: Perceptions of Formal and Informal Support and the Impact on Mental Health

**HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER:** H-2020-025

**PRINCIPAL INVESTIGATOR:** Dr Melissa Oxlad

**STUDENT RESEARCHER:** Alice Rose

**STUDENT'S DEGREE:** Bachelor of Psychological Science (Honours)

Dear Participant,

You are invited to participate in the research project described below.

#### **What is the project about?**

This project aims to increase understanding around the experiences of pregnancy loss for LGBTQIA+ individuals including perceptions about the support (formal and informal) received and its impact on their mental health.

#### **Who is undertaking the project?**

This project is being conducted by *[Removed for blinded submission]*, forming the basis of her Honours degree in Psychology, under the supervision of *[Removed for blinded submission]*

#### **Why am I being invited to participate?**

This research will explore the perceptions of LGBTQIA+ people and/or their partners who have experienced pregnancy loss as the gestational carrier (the person carrying the pregnancy), with their partner as the gestational carrier, or who sought to have a child with the assistance of a surrogate. Perceptions of available formal and informal support and emotional reactions to pregnancy loss and support received will be explored. We are looking to speak to people who identify as LGBTQIA+ and/or their partners, who are fluent in English and have experienced pregnancy loss between 6 months and 10 years ago. Pregnancy loss can include miscarriage, stillbirth, loss of pregnancy conceived through surrogacy, or any event the individual perceives is a pregnancy loss such as medically-indicated termination.

#### **What am I being invited to do?**

If you consent to participate, you will be able to participate in an interview about your experience of pregnancy loss. Interviews can take place at the University of Adelaide (North Terrace Campus), over the telephone, or an alternative public area at a time that is convenient to you. The interview will be recorded, so that an anonymous transcript of the interview can be made.

**How much time will my involvement in the project take?**

Each interview is anticipated to take approximately 1 hour of your time.

**Are there any risks associated with participating in this project?**

Due to the sensitive nature of the topic being discussed, you may experience some emotional distress during the interview. However, every effort will be made to minimise this possibility, and you will be provided with a comprehensive list of supports that you may wish to access following the interview. You can view these supports at the end of this Information Sheet. You can also choose to not answer questions, or to end the interview at any time.

**What are the potential benefits of the research project?**

The perspectives of individuals who identify as LGBTQIA+ who have experienced pregnancy loss have been under-researched. This research seeks to change this, by creating increased community awareness and understanding of the experiences of LGBTQIA+ individuals who experience pregnancy loss. This research may also help to inform healthcare professionals and support organisations about how to best support individuals experiencing pregnancy loss. Although you will not receive any financial compensation for your involvement, your participation in the interview may provide valuable insights that will help future individuals in their journey with pregnancy loss.

**Can I withdraw from the project?**

Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study until data analysis which will begin after participants have been sent their transcript to review.

**What will happen to my information?**

Confidentiality and Privacy

Participant names will not be used in this research. All participants will be given a pseudonym and all information will be de-identified. While all efforts will be made to remove any information that might identify you, as the sample size may be small, complete anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personally identifying details are revealed.

Storage

All information and data for this project will be stored securely. Any hard copy data will be kept securely under lock and key in the School of Psychology at the University of. All electronic data collected will be stored according to the University of Adelaide's policy, on a secure server with password protection. This data will be stored for a period of five years post-publication and will only be accessible by the researchers.

Publishing

Your name and any identifying information will remain confidential. You will not be identified in any publications; only summary data will be published. Findings from the research may be published as a book, thesis, journal article, news article, website, report and in conference presentations.

Sharing

Data will be made available for use in future studies as indicated on your consent form. Only your de-identified information will be used in the future. This de-identified data may be shared with other researchers.

**Who do I contact if I have questions about the project?**

Should you wish to ask any further questions about the project, please contact [Removed for blinded submission]

**What if I have a complaint or any concerns?**

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2020-025). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:

Phone: +61 8 8313 6028

Email: [hrec@adelaide.edu.au](mailto:hrec@adelaide.edu.au)

Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

**If I want to participate, what do I do?**

Please email XXXX. You will then receive a consent form and be able to arrange a time for an interview.

Yours sincerely,

Alice Rose

**Support Resources****To talk to someone right away:**

- [Q-Life](#) (provides anonymous and free LGBTI peer support and referral)  
Available 3pm-Midnight everyday. Call or text : 184 527 <https://qlife.org.au>
- [Beyond Blue](#)  
Available 24/7: 1300 224 636
- [Lifeline](#)  
Available 24/7: 13 11 14
- [PANDA](#) (Perinatal Anxiety & Depression Australia)  
Available 9am – 7.30pm Mon – Fri: 1300 726 306

**Organisations offering support for infertility:**

- [Australian and New Zealand Infertility Counsellors Association List of Counsellors](https://www.fertilitysociety.com.au/wp-content/uploads/ANZICA-PRIVATE-PRACTICE-LIST_FINAL-1.pdf)  
[https://www.fertilitysociety.com.au/wp-content/uploads/ANZICA-PRIVATE-PRACTICE-LIST\\_FINAL-1.pdf](https://www.fertilitysociety.com.au/wp-content/uploads/ANZICA-PRIVATE-PRACTICE-LIST_FINAL-1.pdf)
- [Fertility Support Australia](#)

- <https://fertilitysupport.org.au/>
- The Pink Elephant Support Network – resources and peer support relating to miscarriage and infertility  
<https://miscarriagesupport.org.au/>
- Pregnancy Birth & Baby  
[www.pregnancybirthbaby.org.au/pregnancy-birth-baby-helpline](http://www.pregnancybirthbaby.org.au/pregnancy-birth-baby-helpline)
- Red Nose (formerly SIDS and Kids)  
[www.rednosegriefandloss.com.au](http://www.rednosegriefandloss.com.au)
- Sands (Stillbirth and Newborn Death Support)  
[www.sands.org.au](http://www.sands.org.au)
- Stillbirth Foundation Australia  
[www.stillbirthfoundation.org.au](http://www.stillbirthfoundation.org.au)

**Appendix D**  
**Consent Form**



**Human Research Ethics Committee (HREC)**

**CONSENT FORM**

1. I have read the attached Information Sheet and agree to take part in the following research project:

<b>Title:</b>	LGBTQIA+ Experiences of Pregnancy Loss: Experiences of
<b>Ethics Approval</b>	<b>HREC-2020-025</b>

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project is to improve the quality of health/medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I agree to participate in the activities as outlined in the participant information sheet.
6. I agree to be:  
Audio recorded  Yes  No
7. I wish to receive a copy of:  
 A summary of the emergent themes  
  
 A brief final report



8. I understand that participation in this study is voluntary and I am free to withdraw from the project at any time until data analysis which will begin after participants have been sent their interview transcript to review.
9. I have been informed that the information gained in the project may be published in a book, thesis, journal article, news article, website, report and in conference presentations.
10. I have been informed that while I will not be named in the published materials, it may not be possible to guarantee my anonymity given the nature of the study and/or small number of participants involved.
11. I hereby provide 'extended' consent for the use of my data in future research projects that are:
- in the same general area of research (for example, genealogical, ethnographical, epidemiological, or chronic illness research):
- Yes  No
12. I understand my information will only be disclosed according to the consent provided, except where disclosure is required by law.
13. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

**Participant to complete:**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Researcher/Witness to complete:**

I have described the nature of the research to \_\_\_\_\_

*(print name of participant)*

and in my opinion, they understood the explanation.

Signature: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix E

### Interview Schedule

#### Demographic Questions:

Can you please tell me some background information about yourself such as?

Age? Your cultural background? How many children would you want in an ideal world to complete your family?

Use ACON Recommended Gender and Sexuality Indicators (ACON, 2020)

Key Question: Could you please share a little about your experience(s) of pregnancy loss?

#### PROMPTS

Can you tell me about the feelings you have experienced in relation to your pregnancy loss?

- How does this compare to other types of loss that you have experienced?

How did your grief impact your life?

- What types of activities, work or social related, were impacted?

Were you able to tell your employer about your loss? If so, did they give you leave?

Can you tell me about the support(s) you received at the time of your pregnancy loss?

- What support have you received from
  - Family and friends after your pregnancy loss?
  - Your employer or work colleagues after your pregnancy loss?
  - Health professionals (such as your general practitioner, the staff at fertility clinics)
  - Support organisations
- Have you sought support from other professionals such as a counsellor, social worker, or psychologist?

Did you speak with other LGBTQ+ individuals who have experienced pregnancy loss? If so, can you please describe your experience of interacting with peers?

- What were you hoping to gain by contacting others who have experienced pregnancy loss?
- Did you achieve what you hoped for?
- Do you feel that the actions you took to conceive were acknowledged as part of the support you received?

Were you satisfied with the support you received?

- What have been the most helpful things people have said or done after your pregnancy loss?
- What have been the most unhelpful things people have said or done after your pregnancy loss?

What types of support, if any, are you receiving now (professional, family, friends, online)?

What sorts of challenges did you feel you faced in trying to receive support?

What if anything, made it difficult for you to *seek* the support you wanted?

What, if anything, made it difficult for you to *receive* the support you wanted?

What was it like providing support to your partner?

- Were you and your partner both able to give and receive support?
- How confident were you in knowing how to support your partner?
- Were there any challenges you faced in providing support to your partner?
- What was the most challenging aspect of supporting your partner?

Do you think your relationship with your partner has changed as a result of pregnancy loss?

- How?

What has been the most challenging part of your experience with pregnancy loss?

What TYPES of support do you think would be useful for LGBTQ+ individuals experiencing pregnancy loss?

If you could give one piece of advice to another LGBTQ+ person experiencing pregnancy loss, what would it be?

Is there anything else you would like to share with us?

## Appendix F

### Recommended Gender and Sexuality Indicators (ACON, 2020)

SEXUAL ORIENTATION	INTERSEX STATUS
Do you consider yourself to be: <ul style="list-style-type: none"> <li><input type="checkbox"/> Lesbian, gay or homosexual</li> <li><input type="checkbox"/> Straight or heterosexual</li> <li><input type="checkbox"/> Bisexual</li> <li><input type="checkbox"/> Queer</li> <li><input type="checkbox"/> Different identity (please state)</li> </ul>	Were you born with a variation of sex characteristics? (this is sometimes called 'intersex') <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Prefer not to answer</li> </ul>
GENDER	
Which of the following best describes your current gender identity? <ul style="list-style-type: none"> <li><input type="checkbox"/> Male</li> <li><input type="checkbox"/> Female</li> <li><input type="checkbox"/> Non-binary/gender fluid</li> <li><input type="checkbox"/> Different identity:</li> </ul>	What sex were you assigned at birth (i.e. what was specified on your original birth certificate)? <ul style="list-style-type: none"> <li><input type="checkbox"/> Male</li> <li><input type="checkbox"/> Female</li> </ul>

The following template is recommended by ACON as a minimum standard in research data collection: