GRIEF AND BEREAVEMENT EXPERIENCES OF COUPLES WITH PRENATAL LOSS EXPERIENCE: EXAMINING PSYCHO-SOCIAL INTRICACIES IN A QUALITATIVE PHENOMENOLOGICAL STUDY

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ABSTRACT

GRIEF AND BEREAVEMENT EXPERIENCES OF COUPLES WITH PRENATAL LOSS EXPERIENCE: EXAMINING PSYCHO-SOCIAL INTRICACIES IN A QUALITATIVE PHENOMENOLOGICAL STUDY

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The purpose of this study was to describe the experiences of partners who experienced pregnancy loss. For this purpose, qualitative methodology was preferred, and phenomenology method was used in order to reflect the participants' experiences related to pregnancy loss. After conducting pilot study to get feedback about the quality, wording, and structure of sentences; the interview questions were reviewed by the academicians and psychological counselors. The data of the study were gathered via semi-structured interviews with 10 couples (10 men and 10 women). The couples were interviewed separately, and the transcribed data were analyzed by using thematic analysis method. The codes and themes that were emerged from the data were shaped regarding the research questions and related literature. The results discovered from the data explained four main themes: motivation to have a baby, short-term and long-term effects of pregnancy loss and factors affecting the grief resolution. The findings of the study revealed that pregnancy loss reactions were similar to reactions to other losses people experience. Moreover, the differences between men and women were highlighted. Results regarding the coping of the bereaved participants showed that having a prior or subsequent child, having positive perceived support from the partner and social environment could be protective factors for the bereaved ones. The findings were discussed and interpreted in the light of data gathered and the related literature. Implications for further research and for psychological counseling practices were considered.

Keywords: Pregnancy/prenatal loss, bereavement, effects of prenatal loss, socio-cultural factors, gender differences in grief.

ÖZ

GEBELİK DÖNEMİNDE KAYIP YAŞAMIŞ ÇİFTLERİN YAS VE MATEM TECRÜBELERİ: NİTELİKSEL FENOMENOLOJİK BİR ÇALIŞMADA PSİKO-SOSYAL ETMENLERİN İNCELENMESİ

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Bu çalışmasının amacı, gebelik kaybı yaşamış çiftlerin deneyimlerini tanımlamaktır. Bu amaçla, niteliksel metodoloji tercih edilmiş ve katılımcıların gebelik kaybına bağlı deneyimlerini yansıtabilmek için fenomenoloji yöntemi kullanılmıştır. Görüşme sorularının kalite, ifade ve cümle yapısı hakkında geri bildirim almak amacıyla yapılan pilot çalışmadan sonra, akademisyenler ve psikolojik danışmanlar tarafından görüşme soruları gözden geçirilmiştir. Araştırmanın verileri, 10 çift (10 erkek ve 10 kadın) ile yapılan yarı-yapılandırılmış görüşmeler yoluyla toplanmıştır. Çiftlerle görüşmeler ayrı/bireysel olarak gerçekleştirilmiştir ve deşifre edilen veriler tematik analiz yöntemi kullanılarak analiz edilmiştir. Verilerden çıkan kodlar ve temalar, araştırma soruları ve ilgili literatürle şekillendirilmiştir. Verilerden elde edilen sonuçlar dört ana temayı açıklamıştır: bebeğe sahip olma motivasyonu, hamilelik döneminde bebek kaybının kısa süreli ve uzun süreli etkileri ve yas çözümünü etkileyen faktörler. Araştırmanın bulguları, gebelik kaybı tepkilerinin insanların yaşadığı diğer kayıplara verdikleri tepkilere benzediğini ortaya koymuştur. Ayrıca, erkekler ve kadınlar arasındaki farklar vurgulanmıştır. Yaslı ebeveynlerin baş etme mekanizmalarıyla ilgili sonuçlara bakıldığında, kayıp öncesi ya da kayıp sonrası çocuğa sahip olmanın, partnerden ve sosyal çevreden olumlu algılanan desteğin, yas tutma sürecinde koruyucu faktörler olduğu gözlemlenmiştir. Bulgular, toplanan veriler ve ilgili literatür ışığında tartışılmış ve yorumlanmıştır. İleride yapılacak çalışmalar ve psikolojik danışmanlık uygulamaları için çıkarımlar tartışılmıştır.

Anahtar Kelimeler: Gebelik dönemi/doğum öncesi kayıp, yas, doğum öncesi kayıpların etkileri, sosyo-kültürel faktörler, yas sürecinde cinsiyet farklılıklar.

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CHAPTER 1

INTRODUCTION

1.1. Statement of the Problem

A new life begins with birth and a life ends with death. Notwithstanding, this life assumption may be shattered too much with human experiences (Janoff-Bulman, 1992), sometimes an expectation of a baby may end up with the loss of that baby before birth. In factual numbers, almost one fifth of the pregnancies end with losses, as called prenatal or pregnancy losses (Covington, 2006). Within that, those that occur before the 20 weeks of gestation are called as miscarriages and losses that occur after the 20 weeks of gestation have been called stillbirths (Covington, 2006). In the worldwide statistics, the occurrence of the miscarriages has been defined as 15 % of pregnancies, and for the stillbirth this occurrence has been documented as 1 in every 100 pregnancies (Maker & Ogden, 2003; Reed, 1984; Ridaura, Penelo & Raich, 2017). In a study conducted by Hacettepe University Institution of Population (2013), the number of miscarriages and stillbirths that occurred within the last four years was higher than the statistics: 23 % for miscarriages and 3 % for stillbirths have been documented.

As Wright, Limbo and Black (2016) expressed that "Births are celebrated, deaths are mourned, and the deaths of children are recognized as particularly tragic in light of the universal assumption that children will outlive their parents'' (p.5). For the parents who experience the loss of their child, this loss is more than unexpected. For bereaved parents, this loss ignores the natural order of life (Janoff-Bulman, 1992; Wender et al. 2012). Independent of the age of the child, it is one of the most overwhelming experiences in life and it may have long-standing effects on the bereaved parents, even when there is no time for men and women to see the baby (Leon, 2018; Riley, LaMontagne, Hepworth & Murphy, 2007). When a child is lost, parents not merely lose an important bond, but also their anticipated future of being a parent (Jaffe & Diamond, 2011). That is why; losing a child can be devastating for the parents. Most of the time, child loss gets complicated for the parents with the feelings of guilt because of the presumed failure of protecting their offspring, even if there is actually nothing they can do to avoid the loss. (Volkan & Zintl, 2008).

It is pointed in different studies and theories that the death of a child can be a traumatic experience that can have long-term effects on the partners' lives. For instance, a

comparative study in which parents who lost their children during infancy to 34 years of age were compared with a comparison group of parents (in total 856 parents) demonstrated significant differences between these two groups of parents. Bereaved parents had more depressive symptoms, worse well-being scores and more health problems than comparison group. In addition, they experienced more depression and marital problems than non-bereaved group of participants. When the bereaved parents were compared within their own group, parents who had a purpose in the life and who have living children were more likely to recover from grief. Cause of the death and the time passed since the loss was found to be not related with recovery (Rogers, Floyd, Seltzer, Greenberg & Hong, 2008). While, child loss and its repercussions on parents have been examined a lot, there is a specific kind of child loss that has been unrecognized for many years: prenatal or pregnancy loss. In a study conducted by Hacettepe University Institution of Population study (2013), among married woman (N=7063) the pregnancy loss ratio was between 3 and 23 percent within the last 4 years. In general, 15 of the marriages end with miscarriage, 1 in 80 every pregnancy end with stillbirth, and 1 in 100 ends with an ectopic pregnancy (Maker & Ogden, 2003; Reed, 1984; Ridaura, Penelo & Raich, 2017).

In spite of the high number of pregnancy loss, prenatal losses have not been accepted by the society as a loss that needs to be mourned on. Since 1970s, mental health literature has been paying more attention to the needs of families who experienced prenatal loss (Forresti, Standish & Baum, 1982). The research findings, however, have not crossed the limits of scientific research and not fulfilled the emotional, psychological, physical and societal needs of those bereaved men and women (Reed, 1984). In different studies, parents expressed their sense of isolation or loneliness regarding their expressions of grief or societal expectations for their grief (Heazell et al. 2016; Peppers & Knapp, 1980; Smith & Borgers, 1988; Rajan & Oakley, 1993; Stringham, Riley & Ross, 1982). Moreover, "The parents' grief and mourning are often felt to be 'abnormal', since others cannot readily see the attachment that existed between parent and child before birth." (Kirkley-Best & Kellner, 1982, p. 420). As expressed by Smith and Borgers (1988):

> It should be remembered that the experience of perinatal death is not considered by society as a significant loss on a par with the loss of an older child or adult loved one and that the predominant media messages may convey the impression that perinatal death can be avoided with good medical care and good health habits, this combination of societal indifference and the glorification of a happy, healthy pregnancy often causes the bereaved couple to feel alone in their grieving (p. 211).

Losing a child during pregnancy should not be accepted by the parents, families and the broader society as an ignorable experience. As some research findings on pregnancy loss revealed, when the time dimension was considered, reactions of parents to early miscarriage or stillbirth are as great as the reactions to a neonate loss (Büchi, Mörgeli, Schnyder et al., 2009; Cuisinier et al., 1993; de Montigny, Verdon, Meunier, Dubeau, 2017; Forrest, Standish & Baum, 1982; Krosch& Shakespeare-Finch, 2017; McCreight, 2004; Peppers & Knapp, 1980; Plagge & Antick, 2009; Reed, 1984; Ridaura, Penelo & Raich, 2017). In a study conducted in Finland about the psychological consequences of miscarriage, it was found that during the period between 1987 and 1994, suicide rate of women within a year after the miscarriage was considerably higher (18.1/100.000), than the women who gave a live birth and women in the general population (5.9/ and 11.3/100.000 respectively) (Gissler, Hemminki & Lonnqvist, 1996). Therefore, pregnancy loss might affect partners negatively even though in the past it was believed that an unborn child did not affect the well-being of a mother and a father. Admitting the grief processes of these bereaved parents is very important because when the psychological needs of bereaved partners are overlooked by professionals, friends, or families (Clower, 2003), completion of the normal bereavement process might be harder (Reed, 1984).

Whether it be called stillbirth, miscarriage, or prenatal loss, partners who experience a pregnancy loss are likely to have short-term and long-term reactions to this loss. While loss is a common experience to all human beings and there are some common grief reactions to losses in all cultures such as emotional (feelings of sadness, guilt, anger etc.), cognitive (i.e. difficulty in concentrating in other things rather than loss, decreased self-esteem, cognitive problems), behavioral (i.e. crying a lot, avoidance of social situations) or physical (i.e. eating or sleeping problems, use of addictive substances) (Stroebe, Hansson, Stroebe & Schut, 2001), there are also individual differences as grief is also a personal process that can be affected by different factors. Schut, Stroebe et al. (2001) summarized the factors affecting the outcomes of bereavement under three categories: individual factors like gender, emotional features, religious beliefs, self-issues; situational factors like the loss that is sudden or anticipated and lastly interpersonal factors which are social reactions from others (partner, family, close friends etc.). Some of the pregnancy loss specific factors affecting the grief process are as follows: gender of the parent, gestational age, reactions of partners, whether the mother or father or both saw or held the dead body of the baby, whether there was a funeral or any kind of memorial service applied, whether the reason of the baby's death was analyzed by autopsy, whether siblings or subsequent pregnancies exist, previous loss

experiences of the couple, parent's support mechanisms including the crisis intervention and information related to grieving process, personal psychiatric history, unplanned and unwanted pregnancies (Kirkley-Best & Kellner, 1982; Klier, Geller & Ritsher, 2002;Tseng, Cheng, Chen, Yang & Cheng, 2017).

Different terms have been used for the loss that is experienced during the pregnancy. Wright (2011) drew attention to the problems resulting from the use of diverse terminology to depict the loss during pregnancy. To name a few, fetal death, stillbirth, perinatal loss, spontaneous abortion, early miscarriage, and early pregnancy loss are some of the terms preferred in different studies. Even if some studies may examine the same time interval of pregnancy loss, using the terms interchangeably and giving different names may be confusing for the reader (Krosch & Shakespeare-Finch, 2017) and may create a risk for the validity (Wright, 2011), and probably create confusion for mental health workers regarding their attitudes for pregnancy loss and their reactions to those who suffer from the loss (Wright, 2011).

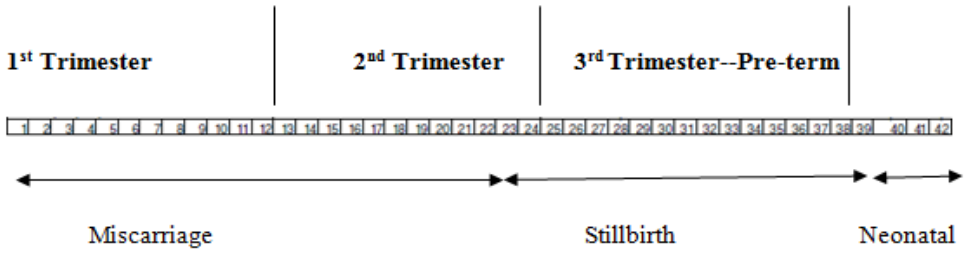

Figure 1: Pregnancy Loss in Different Periods (source: Covington, 2006)

To name a few, **perinatal period** covers the term from the 22th week of the gestation to 7 days after the birth (Yılmaz, 2010). While Elklit and Gudmundsdóttir (2006) define the perinatal loss for death from gestation weeks 28–42 or during birth, Yılmaz (2010) identified perinatal loss as the loss occurring between the start of gestation and period of postpartum. On the other hand, perinatal death term has been used by Thomadaki (2012) or Kersting and Wagner (2012) for both stillbirths and neonatal losses. In their studies de Montigny, Beaudet, and Dumas (1999) identified **perinatal loss** as "a death occurring during pregnancy (miscarriage, abortion, or in-utero death), the birth process (stillbirth), or the 1st week of life (neonatal death)." (p.152). Loss occurred before 16 weeks of gestation was defined as **early pregnancy loss** by Hutti (1986), while the same term was defined as loss before 20 weeks by American College of Obstetricians and Gynecologists (2007) (as cited in Wright, 2011).

Thomadaki (2002) and Yılmaz (2010) have accepted the loss within the first four weeks of life as **neonatal death**. Elklit and Gudmundsdóttir (2006) added the situation in which an infant does not have any sign of life in the womb and is born after gestation week 20.

Stillbirth is the death of a baby or fetus, before its birth or removal in the period at least 20 weeks prior to gestation (Gold, Sen & Hayward, 2010; Li, Zeki, Hilder & Sullivan, 2013). In US the term stillbirth also includes death of a child just before gestation (Cacciatore, Blood & Kurker, 2018). In either case, it is expected that the child is dead when it is born, so it can be a premature birth or at full term (Elklit & Gudmundsdóttir, 2006). A birth weight of over 500 gr. is also used as a criterion for a stillbirth (Kersting & Wagner, 2012). In Australia, a stillbirth is defined as a death in utero occurring at or after 20 weeks' gestation (Australian Bureau of Statistics, 2011). **Miscarriage** refers to loss of fetus or embryo before 20 weeks of gestation (Covington, 2006; Li, Zeki, Hilder & Sullivan, 2013) and it is the most common pregnancy loss (Covington, 2006; Kersting & Wagner, 2012; Meaney, Corcoran, Spillane & O'Donoghue, 2016). Miscarriage has been defined by Klier and his associates (2002) as the premature loss of an embryo or a fetus during the first 27 weeks of pregnancy (Klier et al. 2002)., and as loss occurred before 24 weeks gestation in a fetus weighing less than 500 g. by Meaney et a (2016). There is also the term early miscarriage that is used for pregnancy losses occurred before 16 weeks of gestation (Houwert de Jong et al., 1990). The prevalence rate for miscarriage is between 15 and 27% for women whose ages are between 25-29 age, and the rate is 75% for women who are older than 45 years (Robinson, 2011). This involuntary pregnancy loss also includes ectopic pregnancies (Gold, Sen & Hayward, 2010).

Pregnancy loss has been examined from psychological, physical, social, economic perspectives. However, when looking at the social norms, generally, a woman's pregnancy loss has been considered as a physical concern to others. Moreover, in some cultures, there is a concern for others whether the bereaved woman would be able to have another child. While concern over the physical health and subsequent pregnancy are expected issues for bereaved women, they might also need that other people such as doctors and family members recognize the significance of their loss (Worden, 2009).

Studies focus on the negative effects of child loss on mothers such as prolonged grief reactions, severe grief symptoms, family problems, financial, or emotional problems (Engelkemeyer & Marwit, 2008; Heazell, Siassakos et al., 2017; Helstrom & Victor, 1987; Rowe, Clyman et al., 1978; Li, Precht, Mortensen & Olsen, 2003). Even though fathers' roles are important in complementing the mother's role and in the well-being of the child,

fathers may underestimate their roles in the family because of the societal and cultural factors (Barrows, 2004; Wong et al., 2016). Although not so much in the number, there are also studies investigating the paternal effects resulting from child loss (i.e. Hughes &Page-Lieberman, 1989; Turton, Badenhorst et al., 2006). According to Turton et al. (2006) recruitment of fathers in social studies is difficult, and there are many reasons for the low number of father participants in bereavement studies. For instance, because of cultural reasons, men may be reluctant to talk about their emotions. Sometimes, researcher and study related factors limit the reflection of men's perspectives. Examining the roles of the fathers in terms of their support for the mothers might mean neglecting the grief reactions of men. Thus, even if both partners experience the same loss, grief has been assumed to be a predominantly maternal subject which leads to failing to notice the effects of child loss on men (Beutel, Willner, Deckardt, Rad & Weiner, 1996; McCreight, 2004; Murphy, 1998). By obtaining data from both partners regarding pregnancy loss experiences; it would be possible to understand men and women's reactions as well as interactional results of loss on the partners' relationships.

Exploring personal reactions to prenatal loss of men and women are also important for the need for understanding the maternal and paternal loss experience. Brier (2004) stressed the necessity of determining the impact of child loss on parents' emotional situation because the loss theory has not been specifically developed for the loss experienced by the parents. Lack of an extensive theory for maternal loss and paternal reactions to pregnancy loss may not give the proper information for mental health workers to help those bereaved parents (Wright, 2011).

From another perspective, losing a baby during pregnancy actually means multilayered losses. To name a few; loss of the experience of pregnancy and loss of the opportunity to give birth to a child; loss of the feelings of healthiness and normality; loss of control, loss of identity as a parent; loss of one's sense of self or sense of belonging and closeness to partner and other people in social life; loss of sexual intimacy and privacy, loss of trust in the world (Jaffe & Diamond, 2011). Pregnancy loss not only affects individual women and men, but also their families, society, and the government in different ways such as the costs for medical care, or costs for funeral; reduced social functioning, relationship disruptions in the family; reduced earnings because of maternity or paternity leaves. As a result, a more systematic perspective should be adopted for understanding pregnancy loss (Hansson, Carpenter & Fairchild, 2003; Heazell, Siassako, Blencowe et al., 2016).

In the grief literature, consequences of losing someone to death have been examined with regard to normal grief process, abnormal or complicated grief and post-traumatic growth. There have been certain criteria used to identify the normal and the abnormal grief, but the most common and accepted criteria belong to American Psychological Association's DSM (the latest version DSM-V (2013)) (APA, 2013). In the DSM-V (APA, 2013), normal grief period for an adult person has been identified as six months. It should be expressed that there have been socio-cultural factors affecting the grief, so how the grief has been reflected may differ from one culture to another.

From growth perspective, paying attention only to the adverse and traumatic consequences of an event, however, can be misleading by ignoring the positive effects of the event on the person. Understanding of trauma and adverse life events should include the examination of positive as well as negative changes in order to have a comprehensive understanding of the nature of human experience (Linley & Joseph, 2004). We have increased our knowledge about the possible effects of trauma on people, while our knowledge of people who keep their psychological well-being in spite of experiences of different kinds of adversity has remained very restricted (Linley & Joseph, 2004). Even if the loss experience is painful, grief promotes growth and improvement and it has the capacity to uncover the hidden resources and strength of the bereaved person (Shuchter & Zisook, 2003).

In the literature, positive psychological changes experienced as a result of the struggle with highly challenging life circumstances have been described as *Post-Traumatic Growth (PTG)* (Calhoun & Tedeschi, 1999). In other words, psychological improvements of people who face with diversity in their lives, in terms of their cognitive and emotional understanding of the world and themselves are called posttraumatic growth (Janoff-Bulman, 2006). Post-traumatic growth differs from trauma recovery in a sense that PTG requires more than reduction in symptoms and returning to normal level of functionality. People who experience post-traumatic growth have significantly positive changes after the negative life experience, and have an enhanced meaning of life, even though their stress remains the same (Calhoun & Tedeschi, 2001, as cited in Wild & Paivio, 2003). Post-traumatic growth has been studied with the sample of men and women who suffered from pregnancy loss in different studies (Batool & Azam, 2016; Cacciatore, Blood & Kurker, 2018; Kunt-İşgüder, Batmaz, Yıldız et al., 2018; Krosch & Shakespeare-Finch 2017). Therefore, while admitting the grief and the significant impact of the loss on the individual's coping mechanisms, the partners may regard themselves as "*vulnerable but stronger*" if they experience a post-

traumatic growth (Calhoun & Tedeschi, 2006, p. 5). Studying loss from this perspective does not deny the negative effects of this experience. But rather, it emphasizes the importance of studying the adaptation strategies of healthy individuals; the ways that they are transformed by the loss experience (Tedeschi & Calhoun, 2004; Thomadaki, 2017).

What is more, in the current studies the focus is mostly on the individual effects of the loss; but grief should be understood within the socio-cultural context of the individual (Walsh & McGoldrick, 2004). Even in DSM-V criteria for the duration and expression of normal bereavement the important role of culture on the grieving person has been emphasized (APA, 2013). The culture is so significant for human behavior that it affects the rituals related with loss and these rituals reflect the gender relations in the society, political issues, social status or orders. Therefore, it affects the actions of bereaved people during their bereavement process through these factors (Rosenblatt, 2010). Thus, it cannot be fully understood how specific Turkish culture affected the grief processes of men and women after pregnancy loss by relying only on the Western literature.

The lack of systematic research and methodological issues in bereavement studies in the literature has been verbalized by different researchers (Hendrickson, 2009; Kirkley-Best & Kellner, 1982; Wright, 2011). Even though this research area has reached a certain degree in the Western literature; there are still not adequate information about how men and women experience this loss and what their responses to this painful experience are, specifically in terms of strategies for mental health workers to assist their clients both regarding bereavement reactions as well as long-standing issues (Dyson & While, 1998; Kirkley-Best & Kellner, 1982; Wright, 2011). When the Turkish literature is scanned regarding the effects of pregnancy loss on men, women and the family; it has been realized that most of the studies have been conducted in medicine and nursing area. Only a few studies could have been reached that were from mental health work such as studies conducted by Yıldırım (2003), and Düzen (2016). Therefore, I can be seen that there is a gap in psychology that needs to be filled, especially in psychological counseling and guidance since the preventive studies can be benefited only after learning those protective factors in parents who went through a normal grief process after such a negative life experience.

1.2. Purpose of the Study

Purpose of this study was to understand the overall grief and bereavement experiences of couples with prenatal loss and to determine whether gender roles and other sociocultural factors impact their experiences.

1.3. Significance of the Study

Despite the fact that prenatal or pregnancy losses that have been defined as the loss of a fetus or baby after conception, during pregnancy or shortly after birth (Covington, 2006) are common experiences in the society, psycho-social needs of parents have been neglected, meaning that the partners with the pregnancy loss experience could not have the necessary psychological and social support neither from mental health professionals nor the society while the physical needs have been provided. For both partners who experience miscarriage before the 20^{th} weeks of gestation and partners who experience stillbirth after the 20^{th} weeks of gestation, the implications drawn from this study would give information about the precious data regarding the literature and practices of couple and family counseling, counseling education, supervision of counselors. For instance, how couples could be supported by extended family members and friends; or what kind of psychosocial services could be provided for the couples by mental health workers were discussed. For policy makers, the needs of the bereaved couples were examined. Also, findings of the study can be used by policy makers, couples with prenatal loss experience, and end even by the society. The power of the study regarding the applicability of the findings in different contexts result from a serious need in the literature and practice related to pregnancy loss.

Studies examining the parental experience following pregnancy loss need especially face to face interviews with bereaved parents because most of the studies conducted have used online surveys, quantitative methods to understand the experiences of parents (Heazell, Siassakos, Blencowe et al., 2017; Nuzum, Meaney & O'Donoghue, 2018). In this study, in-depth interviews were utilized to comprehend the inner experiences of partners, how they conceptualized this experience, what were the positive or negative conditions impacting on women and men's grief reactions, and socio-cultural elements affecting their grief processes.

Because there is no theory explaining the attachment between mother and father with their unborn child, information regarding this attachment is needed (Wright, 2011). There are studies that reflect the emotional, social, economic, physical problems parents experience after losing their baby during pregnancy or studies that investigate the attachment

relationship after the birth of a baby and his/her mother. There is, however, not any study that focuses on attachment during prenatal term between mother and baby (Yılmaz, 2010). Therefore, this study aims to understand this bond with mother and her unborn baby as well as the father's bond with the baby during pregnancy. The attachment existed between the partners and their baby could be traced in their grief statements, and their lost dreams related to their dead baby.

When reading the theories of grief and loss, it could be realized that most of them have been defined by the framework of Western cultures. However, it is a fact that culture influences the expression, the manifestations, and the duration of grief and ways of coping with it (Kavanaugh, Trier & Korzec, 2004; Stroebe and Schut, 1998). That is why, with this study that focused on grief experiences of participants with a socio-cultural perspective, the grief literature regarding culture in Turkey was broadened because understanding how Turkish socio-cultural features affected the partners' loss and grief processes, how the specific Turkish culture pave the way for normal, abnormal grief or post-traumatic growth would give practical and theoretical information to help bereaved parents with pregnancy loss.

By getting data from the couples, it could be possible to understand interpersonal processes in grief and factors leading to the normal, abnormal grief or PTG in couples. Indeed, there has been little research exploring these spousal interpersonal processes (Canevello, Michels & Hilaire, 2016). This study aimed to add to the grief literature by considering both intrapersonal and interpersonal factors. Gillbert (1996) suggested investigating both individual and relational factors since family members grieve in the family even if there are individual differences among family members (Gillbert, 1996). Therefore, in this research, the common patterns between partners and unique individual experiences could be identified.

In the literature, there are lots of studies focused on the gender differences. In a review study conducted by Kessler (2000), lifetime prevalence of exposure to a traumatic event is 60.7% in men, while it is 51.2% in women; and for post-traumatic stress disorder the rate is 8.1% in men and 20.4% in women (Kessler, 2000). The difference between men and women may stem from their grief experiences that are shaped by culture. For instance, men generally try to control their feelings and sometimes avoid those feelings (Bowlby, 1960; Stroebe, Stroebe, Abakoumkin & Schut, 1996). There is not much knowledge about gender differences in terms of reactions to various kinds of bereavement, including pregnancy loss (Beutel, Willner, Deckardt, Rad & Weiner, 1996; McCreight, 2004; Rinehart & Kiselica,

2010). Even if this study did not give a causal explanation, data gathered from the participants would give a perspective about understanding gender differences after pregnancy loss.

With the help of this study, it would be possible to gain a perspective about the meaning people give to their pregnancy loss at varying stages (Martincekova & Klatt, 2017; Plagge & Antick, 2009), about how parental factors such as the age of woman, number of children in the family affected their mourning process, how in-family relations and social relations were affected with the loss or how socio-cultural factors affected the grief (De Montigny, Beaudet & Dumas, 1999; Martincekova & Klatt, 2017).

To get back to normal, woman and man may prefer to minimize their loss by not talking about this experience. As the literature shows, however, denial or suppression of their feelings or thoughts about this loss may create further problems in their lives. Bringing these losses back to the consciousness and giving a chance to parents to talk about their experiences (Jaffe & Diamond, 2011) is another important aspect of this study. Even though the participants experienced the loss at most six years ago, and they did not remember the details of what they said, heard, or felt immediately after loss, the important thing in this study was to give a chance to those bereaved men and women to reflect on their pregnancy loss experience. Bereaved parents' need for talking about their grief was discussed in Nikcevic, Tunkel and Nicolaides' study (1998), and one third of the women expressed their need for emotional counseling, for opportunity to discuss their feelings.

As a qualitative research, this study does not aim to make generalizations regarding the pregnancy loss experience. However, with 20 participants, this study used a large sample size as a qualitative study. With the help of the participants coming from different SES backgrounds and different pregnancy loss experiences, we could have a perspective to understand why some couples had suffered more and others seem to manage their grief relatively well. Thus, information regarding different grief reactions of these bereaved participants can help to mental health professionals (Kavanaugh & Hershberger, 2005; Peppers & Knapp, 1980) to develop and implement better prevention and intervention programs.

Taken the scarce framework of studies available addressing the perspectives of parents with pregnancy loss experience, this study has been expected to provide an in-depth perspective for mental health workers that deal with bereaved parents and families. This study presented a systematic qualitative analysis on how partners have experienced child loss and which favorable conditions in the family, social network or individual potential helped

them to handle with pregnancy loss and even to have some positive outcomes from this loss. According to Weiss (1995), qualitative studies can be helpful for the quantitative research by providing information about variables, or hypotheses. As a qualitative interview study, this research can give information- a rich data about processes in the pregnancy grief and grief recovery.

Marriage and family counseling is one of the 19 divisions of American Counseling Association. Partners who experienced pregnancy loss have different counseling needs, therefore helping those bereaved partners requires competence in theoretical and research knowledge as well as practical skills for counselling professionals. The theoretical and research knowledge of the counselors can be increased by the help of the systematic research. This research was the first in Turkey explaining the experiences of partners with prenatal loss experience from the partners' own perspectives.

Overall, based on the best of the researcher's knowledge, this research was a pioneer study for the pregnancy loss literature by using a qualitative research design with couples, thus giving the interpersonal dimension of the pregnancy loss. By using in-depth interviews, individualistic grief responses and grief recovery of the bereaved partners were made observable. Socio-cultural factors affecting the grief of bereaved partners would give additional perspective in the formulation of prenatal loss. In terms of marriage and family counseling, implications of this study would give systematic knowledge for the counselors who work with partners with pregnancy loss experience.

1.4. Research Questions

To reach the mentioned aims, this research was formulated based on the following research questions:

1. How did partners experience prenatal loss?
2. How did partners affect each other's grief process?
3. How did partners support each other after the pregnancy loss?
4. How did men and women differ in terms of grieving process?
5. How did socio-cultural elements affect their loss experience?

1.5. Definition of Terms

As explained in the statement of purpose section above, there are some overlaps among the terms. Since this study was not conducted for medical purposes, the reasons behind the los, the fetus's weight and other factors used in the medicine to identify the prenatal loss were not taken into consideration.

In this study; while prenatal refers to period that starts with the start of the pregnancy to birth time (Duyan, Kapısız& Yakut, 2013), **prenatal loss** is used to refer to loss of baby before his/her birth. **Prenatal** and **pregnancy loss** were used interchangeably during the paper. As Covington (2006) prefers "Pregnancy loss is a broad term used to describe the death of a fetus or baby after conception, during pregnancy, or shortly after birth" (p. 290). Therefore, independent of the week of the loss of the baby/fetus; all parents who lost their child during pregnancy could participate in the study.

- **Miscarriage** was used for the pregnancy losses that occurred at or before the 20th week of gestation (Covington, 2006).

- **Stillbirth** was preferred when the pregnancy loss occurred after 20th week of gestation (Covington, 2006).

- **Grief** may be defined as the experience of losing someone loved and usual reaction to bereavement (Mander, 2006; Parkes & Prigerson, 2010; Stroebe, Hansson, Stroebe, & Schut, 2001; Worden, 2009).

- **Bereavement** is used for the objective situation of losing someone significant (Stroebe, Hansson, Stroebe & Schut, 2001).

- **Mourning** is used for the process for the bereaved person's adaptation to losing someone to death (Worden, 2009).

1.6. Limitations of the Study

Similar to any research conducted in social sciences, there are some limitations of this study that could not be avoided. The first constraint of the study stems from the nature of the research design. Because qualitative research designs need a smaller number of participants than quantitative ones, results of the 20 participants' viewpoints cannot be generalized to other settings or wider populations.

Using purposive sampling strategy limited the generalizability of the findings. However random sampling was not available as there are no data for the entire population of parents who experienced pregnancy loss. Participants were reached by the help of gatekeepers and social media tools. Stroebe, Stroebe and Schut (2003) pointed out to some motives parents may have while participating in these kinds of bereavement studies. For instance, they may want to share their experience, or to help other bereaved parents. Similarly, some parents may refuse to take part in the study because they might think that questions related to their loss would cause further distress to them or they may be too upset to talk about their experience. Therefore, partners' motives may have affected the study results.

Selection bias is another issue that needs further exploration of data. In many social studies, there are more volunteer women than men. It is the same for bereavement studies as well (Stroebe, Stroebe & Schut, 2003; Turton, Badenhorst & Hughes et al., 2006). It was aimed to reach the partners together in order to understand the dyadic factors affecting their grief and similarities or differences between their grief symptoms that were affected by the social, cultural factors. Thus, exclusion of possible participants because of the need for both couple's participation may result in the participation of couples who do not have serious problems after their pregnancy loss experience.

Contrary to standardized measurement tools like scales or tests, interviews were subject to the interviewer's possible effect on the conduction of the study and its results. To minimize the data collector bias, semi-structured interviews were preferred. Also, by getting the expert opinions in the field, such as from psychological counselors and academicians regarding how to reach the sample, format of questions, number of questions and so on, this data collector bias was tried to be minimized. Themes and codes discovered in the interviews' transcripts were discussed with those professionals.

CHAPTER 2

LITERATURE REVIEW

Statistics show that miscarriages and stillbirths are not rare. For every 100 pregnancies, 15 of them end with miscarriage, for some resources this ratio is almost 10-20 % of pregnancies. 1 in 80 pregnancy ends with stillbirth and 1 in 100 ends with an ectopic pregnancy (Maker & Ogden, 2003; Reed, 1984; Ridaura, Penelo & Raich, 2017). For the stillbirth, in other words late pregnancy loss, the ratio is 1 in 200 births (Fretts, 2005, as cited in Lee, 2012). To illustrate with actual numbers, in 2008 almost 1,118,000 of 6,578,000 pregnancies (nearly 17%) ended with fetal loss in USA (Ventura, Curtin, Abma & Henshaw, 2012).

Within the last decade, based on the improvements of "Health Transformation Program", there has been a sharp decrease in the rate of baby mortality. According to Turkey Population and Health Studies Research (Türkiye Nüfus ve Sağlık Araştırmaları- TNSA), baby mortality rate between 1998-2003 and 2003-2008 decreased by 48 %, thus baby mortality rate was 17 of one thousand (as cited in Korkmaz, Aydın, Çamurdan et al. 2013).

The "Baby Death Registration and Notification System" entered into force in 2005 by the Ministry of Health in order to monitor the routine services and special programs carried out (Korkmaz, Aydın, and Çamurdan et al. 2013). With this system, it is aimed to keep the record of all baby deaths that occur within the first year of birth. This system also includes loss of gestations over 22 weeks and death of babies who are born alive with more than 500 gr. With this form, maternal and family related demographic and health related information can be taken. In May 2009, extend of the form has been detailed with a circular letter of 31 named as "Baby Deaths Monitoring System" (Korkmaz, Aydın, Çamurdan et al. 2013). However, this system does not take into account the losses that occurred before 22nd week or when the lost baby's weight is below 500 gr.

Voluntary termination of pregnancy has been legalized with the law that was accepted in 1983. With this act, women can terminate their pregnancy within the 10 weeks of gestation. In a report by Hacettepe University Institution of Population study that was supported by the Turkey Ministry of Development and Scientific and Technical Research Council of Turkey (TÜBİTAK), (Hacettepe University Institution of Population, 2013), stillbirth, miscarriage and voluntary abortion statistics has been recorded in different periods. In Hacettepe University Institution of Population study (2013), married women (N=7063)

were asked how many times they experienced stillbirth, spontaneous abortion and voluntary termination of pregnancy. 23% of women experienced spontaneous abortion at least once, 14% of women experienced voluntary abortion at least once and 3 % of women experienced stillbirth within almost 4 years of period. In the same study, the relationship between the age of mother and voluntary abortion was revealed. While the percentage of women with an age of 15-19 who had voluntary experience is 2; for women whose ages were between 45 and 49, voluntary abortion percentage is near to 27%. Based on this, it was stated that there was a positive association between voluntary abortion and the age of the mother (N=7063) (Hacettepe University Institution of Population, 2013).

To sum up, statistical reports and studies have shown that the number of miscarriages or stillbirths is not low; almost one fifth of the pregnancies ends in pregnancy losses; therefore, the underestimation of these losses is actually misleading. Including many demographic characteristics, perinatal and childhood mortality rates are important in determining the developmental level of a country (Korkmaz, Aydın, Çamurdan et al., 2013). However, prenatal losses are overlooked and partners with prenatal loss experience have not been supported enough by the health workers or mental health professionals. While hospitals provide the medical assistance needed during the pregnancy loss; how these bereaved partners could cope with this difficulty, their confusion and fear regarding having a subsequent pregnancy, or how social system of the partners could support them have been ignored. Thus, this thesis focuses on the loss and grief experiences of individuals with the prenatal loss, so that effective psychosocial supports can be delivered to this population.

This chapter presented a review of the literature structurally framed with a focus on pregnancy loss in relation to counseling and psychology. Firstly, descriptions of loss, grief, mourning and bereavement were presented. Theories related to grief and loss were explained in order to provide comprehension of the issue. After that, pregnancy loss related literature was presented with its theories, research findings, and reports. In order to understand the contextual factors, socio-cultural dimensions of pregnancy, birth, and loss were demonstrated.

2.1. Loss, Grief, Bereavement, and Mourning

In the most books and articles, grief, mourning and bereavement have been used interchangeably (Worden, 2009). Loss has been accepted as an ambiguous, relativistic and complicated concept, especially after the modern medicine's compartmentalization of the death concept. For instance, there have been terms used for different phenomena like clinical

death, biological death, cell death (Göka, 2010). Grief may be defined as the experience of losing someone loved (Mander, 2006; Parkes & Prigerson, 2010; Worden, 2009), a usual reaction to bereavement (Stroebe, Hansson, Stroebe & Schut, 2001). The reactions of the person can be emotional or behavioral (Giddens & Giddens, 2000; Parkes & Prigerson, 2010). Halifax (2008) identified five categories of losses after which a person experiences the deep sorrow: the loss of a loved one, the loss of identity or status, the loss of the relationship, the loss of a place or a thing, and lastly the loss of capacity (p. 335).

After losing someone important, the bereaved ones may feel the ache so much that it resembles a physical ache felt after a wound (Parkes & Prigerson, 2010). Engel (1961) argues that grief resembles a departure from the healthy status and as in physical wounds, human psychology needs a period in order to return to an equilibrium. This restoration and healing process might differ from person to person (Engel, 1961).

Mourning is used for the process of the bereaved person's adaptation to losing someone to death (Worden, 2009). For instance, while crying is related to grief, weeping and wailing are related to mourning (Robben, 2004). According to Mander (2006), mourning differs from grief since grief is mostly related to emotional reactions of the person, while mourning is the wide-ranging, socially shaped manifestations to loss. Rituals, rites of passage regarding the loss are culturally shaped, ethnically oriented, and reflecting the socio-economic status; thus, forming the social and religious expressions of the loss (Kastenbaum, 2003; Mander, 2006; Stroebe, Hansson, Stroebe & Schut, 2001). According to Giddens and Giddens (2000), during the morning, the grief that is inside of the person has been expressed externally. With his studies on the anthropological aspect of grief, Emile Durkheim has had a lasting impact with his explanations regarding the collectively prescribed ways of mourning. From his perspective, mourning is not a spontaneous emotion, but rather a collective agreement expressed in the rites of appeasement (Robben, 2004).

Bereavement is used for the loss the survived one trying to adapt (Worden, 2009), or for the situation of losing a loved one because of death (Kastenbaum, 2003), for the objective situation of losing someone significant (Stroebe, Hansson, Stroebe & Schut, 2001). APA (2013) defines bereavement as "intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with the deceased or the circumstances of the death are expected responses occurring in bereavement, whereas fear of separation from other attachment figures is central in separation anxiety disorder."(p. 194).

Taking these explanations into account, how people grieve after losing someone important may change from one person to another, because of the context of each individual,

thus the mourning process differs among the individuals. In addition to expressed reactions to loss, people also differ in their degree of reactions. Below, the trajectories of the loss were explained: what is normal and abnormal grief, how long a normal grief process lasts, and in the continuum of the reactions, how people may have growth reactions after their loss experience were presented.

2.2. Grief Trajectories

In terms of the definitions of normal and abnormal grief, it can be found many theories, opinions, classification systems in the loss literature. However, it would be very hard to find commonalities between them (Shuchter & Zisook, 2003). Since each individual grieves over his /her loss in his/her own manner and pace, the boundaries between normal and pathological or abnormal have become more flexible (Janssen, Cuisinier & Hoogduin, 1996; Shuchter & Zisook, 2003). While the duration and the intensity of grief changes over time, from person to person and among cultures, the grief cannot be comprehended without full appreciation of its diverse and multidimensional nature. In order to fully understand the grieving process and determine its normality, it is necessary to analyze emotional and cognitive dimensions, coping strategies of the person, continuing relationship between bereaved and the deceased, bereaved one's functionality and relationship changes, and adjustments of the identity (Shuchter & Zisook, 2003).

The high number of people determined as having the pathological grief reactions would be lower if the narrower and more appropriate definition of pathological grief were identified. Presumably, there will be only a small number of bereaved (around 10-15%) who are at risk of developing psychiatric problems following pregnancy loss if the definition of pathological grief gets clear (Janssen, Cuisinier & Hoogduin, 1996).

In the following section, different views about the normal and abnormal/pathological grief reactions will be presented and at the end, DSM-V's symptom-based criteria (published in 2013) by American Psychiatric Association (APA) will be presented. It should be remembered that as society and social systems define the normality and abnormality in all areas of human response, grief is not an exception (Middleton, Raphael, Martinek & Misso, 2003).

2.2.1. Normal Grief

Bowlby (1982) expressed that mourning in healthy adults stands longer than what has been suggested and he asserted that many symptoms that were considered as pathological were actually very common for healthy mourning. Some of these responses are directing anger toward the third persons, the self, and sometimes to the lost one; the disbelief for the reality of the loss a; tendency of the bereaved for searching for the lost person with the hope of re-union with the lost one (as cited in Middleton, Raphael, Martinek & Misso, 2003). According to Worden (2009):

> One benchmark of mourning moving to completion is when the person is able to think of the deceased without pain. There is always a sense of sadness when you think of someone you have loved and lost, but it is a different kind of sadness—it lacks the wrenching quality it previously had. One can think of the deceased without physical manifestations such as intense crying or feeling tightness in the chest. Also, mourning is finished when a person can reinvest his or her emotions into life and in the living (p. 76-77).

For determining the time frame for normal grief, Janssen, Cuisinier and Hoogduin (1996) suggested that the first 6 months following pregnancy loss can be considered as common period for psychological and somatic problems, or behavioral changes. DSM-V (APA, 2013) also determines the time interval as 12 months for normal grief period of adult people.

2.2.2. Pathological Grief

For many years, the term related to abnormal or pathological grief had been discussed in the literature (Stroebe, van Son, Stroebe, Kleber, Schut & van den Bout, 2000) and its different types have been targeted. Janssen, Cuisinier and Hoogduin (1996) analyzed various pregnancy loss studies and identified how different researchers defined the pathological grief. Some of the different terms found in those studies were atypical grief reaction, chronic maladaptive behavior, failed mourning, morbid or prolonged grief reactions, unresolved grief, inappropriate grief reactions, incomplete mourning, atypical response and disturbed mourning (i.e. Lasker & Toedter, 1991; Smith & Borgers, 1988). Conversely, these terms have been criticized with the thought that while the society controls and directs the bereaved regarding his/her behaviors, thoughts, and feelings, people who are not compatible with the societal expectations have been labeled as abnormal. During the time, a culture may apply the pathological griever label for a person with longer grief, or it may be found abnormal if the person grieves in the wrong time or shows no grief reactions at

all; while another culture may use different labels for the same behavior (Walter, 1999). Therefore, as normal grief reactions are determined by the particular culture of interest, abnormal grief reactions were also mediated by the culture's specification of the behaviors' deviation from the expected course that was associated with the excessive or long-lasting psychological or physical disorder (Middleton, Raphael, Martinek & Misso, 2003).

In the early versions of DSM, APA defined the abnormal grief reactions as "complicated bereavement". Horowitz (1980) stated that independent of how researchers called the situation, pathological/ abnormal grief is "the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process towards completion." (p. 1157). Thus, "[It] involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing."(Horowitz et al., 1980, p. 1157).

While there is no agreement regarding the definition of abnormal grief (maybe it is not possible to define an agreed-on definition considering the individual, socio-cultural differences in grief), how can we be sure about its prevalence? When the literature has been examined, it could be realized that what the studies defined as pathological or abnormal grief mostly have been based on the psychiatric problems faced by the bereaved people after losing someone important. Since the APA defined "Persistent Complex Bereavement Disorder" within the five years, before that measurement and diagnosis of the abnormal grief had been done based on other psychiatric disorders. However, it should not be ignored that grief and other psychiatric disorders are not completely different from each other, rather the degree and duration of the behavior determines the bereaved person's place: the higher behavioral, emotional and cognitive problems or the longer the problems, the bereaved one is likely to be diagnosed with one of the disorders that are associated with grief such as PTSD, depression, anxiety disorders. For instance, after experiencing reproductive loss, men and women can be at risk of developing trauma symptoms due to the overwhelmed state of coping mechanisms, feeling terrified, and helpless. People may experience flashbacks, re-enactments, irritability, insomnia or avoiding behaviors (Herman, 1992).

When looking at the percentages of the pathological grief reactions, almost 10-15% of women develop a psychiatric disorder within the first two years after their loss. Parents generally mourn the loss of their baby more than a year that is above the time determined by APA (2013). One in every five women who experiences pregnancy loss has a problem with accepting the reality of the loss. Almost 4 % of parents experience delayed grief and this

pathological grief is more common in men than women (Janssen, Cuisinier & Hoogduin, 1996). During the counseling process, Volkan and Zintl (2008) suggested to take a detailed anamnesis from the clients in order to understand when the grief became complicated in his/her personal history.

The most stated types of abnormal grief were presented below, in order to make the reader get familiar with those concepts. Different types of pathological grief were named in bereavement research (Janssen, Cuisinier & Hoogduin, 1996). Here the most known, four types of abnormal grief will be explained in detail: delayed grief, masked grief, chronic grief, and exaggerated grief.

2.2.2.1. Delayed Grief

Delayed grief is sometimes called inhibited, suppressed, or postponed grief. Basically, the delayed grief can be defined as the person's insufficient emotional reaction or nonexistent grief reaction to the loss (Lindemann, 1944; Worden, 2009). It can be also observed in the bereaved person's behavior. For instance, the person may not be able to talk fully, may not accept or verbalize the loss, may not express his/her feelings, may have difficulty in crying (Middleton, Raphael, Martinek & Misso, 2003). In the future, at a subsequent or immediate loss, the person may have intensified and excessive reactions of grief because of this inhibited grief (Worden, 2009), so it is likely that exaggerated or chronic grief follows these delayed grief reactions (Lindemann, 1944).

Even if delayed grief was the first stage of Bowlby's theory and it was expected to last from a few hours to more than a week (Bowlby, 1982, Janssen, Cuisinier & Hoogduin, 1996; Lindemann, 1944) to what degree absence of grief responses could be considered as normal and where the abnormal grief reactions start is still problematic (as cited in Janssen, Cuisinier & Hoogduin, 1996). If this delay has continued for many months and years, for some researchers this is called absent grief which is a very infrequent form of pathological grief (Parkes & Weiss, 1983, as cited in Lin & Lasker, 1996).

Delayed grief is apparent only in a small number of women following pregnancy loss. Even though, it might be believed that men are more likely to develop delayed grief reactions; according to Janssen, Cuisinier and Hoogduin (1996), empirically it is very difficult to identify delayed grief, so the exact percentages might not be known. Some partners may not show any reaction to the pregnancy loss at all. This does not mean that they repress their loss related emotions, but rather it may mean that this loss does not move their

emotions as it is believed, or they may experience those feelings for only a few days (Wortman & Silver, 1989, as cited in Janssen, Cuisinier & Hoogduin, 1996).

2.2.2.2. Masked Grief

This pathological grief type was put forward by Worden (Janssen, Cuisinier & Hoogduin, 1996). People who experience masked grief have symptomatic behaviors; emotions that cause them difficulty, but they do not recognize that these negative experiences result from their loss (Worden, 2009). Masked or repressed grief can show itself either as a physical symptom or as a maladaptive behavior. For instance, after the loss, the person may have similar somatic symptoms with the deceased or s/he may have somatic complaints that cannot be explained with medical reasons (Worden, 2009).

According to Janssen, Cuisinier and Hoogduin (1996), there is no certain evidence regarding the masked grief. So, it would be more rational to think that in the first months after the pregnancy loss, many parents have somatic complaints and problems in their social relationships. There may be some parents who indeed have masked grief reactions, but there would be no certainty of the number of these parents (Janssen, Cuisinier & Hoogduin, 1996).

2.2.2.3. Chronic or Prolonged Grief

Chronic grief is the most prevalent pathological reaction to bereavement (Volkan, 1970). Chronic or prolonged grief is unending, unchanging, excessive and indefinite grief reactions that never come to a satisfactory resolution. This is generally associated with mental health problems like depression, guilt feelings, marked sadness, withdrawal, overly preoccupation with the lost person and unending distress of the bereaved (Middleton, Raphael, Martinek & Misso, 2003; Worden, 2009). Also, in chronic grief, excessive anger and self-blame is very likely to be experienced. Even if there is a year or more passed, these intense grief reactions do not fade away (Lin & Lasker, 1996).

2.2.2.4. Exaggerated Grief

In exaggerated grief, unlike the masked grief, the bereaved person is aware of the source of the emotional and behavioral issues. Exaggerated grief includes responses that fall into the DSM diagnosis (Worden, 2009). Depression, anxiety disorder, PTSD or substance-abuse disorders, of these criteria that were set in the DSM, are exaggerated grief responses after loss (Janssen, Cuisinier & Hoogduin, 1996).

According to Janssen et al. (1996) exaggerated grief incidence may change depending on the criteria and time of assessment. Percentage of women after their pregnancy loss who met the criteria for a psychiatric disorder is between 10 and 15 percent. Especially depressive disorder is very common since grief and depression are conjoint phenomena, roughly 30 to 50 percent of women who had miscarriage had severe depression symptoms in the first 6 months after the loss (Janssen, Cuisinier & Hoogduin, 1996).

Consequently, different types of pathological grief reactions have been identified based on the frequency, timing and the degree. At the end, APA's criteria to determine the pathological grief will be presented. DSM-V definition of "Persistent Complex Bereavement Disorder" is important in the sense that it gives a coherent understanding of the pathological grief reactions by setting certain time limits and symptomatic criteria. DSM-V criteria for "Persistent Complex Bereavement Disorder" are as follows (2013, by APA):

A. The individual experienced the death of someone with whom he or she had a close relationship.
B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure.

2. Intense sorrow and emotional pain in response to the death.

3. Preoccupation with the deceased.

4. Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.

C. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:
Reactive distress to the death

1. Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.

2. Experiencing disbelief or emotional numbness over the loss.

3. Difficulty with positive reminiscing about the deceased.

4. Bitterness or anger related to the loss.

5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).

6. Excessive avoidance of reminders of the loss (e.g., avoidance of individuals, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

Social/identity disruption

7. A desire to die in order to be with the deceased.

8. Difficulty trusting other individuals since the death.

9. Feeling alone or detached from other individuals since the death.

10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.

11. Confusion about one's role in life, or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased).

12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms (APA, 2013, pp.789-790).

In the same manual, it was stated that the prevalence of the persistent complex bereavement disorder is between 2.4 and 4.8 % and this pathological grief is more common among females than males (APA, 2013).

As another important criterion to distinguish the normal and the abnormal grief reactions is the **duration of grief**: how long the reactions can be considered as normal and from which point they cross the borders of the normality? Janssen, Cuisinier and Hoogduin (1996) stated that based on the gestational age at the time of the loss, mothers' grief reactions change, so that a mother who loses her baby later in the pregnancy will last for one to two years after the loss. However, the society expects partners to get over the pregnancy loss very quickly (Janssen, Cuisinier & Hoogduin, 1996).

Parents who lose their babies through miscarriage, stillbirth, or sudden infant death syndrome have grief resolution terms that last almost three years. Sahu (1981) expressed that even if the parents go back to their normal life, they would not forget the trauma of losing their children (as cited in Yılmaz, 2010). Badenhorst and Hughes (2007) claim that parents should start their normal activities after 6 months from the loss. The intense reactions will typically decrease within the first 12 months, but still it is expected that they may feel significant distress for 2 years or longer after the loss. When looking at the APA criteria, persistent complex bereavement disorder is diagnosed only if the symptoms last more than 12 months for adults, and 6 months for the children (APA, 2013). Thus, it can be said that APA's time limit is more or less compatible with other studies. Especially, studies' findings that focus on pregnancy loss has shown that people have grief reactions after their loss, even if the baby is not seen alive or is lost within the 20 weeks of pregnancy. It is still a loss for the partners and therefore grief reactions after this loss can be experienced whether it be a normal or abnormal grief.

2.2.3. Post-Traumatic Growth (PTG)

As an alternative reaction to loss, PTG has been defined a lot within the last decades with the findings which support the fact that even if loss is a stressful experience, it does not necessarily result in psychological problems for bereaved person as stated in many studies (Bonanno, 2004; Silverman and Worden, 1992). For instance, Bonanno (2004) stated that even though adjustment to loss of someone significant for a person is difficult, chronic depression and distress are likely to occur in 10 to 15 % of bereaved individuals. Only 50% of bereaved people experience lower levels of depression and distress after loss.

While there are many constructs that focus on the positive outcomes of a negative life experience, complicated nature of the post-traumatic growth is conceptualized by different kinds of models that focus on different explanations and contributing factors of post-traumatic growth. Below, the most commonly referred theories were explained.

2.2.3.1. Post-Traumatic Growth Models

Firstly, In Moos and Schaefer's model, environmental (individual's ongoing life context such as finance, home, community, relationship with family members) and personal system (cognitive abilities of the person, health, motivation, self-efficacy etc.) together affect the life crisis and transition (changes in ongoing personal factors such as physical injury, illness; or changes in environmental factors such as loss of someone important). According to Schaefer and Moos (1992) coping responses of individuals can be explained under three headings: appraisal focused coping (efforts to define, interpret, and understand a situation), problem-focused coping (efforts to resolve or master life stressors by seeking information, taking direct action, and finding alternative rewards) and emotion focused coping (attempts to manage emotional reactions to life stressors by regulating one's feelings, expressing anger, and accepting the situation) (Schaefer & Moos ,1992, p. 151). Therefore, it can be stated that according to this model of growth or positive outcome of a traumatic event depends on pre-trauma factors of individual and environmental resources; trauma-related factors (type of event, severity, duration etc.) as well as post-trauma factors such as coping responses, cognitive appraisal of the person. The positive outcomes of life crisis and transitions can be like enhanced social resources (development of a confident relationship, better relationships with family members and friends, and formation of new support networks), enhanced personal resources (cognitive and intellectual differentiation, self-reliance and self-understanding, empathy, altruism, and maturity and changes in basic values and

priorities),and development of new coping skills (cognitive coping skills, problem solving and help-seeking skills, and ability to regulate and control affect) (Schaefer & Moos, 1992, p. 153).

Secondly, Tedeschi and Calhoun's Functional Descriptive Model includes more factors to explain the post-traumatic growth compared to Schaefer and Moos's model (1992). These two models, however, have something in common in explaining the PTG based on pre-trauma, traumatic event and post-trauma factors. In Calhoun and Tedeschi's model, person's pre-trauma factors can be individual characteristics, assumptive world beliefs. After trauma, emotional distress, challenged assumptive beliefs, rumination, emotional distress, and social support are the factors affecting PTG. One of the important factors in this model is the change of the individual's schemas and belief systems; if the cognitive processes are activated by the negative life experience "seismic event" that PTG is likely to occur (Tedeschi & Calhoun, 2004).

Calhoun and Tedeschi (2006) stressed the important distinction that to experience PTG does not mean that the person did not experience any negative experience after the traumatic event. They stated that paradoxically traumatic events result in both negative and positive consequences for some people. In this model, PTG can be evaluated under five domains which are greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength, spiritual development; and new possibilities (Calhoun &Tedeschi, 2006).

In this model, it is accepted that distress should be in a degree that the person can manage it to develop PTG. To achieve the management of distress, deliberate rumination is used to decrease the emotional disturbance. This functional descriptive model also gives importance to the social support that bereaved person get from significant others, so that the bereaved one can share and relieve from negative emotions and grow (Calhoun and Tedeschi, 2006; Tedeschi & Calhoun, 2004).

2.2.3.2. Studies Related to Pregnancy Loss and PTG

As explained, not every negative life experience has to lead to traumatic experiences for the individuals. There are instances that the individuals experience growth. There are many studies examining the growth experiences of bereaved parents after their pregnancy loss experience and some of them were shared below.

In a study conducted by Krosch, Shakespeare and Finch (2007) with 328 women who experienced a miscarriage or stillbirth, the relationships between core belief disruptions,

grief symptoms, PTG and post-traumatic stress were analyzed. Correlational and hierarchical regression analysis showed that higher grief scores predicted lower PTG; core belief disruption has been found to be significantly related to perinatal grief, post-traumatic stress and PTG are related to weak to moderate degree. There was no relationship found between PTG and post-traumatic stress. In this study, contextual loss factors (time since the loss, gestation, personhood, severity, number of other losses, and having a living child or not) had been hold constant.

Lafarge, Mitchell and Fox (2017) conducted an online, cross-sectional survey with 161 women, who had undergone termination of pregnancy for fetal abnormality, to examine the post-traumatic growth, relationship between PTG, perinatal grief and coping, as well as to determine the PTG factors in bereaved mothers. Results revealed that adaptive coping strategies such as acceptance, emotional support were negatively correlated with perinatal grief, and they were positively correlated with PTG variables. Similarly, maladaptive coping strategies like self-blame, behavioral disengagement were positively correlated with grief. All perinatal grief subscales were correlated with PTG subscales, except for spiritual change. Therefore, the results of this study showed that even if the grief reactions of women are still high, there is still a positive correlation with PTG, meaning that grief and PTG are not two opposite ends; existence of PTG does not mean absence of grief symptoms and vice versa.

To determine the factors that lead to PTG in a sample of bereaved parents and to propose a multidimensional model that consists of socio-demographic, situational, interpersonal and intrapersonal factors, a sample of 197 bereaved parents (89.8% of them were female) who lost a child (of any age) by death was used for data collection. The results showed that higher levels of PTG were significantly correlated with being a female, losing a younger child, and higher levels of resilience. Also, parents who have internalized continuing bonds with the deceased child and who communicated their distress with their partner had higher levels of PTG (Albuquerque, Narciso & Pereira, 2017). Even if this study was conducted with parents who experienced not only pregnancy loss but also there were child losses at any age, the results showed evidence for the importance of the dyadic support from partners (Albuquerque, Narciso & Pereira, 2017).

In her doctorate thesis, Thomadaki (2012) conducted a qualitative research study with 8 women who experienced the loss of their first-born baby prenatally and the data related to interviews will be analyzed with Interpretative Phenomenological Analysis (IPA). The results of the study revealed that loss of an unborn baby also means other losses such as social recognition of mother identity, or the fear of losing reproductive ability. Moreover,

even though PTG was stated by participants, their grief symptoms go and return at different time points (oscillation process). Regarding PTG related results, participants' transcribed verbatim show that they had transformations in their identity, self-perception, appreciation of life and changes in their priorities, as well as transformations in their relationships (like being more empathetic) (Thomadaki, 2012).

Regarding the parents' post-traumatic growth experience after their child loss, Büchi, Mörgeli and their associates (2007) explored how men and women were affected by the premature baby loss. Findings from the 54 parents showed that even if 2 to 6 years passed since their baby loss, they still suffer, and the women's grief was higher compared to men. As similar results found in other studies, women had higher scores in PTG than men.

In a mixed-type study about the forgiveness and post-traumatic growth in a sample consisting of people who experienced loss of a child was conducted by Martincekova, and Klatt (2017). The quantitative part showed that forgiveness and grief were negatively; and forgiveness and post-traumatic growth were positively correlated. In the qualitative part, it was revealed from the participants' experiences that mother had difficulty in accepting the loss, while acceptance does not mean ending of their sorrow but with this acceptance, they began reconciliation with the God that helps them control their feelings of anger toward themselves and the God (Martincekova, and Klatt, 2017).

To sum up, these post-traumatic growth and pregnancy loss related studies showed that parents may have grief reactions, even if the loss occurred during the pregnancy. Even if grief and post-traumatic growth are not mutually exclusive, meaning that existence of one of them does not necessitate the absence of the other. That is why, in some studies grief was found to be related to PTG, but higher grief may mean lower PTG in some participants. Also, coping strategies have found to be related to PTG, while adaptive coping was positively related, maladaptive coping was negatively correlated with the PTG. Also, disruptions in the core beliefs of bereaved people may mean more grief reactions that may show the cognitive effects of the loss on the bereaved person.

2.3. Historical Perspectives on Grief

After presenting the grief trajectories in parents with pregnancy loss experience, how different theories conceptualize grief will be explored. These theories are important in the sense that they give a rationale about normal and abnormal grief reactions. Before 1970s, grief after a pregnancy loss was not acceptable, even these losses were thought like it never happened so that families were given suggestion to get on with their lives (Brownlee &

Oikonen, 2004). Based on this information, unfortunately there has been no theory that specifically conceptualizes the pregnancy loss experience of parents. That is why, the most known theories in the grief literature and their connections, mostly done by the researcher herself, were explained.

2.3.1. Attachment Theory by Bowlby and Its Application to Prenatal Loss

Undeniably, the most known person in the attachment theory is Bowlby. He constructed his theory on his observations of young children. By explaining the attachment between the child and his/her first caregiver, he also explained how a child could react to the separation from his/her primary attachment figure. According to his theory of grief, grief occurs in four phases. In the phase of numbing, the person experiences intense anger, distress and the length of this period may last for weeks. In the second phase, the person yearns for the lost one and many feelings are present in this stage such as anger, confusion, preoccupation or anxiety. In the third phase of grief (disorganization and despair), the bereaved person withdraws herself and there is a deep sadness and despair. In the fourth phase (reorganization and recovery), even if the grief is never totally resolved, the person's positive emotions and memories of the lost one take over, his/her energy levels increase, and the person begins returning his/her normal life activities (Bowlby, 1980).

While Bowlby did not express different stages for different types of grief, he stated that people may have different reactions to losing someone who is older or to experiencing a pregnancy loss. For instance, while loneliness is the principal feature for the death of a spouse, this loneliness may not be observed after loss of a child, so “whatever the different types of affectional bond may have in common, they cannot be regarded as identical" (p. 98). According to Klier, Geller and Ritsher (2002) as the mother may feel the fetal movement as early as 16th of gestation, attachment between mother and the baby increases after this period. Their assumption, therefore, is that there is a relationship between gestational age, degree of attachment, thus with the level of intensity of grief (Klier, Geller & Ritsher, 2002).

Kirkley-Best and Kellner (1982) in their papers used the Bowlby and Parkes' grief stages for women who experienced prenatal loss. Based on their interpretation, the first phase is shock, numbness and disbelief; and this acute phase is shorter than the other phases. Secondly, in yearning and searching phase, parents realize that the discrepancy between their idealized child and the outcome is so huge because while they expect the birth of child, they experience the greatest sorrow and pain. Yearning of grief is compounded by the fact that sometimes there is no body of the baby to hold and cry with. These symptoms of grief are

similar as stated by Kirkley-Best and Kellner (1982) with other types of grief reactions by adults. In this phase, parents may have reactions like preoccupation with image or thoughts of baby, anger and reproach, guilt, injustice, despair, sleep or eating disorders, somatic symptoms, depression, hallucinations like hearing the voice of baby (Kirkley-Best & Kellner, 1982). If the parents did not see or hold the baby, this phase may be longer. In the disorganization phase of grief, contrary to other two phases, mothers' social support or medical support is lowered because in the two phases, medical or mental health were given, friends or family were always around the parents. Then, mothers experience intense feelings of depression, devaluation of the self, and apathy. In the last phase, bereaved ones' reorganization is observed; the mother resumes her role in the society. While she does not deny her loss, her focus is on the life. A complete resolution may be thought of having a subsequent pregnancy (Kirkley-Best & Kellner, 1982).

Doubtlessly, Kirkley-Best and Kellner's interpretation of Bowlby's theory from the pregnancy loss should be appreciated. Still, their lack of explanations regarding the paternal grief is missing. From their model, the mother, as she feels the movements of the baby, may grieve; while the father, since he does not see or hold the baby until his/her birth, may not experience grief reactions.

2.3.2. Psychoanalytic Theory

Freud (1917) characterized mourning as "...its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (p. 243-244).

With the loss of a loved one, the bereaved loses his/her interest in the outside world, so s/he is indifferent to adopt any new object of love. According to Freud (1917), when the "work of mourning" is accomplished by the ego, it is free and inhibited, and the libido withdraws its energy from the lost object. For this work to be accomplished, the person needs time to check reality (Freud, 1917).

Although this psychoanalytic model of mourning has been highly referred, recently this theory has been analyzed more critically. Strobe and Schut (2001) stated that this theory is obscure since it is very broad; it fails to explain the differences among rumination, confrontative coping and emotion expression. The same critique may be valid for the pregnancy loss since this theory does not pinpoint where the pregnancy loss fits in, how a person (mother-to be or father-to-be) could grieve even s/he did not see their baby before.

2.3.3. Stage Model of Kübler-Ross

Kübler-Ross's five stage model of grief has been the most known theory in the loss literature and its applicability to different cultures has been still discussed. In her theory, she stressed the fact that the stages she explained should not be observed exactly in the same order and the length of the period of these stages may change from one person to another. Even though she did not explain her theory specifically for one type of loss, her clinical observations mostly depended on the loss of cancer patients. Nonetheless, her theory has been used largely in the psychology area as these stages could be observed in different kinds of losses (Kübler-Ross & Kessler, 2014).

In the first stage of grief, the person is paralyzed with loss; there exists numbness, and shock. This stage does not mean that the bereaved one does not literally know his/her loved one is dead. The person may say s/he cannot believe the loss, but this is because the ache felt is too much for the psyche of the bereaved. In this stage, the bereaved found no meaning in the life, the world becomes meaningless. Telling and retelling of the stories related to the lost one is very common; it is the way of the mind to deal with trauma. With the fading of denial, the bereaved begins to understand the finality of the loss. In the second stage, anger is present that can be directed to oneself, to the lost one or other people such as doctors. The bereaved may be angry to oneself because s/he did not do the necessary things to save the lost one, or s/he did not spend time with him/her. This anger s is still normal, and this stage can be visited many times during the grief by understanding all the emotions under the anger. It is not surprising when the anger is turned towards God, with the questioning of one's beliefs, religion, and spirituality. In the reality, all anger emotions actually related to the pain of the person. Kübler-Ross and Kessler (2014) stated that "Anger is strength and it can be an anchor, giving temporary structure to the nothingness of loss"(p.26). After the denial stage, anger is a way to hold on to life. In the third stage, the person is in a negotiation and the feelings guilt accompany this situation. The bereaved one can do anything to go back to the time to find the necessary treatment; prevent the accident and so on. The person is in the past by negotiating his/her way out of the pain s/he feels. Fourthly, when the person gets over the denial, anger and negotiation, s/he begins experiencing intense sadness that results from realizing the present state. Contrary to clinical depression, experiencing depression after a loss is very natural and an expected response. Rather than resisting these depressive feelings, it is suggested to experience those feelings. Finally, acceptance is on the way, but this does not mean that the bereaved person is all right about the loss. Rather, in this stage the person accepts the fact that the beloved one is physically gone, and the loss is permanent.

To remember, recollect and reorganize are the ways toward healing. Readjustment of the life after the lost one's leaving is possible for the bereaved. This acceptance is a process, and every person has his/her own time: "We can never replace what has been lost, but we can make new connections, new meaningful relationships, and new interdependencies." (Kübler-Ross & Kessler, 2014, p. 35). From pregnancy loss perspective, this re-adjustment may mean parents' future plans for a baby or dreaming about having a baby.

2.3.4. Worden's Task Model and Mediators of Grief

According to Worden (2009), to grieve healthily and to cope, four tasks of mourning should be accomplished: accepting the reality of the loss, experiencing the pain of grief, adjusting to the environment from which the deceased person is missing, and withdrawing from the relationship with the deceased and reinvesting that energy in a new relationship (Worden, 2009). Worden's another contribution to grief literature is that he identified the mediators that likely to affect the course of grief experience. These mediators are the reason behind the different reactions to loss by different people. Even if Worden (2009) did not discuss these mediators from a pregnancy loss perspective, the author of this study makes comments about those mediators' effects on the grief after pregnancy loss.

- **Mediator 1: Who the Person Who Died Was**

From the pregnancy loss perspective, this mediating factor may be related to the gestational age of the baby during pregnancy. As was explained in the upcoming sections of the paper, gestational age affects the grief process because it affects the degree of the affectional bond between partners and their baby.

- **Mediator 2: The Nature of the Attachment**

It is related to the the strength and the security of the attachment, the ambivalence in the relationship, conflicts with the deceased, or the relationships' being dependent or not.The nature of the attachment between partners and their baby during pregnancy may be affected by their reasons to have a baby, their own reproductive history as told by Jaffe and Diamond (2011).

- **Mediator 3: How the Person Died**

How pregnancy loss occurred might affect the grief responses. For instance, whether the pregnancy loss was voluntary (i.e. voluntary abortion) or not; whether the reasons of the loss were known to the bereaved or not, whether the baby was lost because of a genetic reason or not might have affected the degree of the bereaved's grief.

- **Mediator 4: Historical antecedents**

Historical antecedents refer to bereaved person's loss history, and how those losses were grieved at that time, or mental health history of the bereaved (Worden, 2009).

- **Mediator 5: Personality Variables**

Bowlby (1980) warned the mental health workers about paying attention to mourner's personality variables in order to comprehend his/her reactions to loss better. Therefore; age, gender, coping styles (whether problem-solving coping, active emotional coping, or avoidant emotional coping was used by the mourner), attachment style (secure attachment or avoidant/preoccupied, avoidant/dismissing, avoidant/fearful), cognitive styles (being optimistic or pessimistic, whether the person has ruminative thoughts or not), ego-strength of the mourner (whether the mourner's self-efficacy and self-esteem is high or low), assumptive world beliefs and values are the personality factors affecting the mourning process (Worden, 2009).

- **Mediator 6: Social Variables**

For the mourner, social support is significant in regard to mourner's satisfaction from that support, social role involvements of the mourner (involvement in multiple roles have been found to be better adjustment to loss), religious and ethnic expectations of the mourner.

- **Mediator 7: Concurrent Stressor**

Simultaneous stress factors occurring in the life of the mourner may affect the degree of the impact of the loss. For instance, for a couple who experienced pregnancy loss, economic problems of the family, or health problems of the mother may affect their grief process.

2.3.4.1. Studies Examining the Mediators Affecting the Pregnancy Loss Outcomes

To clarify the differences in grief reactions, examining those mediators would be helpful in the conceptualization of the prenatal loss. Some of these factors were gender of the parent (whether the men or women grieve more after the pregnancy loss, what kind of behavioral, psychological, cognitive reactions men and women have after such a loss and so on); having prior psychological problems; gestational age (whether a loss that occurred at later periods of pregnancy was related to higher and more negative grief reactions); religious beliefs and rituals (whether fulfilling religious ceremonies help the bereaved parents or not; whether religious beliefs are helpful in grief resolution etc.); having prior pregnancy losses;

social and spousal support; previous or subsequent births; demographic factors (age, education, SES etc.); resilience and coping styles of bereaved parents; touching or seeing the baby/fetus (i.e. Buchi, Mörgeli, Schnyder et al., 2009; Klier, Geller & Ritsher, 2002; Lafarge, Mitchell & Fox, 2017; Lasker & Toedter, 1991; Miron & Chapman, 1994; Murphy, 1998; Nikcevic, Tunkel & Nicolaides, 1998; Smith & Borgers, 1988;Swanson, 2000; Yıldız & Cimete, 2017).

Firstly, in terms of whether there were **gender differences** after the pregnancy loss between men and women; there are contradictory s opinions and findings in the literature. Condon (1995) asserted that even though men and women might differ in their grieving, the intensity and the quality of affective responses of men might be similar with women. It was acknowledged that men can also have attachment with the fetus, even in early stages of the pregnancy and they can grieve as much as women do. But there are societal pressures and gender expectations that men should be strong for the women and support their wives; so, their rapid recovery is expected (Buchi, Mörgeli, Schnyder et al., 2009; Murphy, 1998). These societal expectations may be the reason for their denial of their own grief (Puddifoot & Johnson 1997). This idea was supported in a qualitative study with 8 Canadian men whose partners experienced early miscarriage and Miron and Chapman (1994) explained in their findings that men experienced feelings of sadness, loss and anger and as expected men talked about their supportive role in their relationship after their loss experience (Miron & Chapman, 1994).

Murphy (1998) in his phenomenological study with five men whose partners experienced early miscarriage, aimed to describe the experiences of early miscarriage from a male point of view. Analysis of the unstructured interviews with the participants revealed seven main themes (feelings, loss, characteristics and differences between men and women, staff action and attitudes, what to do, time and coping). Themes of the study showed that men experienced different kinds of emotions like shock, disbelief, upset, helplessness in the short term, and anger, hurt, frustration, guilt, concern, bereaved in the long-run after the miscarriage experience. Even if they expressed themselves in the study, they admitted that they keep their feelings suppressed in order not to affect their partners. Moreover, they accepted that they and their partners grieved differently in terms of duration, intensity and expression. Very similar themes were also identified in Kimbre's study (1991). In this qualitative study with men who experienced neonatal death, men accepted that their grief reactions were different from their partners. They also mentioned their loneliness after the loss because of the limited social support offered to them (Kimbre, 1991).

Corr, Nabe and Corr (2009) talked about three issues in the relationship between gender and grief First of all, there might be a feminization of grief, so women are more likely to express their emotions and seek support when they need. Secondly, men have their own ways to grieve such as active problem solving and using cognitive perspective rather than emotional one. Anger and guilt responses have been considered as the muted emotional responses of men. Then, the different grieving style of men should not be minimized, and these differences should be kept in mind in counseling interventions directed to men. And lastly, critical examination of all factors might show that grieving can be influenced by gender. Gender roles affect men and women differently. Lasker and Toedter (1991) who are researchers in the psychology area studying the effects of perinatal loss concluded that men are at higher risk of having chronic or abnormal grief reactions because of the gender roles affecting the social support they receive. As men are believed to be more powerful, more able to solve their problems easily and so on, the society would direct their support systems less towards men than women who are believed to be in need of help after pregnancy loss.

While women have been accepted as emotional, men have been assumed to have a more unemotional stand, keeping their inner emotions and thoughts inside. It has also been assumed that children are more important to their mothers than to their fathers which minimizes the significance of fathers' roles (Dyregov & Matthiesen, 1987; Peppers & Knapp, 1980; Plagge & Antick, 2009; Stinson et al., 1992). Sattel (1976) evaluated the male inexpressiveness as power issue between males and females in society. According to him, men use this as a method to gain and maintain power over others by being in-control, making decisions more rationally and by avoiding personal involvement (as cited in Stinson, Lasker, Lohmann& Toedter, 1992). Peppers and Knapp (1980) called the differences between men and women in their grief experiences incongruent grief. Based on that term, women have an early attachment with their fetus at earlier phases in their pregnancy, while their partners develop this attachment later on. Maybe this incongruence is the reason for especially women's feeling of loneliness and being misunderstood. Another explanation is made by Kavanaugh and Hershberger (2005), who asserted that fathers do not express their emotions due to fear of upsetting the mother as well as not knowing how to support their partners.

Men's grief reactions both in the everyday life and in the literature have been overlooked for many years. There are many reasons for that. Essentially, there are limited amount of studies in the field regarding the men's viewpoint of pregnancy loss. Also, the effects of loss on men have been sometimes studied as the result of change in the relationship dynamics between men and women after pregnancy loss, and sometimes as a

direct result of the pregnancy loss. (Miron & Chapman, 1994; Murphy, 1995; Kersting & Wagner, 2012; Worth, 1997). In the literature, fathers have been sometimes called "forgotten mourners" as if they have not experienced the pregnancy loss (Kellner & Lake, 1993, as cited in Samuelsson, Radestad and Segesten, 2001). However, it is promising that studies examining the reactions of men are gradually increasing. One of the reasons of this increase in the number of studies examining men may be the changing social roles in the society. While fathers have started getting more responsibility of child care and spending more time with the child; it became necessary to understand the paternal view point (Turton, Badenhorst et al., 2006).

While some studies expressed that the grief reactions of men and women do not differ (i.e. Turton, Badenhorst, Hughes et al., 2006), in some quantitative studies, differences between men and women were realized. For instance, in Murphy, Shevlin and Elklit's study (2014), in all subscales of The Trauma Symptom Checklist, women had higher scores of trauma symptoms. In a Turkish sample of participants, mothers were found to suffer more intensely than fathers did in terms of severity of parents' grief scores (Yıldız & Cimete, 2017).

To sum up, in terms of gender differences, in some studies there were grief differences detected between men and women, but these differences did not reach a significant level in some studies. There may be many reasons for these different views. For example; not all studies were controlled studies, they did not use the same measurement tools etc. Therefore, comparing the results of this study might be problematic. However, almost in all studies it was discussed that cultural and social variables might have affected the grief reactions of men and women who participated in their studies. That is why, while reading the results of these studies, keeping the socio-cultural factors in mind is recommended.

Secondly, **social support** is an important mediator. Since grieving is a social phenomenon (Worden, 2009), both women and men need to express their emotions and to be listened by others. In the literature, commonly expressed feelings by the men and women who experienced involuntary pregnancy loss were feelings of isolation, anger, frustration, resentment and so on (Reed, 1984). Even if those feelings were associated with the men and women's loss experience, not having emotional support from friends, relatives, spouses, or health care professionals lead to problems in the process of resolution. Parents' sense of isolation and anger has been increased with the uncomfortable and unwilling family members and friends that were expected to provide support for the bereaved ones (Nuzum,

Meaney, O'Donoghue, 2018; Reed, 1984). One of the most stated problems of women was their friends' or relatives' ignorant attitudes such as changing their ways to avoid talking with the bereaved parents. Most of the mothers were aware of the fact that that it is difficult for others to find the right words, but they would have appreciated any kind of sympathy or support (Rojan & Oakley, 1993).Presence of supportive others is a significant resource for women with pregnancy loss, which helps women increase their emotional strength and use more active coping strategies (Swanson, 2000), while when this support was perceived as insufficient and limited, experience of isolation might be experienced (Koopmans, Wilson, Cacciatore & Flenady, 2013).

It is aimed by Plagge and Antick (2009) to learn about the perceptions of women's social support networks in terms of their views of the importance of gestational age on perinatal loss. So, it was hypothesized that stillbirth vignette would be evaluated with higher perceived grief than miscarriage vignette. 84 women read the miscarriage vignette and 85 stillbirth vignettes. Mean of the age of participants were 27.21. All the participants were university students, from different cultures and different departments such as clinical psychology, counseling psychology, physical therapy. 91% of the participants did not have a personal history of perinatal loss, 5.3% of participants had miscarriage, 2.4% had other losses excluding the miscarriage, stillbirth, and neonatal death; and 1.2% had experienced more than one kind of perinatal loss. 138 participants knew someone who experienced the perinatal loss. In terms of discomfort visiting the woman, there were significant difference between the group that reviewed the stillbirth vignette (M=12.32, SD=2.97) and the group who reviewed the miscarriage vignette (M=10.49, SD= 2.76). So, participants found it more difficult to visit a woman who experienced stillbirth than women with miscarriage experience. Moreover, there were statistically significant differences between the group who evaluated the stillbirth (M=123.42, SD= 14.36) and the group who evaluated the miscarriage (M=113.23, SD=17.91). Participants expect higher grief scores with stillbirth related prenatal losses. Therefore, the authors commented that type and degree of support may be affected by the others' view of perinatal loss. If others (friends, relative, colleagues etc.) do not view the perinatal loss as a significant loss, they may not show empathy for the bereaved women, and in turn provides little support (Plagge & Antick, 2009). In other words, it seems that visiting after perinatal loss and giving the necessary type and quality of support depends on how others give meaning to this loss experience.

The support from the health professionals also might differ depending on the time that termination of pregnancy occurred. Cuisinier, Kuijpers, Hoogduin et al. (1993) explored

how mothers who experienced miscarriage and stillbirth coped with their loss, what was the relationship between the time elapsed since the loss and grief intensity and women's satisfaction with the professional care and support. Data from 143 women (73% of them experienced the miscarriage) who experienced a miscarriage or stillbirth in Netherlands whose loss experience was no longer than 3 years prior to the study, showed that most of them had dissatisfaction with the professional support. In terms of pre-loss care, women talked about the insufficient understanding by the health professionals regarding women's anxious feelings such as giving little information or behaving insensitively. In terms of care during delivery or curettage, it was stated that health professionals such as doctors or nurses did not have understanding for their emotions; they were too impersonal and uneager to talk with mothers. Mothers who experienced stillbirth sensed that doctors treated them like a case not like a human being. "Curetting seems just like a production line" was stated by one of those women with miscarriage experience. But some women who experienced stillbirth was given chance to say goodbye to their baby and sensed the sympathy from the health care professionals. For after-care, many women expressed that they felt abandoned by the health system, they had to get over the grief of their own, and only a small number of them could get support from the health professionals. This was the case especially for women who had an early loss (Cuisinier, Kuijpers, Hoogduin et. al, 1993).

> Perhaps one of the two most difficult problems that face women who experience perinatal loss is the common assumption that it is not necessary to mourn something that had no 'real' existence -Pregnancy is not regarded as the start of an individual's life, even by the medical profession, because the fetus does not have a social being at that stage" (Rajan & Oakley, 1993, p.81).

Pre-loss social support was correlated with difficulty in coping and despair grief measures, but not correlated with active grief of Prenatal Grief Scale (Cuisinier, Kuijpers, Hoogduin et. al, 1993). Source of support may be important in some cases. For instance, in the long run, not having enough support from the family is a risk factor for complicated grief, but in the short time, immediately after the experience of loss, support from friends was found to be more important (Lasker & Toedter, 1991).

On the other hand, there were studies that showed that parents had growth experience in terms of their social relationships. In these studies, parents reported that they related more with others (Lafarge, Mitchell & Fox, 2017) and relating to others was predicted by positive reframing by the bereaved and emotional support experienced (Lafarge, Mitchell & Fox, 2017). When parents were assessed based on the effectiveness of

volunteerism on their post-traumatic growth after their experience of stillbirth, it was found that prosocial helping behaviors increase meaning-making and this social participation is positively related to PTG in parents who experienced stillbirth (Cacciatore, Blood & Kurker, 2018).

Thirdly, **how partners supported each other during and after grief**, whether they had a shared or discordant grief reactions and how their relationship has been affected by the loss got a lot of attention. Even though the loss was a shared loss, to what degree partners supported each other during the grief might have affect their psychological well-being. As it was explained in the studies related to gender differences, as men and women might have different grief reactions, these differences p might create problems for the couple. For instance; there might be disbeliefs in the grief of the other spouse, or doubts on the support of the other (Beutel et al., 1996). Shumaker and Hill (1991) based on their review of studies, concluded that the differences between men and women in their giving support to their partner during crisis times (in their article mostly physical situations were examined), might also result from their differences in socialization by gender roles. So, women may be more likely to show their nurturance, love, and care to their partners; while men may not show their emotions and give a different kind of support such as practical help (Shumaker & Hill, 1991). Thus, in addition to how partners grieve, how partners give support to each other might be affected by the gender roles which have been developed through the socialization process. In this picture, perceived support and giving each other different support might have affected the individual's own grief and because of the feelings of loneliness, misunderstanding, or of the disappointments related to spouse, partner who thinks that s/he could not get support might have psychological problems after the loss.

In his review article, Hutti (2005) expressed that women who already expressed loneliness in their lives are more likely to view miscarriage as a significant loss. They have more fears of getting pregnant; they may not talk about the loss with their partners, so they may perceive less support from them. Even after this miscarriage experience, the partners' sexual life might have been affected which also creates a problem in the relationship. A year after the miscarriage, if their partners still do not show the care they desire, women are likely to feel more distance in their relationships. When the partners share their emotions and experiences with each other after the miscarriage, then they perceive their partners as caring, loving and close (Hutti, 2005).

In a grounded theory-based study with eight women who experienced miscarriage, participants were asked about their perceptions regarding the effect of the perceived partner

support provided to them (Corbet-Owen, 2003). Results of the analysis of interviews demonstrated that some of the participants could not ask for help from their husbands because of their preexisting marital problems such as alcohol, or an extra-marital affair. Generally, women want to get support from their partners, and they want this support to be sustained since some of the women stated that they could get some support immediately after the miscarriage, but this support faded with time. Some women perceive the instrumental help from their partners as husband's distancing strategy or as a sign of non-caring. Authors interpret these findings as the differences in gender socialization since men's attempts to support their wives may be misunderstood by women who then feel hurt, resented; and eventually it may result in marital problems. That is why, the author suggests that couples should recognize that they might have different support-giving methods and validate each other's grief and support (Corbet-Owen, 2003).

Büchi et al.'s study (2009) showed that partners' grief process whether it is concordant or discordant has effects on the post-traumatic growth of the partners. If partners do not share the growth process, their individual worlds are separate from each other that might result in decreased satisfaction with their relationship or in separation. When the partners are concordant, their bereavement, depression, and suffering levels are correlated (Büchi, Mörgeli, Schnyder et al., 2009).

The fourth one, **partner's prior psychological problems** may have affected the course of their grief reactions. Longitudinal inspection of grief reactions of women showed that grief reactions may get less unless there were anxiety or depression history of the bereaved (Lee & Rowlands, 2015). Similarly, even after two years from their loss, parents who reported depressive symptoms before the pregnancy had higher levels of suffering because of their pregnancy loss. Parents who had prior mental health problems had higher grief scores both in two months and two years after the loss (Lasker & Toedter, 1991). Even five years after miscarriage, for women who had poor psychiatric health (Broen, Mourn, Bodtker & Ekeberg, 2006).

Gestational age has been another mediator in the pregnancy loss literature. According to Jaffe and Diamond (2011), regardless of the period the pregnancy ended, couples experience loss, trauma, grief, depression, esteem problems, relationship problems, health problems, financial problems. All these losses are in the category of loss of reproductive story that is the part of the self-harmed with the loss affecting the pregnancy and parenthood expectations (Jaffe & Diamond, 2011).

Very well-known researchers in the pregnancy loss area, Lasker and Toedter, expressed that acute grief (as a part of total grief score) can be predicted by the length of the pregnancy both at the measurements in 2 months and in 2 years after loss. Length of pregnancy was also a significant predictor for difficulty in coping and despair subscales in 2 months after the loss experience, but it did not explain the variance in grief reactions at 2 years after the loss for despair and difficulty coping subscales (Lasker & Toedter, 1991). A similar explanation made by Cuisinier, Kuijpers, Hoogduin and their colleagues (1993). Women who experienced stillbirth had more intense grief reactions in terms of both overall PGS (perinatal grief scale) scores and three subscales of PGS: active grief, difficulty coping, and despair compared to women with miscarriage experience. However, it did not mean that women who experienced miscarriage did not grieve; they also had grief reactions (Cuisinier, Kuijpers, Hoogduin et. al, 1993). They concluded that grief is more severe when gestational age is longer (Cuisinier, Kuijpers, Hoogduin et al. 1993).

On the other hand, there are studies that found that there are no significant differences among the bereaved parents regarding the time of the loss, whether it be during the perinatal, prenatal or postnatal term. A quantitative research was conducted with parents who lost their child to prenatal (loss during pregnancy or labor) or postnatal loss (loss occurred within the 2 years of life of baby) (N=455) and were compared with parents who did not have child loss experience (N=110) to explore the psychological consequences of infant death parents experience. There were no significant differences found between parents who experiences prenatal loss and parents who experienced postnatal loss in terms of their scores on The Trauma Symptom Checklist (Murphy, Shevlin & Elklit, 2014). Multivariate and univariate test results revealed that type of loss like miscarriage, stillbirth, live birth, infant death experienced by mothers and fathers did not have significant effect on GEI scores (Smith & Borgers, 1988). A similar finding was found by Peppers and Knapp (1980), who y found no difference in grief scores among mothers (N=65) who experienced miscarriage, neonatal death or stillbirth, with a mean of 8.1 years after their loss experience (the range was between 6 months to 36 years). What they inferred from this result is expressed as follows: "Our data provide direct evidence of prenatal attachment. Apparently, the affection ties develop very early in pregnancy" (p.158).

In Swanson's study (2000), the gestational age and its relation to personal significance was analyzed and it was found that a higher gestational age was related with higher personal significance at 4 months after the loss. However, 1 year after the loss,

gestational age becomes less important in terms of the appraised harm, loss or threat and time passed since the loss decreased the significance attributed to the loss by the women.

It seems that how a person reacts to prenatal loss depends not only on how long the pregnancy lasted, but also on the personal attributions to pregnancy. Maybe longitudinal studies that examine the effect of the length of the gestational age on the grief symptoms should be increased in number to understand the long-term effects.

Another mediator in the pregnancy loss literature was the **religious beliefs and rituals.** Although parents who lost their baby via stillbirth or neonatal death may use the customs or support systems of the society, there is not a specific ritual or a cultural norm for the miscarriage or infertility (Jaffe & Diamond, 2011). Religious beliefs hold by the bereaved may play an important role in his/her meaning making, coping mechanisms and even the social support they receive. The negative relationship between religious attendance and pregnancy loss grief reactions was identified by a quantitative study (N=404), and the author commented that significant involvement in the religious activities provides support and encouragement for the bereaved person (Mann et al., 2008).

Moreover, whether the grief or other symptoms like depression, anxiety, PTSD decrease over **time** after the experience of prenatal loss has been examined. In the Cuisinier's and his friends' study (1993) when the time since the loss was longer, participants' grief reactions were significantly less severe ($p<.05$). 245 women who had experienced a miscarriage participated in a study that aimed to determine whether depressive and perinatal grief symptoms have changed through time since miscarriage; whether there were any differences among women who experienced prenatal loss within the 6 months, with women who experienced between 7 and 12 months and women who experienced miscarriage more than 2 years ago (De Montigny, Verdon, Meunier & Dubeau, 2017). One-way ANOVA results showed that there were significant differences among the groups in terms of their depressive symptoms regarding the time since miscarriage. Women who had experienced miscarriage in the last 6 months had higher depressive symptoms than women who experienced between 7 and 12 months ago and women who experienced 2 years ago. On the other hand, women who experienced miscarriage between 1 and 2 years ago did not significantly differ from women who experienced within 6 months in terms of depressive symptoms. For grief scores, however, there were no significant differences found in mean scores of perinatal grief according to time since the miscarriage (De Montigny, Verdon, Meunier & Dubeau, 2017).

Another mediator in the studies was related to having other children; whether a **previous or subsequent child** affects the course of grief. Approximately 86% of women become pregnant again after they experienced perinatal grief that occurred over than 18 months (Cuisinier, Janssen, De Graauw, Bakker & Hoogduin, 1996). Having more children may mean less personal significance the loss had for her. So, having a child may function for the woman as a reassurance of having a full-term pregnancy with a healthy baby at the end (Swanson, 2000).

In terms of depressive symptoms, childless women were found to have higher depressive symptom scores (M=12.24) than women with children (M=9.88) after experiencing a miscarriage and childless women had a higher perinatal grief symptom (M = 84.38.) than women with children (M=64.09) (De Montigny, Verdon, Meunier & Dubeau, 2017). For the grief symptoms, for women with children it decreases by the time since the miscarriage, but for childless women, grief symptoms have increased and reached a stable level. Therefore, it could be stated that for the childless women, perinatal grief symptoms were same based on the time after their loss. Even there were significantly large differences between women with children who experienced miscarriage more than 2 years ago and women who experienced miscarriage within the last 6 months, the former had fewer perinatal grief symptoms (De Montigny, Verdon, Meunier & Dubeau, 2017).

Whether the **number of prenatal loss experiences** of the parents might have affected their grief was also examined. Mothers' and fathers' GEI scores were compared based on the number of prenatal losses they experienced (parents who experienced one prenatal loss versus parents who experienced two or more losses) and results revealed that there was no significant difference, so the null hypothesis was not rejected. **(**Smith & Borgers, 1988).

Last but not the least (since explaining all other variables affecting the pregnancy loss might not be possible) **seeing the baby in ultrasound pictures or hearing the sounds during pregnancy** has been a new subject, and its effects on the parental attachment and grief reactions have been studied. According to Klier, Geller, and Ritsher (2002), with the technological improvements and men's ability to see and hear the baby, the attachment of the men to the baby improves. For the mother, the attachment can begin earlier than this kind of technologies was present, and with this early attachment to child, actually the degree of attachment has been getting higher, too (Jaffe & Diamond, 2011; McCreight, 2004). In terms of how this technology has affected the parental grief, there were conflicting findings. For instance, women may have mental representations of the child since the conception, even

around 10 weeks independent of the ultrasound visualization, since after the woman learns about the baby, she begins to see the baby in her dreams, to daydream, or to buy clothes or other staff for the baby; then the mother's attachment development may be independent of seeing the baby in ultrasound (Beutel, 1995). On the other hand, in the research that focused on the men's reactions to their partner's miscarriage experience, Puddifoot and Johnson (1999) discovered that men who had seen the ultrasound images of their baby had relatively higher grief reactions to the miscarriage than the men who did not see the ultrasound images. However, some positive effects of seeing the baby during pregnancy have also been expressed. According to Gilson (1976) seeing or touching the baby after loss may have a beneficial effect that helps the couple realize the reality of the death. Thus, whether seeing or hearing the baby influences grief does not have a certain answer yet, but recent studies focus on this issue.

To sum up, there were many mediators mentioned in the pregnancy loss literature, some of them were explained above. As the readers can infer, studies cannot be certain about these factors because as a social science, it would be impossible to control other variables that influence the grief process. Or, there may be so many factors that cannot be determined one by one, so rather than testing all the variables and creating experimental situations to study such a sensitive and critical issue, hearing the life experiences from the bereaved parents by understanding their context (where they live, what kind of life conditions they have, their relationships with their spouse, friends and larger family, their marriage related problems and so on) might add a new dimension to pregnancy loss literature.

2.3.5. The Dual Process Model of Bereavement

This model was created because of the belief that existing theories and models were not sufficient for the grief and loss literature. Especially "grief work" was criticized with its over emphasis on the intrapersonal processes by neglecting the interpersonal processes, by its use of unclear terms, and its lack of evidence. Prior models were criticized since they minimize the efforts of the bereaved for the grieving process that constitutes a big part. (Stroebe & Schut, 1999; Stroebe & Schut, 2010). By this model, it was aimed to explain the coping and predict the course of grief, so it would be possible to comprehend the individual differences after loss. This model was created to explain "coping with loss" (p. 274). (Stroebe & Schut, 2010).

Dual-process model explains two categories of stressors related to bereavement: loss oriented and restoration oriented. In the loss orientation, "bereaved person’s concentration

on, appraising and processing of some aspect of the loss experience itself and as such, incorporates grief work." (Stroebe & Schut, 2010, p. 277) and this process is similar to grief work, the person yearns for the lost one and experiences pain. Restoration orientation, however, is related to secondary stressors and the bereaved person adapts oneself to the word that was changed with the loss of the person (Stroebe & Schut, 2010).

In Thomadaki's doctoral thesis with women experienced perinatal loss (N=8) there was a theme related to this oscillation process defined by Stroebe and Schut. Participants in this study sometimes avoided the pain by focusing on their daily lives, staying away from the reminders of the loss. On the other hand, same participants also actively used their cognitive-emotional coping mechanisms in order to make sense of their loss, and to re-understand their loss experience (Thomadaki, 2012). Therefore, with this dual process model of grief, it is possible to understand the conflicted coping mechanisms of the bereaved parents, sometimes because of the pain they feel, they try to be away from all loss-related material, while sometimes they want to make sense of this loss and think about it (its reasons, consequences).

2.3.6. Social Constructionist Perspective to Grief

As reported by Gillies & Neimeyer (2006), before understanding the reconstruction of meaning in grief, how meaning can be lost should be understood. In their normal lives, people have unchallenged, unquestioned beliefs related to themselves, others and the world (Janoff-Bulman, 1989). These assumptions of the self, world and others would be shaken by the negative life experiences especially with the traumatic ones, such as losing someone loved that lead the person to either reaffirm, repair or replace those life assumptions (Calhoun & Tedeschi, 2006). Neimeyer and Sands (2011) expressed the process of accommodation of life assumptions occurred after the negative life events as:

> In the aftermath of life-altering loss, the bereaved are commonly precipitated into a *search for meaning* at levels that range from the practical (*How* did my loved one die?) through the relational (*Who* am I, now that I am no longer a spouse?) to the spiritual or existential (*Why* did God allow this to happen?). How—and whether—we engage these questions and resolve or simply stop asking them shapes how we accommodate the loss itself and who we become in light of it. (p. 11)

Another premise of social constructivism was that social constructivist perspective to grief asserts that grief is not only personal but at the same time a social phenomenon (Averill & Nunley, 2003; Neimeyer, Klass & Dennis, 2014). It should be stressed that social-

constructivists do not deny the biological or psychological determinants. Averill & Nunley (2003) explained the assumptions of social constructivism as follows: Firstly, emotions are part of a larger, more complex behavior. Secondly, how a person expresses events is a part of her emotional situation. Thirdly, culturally shaped beliefs and values affect the expression of grief. Fourthly, there is no innate emotional expression that is independent of a belief and value system. Lastly, emotional syndromes are the means reinforcing the beliefs as well as values that create emotional reactions (Averill & Nunley, 2003). Therefore, comprehension of any complex human behavior (including emotional syndromes like grief after losing someone important) is achievable when it is refined from the biological, social, and psychological systems (Averill & Nunley, 2003). From this viewpoint, early theories of grief such as Freud's grief work may be criticized because of its overemphasis on individual dynamics and medical investigation of grief (Gillies & Neimeyer, 2006). In other words, grief is socially constructed "as a situated interpretive and communicative activity", so mourning and grief is a narrative process within a societal context (Neimeyer, Klass & Dennis, 2014, p. 2).

Neimeyer (2000) explained the meaning making under two categories: sense-making and benefit finding. When Neimeyer (2000) analyzed the responses of grieved people, it was found that the content of neither sense making (thinking that death as a part of life, death was the God's will etc.) nor benefit finding (changed perspective of the bereaved, perceived social support from the family), but basically whether the person made meaning of the loss or not predicted his/her adaptation after loss.

Social-constructivist and meaning making theories may be helpful in understanding how parents gave meaning to their baby, themselves and the world that may have been affected by the loss experience. Also, conceptualizing grief from a socio-cultural perspective as well as a personal perspective has been helpful in explaining the common grief reactions of the people in the same society. From pregnancy loss perspective, this theory might be helpful in comprehending how socio-cultural structure in Turkey affects the partners' grief reactions.

2.4. Literature Regarding Becoming a Parent

Even if the theories explained above are the general grief theories in the literature, still they present a perspective for the pregnancy loss. While understanding grief is a necessary step for pregnancy loss, understanding the motives of people for becoming a parent should also be understood, since the t meanings the parents attributed to the child may

have affected their grief. That is why, both theories and research studies related to becoming a parent, motivation factors were given below.

Grete Bibring as the first theorist evaluating the pregnancy as a separate developmental stage in becoming a parent, described the pregnancy as a crisis point in which the person reviews her earlier wishes, dreams, unresolved conflicts and reaches more adaptive or less adaptive solutions (as cited in Leon, 1990). The expectant mother reassesses her past, thinks about her future, so essentially it is the time of pondering over one's place in life. Phantasies that are unconscious enter the area of consciousness; they show themselves in the dreams and symptoms of the expectant mother. From this sense, pregnancy period is a potential time for women to reach a higher psychological growth, while the women may think that there is an imbalance and a lack of imbalance in her life (Birksted-Breen, 2001). Therefore, it is evident that in addition to physical preparation, the expectant mother needs to prepare herself psychologically for the birth and childrearing (Leifer, 1977; Birksted-Breen, 2001). According to Birksted-Breen (2001), having a baby was an opportunity for women to work on their inner conflicts and relationship issues, or to make changes in their perceptions of themselves or their worlds. Thus, they can be able to experience a new identity of themselves.

The most-known theory regarding the adult development is Erikson's psychosocial development theory. Erikson (1977) talked about the adult's needs as follows: "Mature man needs to be needed, and maturity needs guidance as well as encouragement from what has been produced and must be taken care of." (p. 240). From a psychosocial development perspective, parenthood is an expression of generativity. Parenthood is described by Benedek (1959) as a developmental phase in which there is a potential for growth and mastery of the past experiences with the help of the relationship with one's children. While children pass through some developmental stages such as from babyhood to childhood or to adolescence period, parents can get a different perspective to their own experiences and they can use this time to process their childhood (Benedek, 1959). That is why; Jaffe & Diamond (2011) stated that a person becomes a psychological parent before being a physical or biological parent. And, even though the men cannot experience the physical aspect of pregnancy, their psychological changes experienced during the pregnancy are parallel to those of women (Osofsky 1982, as cited in Leon, 1990).

Pregnancy process needs emotional, psychological, physical, even economical adjustments, specifically with the first pregnancy experience (Jaffe & Diamond, 2011). That is why; this period is accepted as a crisis point like in other developmental periods (Leon,

1990). The importance of experiencing pregnancy and its outcomes might not change even the pregnancy ends in abortion or miscarriage. In a sense, pregnancy identifies the terms that the women leave her independent identity and begins her unchanged and irrevocable mother and child relationship (Pines, 1972). Condon (2006) suggests that this period has importance also from a paternal point, too. The expectant father develops attachment with the fetus, he adjusts himself to the dyad (man and woman in the same home) becoming a tried (mother, father and a child), and improves his appreciation of father role. Whether men develop attachment to their children in antenatal term have been widely discussed. Condon (1985) examined whether there were many differences and similarities between men and women regarding the attachment during pregnancy with 54 couples. They found that men's inner world experiences of the internalized representations of the fetus (their thoughts and feelings regarding the expected baby) were similar with women, while the men's outer world expressions like their behaviors were different from women's. The author discussed that the men's reluctance to express their inner worlds were the results of male sex role stereotypes, that is why there were believed to have lesser attachment compared to women.

Additionally, becoming a parent has some societal importance for the person. By being a parent, people can accomplish the moral, civic and marital duties and show their sexual competence (Jaffe & Diamond, 2011; Veevers, 1973). Pregnancy helps women and men to prepare themselves for their future roles; after having a child, both men and women are equal to their own parents. In addition to that, the idea of having a baby may give a sense of purpose; it can help a person reach a higher maturity level, gain psychological independence, improves relationships between and across generations, show their love, nurturance, empathy to next generations (Jaffe & Diamond, 2011; Leon, 1990).

The Turkish Value of Children (VOC) study had been conducted for three generations in different socio-economic strata (two rural, and one metropolitan) for 30 years (Kagitcibasi & Ataca, 2005). The results of these longitudinal studies showed that in Turkish culture the child's psychological value is significantly higher when compared to previous generations. Psychological value of child means psychological benefits of having children such as spending good time with the child, fun, joy, and parents' sense of accomplishment by having a child. Another attribution to child that was examined in this longitudinal study was economic value of the child which means children's economic and material benefits for his/her family both during childhood and during adulthood. Social value is the third and last one, and it means the societal benefits of having a child such as with the child (if it is a boy) families' surnames can be used in the future and family traditions can continue. The decrease

in the economic value and increase in psychological value was attributed to economic changes and increased education level in the society. Because the families can experience the psychological satisfaction with only one child, contrary to economic value where the families needed more children to increase their materials, the decreased fertility was implied (Kagitcibasi & Ataca, 2005). Therefore, what a child means to a family may change according to education and SES levels of the families, and what attributed to a child may change with the time that affects the family dynamics and roles in the family.

While the child may have psychological, social or economic value for the family, what if their plans for the child do not come true? After all the preparation to pregnancy, when the pregnancy does not end with a healthy child, the men and women do not feel the sense of mastery, even they may feel personal failure, can experience stagnation and there might be long-lasted problems that reinforce the past issues, earlier self-defeating patterns (Jaffe & Diamond, 2011; Leon 1990). Especially the women may feel embarrassment which may prevent her from talking about her loss. Especially in the cultures that give importance to motherhood, resolving the grief is difficult (Frost & Condon, 1996).

"Reproductive story" term has been used by Jaffe, Diamond and Diamond (2005) as "the conscious and unconscious dreams, plans, and expectations about becoming parents" (as cited in Jaffe & Diamond, 2011, p. 4). Since this story has an indicative role in one's identity, when it is failed, the loss is perceived as a narcissistic blow to self, affecting the adult development (Jaffe & Diamond, 2011). When the pregnancy does not end in the way they assumed, their fundamental beliefs, relationships, future plans all change unexpectedly. That is the reason why, these bereaved parents not only experience a physical loss but also a loss of their reproductive story (Jaffe & Diamond, 2011).

To sum up, having a child may have different meanings in each society and in each family based on their education and economic resources. Also, an adult has been supposed to have a child from a cultural point. From a developmental perspective, for the adult person experiencing generativity may be another motivation since as Erikson (1977) explained that a person's inability of generativity can lead the person to experience stagnation. While psychologically and socially, the child may mean more than having fun; understanding how society reacts to people who lost their baby during pregnancy is significant. In the coming section, how the grief of people who experienced pregnancy loss might not be validated by the society and how people react to societal denial of their loss will be explained.

2.5. Pregnancy Loss and Disenfranchised Grief

Socially unaccepted grief is described with different terms. One of them is the disenfranchised grief which is described as the deprivation of someone's right to grieve (Clower, 2003). Kirkley-Best & Kellner (1982) define the same situation as "forgotten grief", McCreight (2004) as "ignored grief" and" intangible loss". Three conditions are explained when talking about disenfranchised grief (Doka, 2002, as cited in Clower, 2003). Firstly, the society sets some rule regarding who can grieve after loss and this criterion is determined by the relationship with the lost one. For instance, former spouse's, homosexual partners' or coworkers' grief may not be recognized. Secondly, sometimes the person is the subject of criticism and s/he is accepted as incapable of grieving. This situation can be observed in individuals with special needs, or people who are too young or too old. (Doka, 2002, as cited in Clower, 2003). And lastly, the loss itself may not be admitted socially as a significant loss to grieve.

During 1970s, the most accepted strategy to make interventions for the women who had an involuntary loss experience is accepting this problem as a medical one, by ignoring the psychological impacts it has on the women and men. Those times, stillbirths were recognized as "hush-hush"[silent] affairs (Reed, 1984, p. 210). Immediately after the delivery, baby's body was removed from the delivery room and mother neither could see nor touch the baby. It was believed that seeing or touching the baby could have harmed the woman. By taking a stand against these practices, Kennel, Slyter and Klaus (1970) studied about involuntary pregnancy loss. This study has been accepted as one of the first research in this area. In this study, there were 20 mothers from different socioeconomic backgrounds participating in the study who had at least one living child. All of the participants have birth to live babies, but the infants died between one hour and 12 days after their birth. Semi-structured interviews that took place at the hospital 3 to 22 weeks after mothers' loss were recorded and they lasted almost an hour (Kennel, Slyter & Klaus, 1970). Results showed that all mothers had mourned; this implied that there was an affectional bond between all mothers and with their dead babies. Having positive attitudes toward pregnancy and having a physical contact with their child before s/he died were important factors in the bonding process. Finding of all mothers' having grief reactions after the loss showed that whether mothers had physical contact with the baby or not, they still had mourned after their loss. Thus, the researchers concluded that tactile contact with the baby does not necessarily lead to upsetting immediate reactions or pathological grief reactions. This study also shows that emotional bond with the child does not necessarily happen after a long time. The authors

criticize the medicine-based cold practices to these mothers by not allowing their grief reactions to occur in a normal way, thus inhibiting the fundamental requirements of the bereaved individual. Some of the participants talked about their anger toward the hospital staff that ignored their loss experience for instance by asking the mother when to feed their child without knowing that the mother lost the baby. This study's results have led to some practical suggestions such as arranging rooms based on the needs of these bereaved mothers because as the participants of the study exemplified, they may be hurt by seeing other mothers' feeding their babies. Moreover, this study implies that hospital staff should be informed about the mothers' situations that lead to more sensitive practices for the bereaved mothers (Kennel, Slyter & Klaus, 1970).

In their study, Stringham, Riley and Ross (1982) interviewed 20 women for the purpose of understanding the experiences during and after stillbirth. Participants were selected based on some criterions. Firstly, stillbirth experienced by women whose pregnancy lasted at least 7 months and delivery occurred at least 6 months and no more than 10 years prior the study's data collection. Data was collected in participants' homes and interviews lasted at least 2 hours. The interview questions were developed by the authors and were administered by one of the authors. The interview consisted of 80 questions about pregnancy delivery, their stay in the hospital, postnatal time and so on. All 20 women were married, and their ages were between 23 and 35. 3 out of 4 women expressed that they did not have a serious health problem. 11 stillbirths occurred in the first pregnancy, 6 in the second and the rest in the third pregnancy. During the interview 10 women had had subsequent successful pregnancies. When they were asked about their opinions in terms of the differences they see between grieving over the stillbirth and other kind of losses, parents expressed their feelings of isolation and loneliness because their baby was unknown to other family members or friends. Even most of the women expressed that their grief reactions were not socially sanctioned, and they did not find statements that minimize their experiences as helpful such as suggestions to have another baby, or opinions claiming that not seeing the baby means not being a mother, so grief is meaningless from others' perspectives. The mothers also talked about the unjustness of stillbirth, because they believe that their baby did not have a chance to live. While they think that for an older person’s death there is time to be prepared for the surviving ones, for the babies there was no time for a preparation to the loss (Stringham, Riley and Ross, 1982).

In another study with 509 women, two groups of participants were randomly allocated to experiment (N= 255) and control groups (N=254) aiming to understand the

importance of social support regarding the physical and emotional health for the subsequent pregnancy of those who have experienced pregnancy loss (Rajan & Oakley, 1993). The social support intervention included at least 3 home visits and 2 telephone calls between visits from the research's midwife. Also, the midwife could have been reached by phone; women were expected to ask for their needs. Both quantitative and qualitative data were analyzed. All participants had standard antenatal care. Findings revealed that for the bereaved mothers, most significant social support they needed was the permission to grieve in an emotionally supportive environment. Women expressed the unspoken pressure that results from customs or conditioning. They saw from their environment that an unborn child is not accepted as a person to grieve after him/her, or it is not worth to grieve or there is a time and a place for mourning. Authors discuss this finding as "all of these *can* stifle the natural process of grief, and may contribute to the condition of pathological mourning, from which severe long-term clinical depression may result" (Rajan & Oakley, 1993, p. 81).

To understand whether parents who experienced perinatal loss had different grief responses than adult mourners, and to examine the outcomes of variables such as sex, type of loss, length of time after loss, frequencies of the loss experiences and subsequent pregnancy on the grief responses of bereaved parents, in the study of Smith and Borgers (1988), 176 participants (115 mothers and 61 fathers) were contacted by the help of support groups and support group newsletters. There were different types of losses experienced by participants like miscarriage, stillbirth, live birth, infant death. The mean of time after the loss was 20 months, ranging between 6 months and 7 years. When fathers and mothers were asked whose acts or words hurt them the most after their loss experience, fathers answered that they were hurt by the attitudes of relatives, friends or coworkers who acted as if nothing happened and who did not say anything about their babies. Fathers expressed that the statements like "You can always have another baby" is hurtful. They were also hurt by the question "How is your wife" because they believed that this kind of questions have ignored their psychological needs. In-laws and physicians were the two specific groups that were more cited by parents as hurtful. Mothers also found comments that minimized the effect of death as hurtful. They were specifically hurt by people who were close to them like friends, their parents, or in-laws, and their spouses. Mothers found physicians' acts or statements more hurtful than nurses (Smith & Borgers, 1988).

McCreight (2004) studied with only male partners to examine the effects of pregnancy loss, specifically miscarriage and stillbirth. Qualitative research design was used. For data collection over a 3 year of period observation notes of pregnancy loss self-help

groups like Stillbirth and Neonatal Death Society, Remember Our Child in Northern Ireland and semi-structured interviews of 14 male partners with an age range of 21 to 43 that were participants in those groups were used. Findings of the study showed that miscarriage could be regarded as an intangible loss with no formal mechanism because the fathers whose baby was born under the age of legal viability, were not allowed to bury the remains of their baby. All fathers expressed that they mostly felt that their lost was not accepted by the society; they stated that they could sense this devaluation of the wider society from the expressions like 'never mind, you can always have another baby' that result in feelings of anger and despair (McCreight, 2004). In addition to society's evaluation of their loss, the study findings also shed light on how those men also questioned their own identity after their loss. For instance, whether they should have used the "father" title for themselves even if they lost their baby is unclear for most of the participants. Therefore, when a pregnancy ends, we not only talk about the loss of the baby but also about the loss of future hopes, dreams and identity. Dave as one of the participants of the study exemplified this situation by his dilemma of what to say to the question of how many children he had.

When all the studies regarding the societal devaluation of pregnancy loss and status of baby were considered, it can be interpreted that the absence of rituals and support from the society may deny the loss experience of men and women that hinders their opportunity to grieve after their loss, or to share their emotions with others. As a result, abnormal grief reactions or other psychological problems like anxiety, depression, or trauma related disorders are likely to occur.

In order to make the society be aware of the impact of assuming the pregnancy loss as an easy-to-forget experience for the partners and their families, research studies focus on this "intangible loss" as voiced by the society. Making this loss tangible and hearing the voices of these bereaved parents might be possible with qualitative research designs since as the above studies illustrate (i.e. McCreight, 2004; Stringham, Riley and Ross, 1982) qualitative studies, rather than quantitative studies that talk with the numbers' and statistics' language) give in-depth data about those experiences that might not be measured with the help of any of measurement instruments.

2.6. Socio-Cultural Dimensions of Pregnancy and Loss

When looking at the socio-cultural rituals, rites and customs of the Turkish society, so much importance is given to having a baby. That is why, there have been many studies examining these rituals regarding having a baby, rituals related to the postnatal period, or

rituals for individuals who have reproductive problems. This pregnancy related (pre-birth, birth, after-birth) practices and rituals draw a road for the society. After these rituals and practices, socio-cultural elements of loss will also be explained. When the context of Turkish families is understood, understanding the grief reactions of parents will be possible. As explained below, in Turkey, as a socio-culturally rich country, practices and rituals related to pregnancy and death change a lot from one country to another. So, description of the socio-cultural elements of Turkish culture that affects the couple' grief process after pregnancy loss in terms of gender roles, partner relationship, extended family relations will be presented below.

2.6.1. Pregnancy, Birth and Loss Related Turkish Folk Culture

People living in a country, a region, a city exhibit common behaviors in order to be able to keep up with the people around them. There are many common widespread behaviors in the face of events and situations that determine the way of how people live in that society, of how people comment on the events and situations. Customs, traditions, beliefs that have existed for many years in the society constitute the folk culture of that society (Teke, 2005). According to our culture, there are three rites of passage in human life: birth, marriage and death. Every transition period has its own ceremonies and customs (Teke, 2005).

Whether it is a primitive or a developed country, a child is an important existence for the society especially for the traditional countries. For a woman, getting pregnant, giving birth and having a child are like her duties and responsibilities in a society, so the prestige and identity of a woman depends on her motherhood in the societies like Turkey (Bayık& Bahar, 1985; Hotun, 1990). For men, having a child similarly affects their identity as well. However, the cultural beliefs and practices regarding having a child are generally defined from the women's perspectives (Yalçın & Koçak, 2013).

After the 15th century, the concept of public health has increased its importance especially in the Europe and United Kingdom. In Turkey, however, public health has been given a voice after the World War I, specifically with 1961 Law of Socialization of Health Services. In principal, this law was supposed to be a turning point in the health system, but due to some factors like low number of health personnel in the health, political discrepancies, or service discontinuation, this law did not work as it was supposed to do. In addition to these problems, because of the inequality in the distribution of the health services to all SES levels in the society, the cultural characteristics of society, low education level of people, in Turkey traditional customs and practices still maintain its significance (Bilgiç,

Demirel & Dağlar, 2018; Hotun, 1990). Turkey is a rich region in terms of the traditions, customs, and beliefs with its large geographical area that have been enriched by the different communities. (Teke, 2005).

In Turkish culture, from one region to another the customs and beliefs for pregnancy, or birth change a lot, while there were some common practices and beliefs. That is why, studies conducted to understand the folk culture in Turkey about pregnancy and giving birth focus generally on one village or city. For instance, a study was conducted in Sivas by Bilgiç, Demirel and Dağlar (2018). In this descriptive study, pregnant women's (N=368) cultural myths in relation to pregnancy and birth were questioned. When the frequency analysis was conducted the most frequently voiced myths of pregnant women were as follows. In terms of pregnancy most of the women accepted these as reality: "It is bad to cry and get upset in pregnancy, baby is affected" (91%), "Applications such as hanging curtains, lying down, removing something heavy during pregnancy absolutely leads to miscarriage" (88%). When looking at the myths about nutrition in the pregnancy, 83.2% of women expressed that they thought "Everything the woman longs for during pregnancy should be supplied", and 60.8% of them believe that "Obese or very fat pregnant women cannot have healthy babies". Because gender is a highly valued subject in some regions and sub-cultures of Turkey, the authors also questioned the myths regarding the gender of the baby. They found that 56.2% of women believe that if the mother's belly is big, the baby is a boy; while the baby is girl if the mother's hip is big. Similarly, 52.7% of participants believe that if the mother is getting prettier, it means the baby is a boy (Bilgiç, Demirel & Dağlar, 2018).

Especially in our country, it is believed that the family is the smallest, but the most stable core of the society and the existence and continuity of the family is based on next generations (Başal, 2006). That is why, beliefs, practices, rituals regarding the pregnancy and post-natal period are many. The most common myths, beliefs and cultural practices expressed in the studies regarding pregnancy, birth, and infertility are as follows (Başal, 2006; Bayık & Bahar, 1985; Çakırer & Çalışkan, 2010; Hotun, 1990; Teke, 2005):

2.6.1.1. Myths Related to Pre-birth

- A woman without a child should jump over a non-Muslim's tomb three times. With this practice, the woman is believed to become pregnant.
- There is a faith that it is a bad luck for a pregnant woman to have a haircut during pregnancy.

- A child would be alike to the person or the object that the expectant mother looks at when the baby first moves during the pregnancy. That is why; women avoid looking at the things she thinks as ugly. For instance, if the woman looks at the bunny, it is believed that the baby would be harelipped, or looks at the donkey then the baby would have long ears.
- Pregnant woman should not take anything secretly such as fruits, flowers. Otherwise the baby would be born with stains of that on her/his body.
- Pregnant woman should not jump over the rope. According to the belief, the cord would run around the baby's throat and the baby will die.
- Pregnant women should look at the moon to have a beautiful baby and eat quince to have a child with dimples.
- The pregnant woman should not condemn the disabled and the ugly because there is the belief that their children will be like them.
- To have a baby, rituals like visiting the holy places, drinking holy water, sacrificing an animal for God have been conducted in different regions of Turkey.
- A boy is seated on the bed of the new married couple while preparing their bed. This is done for couple's future child to be a boy. A child is seated on the lap of the bride for a similar purpose.
- For the men who are infertile, there are some practices such as eating mesir paste that includes honey, different spices, vegetable and fruit seeds that are supposed to give strength to men.
- When the pregnant woman's birth pain starts, she is given an apple and she does not finish the entire apple; then the half-eaten apple is given to an infertile woman to eat. It is believed that by this way, the infertile woman will have a baby.

2.6.1.2. Gender Prediction

Gender issue has been talked a lot before and during pregnancy. There are some beliefs regarding the prediction of gender of the baby during the pregnancy. These predictions are made based on the shape of the mother's belly, and on the food the mother prefers during pregnancy.

- There is a belief that if the baby moves early in the womb, the baby is a boy. However, if the baby moves later in the womb, the baby is believed to be a girl. This belief results from the idea that men move more than women.

- If the pregnant woman is getting prettier, it means the baby is a boy; otherwise, the baby is a girl. This belief is parallel to society's desire to have a boy rather than a girl.
- If the pregnant woman craves for the desert, the baby is supposed to be a boy; if the woman craves for sour food, then the baby is a girl. This is because it is believed that the boy brings happiness, joy; and the girl brings sadness and displeasure.
- If the pregnant woman has a dream of a snake, sun, money, or gun, the baby is supposed to be a boy; if she has a dream of a pear fruit or gold then the baby is supposed to be a girl.
- If the pregnant woman's belly is pointed in its shape, the baby is predicted as a boy; if her belly has a flat shape, the baby is a girl.
- If the pregnant woman is agile and not-heavy, the baby is a boy; but if she is lazy and heavy then the baby is a girl.

2.6.1.3. Birth Related Myths

- Pregnant women whose birth spasms have started, should have a walk around. With this, it is aimed that the movement of the mother passes to her child.
- The pregnant woman is jumped over a thick thing such as over a puddle. Water is fluent, and by jumping over the water, the pregnant woman is in contact with this power of fluid, and this power passes to the baby though the mother.
- In order to make the birth process easier, pregnant women's hair ties, belts, knotted goods are dissolved, and windows, door locks, scissors and blades are opened.

2.6.1. 4. Postnatal (After -Birth) Related Myths

- Where the child's umbilical cord is buried, the child acquires a personality associated with that place. For instance, the umbilical cord of the baby is buried in the yards of the universities with the intention that the baby will have his\her education there when s/he is grown up.
- When partners lose their babies, they give names like "Durmuş, Yeter" in order to prevent further losses.

As it has been discussed in the studies regarding the cultural beliefs and practices related to pregnancy, birth and child rearing; there are some beliefs and customs that may foster the importance of motherhood and fatherhood in the society but at the same time,

some of them may affect adversely both the family and the larger society (Shojaa, Jouybari & Sanagoo, 2009).

In Turkish culture, a new baby is supposed to give power and dignity for the family, the child empowers the cultural identity of his/her parents and the baby is seen as an important figure for the next generations of the society. Also, the child may be accepted as a support figure for the parents both psychologically and economically when the parents get older (Taşi 2002, as cited in Başal, 2006). Looking from this view, it would not be surprising for the society's effort to keep the women pregnant. The family and friends of the pregnant woman do not let her to make heavy household chores, want her to be careful about what she eats. That is why, it is considered pregnancy and birth reinforced feminine identity and maternity status. In other words, by having a baby the woman strengthens her own place as well as her husband and her family's place in the society (Başal, 2006). Findings regarding the prevalence of the cultural rituals for having a baby are the proofs for the value of children in Turkish families. For instance, in Bayık and Bahar's study (1985) with 107 women who lived in different regions of Turkey, 42.8% of them revealed that they used religious or public health techniques to get pregnant, while 33.4 % applied a medical help. In another study that was conducted in Erzurum and its precincts, among the women who applied medical assistance for the infertility problem (N=83), 50.6% of them asked for help from the Muslim preacher (hodja) and 44.6% of them asked help from the midwives (Engin& Pasinlioğlu, 2002). A similar ratio was found in Çakırer and Çalışkan's study (2010) with 184 women, in which 70 .7 % of the participants used traditional ways to get pregnant. In the Engin, and Pasinlioğlu's (2002) study, there were revealed practices to get pregnant such as eating or drinking related practices (i.e. drinking the three-days-waited water that included the hodja's pray words, or drinking the boiled parsley juice), placing something into the vagina such as different herbs, putting eggs into the vagina for three days, mixing honey and spices and putting them into the vagina. In addition, sitting on different spices etc. is a commonly used practice by the participants (Engin& Pasinlioğlu, 2002).

2.6.2. Socio-Cultural Elements of Loss, Grief, Bereavement and Mourning

Individual factors affecting the pregnancy loss were explained in the previous sections of the paper. While those factors may explain some variance in the differences among different people's grief process; they may not explain the whole picture. In addition to personal specific factors influencing the grief process, there are also socio-cultural elements that fill the gap left from personal grief related factors. Cultural norms determine the

experience of bereavement in such ways like acceptable patterns of behaviors, feelings and similarly society creates social norms for people and circumstances to evaluate the appropriateness of grief (Rosenblatt, 1988; Werner-Lin & Moro, 2004). That is why, normal and abnormal grief reactions may be defined differently from one culture to another (Stroebe and Schut, 1998) since every culture has its own unique beliefs, customs, behaviors related to loss, disposition of the body and ceremonies for mourning and remembrance of the lost one (Shuchter & Zisook ,2003). How different cultures react differently to the loss experience is exemplified by Catlin (1993)'s study examining the effects of culture on grief in a sample of American and Spanish students. When the grief responses were thought, although these two different cultures have shared some common reactions to loss such as sadness, depression, negative beliefs about world, isolation and withdrawal (in the short term) and accepting mortality, anger, learning something (in the long term); there were also some differences between these two cultures. For instance, it was found that Americans experienced significantly high levels of anger, loneliness, confusion, guilt, denial, religious doubts (as initial effects of loss), fear of losing others (lasting effects of the loss) compared to Spanish participants. Spanish participants had higher score just in the reaction of "accepting mortality" (as initial effect). They expressed that the loss experience had a more negative effect on their self-esteem and had a more positive effect on liking and trust of others than Americans had. The authors expressed that these differences result from Spanish's having more affiliation with others, so losing someone important may mean more to their self-esteem. Also, Spanish would tend to get closer to others in the time of losing someone. As Americans having a more autonomous culture, their self-esteem would not be affected with losing someone neither they would have a need to improve their relationships with others (Catlin, 1993).

In the past, culture had a more significant role in regulating the grief practices of people. Parkes, Laungani, and Young (1997) believe that inability to confront death (our own death or death of someone important) because of the improvements in the medicine area that resulted in the faulty belief that every health problem could be overcome, leads to decline in fulfilling religious customs that follows death. Those abandoned rituals such as burial customs were important in the past that were a source for the social support for the bereaved person. However, it should be also noted that, not every culture and society were affected equally with these changes (Bağcaz, 2017). What a society attributes to its individuals and the group has a lot of importance on the behaviors of individuals. For instance, in countries where the individualistic characteristics are more important, and

autonomy of the individuals is reinforced such as the American culture, resolution of the bonds with the lost one and reestablishing new bonds are encouraged. In many of the Western countries, similar attitudes could be observed.

Contrary to these individualistic cultures, in collectivist cultures such as Eastern countries, i.e. Japanese, being an individual means existence in the society. In these collectivist societies, people cope with their loss by continuing their attachments with the lost ones. Therefore, whether a person has continuing bonds with the lost one and whether this behavior is healthy or not depends on the culture the person lives in (Bağcaz, 2017). In a cross-cultural study conducted by Lalande, and Bonanno (2006) with 61 participants from US and 58 participants from China, the difference of adjustment between two groups of participants when they continued their bonds with the lost one was detected. In Chinese participants, continuing bonds with the lost one at four months were found to be associated with better adjustment in 18 months after loss. On the contrary, in US sample the higher the continuing bonds with the dead one was related to poor adjustment in the 18 months (Lalande, and Bonanno, 2006). Therefore, what is healthy, normal adjustment or bereavement after loss should be evaluated based on the cultural practices and norms. When Turkey has been considered within the two poles of the individualistic and collectivistic cultures, as Yetim (2003), Imamoglu and Gultekin (1993) stated that Turkey is neither a fully individualistic nor a collectivist culture. Depending on the regions of the Turkey, on rural or urban living, SES levels of people, individualistic or collectivistic features outweigh. Kagitcibasi (1996, also in Kagitcibasi & Ataca, 2005) preferred using the term "autonomous related self" concept to define Turkish culture, where she means the becoming individualistic culture while holding on the emotional relatedness and having some collectivist culture features. Consequently, when thinking about Turkey and its cultural values, Turkish culture reflects both individualistic and collectivistic cultural feature, and depending on some factors (urban vs. rural, SES and so on) groups and individuals might have different cultural rituals, norms that might affect the grief responses, social support they got from their social environment.

In each society, each generation has approached to the phenomenon of death with its own way, with its own beliefs and customs. Throughout the history, Turks have entered different religious and cultural environments, so there have been different understandings of death in different times and geographies (Ersoy, 2002). Parkes, Laungani, and Young (1997) stated that while beliefs and customs seem to vary in a large spectrum, there are also common practices and beliefs observed in in each society, the same is true for Turkish

society. When the contemporary rituals and rites have been examined, the effect of Islam in Turkey on the death phenomena is apparent (Cimete & Kuguoglu, 2006; Ersoy, 2002). It should be mentioned that in a Muslim context, reactions to loss and rituals related to loss vary widely both among the countries and within the country. Even it could be stated that rural customs and customs in the cities are different (Jonker, 1997). So, it would not be possible to explain all cultural and religious practices and beliefs. That is why, the researcher, in this paper, preferred to mention about the most known and prevalent practices and beliefs mentioned in the studies and papers.

Cultural belief system and practices have a role in adaptation to and coping with the loss. In the literature, there are high number of evidences supporting the significance of the religious beliefs and spirituality on the adaptation to loss experience (Benore & Park, 2004; de Vries, Davis, Wortman & Lehman, 1997; Parkes, Laungani, and Young, 1997). Becker, Xander, Blumet et al. (2007) expressed that fulfilling religious practices with one's own will have important positive consequences on the grief process of the bereaved. Aksöz-Efe, Erdur-Baker and Servaty-Seib (2018) also found a similar theme in their qualitative study with eight participants who experienced the loss. In this study, participants talked about their feeling of relief when they take part in the religious rituals with their own will. Therefore, while religious practices have found to be helpful in resolving the grief of the bereaved and provides some relief feeling, it does so when the person participates in these religious or cultural practices with their own wish (Becker, Xander, Blumet et al., 2007; Aksöz-Efe, Erdur-Baker and Servaty-Seib, 2018).

In Turkish culture, when a death occurs in a home, all friends, family members, relatives, neighbors of the family gather together especially within the first days after the loss. Because the bereaved family has issues related to funeral, people coming for condolence help the family members about preparing food, helping about housework, helping family about the funeral issues and so on. (Cimete & Kuguoglu, 2006). Example rituals completed are as follows (Aksöz-Efe, Erdur-Baker and Servaty-Seib, 2018; Bağcaz, 2017; Cimete & Kuguoglu, 2006; Özmen, 2014):

- The shoes of the deceased are placed in front of the door,
- The clothes of the dead are distributed to the poor people,
- Donations can be made for the poor people in the name of the dead one,
- Some of the belongings of the dead one will be kept by close family members as souvenirs
- Presenting food for the people who come for condolence visit,

- There are religious rites on the 7th, 40th and 52nd days of the loss,
- Religious prayers are done such as reading Yasin (a pray from the Quran) or Mevlud ("meaning *birth, birth day* specifically indicates the birth of Prophet Mohammed and as a literature term, refers to all passages, poems, and stories written to praise Mohammed and to explain his life" (Aksöz-Efe, Erdur-Baker and Servaty-Seib, 2018, p. 2) or other parts of Quran for the lost one,
- Visiting the grave in important days (such as in Bayrams, religious days, anniversaries),
- Giving the name of the dead to the newborns,

Another important effect of culture on people is related to expression of emotions. Which emotions are proper to express and to what degree and where, change according to cultures. In Turkish culture, people who know the lost one may prefer to go to funeral even if the relationship with the lost person was not so close. During the grief process, expression of emotions, lamenting (i.e. crying too much for the bereaved) after the loss are thought as normal. In the Islamic belief, the death of person is not "the end" because the life on the earth has been believed to be as an exam for the dead person and by dying, s/he would be on the way to God, so the death is a part of life. Because of this religious belief (this belief-life after death-could also be observed in the previous Turk states that were located in the Asia (Ersoy, 2002), crying after the loss, lamenting is accepted as normal while negative emotions like denial, anger, disappointment are not accepted by Islamic philosophy (Cimete & Kuğuoğlu 2006). Maybe this is the reason of the prevalence of somatic symptoms (Bağcaz, 2017) that are very common after the loss experience. According to Cimete and Kuguoglu (2006), cultural rites sometimes may hinder the resolution of grief process for the bereaved, especially the ones that does not give the necessary time for the bereaved members by occupying them mindfully. That is why, it is possible in the Turkish culture that bereaved people may inhibit their emotions related to their loss when other people are around to give support, to show their condolence to the family within the first weeks or months after the loss. Family members may realize their loss after all guests cease their visits and leave them alone to face with their inner emotions. Nonetheless, if these visitors and the bereaved are able to talk about their emotions regarding the loss, then this grief period may be easily resolved (Cimete & Kuguoglu, 2006).

Sometimes, expectations regarding the emotional expressiveness of the bereaved may create burden for the bereaved because of the thought that their emotional reactions

were not adequate for the social standards (for instance, in the case of cultural norms that accept intense negative feelings as normal) (Aksöz-Efe, Erdur-Baker and Servaty-Seib; 2018). In terms of the accepted normal grief period, this period might differ based on the place bereaved lives in (rural or city) and the position of the bereaved in the society. In the rural areas of Turkey, the grief might last more than a year, while this period is shorter in the cities. For instance, people who are civil servants have less time for their grief, because of their time constraints (Ersoy, 2002). To console the bereaved, there have been some sayings that were common in Turkish culture: "*Allah geride kalanlara sabır versin* (i.e., may God give you patient), *başınız sağ olsun* (i.e., may your life be spared), and *acıları üstünde kalsın* (i.e., may you live with your pain), *Allah rahmet eylesin* (i.e., may God have mercy), *nur içinde yatsın* (i.e., may the deceased rest in peace), and *Allah taksiratınıaffetsin* (i.e., may God forgive their faults and sins)" (Aksöz-Efe, Erdur-Baker and Servaty-Seib; 2018, p. 5) (Italic emphasizes belong to the authors).

While there are rituals, ceremonies, rites related to loss in Turkish culture, it seems that there are no specific acts for the pregnancy losses (Maker & Ogden, 2003). In the Shaw's case study (2014), pregnancy losses before fetal movements may be accepted as loss of a child, child before its movements, it is accepted as early miscarriage or loss of blood or tissue. This finding was similar to Islamic belief that "life begins when the spirit (ruh) has been breathed into the baby"(p. 90). In a Hadith it was expressed that "a fetus as 'semen' at 40 days from conception, a 'clot of blood' at 80 days and a 'lump of flesh' at the 120 days of the pregnancy, and in this point of pregnancy God sends an angel to breath the spirit into the baby (Shaikh, 2003, as cited in Shaw, 2014, p. 90). Because live birth is a necessity for Muslim burial, for the pregnancy losses this will not be fulfilled. A funeral is a way to express community's loss experience, and it is somehow affirming the importance of the lost one for the community (Shaw, 2014). Therefore, especially for early pregnancy losses, there were no determined religious and cultural practices. Nonexistence religious beliefs and practices regarding the pregnancy losses and socio-cultural system's unwillingness talking about pregnancy losses do not help the family in the resolution of their grief (Worden, 2009).

Briefly, religious and cultural beliefs and practices are so important for the society that bereaved people make meaning of their loss experience by taking into consideration their personal belief system and cultural context (Horowitz, Bonanno & Hole, 1993). The literature supports the view that bereaved individuals who cannot benefit from religious and cultural practices are away from the social validation which leads to disenfranchised or abnormal grief (1988; Rosenblatt, 1988; Romanoff, 1998; Stroebe & Schut, 1998). Grief can

be resolved by the help of cultural and religious beliefs and practices since they give an existential framework for the bereaved by their principles regarding the life and its beyond (Walsh, King et al., 2001) and by their social support (Özmen, 2014).

2.7. Summary of Literature Review

In this part of the thesis, losing a baby during pregnancy was explained from individual, couple and societal perspectives. Like in other loss experiences of individuals, pregnancy loss also results in grief reactions in the bereaved person. These reactions can be emotional, cognitive, behavioral or spiritual. The grief reactions of bereaved parents have been accepted as normal if the grief lasts within the determined time limits (generally 12 months for adults). However, there are also abnormal/pathological grief reactions for the bereaved ones. Even if what differentiates between abnormal and normal grief may change from one culture to another, still there are some criteria (i.e. DSM-V) have been used to define the pathological symptoms. Apart from normal and abnormal grief reactions, there is another reaction to loss that is Post-Traumatic Growth. PTG has been defined by Tedeschi and Calhoun (2004) as the positive changes in the appreciation of life, sense of priorities, relationships, personal strength, spiritual development and new possibilities after experiencing a traumatic life experience. Studies in the literature showed that although all of them experienced the pregnancy loss, every partner, every men and women gave different reactions to the same loss. Why some people grieve normally, while others have pathological grief? What differentiates a person's grief from other ones'?

As the literature promotes that there were individual, relational, and socio-cultural factors that affect grief reactions of partners. As Worden's summarizes these factors affecting the course of grief, bereaved person's grief cannot be fully explained just by explaining the individual variables. Since the pregnancy loss is a shared loss between partners, between man and woman, understanding the both perspectives can be important for the pregnancy loss literature.

Additionally, while grief is personal and relational; it is also a socio-cultural construct since the person grieves in a society and society provides rituals, rites for the bereaved ones, thus in a way, the societal applications give person a meaning after their loss. For the pregnancy loss, however, there were many few beliefs and very limited rituals. Based on the religious beliefs, practices cannot be applied, except the pregnancy loss occurred within a time limit (in 120 days of gestation, the baby has got the spirit according to Islamic beliefs, and if the baby has a soul then for s/he, praying is allowed). Not only religion but

also medical records somehow deny this loss, only pregnancy losses that occurred after 20 weeks or in that baby weigh more than 500 gr have been recorded in the health system. As the society gives importance to getting married and having a child, then those bereaved parents who lost their baby during pregnancy might be at risk of developing psychological problems.

Consequently, while the existing theories might be helpful in understanding grief reactions of people, they were not created specifically for the pregnancy loss phenomenon. That is why, there may be some factors that these theories cannot handle. Because grief is a personal, relational and socio-cultural concept; explaining only the individual factors might leave some factors unexplained. Based on the study findings in couple studies, examining the partners' grief reactions and their interactions would give a lot of data in predicting and preventing the couple problems after pregnancy loss. Also, studies that examine how socio-cultural factors affect the couple's grief process might be helpful, since to the author's knowledge there is no study conducted in Turkey examining both personal, relational grief process and the effects of socio-cultural factors.

CHAPTER 3

METHODOLOGY

In this chapter of thesis, the overall approach and design of the study regarding the sampling procedure, participants, researcher identity, data collection instrument, data collection procedure and data analysis method were given. Also, because of the sensitivity of the topic, ethical issues handled throughout the study were presented.

3.1. Research Approach

Scientific research in social sciences has been explained under two main research methodologies: quantitative and qualitative. These two methodologies are different in terms of their assumptions, purposes, methods used by researchers, researchers' roles, whether generalization of results is aimed or not (Fraenkel, Wallen & Hyun, 2011; Merriam et al., 2002; Gall, Gall and Borg, 2010). Qualitative research has its roots in anthropology and sociology, but nowadays it has been an accepted methodology in all social sciences (Merriam et al., 2002). In the past, quantification methodologies were believed to be more scientific. However, within the last decades, social sciences' too much emphasis on the sterile survey techniques has been criticized. With the emphasis on the individuals and their life-worlds, qualitative data and its distinct methods have got its place in the social sciences. Thus, with the utilization of qualitative study, life-worlds of participants such as their emotions, motivations, and meanings they attached to events, natural lives of individuals and groups in their usual settings have been considered (Lune & Berg, 2017) with the assumption that knowledge is constructed by people (Stake, 2010). The process in qualitative method is inductive; researchers try to build concepts, hypotheses from the data (Merriam et al., 2002).

What is more, qualitative research is preferred when the research questions are interested in the "how" and "why" questions, getting information in participants' natural settings and when there is a need for the detailed perspective of the phenomenon. Quotes and excerpts have been used very often, that also reflects the descriptive nature of the qualitative studies (Creswell, 1998; Merriam et al., 2002). Thus, it gives chance to understand the social, cultural, and political environments affecting the experiences of participants (Glesne, 2006). In this process, the researcher becomes the main instrument for the data collection (Glesne, 2006; Merriam et al., 2002). However, it should be reminded that qualitative

research has been criticized for its subjective nature, high risk for ethical issues, and its higher costs (Stake, 2010, Yin, 2016).

The purpose of this study was to understand the overall grief and bereavement experiences of couples with prenatal loss and whether gender roles and other sociocultural factors impact their experiences. In this study, qualitative data collection and analysis methods were utilized since qualitative methods could be essential when the aim was to capture the important aspects of bereavement from the participants' perspectives with their own words. Thus, socially and personally constructed realities can be explored with in-depth data (Nuzum, Meaney & O'Donoghue, 2018; Stroebe, Stroebe & Schut, 2003).

3.2. Design of the Study

The phenomenological study has been founded with the work of Edmund Husserl at the beginning of the 20th century. He criticized the scientism that occurs because of the universalization of the research methods of physical sciences because according to him, physical sciences could not answer all the questions that were related to human beings. He suggested that subjectivity could be studied with rigorous methods. The study of human meanings, values or cultures necessitated suitable methods. That is why, he suggested pluralism in methodology, especially in terms of rational and unprejudiced knowledge (Wertz, Charmaz, McMullen, Josselson, Anderson & McSpadden, 2011). The phenomenon in these studies can be experiences, perceptions, concepts, or situations, in other words anything that enter the area of consciousness can be subject of phenomenology (van Manen, 1990; Yıldırım, & Şimşek, 2016). Therefore, in the phenomenological study the researcher tries to understand the meaning of events, experiences, interactions, situations of ordinary people (Bogdan & Biklen, 2007; van Manen, 1990). In another definition, phenomenological study focuses on the phenomenon of that we are aware but for that we do not have detailed understanding (Yıldırım & Şimşek, 2016). According to Creswell (2007) what all participants of the study had in common while experiencing the phenomenon was paid attention in phenomenological research.

Phenomenology tries to understand the nature of meaning of everyday experiences by asking the question of "What is this kind or that kind of experience like?" (van Manen, 1990, p. 9). By doing a phenomenology, it is not aimed to reach a theory by that we could explain the world, but rather with the help of phenomenology we could gain insights about experiences that make the more direct contact with the world possible (van Manen, 1990).

As a kind of qualitative study, phenomenological studies might not give cause-effect relations or certain results. However, they enable the researcher and the readers make sense of the phenomenon better by its giving examples, explanations or experiences that could make significant contributions to both literature and practices (Yıldırım & Öztürk, 2016). Another significant feature of these studies was being reflective rather than introspective. Experienced phenomenon is always re-collective, people in these studies talked about what was lived, already passed (van Manen, 1990). That is why, researchers with phenomenological perspective aim to reach these re-collective meaning makings of participants.

In the literature, grief has been studied a lot by using the phenomenological research as the method of study. For instance, Aksöz-Efe, Erdur-Baker, Servaty-Seib (2018) explored the grief phenomenon by focusing on the death rituals, and religious beliefs of the participants with loss experience; Özmen (2014) used phenomenology as the design for studying the grief experiences of Turkish and American adult women's grief experiences, coping and expressions of their loss; Meaney, Everard, Gallagher, and O'Donoghue, K. (2016) studied the participants' stillbirth experiences, Harper, O'Connor, Dickson, and O'Carroll (2011) examined the coping strategies of bereaved mothers with child loss experiences (child ages were between two weeks to 29 years), Meaney, Corcoran, Spillane, and O'Donoghue (2017) by using the accounts of men and women who experienced miscarriage, were conducted a phenomenological study.

As emphasized previously, pregnancy loss is an important issue for couples both in Turkey and in worldwide. While there were studies which have analyzed this issue by using quantitative methods, there has been a need for qualitative research to make the voices of partners who experienced prenatal loss more visible in the studies. It was a fact that almost one fifth of the pregnancies end with losses (Hacettepe University Institution of Population, 2013; Ridaura, Penelo & Raich, 2017), so the number of the bereaved people with pregnancy loss experience is undeniably high. That is why, with this study it was aimed to understand the overall grief and bereavement experiences of couples with prenatal loss and to examine whether the gender roles and other socio-cultural factors impacts their experiences. This information was best emerged from the participants' own words, by their descriptions of their own experiences (Glaser & Strauss, 2006). Then, the phenomenon under the scrutiny was the "pregnancy loss experience" that was either a miscarriage (occurrence of the loss before the 20 weeks of gestation as suggested by Covington (2006)) or a stillbirth (occurrence of loss after the 20 weeks of gestation, suggested definition by Covington (2006)) of participants.

3.3. Researcher Identity and Reflections of the Researcher

While in quantitative studies, role of the researcher has been certain and generally not defined in the research papers, in qualitative studies, the readers should be informed about the role of the researcher since the researcher becomes the part of the data collection process by spending time in the research site, by knowing and living the events in the site, by spending a lot of time with the people in the site (Cook, 2010; Parkes, 1995; Yıldırım & Şimşek, 2016).

The research topic was chosen based on the professional interest of the researcher in the grief studies that started eight years ago when her aunt died in a traffic accident. After this loss, how families were affected by the loss of a loved one became a very important topic because no one in the world could stop the losses occurred or losses that would occur, even the best medical techniques would be discovered. While the losses are mourned, the society's indifference in the pregnancy losses (if there is) took the attention of the researcher since the births have been celebrated, while miscarriages or stillbirths have been experienced in silence as she observed.

The researcher of this dissertation has been working as a psychological counselor since 2010. She has worked with children, adolescents, their families and teachers. Nowadays, she has been working in Sarıyer Guidance and Research Center with people with special needs. As a counselor, she had trainings in family therapy, trauma interventions, short-term brief therapies, crisis intervention, creative drama, children assessment tools, EMDR, conflict resolution and mediation. Also, since the last year, she has been a member of Sarıyer District Crisis Intervention Team which supported schools during crisis events. Therefore, from professional experiences, she was able to conduct such a sensitive research by putting the presumptions aside, and by being there while the participants were talking about their loss.

Why other subjects did not take the attention of her, but this issue did? Personally, she was the replacement child in her own family. She was born one year after her mother's loss of sixth month baby (whose name was also Betül). After her mother lost her baby, she and her husband moved to another city, while there was no grave for her. After the years, when the researcher saw the lost baby's photo in their family album, her mother used to talk about her like nothing had happened to her. And when the researcher is a grown-up now, sheknows that that loss affected her too much, but she could not have found a way emotional abreaction since at those times there was a belief that grieving after a baby who was 6 months of her age was not proper.

Now years after her loss, my mother still had regrets over the baby's not-having a grave, a grave to pray after her and to know that she was there.So, I, as the researcher, want to be a messenger between those bereaved mothers and fathers and between other people who did not realize these people's grief experiences.

3.4. Data Collection Instruments

Main tool was the semi-structured interviews with the couples. Interviews' purpose was to make readers comprehend the issue of pregnancy loss experiences from the perspectives of participants. By using interviews, it would be possible to determine how parents interpreted their perceptions of loss experience, factors facilitating their growth (Weiss, 1995). Also, interviews are tools to learn about the past, private lives, things that cannot be observed by the researcher, to understand fully the experiences and interpretations of respondents (Stake, 2010; Weiss, 1995). By asking their experiences, participants could have a chance to tell their stories that was important for their meaning-making process (Seidman, 2006).

Related to the nature and epistemological approach of qualitative studies, interviews do not aim to test the hypotheses, to get specific answers from the participants. It is interested in the comprehending the lived experiences of participants and their meaning-making attached to those experiences (Seidman, 2006). As Weiss (1995) put it another way: They can foster the kind of understanding that might be expressed as "Had I been in that situation, I'd have acted that way too." (p. 10).

For some, using interviews for data collection seems easier because it just consists of two people speaking and listening to each other. But interviewing differs from normal life conversations in many ways. Communication errors like failure in listening, prejudices are not allowed; the researcher fully concentrates on what participants say (Yıldırım & Şimşek, 2016). In an ordinary conversation, each part of the communication talks about their opinions, feelings; either of them can start a new issue and ask questions to the other. On the other hand, in qualitative interviewing the participants give the information while the researcher as the interviewer is responsible with directing the communication based on the purpose of the study. Also, it is the researcher' responsibility to decide about when to elaborate on the issue that has been expressed by the respondent (Weiss, 1995). Even the voice of respondent and researcher is different. The researcher has a more serious, respectful and interested voice while the participant's voice is relaxed, unhurried, reflective and inward (Weiss, 1995).

Interviewing as method to learn more about the inner experiences of individuals has some powerful features and shortcomings. Firstly, using interviews gives the flexibility to the researcher. For instance, the researcher can ask additional questions, use probes to clarify the responses, can change the order of questions or skip some according to flow of the interview and respondents' manners. Secondly, although recruitment of participants is harder than quantitative methods, the response rate from the participants is higher in interview studies. If the respondent's does not have reading and writing skills, or if the motivation to fill the questionnaires is low, interviewing could be an easy way to get the opinions of participants (Bailey, 1982, as cited in Yıldırım & Şimşek, 2016). In addition to these, ability of the researcher to get data in controlled environments is possible, such as quiet and comfortable places could be preferred. Researchers benefit from interview's feature of getting information regarding the verbal as well as non-verbal behaviors, of estimating the momentary reactions of respondents (Bailey, 1982, as cited in Yıldırım & Şimşek, 2016). Additionally, interviews' very well-known features of developing detailed descriptions, integrating multiple perspectives, describing the process, having a holistic description are the reasons to choose the interviews as data collection method (Weiss, 1995).

The most salient disadvantage was its cost during data collection. Additionally, while in quantitative studies, participants did not have to spend additional time; they could fill the questionnaire at any time and at anywhere; in qualitative studies, especially during interviews participants and the researchers should find the common times to conduct the interviews (Bailey, 1982, as cited in Yıldırım & Şimşek, 2016; Weiss, 1995).

The guiding interview questions were generated as inspired by the literature. Observation notes and field notes were included in the data, they were especially helpful in making meaning from the data in the discussion part of the research. The interview protocol used could be checked in Appendix D.

Getting data related to pregnancy loss that occurred 6 years ago may seem problematic to the other researchers, there may be some belief regarding that participants would not be able to remember the event like an event that happened at a sooner time. Our purpose, however, was not to get the objective reality of the event. As what Davis (1986) called "*reconstructive recall*" was also a valuable matter for us, because the participants could have talked about the events and emotions that were more salient to them, and they had reflected on those events and emotions and their answers to interviews questions came from their meaning-making of their experiences when they looked at the event from the outside as well as from inside. Therefore, the recalling of the past experiences gave them a

chance to reconstruct the past, interpret it and reveal how the past impacts their past and present (Davis, 1986).

3.5. Procedure

In this section, sample inclusion criterions, how participants were recruited, characteristics of the participants, interview procedure, transcription of audio material, analysis of data, and personal accounts of researcher during the research were presented.

3.5.1. Sample Inclusion Criterions

The inclusion criterions for this study were;

1. Participants should have been older than 18 years old,
2. Having experienced a child loss during the pregnancy. The pregnancy was not ended with the will of the mother or father, so voluntary abortion/curettage cases were excluded.
3. The loss has been experienced not more than 6 years before the study was conducted. In different studies different time limits were set. For instance, in de Montigny et al. 's study (1999) parents experienced perinatal death within the 6 years were accepted as participants, while in Davis' dissertation (1986), 10 years were set as the criterion to be accepted to the study.
4. Both partners were willing to participate in the study. Because the purpose of this study was related to their very personal experience of loss, participants' willingness to participate was very important. Therefore, voluntary participation had the utmost importance in this study.

3.5.2. Recruitment of Participants

Constructivist and interpretivist paradigm pay attention to study in the natural contexts of the people, to examine the events and the phenomena in its natural flow rather than artificially created controlled experimental environments (Yıldırım & Şimşek, 2016). So, people in a study should be the participants who are volunteer to participate with their own will. The relationship between the researcher and the participants should be described as equality based, fair, transparent and interaction-based (Yıldırım & Şimşek, 2016).

During the phase of reaching out the participants for this study; it was realized that women tended to ignore their experience of pregnancy loss. Some women stated that they were not affected by their loss because their pregnancy ended within the first 16 weeks or

less. I did not want to push these people to talk about their loss, but in my opinion their pent-up feelings and thoughts should have been discussed, so I let the communication channel open by stating that they could reach me if they changed their mind about participating in the study.

3.5.2.1. Sampling Procedure

In qualitative research, sample selection has a significant role for the quality of the research (Coyne, 1997). In this study, to reach the sample from population, **purposive sampling** strategy was used. As Fraenkel, Wallen & Hyun (2011) stated that in this kind of sampling method, the researcher use judgment to select a sample based on prior information, so that the participants would provide the necessary data related to research question. People who are targeted by the researchers should be information-rich regarding the phenomenon being studied (Creswell, 2012; Gall, Gall & Borg, 2010). Patton (1990) expressed the powerful side of purposeful sampling as "selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling" (p. 169). Even though purposive sampling strategy may have the shortcoming of that the sample may not be representative regarding the information needed, this shortcoming was tried to be handled by identifying inclusion criterions set by the researcher based on the purpose of the study. Also, it should be kept in mind that because of the sensitive nature of grief studies, it was not possible to reach a random sample (Smith & Borgers, 1988).

To recruit the participants, gatekeepers were used. A couple was reached (couple A) by a gatekeeper, who provided entrance to the researcher by helping to find the people who were information-rich and were providing the requirements for the study (Creswell, 2012). In this study, the gatekeeper for the couple A. was an acquaintance of the researcher, who was also a doctor. She published the social-media announcement text (see Appendix C) the researcher wrote in a Facebook group that consists of doctors, and thus couple A. was reached by this social media group.

Other nine couples were reached by different gatekeepers. While the researcher was the head of Guidance and Psychological Counseling Department in the Sarıyer Guidance and Research Center (Sarıyer Rehberlik ve Araştırma Merkezi), the study was announced to psychological counselors in a meeting. These gatekeepers were informed about the study and the inclusion criterions; and requested to suggest any person they knew in their social or work environment. After the gatekeepers found potential participants, contact information

was got from them and either with telephone conversation or with messages, the researcher talked about the details of the study with prospective participants. For instance, they were informed about who would conduct the study, reasons of the study, how potential participants were reached, what was the purpose of interviewing, what kind of questions would be posed to respondents, how confidentiality was assured, and recording of the interviews; as these were suggested by Weiss (1995). Especially, the necessity of both partners' voluntary participation was emphasized. All people who were contacted first were women, so they were requested to tell their partners about the study. A few days later, the researcher had another phone contact with those women and if they and their partners decided to participate, the day for the interview was decided together.

To the people who did not want to participate, the reasons of their refusal were asked. Six women expressed that they wanted to participate in the study, but their husbands did not; two expressed that she had fears about remembering those bereavement days again and one said that her husband had fears that this study would harm her psychological well-being even if she did not think that such negative emotions would hurt her. The researcher still left the door open to these women and men by expressing that if they or their husband would change their mind, they should have made contact in the future. None of them changed their mind, thus the total number of participants who accepted to be a participant of the study was 20 individuals (10 couples).

3.5.3. Sample Size and Demographics of Participants

3.5.3.1. Sample Size

The data collection would have aimed to continue until data saturation was reached and 10 couples were enough for this purpose. As Creswell (2012) suggested that in qualitative research, to present information-rich data of experiences from the participants, the sample size should not be large and when considering the other studies related pregnancy loss which were also conducted via qualitative methods, this sample size was both manageable and enough to give in-depth data about the prenatal loss experiences. For instance, when looking at the qualitative studies in the literature, in Nuzum, Meaney, and O' Donoghue's study (2018) there were 17 participants, in Meaney, Corcoran, Spillane, O' Donoghue's study (2016) there were 16 participants, in O' Leary and Thorwick's study (2005) there were 10 participants; in Samuelsson, Radestad, and Segesten's study (2001) there were 11 participants; in Lindgren, Malm, and Radestad's study (2014) there were 23 participants, in Meredith, Wilson, Branjerdporn, Strong, and Desha's study (2017), there

were 10 participants. In these and many other qualitative research studies, rather than the number but the quality of the data gathered and profoundness regarding the information were given more importance, since as it was discussed in the research approach and design, what was important in this study was to get deeper understanding of pregnancy loss, grief and bereavement.

3.5.3.2. Participants

Reflecting on and understanding the experiences of partners require examining their demographic characteristics. Before commencing on the interview questions, demographic questions were asked to participants (to see interview protocol, check the Appendix D). Below, couples' demographic data was shared. For a visual and detailed explanation of the couples' demographic data, you can check the Appendix E.

3.5.3.2.1. Mr. & Mrs. A

Mrs. A is 28 years old, doctor, working as a family doctor (*aile hekimi*). Mr. A is 35 years old, lawyer, working in a government bank. They have been married for almost five years, living in Istanbul. Both define their SES level as upper-inter. They have a child who is almost two years old. They experienced only one pregnancy loss that occurred three years ago, when the gestation was 10-weeks. Both Mr. and Mrs. A experienced other losses in their lives. Mrs. A stated that in 2001, they lost their uncle who was Mrs. A.' s mother's younger brother, in a traffic accident and this loss affected their family so much that, Mrs. A's mother gave the name of the lost uncle to her newborn baby. Mrs. A's own mother lost a child, so she thinks that she could better understand her mother's ache after her own experience. Mr. A experienced loss of grandmother and grandfather. He also had experienced the 1999 Marmara earthquake, and lost his distant relatives and some of his friends. The lost pregnancy was a planned one, and they tried to have a baby for almost five months before Mrs. A.'s pregnancy.

3.5.3.2.2. Mr. & Mrs. B

As 2.5 years married couple, Mr. and Mrs. B experienced one pregnancy loss 15 months ago when the gestational age was 11^{th} week. They had a baby one year after their loss. They have been living in Istanbul. Mrs. B. who is 33 years old, has been working as an English teacher at a public school. She lost her mother from cancer 2.5 years ago. Even if her diagnosis was already known to everyone, she had difficulty in accepting the seriousness of

the illness and had hoped that she would be better. While she was talking about this loss, her voice clearly showed how much pain she feels regarding her loss. Mr. B. is 46 years old, graduated from university and has been working in the textile sector. He lost his father almost 7 years ago. He also described his brother's imprisonment as a traumatic experience. They had a planned pregnancy but especially Mrs. B.'s desire to have a baby affected their decisions. Mrs. B. stated that they were married only because of their will to have a baby. Mr. B. did not want to have a baby because he thought that having a baby meant a lot of responsibility, but he could not resist the huge dream of Mrs. B. regarding having a baby. They described their SES in middle range.

3.5.3.2.3. Mr. & Mrs. C

Mrs. C is 36 years old psychological counselor at a public institution; she had a master's degree in applied psychology. Mr. C. is 36 years old, is an academician. They have been married since 2016, living in Istanbul. The both partners thought that they have average SES level compared to the society. Their pregnancy loss occurred at March 10th, 2018, that pregnancy was a wanted and planned one. It was their first pregnancy and first lost. Mr. C.'s biggest lost occurred when she was just a child, she lost her father. She lost in 2005 her uncle, in 2007 her grandfather and in 2016 her grandmother. According to her, these three losses were also important in her life because after her father's death these two people (grandfather and grandmother) were very important in her family. At January of 2016, Mr. C. lost her mother to cancer. His mother was hospitalized for almost 6 months before her death. Mr. C. thought about life and death issues after his mother's loss, especially about what is normal grief, how long grief should last and so on. During our interview Mr. C. the topic of losing his mother and experiencing pregnancy loss were intertwined from time to time.

3.5.3.2.4. Mr. & Mrs. D

Mr. and Mrs. D have been married for 11 years, living in Istanbul. Mr. D. 33 years-old, had a high school diploma. He has been working as a janitor. According to him, he did not experience someone close death. Mrs. D. is 31 years old, middle-school graduate and she works as part-time house-cleaner. Both think that they have middle SES level. They have a child, she is 10 years old. Their pregnancy loss occurred at October 2017. Mrs. D. lost her mother last year and after this loss, her sister's husband died. She experienced psychological problems after all three losses; she went to a psychiatrist and used the medicine prescribed to

her. She said that the most important problem for her was that she did not want to socialize with others. She thinks that her grief took longer than normal because of the all losses occurred in very close times. Her psychological problems still continue, such as she has been feeling tedious, had sleep problems. After the interview was over, she asked me where she could get psychological support. I referred her to a state hospital psychiatrist that I suggested for some of my clients.

3.5.3.2.5. Mr. & Mrs. E

Mr. and Mrs. E. have been living in Istanbul. They had two children one is three and half years old, and the other child is three months of her age. Mr. E. evaluated their SES as low, but his wife thought that their SES was middle. Mrs. E. dropped out of high school, and she is a housewife. Mr. E completed two-year vocational school of higher education; he works in a factory as a security personnel. Both for Mr. E and Mrs. E., this is their second marriage. While Mr. E. did not talk about his prior marriage as detail, Mrs. E. gave some details. As she said, she divorced from her first husband immediately after her first miscarriage because of mother-in-law issues. When I asked her whether the problems with her mother-in-law were related to her miscarriage, she said the problems had existed before this loss. Therefore, Mrs. E. experienced two pregnancy losses in her both marriages (the second one occurred one year ago, when the gestational period was within 12^{th} weeks. In this study, we mostly talked about her second loss but in different times she referred her first pregnancy loss. When asked about other negative life experiences, Mrs. E. mentioned about her prior marriage and specifically her divorce period that took almost three years, she did not have any other significant one's loss. Mr. E. experienced grandmother loss 16 years ago; he remembers he was very sad for this loss. He also experienced a serious illness related to his lungs, and this problem has been affecting him now in his daily life.

3.5.3.2.6. Mr. & Mrs. F

Mr. and Mrs. F. have been married for 4 years. Mrs. F. was graduated from university, is 36 years old and she has been working for a few months in the finance office where her husband has been working. Mr. F. is 34 years old, has university diploma. They experienced more than one pregnancy loss experience. She lost her grandfather, and grandmother. She was affected by these losses so much, she cried while mentioning about the losses. Another negative life event she was affected too much was her father's experiencing stroke. She views herself as the problem-solver of the family, taking care of the

health issues such as organizing the doctor appointments, helping the family in the times of important problems. When Mr. F. was 8 years old, his mother died. He did not express any other negative life event.

3.5.3.2.7. Mr. & Mrs. G

Mr. and Mrs. G. have been married for 6 years. Mr. and Mrs. G. has a daughter who is 2.5 years old, was born after their pregnancy loss experience. They experienced the pregnancy loss 4 years ago. Mrs. G. 31 years-old, working as a preschool teacher in a public school. Because she finished a 2-year undergraduate program, she is a substitute (paid-*ücretli*) teacher. Mr. G. is 32 years old, a teacher in a public school. Mrs. G. had many losses in her life, when she was 16 years old, her father died. And in the last decade, she lost her grandmother, grandfather with whom they shared their homes. Mr. G. lot his grandmother and grandfather within last 10 years. But the most traumatic experience he defined was his brother's traffic accident after that he had physical disability. They have been living in Antep (a city in south-east part of Turkey). They defined their SES as on the average.

3.5.3.2.8. Mr. & Mrs. H

Mr. and Mrs. H. have been married since 2000. They have been living in Istanbul. They have a son who is 17 years old, is in high school. They experienced one pregnancy loss (stillbirth) when the gestational period was in the 8th months. Mrs. H. is 38 years old, working in a haberdashery (tuhafiye) as a social-media curator. She lost her mother when she was 8 years old. This loss was so important in her life that according to her that affected everything in her life such as her education, her punctiliousness, and her relationships with her siblings. Mr. H. has been working in textile sector. He did not specify the loss experiences he had, but he identified their pregnancy loss experience as "We have experienced losses, but this one [pregnancy loss] was different. I could not think that I would experience an event that is more painful than this (*Karşılaşıyoruz ama bu tabii farklı oldu.Yani daha acısını yaşayabileceğimi düşünmedim)*", for him that was the most painful experience.

3.5.3.2.9. Mr. & Mrs. I

Mr. and Mrs. I. have been married for 11 years. They have been living in Izmir. They experienced a pregnancy loss 6 years ago, Mrs. I.'s pregnancy was ended during the 9th week of pregnancy and curettage operation was done in the 10th week. Mrs. I., who is 34

years old, has been working as a teacher in a public school, but for now she is using her unpaid time off because of her son's born. For Mr. I. the pregnancy loss the first shock in her life, and the worst traumatic experience. She lost her grandfather recently. Mr. I. is 34 years old, has been working as military personnel. He did not experience someone close death. Similarly, for him, the pregnancy loss was also the most important loss in his life. Both and Mr. I and Mrs. I. defined their SES as above the average.

3.5.3.2.10. Mr. & Mrs. J

Mr. and Mrs. J. have been living in Izmir. They have a daughter who is 12 years old. They experienced their pregnancy loss 14th of February, for Mrs. J. that was a misfortune to lose the baby in the Valentine's Day. When I asked the time of the loss, she replied, "I do not know how many months passed, I try to not to think about it [the loss] (*kaç ay oldu bilmiyorum şimdi, düşünmemeye çalışıyorum)"* Their lost baby' gestational age was either 13 or 14 weeks. They experienced another pregnancy loss before their first child was born, and according to Mrs. J. because the pregnancy ended very early, she did not experience the loss as much as the last miscarriage. Mr. J. 43 years old, is a primary school graduate and he has own hair dresser salon. Mrs. J. is 40 years old, is a charwoman in a school. She has been trying to get her secondary school diploma from distance education.

3.5.4. Procedure for Interview Questions and Interviews Conducted

The interview questions were developed by the researched based on the related literature. To evaluate the interview questions, a pilot study was conducted with one couple who the researcher knew personally. After the interview questions were completed in the pilot study, the couple's opinions regarding the quality, wording, structure of questions were asked. After the revision of the questions based on the feedback of the couple and related literature, this format of interviews was sent to an academician who have PhD degree in psychological counseling and guidance, a PhD student at the forensic psychology and three psychological counselors who work with families, couples, and children at the ministry of education. After their views regarding the interview questions were got, final revision of the interview questions was decided.

Before the study was conducted, the ethics committee's permission from university (İAEK) was taken. The final revision of the interview questions, purpose of the study, procedure of the study, social media announcement text, and informed consent forms were reviewed by the ethical committee and the study was approved in June 6, 2018 (Acceptance

no:28620816/335). The semi-structured interview questions could be checked in the Appendix D and ethical permission from the ethics committee could be checked in the Appendix A.

Participants who were voluntary to participate and who met the inclusion criterions could have participated in the study. At the day agreed with the couples, semi-structured interviews were completed in their homes (16 individuals) and in their workplaces (4 individuals) and all the interviews were recorded and transcribed for data analysis. The reason for conducting interviews at home or work was to make the participants feel comfortable while talking about this sensitive topic. Men and women were interviewed separately since it was aimed that the personal expressions of the participants would not be interrupted. Moreover, timing of the interviews would be harder with two partners. So, both practical and purposive reasons, two individuals in the same couple were interviewed at different times. By making interviews individually, it was possible to understand how the partner evaluated the other partner's grief process, whether his/her spouse gave support to him/her and how this support was evaluated.

A few times, the interviews were interrupted because some participants had a child in the home and especially the newborns required the attention of their mothers, such as during the interview with Mrs. B., I helped her to make sleep her newborn baby, I watched her clean the baby. Even if these were the interruptions, they did not harm the flow of the interview, but rather it was a great opportunity to know the participants better. Just one time an awkward situation occurred: while interviewing with Mrs. J., the time when she was talking about her husband's boy dreams regarding the lost child; her husband came into the room and heard Mrs. J.' s comments and he refused her though that he wanted a boy. This discussion between couples lasted a few minutes. Still, this was an opportunity to see their interaction and talks about their lost child in the home.

All participants made necessary arrangements for our interviews and they were hospitable toward the researcher. Women I made interviews at their homes prepared food for me, I sit on the table with them and talked a while after the interviews were finished. Even once, Mr. and Mrs. D. wanted to take me to the subway, I accepted their offer and they even came with me to the stairs of the subway.

Participants were told that they could have asked anything related to the study during the interviews or even after calling or texting me via the contact information I gave to them. All participants appreciated that this subject would be studied since the subject was very important to them and they wanted other people also know this issue. Mrs. C., for instance,

stated that "Thank you, we talked about the issue again. And you found the topic as important to talk about it, and you gave similar importance to the subject. (*teşekkür ederim böyle bir yeniden üzerine konuştuğumuz için. Konuşmaya önemli bir şey bulduğunuz için. Aynı önemi verdiğiniz için. Teşekkür ederim*)"

A few participants were contacted again about the issues deemed to be misunderstood during the transcription of voice recordings that were completed via the telephone application. All tape-recorded interviews were transcribed by paying attention to transcribing all the verbal and significant nonverbal expressions such as laughs, crying, or environmental situations like baby cries as suggested by Smith, and Osborn (2008), and if appropriate spelling errors were corrected, punctuations were added to clarify the sentences (Lee, 2012).

3.5.4.1. Interview Questions and Their Relations to Research Questions

Because the interview questions were created based on the purpose (examining the overall grief and bereavement experiences of couples with prenatal loss and whether gender roles and other sociocultural factors impacts their experiences) and research questions; in the following table how the research questions were handled in the interview data was presented.

Table 1: Information Regarding How Research Questions Were Handled in the Interview Protocol

Research Questions	**Interview Questions to Handle with the Research Question**
1. How did partners experience prenatal loss?	• Before the baby you lost, have you tried to have children? -What motivated you to have a child? -What was the importance of having a child for you, your partner and your environment? • In which month did you lose the baby? Was the lost of the baby expected? • Has your life changed after this loss? • Which strategies have you used to deal with these changes after your loss? • Is there anything you want to change after the loss when you look? If so, what are these changes? • If you return to one / two / six years/months ago (depending on the year/month after the loss of the baby), would you do anything different in the mourning process? • What suggestions do you have for families who have experienced similar losses? • Did you see psychological support from hospital staff in the lost period?

Table 2 (Continued)

Research Questions	Interview Questions to Handle with the Research Question
2. How did partners affect each other's grief process?	• How did you support each other as a couple? • How do you support each other as a couple?
3. How did partners support each other after the pregnancy loss?	• How did you support each other as a couple? • How do you support each other as a couple?
4. How did men and women differ in terms of grieving process?	Themes and codes regarding this research questions were gathered from the data based on the answers of the participants and by comparing the men and women's experiences of prenatal loss.
5. How did socio-cultural elements affect their loss experience?	• What was the importance of having children for you, your spouse and your environment? • How did your family, friends, social environment react to this loss? • How did your family, friends and social environment support you after your loss experience? • Was there a funeral or religious ritual for your baby? • What were the social, cultural and religious practices that helped you to overcome your loss experiences? • How do you define the support you got from your family, friends, and social environment? • What kinds of rituals are performed after the loss? Religious, social?

3.6. Data Analysis

Qualitative data analysis permits getting a new perspective over the data. Before reaching conclusions and interpretations, qualitative data analysis breaks the data into smaller units and connects the pieces of information which have a common ground. That is why; data has been broken down to classify it and concepts and connections drawn from the data provide the basis for a new description (Dey, 2005).

Before starting the analysis process, all interviews were read separately a few times to have an overall understanding of participants' experiences. Thus, reading the all transcriptions made the ground for analysis (Dey, 2005). MAXQDA 10 that as one of the CAQDAS (Computer-Assisted Qualitative Data Analysis Software) was used for the data analysis. By using program, it was easier to explore the codes and themes.

Analyzing transcribed data were done for everyone separately. This is because of the need to understand how individuals were affected by the pregnancy loss and to understand

their meaning making of the loss. In the figure below, visualizing the individual analysis can be checked.

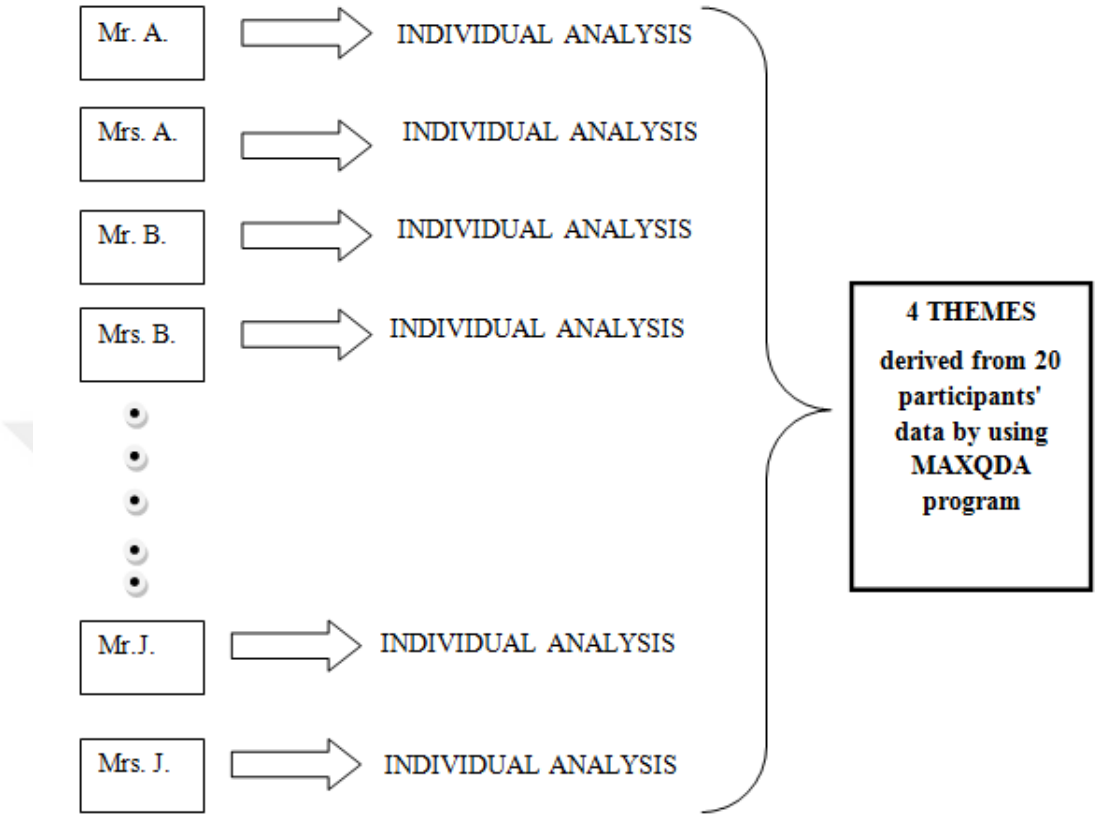

Figure 2: Individual Analysis of the Transcribed Data

Interview transcripts were analyzed by using thematic analysis technique, by which the main themes and sub-themes were emerged from the data. A theme was defined as "A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set." (Braun & Clarke, 2006, p. 82). Thematic analysis may be defined as: "Thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail." (Braun & Clarke, 2006, p. 79). Thus, individual narrative materials regarding their pregnancy loss experience of each participant (N=20) were analyzed by thematic analysis (Vaismoradi, Turunen & Bondas, 2013).

To find the themes in the data, codes were brought together and the commonalities between the codes were found, and codes were categorized based on these commonalities and themes were created (Yıldırım & Şimşek, 2016). As Gibson and Brown (2009) stated that when conducting a thematic analysis, we look essentially three things: commonalities,

differences and relationships in the data. Themes can be generated both inductively (just from what the data reveals) or deductively (from the theoretical knowledge of the researcher before the study) (Ryan & Bernard, 2003). In this study, themes were created both inductively and deductively, meaning that there were codes that were stemmed from the participants' narratives as well as codes that derived their name and framework form the literature.

3.7. Ethical Issues

Cook (1995) expressed in her paper that sex and death issues have been accepted as two common taboos in the society. This opinion still holds true in traditional societies, as it is in Turkey. Because loss is very personal issue, ethical issues of this study were very important. For any study, causing distress for the bereaved and even harming could be possible if the ethical issues have not been targeted enough (Cook, 1995, Parkes, 1995). There were some specific ethical issues that needed to be addressed for this study: informed consent, protecting participants from any harm, voluntary participation, training of interviewer to conduct a bereavement study, confidentiality, not crossing the boundary of research and holding the researcher identity rather than a therapist during the research process (Allmark et al., 2009; Cook, 1995, Creswell, 2012; Newman, Risch & Kassam-Adams, 2006; Parkes, 1995; Rosenblatt, 1995).

Getting the permission from the ethical committee was needed to ensure that there would be no harm to participants. Also, by getting ethical permission, an objective committee could have evaluated the study, as suggested by Parkes (1995). Informed consent was taken from all participants, so there was no pressure on people to take part in the study (Cook, 1995; Parkes, 1995). Also, participants who were volunteer were reassured verbally and in written form (can be checked in the informed consent from at Appendix B.) that they could have withdrawn at any time and their anonymity and confidentiality would be maintained at all stages of data collection, analysis, and dissemination of results. Cook (1995) discussed that bereaved people may be so overwhelmed with their emotions that they could not decide about the participation or they could not evaluate the possible effects of the study on themselves. This can be true for the people who have overwhelming emotions or who could not control his/her behaviors and negative cognitions that interfere with their daily lives. None of the participants were so much overwhelmed that prohibits their talking or expressing themselves during the interviews. Of course, some participants cried, but talking about a loss that mattered to them could bring some emotions and it was normal.

Also, before conducting the interviews, they were contacted many times in order to be sure about their willingness to participate as suggested by Allmark and his associates in their review paper (2009)

Another ethical issue was to reassure the security and well-being of the participants; for this purpose, at the start of the study it was planned that participants who had risk of re-dramatization during the study would be referred; and the data of those would not be used. As Stroebe, Stroebe, and Schut (2003) explained that especially for bereavement studies, protecting the dignity and well-being of participants has higher priority. However, there was not such a case; participants were asked about their emotions at some point during and the end of the interviews. They were informed that they could reach the researcher via the contact information given to them, if there was a problem about the talking about their loss experience, or they had any question. Even though, the possible side effects of bereavement studies have been discussed, it should not be forgotten that sometimes these studies give chance to be listened, to express their emotions, to realize new insights about their experiences for the participants (Cook & Bosley, 1995).

How to reach the participants has an ultimate importance for bereavement studies, because according to where the study was conducted, sample characteristics may create selection effects on study (Stroebe, Stroebe & Schut, 2003). That is why; rather than using one channel to reach the sample, many methods were used to reach participants. For instance, social media of doctor mothers, using gatekeepers by informing people about the study were the channels to reach the study's participants. Additionally, regular supervision of the researcher was provided by the academic consultant to minimize the any psychological harm as well as to ensure the ethical execution of the study.

Finally, as a psychological counselor I had necessary skills to use interviews as method of data collection, to work with bereaved individuals and conduct a systematic research. That is why; I told the participants that this study would not aim to make a therapeutic intervention, this study aimed to hear the experiences of participants. Even if the probes or additional questions were asked to participants, all questions were related to purpose of the study and aimed clarification of questions. I had neither a dual-role nor over-involvement with the participants as discussed by Allmark and his associates (2009).

3.8. Trustworthiness of the Data

Positivist approach questions the trustworthiness of the qualitative research since the validity and reliability issues are not handled in the same way as quantitative studies follow (Shenton, 2004). Guba (1981) identified four strategies to ensure trustworthiness in qualitative research: credibility (truth value), transferability (applicability), dependability (consistency) and conformability (neutrality).

In the qualitative research, degree of congruence between the data and what the research finding revealed has been called as credibility (Merriam et al., 2003). Collecting data just from participants who were volunteer was a way to ensure that participants were honest with their information revealed to the researcher (Shenton, 2004).

By transferability, it has been aimed in qualitative research studies whether the results of the study can be replicated in other settings with different participants (Guba, 1981). For transferability of the study, thick descriptions related to participants were presented. Also, there were many participants' quotes used in the findings sections of the study. Thus, for the reader, it would be possible to visualize the context from where the data was collected (Yıldırım & Şimşek, 2016). Also, semi-structured interview questions were shared at the end of the paper (Appendix D.). To ensure the validity of themes and codes of the study, peer and expert reviews were completed.

Dependability of the study means looking at the research from the outside and determining whether the research steps followed by the researcher were consistent (Yıldırım & Şimşek, 2016). To provide evidence for dependability, the research steps followed were presented in the methodology section of the study where the rationale behind the study design, steps followed to reach participants, rationale of the data analysis, ethical issues were given (Shenton, 2004). Moreover, advisor of the research had information in every step of the study.

Lastly, conformability is similar to objectivity in the quantitative studies, meaning that the researcher is unbiased and away from his/her assumptions and the whole process of data collection, data analysis and findings are adequately handled so that the reader could confirm the adequacy of findings (Morrow, 2005). Management of subjectivity was one way of conformability in this study. To prevent subjective interpretations of data, data was examined by the supervisor of the study and an academician in METU.

CHAPTER 4

FINDINGS

As the quantitative data regarding the miscarriages and stillbirths have exemplified that, the prenatal loss experience is not low in number among the worldwide and Turkish population. 23% for miscarriages and 3 % for stillbirth have been documented in Hacettepe University Institution of Population's study (2013). With this reality in mind, the purpose of this study aimed to comprehend the miscarriage (occurrence of prenatal loss before the 20 weeks of gestation (Covington, 2006)) or stillbirth (occurrence of the prenatal loss after 20 weeks of gestation (Covington, 2006)) experiences of partners and to examine whether gender roles and other sociocultural factors impacted their experiences with research questions of:

- How did partners experience prenatal loss?
- How did partners affect each other's grief process?
- How did partners support each other after the pregnancy loss?
- How did men and women differ in terms of grieving process?
- How did socio-cultural elements affect their loss experience?

In this chapter, results of the qualitative analysis based on the transcribed interview data were presented. Audio-taped interviews were transcribed, and the data were analyzed by using MAXQDA 2018. 20 participants' data were analyzed individually by using thematic analysis, so codes and themes were discovered from all the participants in order to understand individual prenatal loss experiences of participants. How partners experienced the pregnancy loss as a couple was handled in the "partner support" theme specifically, but the partner's grief was also addressed throughout all themes.

For analyses of data, all participants' data (N=20) were analyzed jointly. By doing this analysis, the unique experiences of individuals after their pregnancy loss experience were examined. The dyadic experiences were examined in different themes. Participants' quotations were given as testimonial evidences throughout all themes and sub-themes to ensure the credibility and trustworthiness of the data. There were four themes derived from the data.

Table 2: Themes and Sub-Themes Derived from the Data

THEME 1: MOTIVATION TO HAVE A BABY	Family, marriage and social related motivation factors	Accepting the partner's desire to have a child
		Economic reasons
		Social system's pressure for a baby
		Child as a completing figure of the family
		When marriage reaches a point
	Personal motivations	Personal history of the participant
		Gender related motivations
		Personality
		Experiencing parenthood and emotional value of the child
		Raising a child who carries the parent's values
		Age of parent
THEME 2: SHORT TERM GRIEF AND BEREAVEMENT RESPONSES	Psychological reactions	Denial
		Sadness
		Shock
		Anger and accusation of others
		Self-accusation
		Loneliness
		Panic
		Withdrawal
	Failed hopes	
	Anxiety regarding possible future pregnancies	
	Curettage operation	
	Losing a part of oneself	
	Paying attention to other pregnancies and other losses	

Table 2 (Continued)

THEME 3: FACTORS AFFECTING THE GRIEF RESOLUTION	Partner support	Communication and support between partners
		Men vs. women's gender roles
	Gestational age	Religious ceremonies based on gestational age
		Seeing the baby in ultrasound
		The attachment between parent and baby
		Gender reveal
	Coping with the loss	Social based coping
		Cultural and religion-based coping
		Cognitive based coping
	Having a subsequent child or already having a child	
	Hope for future fertility	
	Other stress factors	
	Lack of control	
	Views on normalcy of grief process	
	Self-changes	
THEME 4: LONG-TERM GRIEF AND BEREAVEMENT RESPONSES	Suggestions for men and women	
	Time heals the wounds	
	Oscillatory process of grief	
	Professional support	
	Anniversaries	
	"What if the child would live" thoughts	

4.1. Theme 1: Motivation to Have a Baby

This theme gave information about the context of the partners and how the partners and their social context had perceived the pregnancy. By understanding this context, making sense of why partners and their social environment gave the reactions presented in the following sections would be possible for the reader. Because even if this loss has commonalities with other loss experiences regarding the psychological, physical, cognitive aspects; the pregnancy loss has its own context that should be kept in mind. And one of the contextual factors of this loss was the motivation factors of the partners to have a baby since by understanding these variables, what meanings attributed to baby, thus to meanings to loss could be discerned.

Table 3: Motivation to Have a Baby

THEME 1: MOTIVATION TO HAVE A BABY
•Family, Marriage, and Social Related Motivation Factors
•Personal Motivations

4.1.1. Family, Marriage and Social Related Motivation Factors

In this sub-theme how family, marriage or social environment affected the partners' motivation to have a baby were presented. Even if the individualistic features of the culture have been increased, as Kağıtçıbaşı (1996) expressed the collectivistic cultural features in the society still exist. Even if the partners in this study had nuclear families, their families or other people in their social environment might still have affected their motivation to have a child.

Table 4: Family, Marriage and Social Related Motivation Factors

FAMILY, MARRIAGE AND SOCIAL RELATED MOTIVATION FACTORS
•Accepting the Partner's Desire to Have a Child •Economic Reasons •Social System's Pressure For a Baby •Child as a Completing Figure of the Family •When Marriage Reaches a Point

4.1.1.1. Accepting the Partner's Desire to Have a Child

All individuals (n=18) in the study except two men (Mr. B. and Mr. E.) wanted to have a baby. Mr. E. did not oppose to having another child, but because they already had one child, he did not believe that the second child as necessary. At the end, he accepted his partner's desire for second child. Mr. B. did not want to have a child even if he likes spending time with children, especially Mrs. B's nieces whose home is very close to them. As Mrs. B. stated that because she wanted to have a baby so much, Mr. B. was convinced to have a baby. After a long period of relationship, having a baby was a reason for them to get marry. As can be read in the following quotations of Mr. B., according to him having a child brings many responsibilities, and that was his reason of unwillingness to have baby.

"*Ben kendi açımdan sorarsanız ben normalde kendi yani bebek sahiplenen bir insan değilim. Benim çocuğum olsun gibi bir zihniyetim yoktu. Bütün çocukları seven bir insanım da tabii daha çok eşim istiyor diye. Ben kendim biraz sorumluluktan kaçan bir insanım o yüzden çocuk yapmak da pek bana şey değildi, beni sorumlu edecek bir durum olduğu için. Çok istiyor değildim yani açıkçası. Ama olması kötü bir şey değil, daha sorumlu oluyoruz hayata karşı. İşte istemiyordum diyebilirim. Ama yalnızca sorumluluk açısından. Yoksa tabii ki çocuk çok güzel bir şey*." (Mr. B.)

"If you ask me personally I am not a kind of person who needs to have a child. I didn't have the mindset of having a baby. Of course, I love all children, but it is mostly my partner's wish. Having a baby didn't appeal to me as I have always been a person who escapes from responsibilities. I didn't really want it, to be honest. But it is not a bad thing after all, it makes you more responsible in life. In short, I can say that I did not want it, but only because of the responsibility part. Otherwise a child is a wonderful thing." (Mr. B.)

4.1.1.2. Economic Reasons

Sometimes economic issues may be a reason for the individuals to postpone their desire to have a baby. Having a prior child and the wish for providing equal opportunities among the children were motivations to delay child making decision. So, this motivation factor was only observed in the participants (n=4) with a previous child. Within the 3 couples, 2 couples mentioned the economical factors in their motivations.

"*Bilmiyorum ya böyle çok, çok çocuk çok mantıklı gelmiyordu bana. Çok çocuk ne bileyim yani ona vereceksin, öbürüne veremezsin diyorum. E tek kişi çalışıyor, eşim çalışıyor ev zaten kira, maddiyat da var tabii işin içinde*." (Mrs. H.)	"I don't know, to have several children never seemed sensible to me. Having several children has the risk of failing to provide each one of them equally. Only one of us is working, my partner, and we are tenants. So, the financial issues are in the picture." (Mrs. H.)
"*E tek bir çocuk, yani az olduğunu düşündüm. Ya çocukları da seviyorum ama sosyo-ekonomik nedenlerden 43 yaşında hala bir çocuk sahibiyim. Yani onun eğitimi vs. geleceğini düşünürken ha nihayetinde bir düşük oldu ama sonuçsal olarak bir tane çocuk sahibiyim zaten çocukları seven birisiyim, geniş aile, yani üç falan gibi. Ama sosyo-ekonomik nedenlerden hala bir falan gibi kaldık yani. Düşüğü saymazsak*." (Mr. J)	"We have only one child, it seems not enough. I love children, but I am 43 and have only one child due to socioeconomic factors. Caring for his education, his future… There was also a miscarriage, but I have only one child after all. In fact, I love children a lot, a large family, three kids for example. But due to socioeconomic reasons we have only one, if not counting the miscarriage." (Mr. J)

4.1.1.3. Social System's Pressure for a Baby

This sub-theme included whether the participants perceived any social pressure or comments regarding having a baby, and if they did, how these pressures or comments were perceived and reacted to by participants. The number of participants who talked about the existence of social pressure or comments for them to have a baby was 11, and 7 of them were women and remaining 4 were men. Remaining participants did not express these societal expectations.

According to participants, families, wife's and husband's nuclear family, and sometimes other people like extended family members or neighbors expressed their wish for couple's having a baby. For almost all participants, these discourses did not go far enough to affect their decision; so final decisions still belonged to participants.

"*Başlangıçta bir iki kere dile getirdiler ama onun üstüne düşünmediğimizi söyleyince çok da hani böyle üstümüzde bir baskı uygulayan olmadı açıkçası...Ben şunu hep söylerim yeni evlenenlere de. Yani bir iki-üç yıl en azından çocuk yapmayın, birbirinizi tanıyın. Hani çevrenin baskısı vs. olur çok olur ama. Hani bizde de oldu. Ama biz dört-beş yıl, yani üç-dört yıl diyelim, yapmadık. Düşünmedik. Sonra yapmaya karar verdik*" (Mrs. I.)

"At the beginning they brought the subject up every now and then, but when we told them we didn't consider it, no one really pressured us to be honest...I always say this to the newly-wed: don't have a child in the first two-three years, get to know each other first. Of course, people would pressure you to do it. They did to us as well. But we didn't consider it for the first four-five, or let's say three-four years. We decided to have a child later on." (Mrs. I.)"

For the couple F. who experienced pregnancy loss more than once, this social pressure had a different aspect on them. Mrs. F. felt like her potential to get pregnant was questioning. Mrs. F. further explained how her relationships with the people who were trying to give suggestions have been changed, because after her frustrations regarding her pregnancy losses, those comments, suggestions or social pressures were intolerable for her, so she avoided spending time with those people.

"*İkincisinde tabii ki şey oldu, sürekli dışarıdan baskı geliyor işte hani insanlardan "Ay siz tedavi görüyorsunuz zannediyoruz." Hani "Çocuğunuz olmuyor mu?" İşte doktorla aynı şeyleri tekrar tekrar anlatıyorsun, tekrar tekrar anlatıyorsun, soruyorlar, anlatıyorsun. Sonra sanki hiç bunları anlatmamış gibi tekrar tekrar soruyorlar*" (Mrs. F.)

"At the second time, people asked and commented a lot. They asked if we were under treatment or not, if we were impotent or not. You explain the same things again and again and they ask you again as if you never have explained them before." (Mrs. F.)

4.1.1.4. Child as a Completing Figure of the Family

7 of the 20 participants talked about this issue. In this sub-theme, participants talked about how they perceived the child role in the family. Generally, statements related to this sub-theme expressed the child as an important part of the family, like without a child a family could not be felt completed. Child might have been seen in a role that strengthens the family bounds.

"*Ailevi olarak umutlu olmanın önemli bir parçası da çocuk sahibi olmaktır. O duyguyu yaşamaktır. Benim için anlamı biraz o*." (Mr. G.)

"An important part of being hopeful as a family is having a child. To experience that feeling. For me it mostly means this." (Mr. G.)

"*Yani o biz artık evliliğin belli bir evresinden sonra artık çocuk sahibi olmamızın hani aile içerisinde daha güçlü bir motivasyon daha iyi bir şey olacağını düşündüğümüz için çocuk isteğimiz şey oldu*." (Mr. A.).

“After a certain point in our marriage, we wanted to have a child, believing that it would bring a stronger motivation as a family, and make everything better.” (Mr. A.)

In this Turkish sample of participants, defining the child as "the fruit of the relationship" was common.

"*İşte insanlar birbirini tanıdıktan sonra artık hani bir birlikteliğin meyvesi olsun, işte neslimizi ilerletelim, e çocuk sevgisi de var. Yani hepsi birleşince çocuk yapma isteği oluyor tabii*." (Mrs. I).

“After getting to know each other one wants to have a fruit of the relationship, to further the lineage. And of course, we love children. We wanted to have a child because of all this.” (Mrs. I)

Child might be seen as a completing figure of the sibling, too. After the first-born child passed the childhood phase and became more independent from the family, the family wanted to have another child for whom they could show their care. Also, in their opinions, with another child, previous child would have a sibling and they could have supported each other in the life. All three couples who had a previous child (couples D, H. and J.) talked about this. Some of the participants said they wanted second child after their conditions were more proper to raise a child, such as economical conditions or time necessary to devote another child (taking care of his/her physical needs, academic needs could be difficult etc.).

"*Tek bir çocuk tek olmaz, biz bunla hayatta sürekli olamayacağımız için bunun yalnız kalmaması lazım. Birbirlerine dayanışmaları lazım, bu kendini artık taşıyabilecek durumda. Artık bir tane daha olsa fena olmaz dedik. Ama kısmet olmadı*." (Mr. H.).

“Having an only child is not a good thing to do. The child needs to have a company in life, as we will not be around forever. Since this one is self-sufficient now, we thought it was time to have another. But it didn’t happen.” (Mr. H.)

"*Hem annelik duygusu. Burcu’nun hem de kardeşi olsun istedim. Yani Burcu yalnız kalmasın. Çok burası biliyorsun dağ başı, sıkıcı, kış geldi mi herkes eve kapanıyor. Burcu çok yapayalnızdı*." (Mrs. E.)

“Both for the motherhood and for Burcu to have a sibling. I didn’t want her to be all alone. As you know, this is a boring countryside. People shut themselves to home in winter. Burcu was so lonely.” (Mrs. E.)

4.1.1.5. When Marriage Reaches a Point

Half of the participants (n=10) in the study talked about the importance of marriage status when deciding about a child. Participants wanted to know each other, spent more time together as a couple or wanted to make their dreams come true such as visiting the places they wanted to see, or experiencing new things together before having a baby. This theme was valid both for the partners whose dating period was longer and for the couples who did not know each other well before their marriage.

"*Biz çok küçük yaşta evlendiğimizi düşündüğümüz için eşimle bir süre gezmek istemiştik. Bir süre çocuk istemedik. Sonra evliliğimiz ilerledi, baktık gördük birbirimizle iyi anlaşıyoruz, ilk beş yıl zaten şey demiştik birbirimizi bir tanıyalım, çocuğu sonra düşünürüz. Bakalım biz iyi anlaşabiliyor muyuz? Sağlıklı bir ortamda çocuk büyütebilecek miyiz? İlk amacımız çocuk olmasın, önce hani güzel bir aile miyiz? Birlikte durabileceğimiz bir aile miyiz? Derdindeydik*." (Mrs. I)	**"**As we think we got married quite early, we wanted to have fun for a while before having a baby. Then our marriage progressed, we saw that we are getting on well. We already planned not to have children in the first five years to see if we get on well to raise a child in a healthy atmosphere. Having a child was not something we would rush to. We wanted first to see if we could make a good and strong family." (Mrs. I.)
"*Ya tabii ki şimdi ilk evlendik, zaten evlendikten ilk bir iki sene çocuk düşünmedik. Ondan sonra tabii ki çocuk istedik. Gerçekten istedik*." (Mr. D.)	"We didn't consider having a child in the first couple of years after we got married. Then of course we wanted to have a child. We really wanted." (Mr. D.)

4.1.2. Personal Motivations

Table 5: Personal Motivations for a Baby

PERSONAL MOTIVATIONS
•Personal History of the Participant •Gender Related Motivations •Personality •Experiencing Parenthood and Emotional Value of Child •Raising a Child Who Carries the Parent's Values •Age of Parent

In this theme personal motivation factors for the baby were presented. Personal history of the participant, gender related motivations, personality, experiencing parenthood, raising a child who carries the parents' values, emotional value of the child and age of parent were major reasons of participants when considering having a baby. These factors were thought to be more related to inner motivations of the participants, independent of the societal or family related factors.

4.1.2.1. Personal History of the Participant

Participants' own experiences may lead their decision to have baby. 5 of the participants' personal history related motivations were identified in this sub-theme. Jaffe and Diamond (2011) talked about how this personal history affected the reproductive story of the individuals, thus according to them from the person's birth-even sometimes before that-the developmental history should be listened in order to understand the grief reactions after their pregnancy loss. In this study, Mrs. D. Mrs. B. and Mr. C. experienced mother loss in a very short time before their pregnancy loss experience. During the interviews both of them talked about their mother loss experience too. Even sometimes, the answers of the participants were blurred between the mother and pregnancy loss, so that the researcher had to ask elaborative questions in order to differentiate whether the participants were talking about mother loss or pregnancy loss. Both Mrs. D. and B, and Mr. C. expressed another motivation that were not present in other participants of the study. They expressed that they wanted to fill the gap left from their mother with their future child.

"*Annemin gidişi. Yani o gittikten sonra toparlanabilmem için, hatta ben bir psikologa da gitmiştim ona söylemiştim o zaman fark ettim. "Neden çocuğu bu kadar çok istiyorsun?" dedi, dedim benim canımdan bir can gitti, yeni bir can istiyorum onun yerine. Hani biz eşimle zaten sekiz yıldır birlikteydik, evli değildik. Evlenmemizin amacı da oydu. Dedim "Evlenelim, çocuk yapalım. Ben artık çocuk istiyorum." dedim*." (Mrs. B)	"My mom's passing away. I mean, I did it to recover from her loss. I also went to a psychologist, I realized when I told him about it once. He asked me why I wanted this child so much. I said I lost a part of my soul, I want to have another one. We had already been together with my husband for eight years then, unmarried. That was because we got married. I said, 'Let's have a child, I want to have a child now.'" (Mrs. B.)

Participants own relationship with his/her parents was another reason expressed by the participants. Below, expressed reasons of Mr. C. were many. He wanted to fill the gap left from his mother with the baby, he wanted to create a different and warmer family

environment that he did not experience in his childhood with his parents, and he wanted to be a father he always dreamed for.

"*Annem benim için önemli bir insandı. Daha yakındım, annemle ben daha yakındım babamdan. Biraz da onu söylemeye çalıştım mesela benim babam gibi, babam kötü bir insan demiyorum da hani benim babamla olan ilişkiden farklı bir ilişkim olmasını isterim çocuğumla. Hani böyle daha arkadaşça bir şeyim (ilişkim) olsun isterim. Böyle annemle daha yakındık. ...daha böyle annemin boşluğunu dolduracak bir şey geliyordu bana. Daha böyle çok zaman geçireceğim, daha böyle, ama bunda galiba bencillik de var*." (Mr. C)

"My mother was important for me. I was closer to her than I was to my father. I am not saying that my father is a bad person, but I want to have a different relationship with my child than I had with my father. I want a friendlier relationship. I was much closer to my mother… it seemed to me as a way of filling the gap my mother had left. A way of devoting my time. But I guess it is selfish." (Mr. C.)

Mrs. H. talked about her nuclear family relationships and how that affected her relationship with her son, and her decision to delay the second baby. Because she grown up in a bigger family in which she was the nurturing sibling, taking care of other siblings and helping the mother-in-law for the household chores, based on her experiences she believed that a family should not have many children if the family could not meet the needs of whole children.

"*Yani kesinlikle biz dört kardeş, beş kardeş büyüdük ama onunkiyle ben benimkini o, benimkini o giyiyorduk yani. Yani tek babam çalışıyordu, ya çok zahmetli büyüdük. Biz de çok kolay büyümedik. Okuyamamamızın sebebi de odur yani. Bir dershaneye gidemiyorsun, bir hani yeri geliyor biz özel ders aldırıyoruz mesela o çocuğa. Dershaneye yazdırdık üniversiteye hazırlık için...Annem olsaydı belki okurdum diyorum. İşte hani üvey annenin etkisi vardır diye düşünüyorum ama şey yok yani annem olsaydı da belki okuyamazdım. Çünkü imkân yok, maddi imkan yok. O yüzden yapmadım, bilerek yapmadım. "Olmasın." dedim, "Boş ver. Tek kalsın." dedim, "İyi yetişsin." falan dedim yani. Ama çok pişmanım, bunu kimseye söylemedim. Keşke yapsaydım*." (Mrs. H.)

"We were four or five as we were growing up but we used each other's clothes. Only my father was working, we grew up with great difficulties. It wasn't easy. That was the reason we couldn't go to school. We couldn't get any tutoring, now we are hiring a tutor for our child when necessary, we sent him to a prep-course for the college entrance exams…Sometimes I tell myself I could have gone to school if my mother had been alive. I think my step-mother had a role in this but perhaps I couldn't have done it all the same. Because we didn't have the money. That's why I didn't have another child, on purpose. I said, 'let him stay an only child, but get a proper education.' But I regret it, couldn't share this with anyone. I wish I have done it." (Mrs. H.)

4.1.2.2. Gender Related Motivations

For the 4 participants, gender of the baby was an issue that they talked about in the interviews. 2 of the couples (D. and J.) in the study talked about gender as a motivating factor. Both of the couples had a prior child and they wanted to have a second child. Both couples wanted their second child to be a boy. While Mr. D. accepted his desire to have a boy, Mr. J. did not accept that. During the interviews with Mrs. J., at the point that she was talking about her husband's wish for second child's being a boy, her husband entered the room and heard what she was saying, and he rejected her thoughts and he stated that he never wanted a boy from her wife, this was her thoughts not his. I sensed there that Mr. J., whether consciously expressed his desire to have a boy to his wife or not-even if he did not have a such a wish, he did not want me think that he made pressure on his wife about he gender of the baby. Mrs. J., however, was pretty sure about her husband's desire and she wished she could help him fulfill his dreams.

"*Kayın validem mesela oğlunun her zaman için erkek çocuğu sevdiğini söylemişti. Bu çocuğa hamile kaldığım zaman zaten ilk düşündüğüm şey bu oldu. Ve eşimin gözlerinde zaten bir oğlan beklentisi vardı. Sağ olsun, o da oğlan olması için her deneyimi yaptı. Hani kız olacak korkusu çok fazlaydı bende zaten*." (Mrs. J.)

"My mother-in-law always told me about his son's desire of having a boy. The first thing in my mind, when I got pregnant, was this. And I always saw in husband's eyes that he was expecting a boy. He tried everything for this. I mean I was always afraid of the possibility of having a girl." (Mrs. J.)

"*Yani öyle cinsiyet derdinde değilim. Ama bir oğlum bir kızım olsun isterim yani. Onu niye yalan söyleyeyim ki şimdi? Yani liberallik yapacağım diye içimden geçen duyguları, ha kız olursa sorun değil. Erkek olursa da büyük bir onur değil. Yani bir tane oğlun olur, berduştun haylazın biri olur, başına dert yani. Ben öyle çok insanlar gördüm. Anlatabiliyor muyum? Ha benimki nefsidir belki. Duygusaldır belki. İşte yeğenim var kızımdan iki yaş büyük, akşam sinemaya gittiler. Yani bir erkek bir kız onları böyle sinemaya giderken, yani bir yere giderken gördüğümde hoşuma gidiyor*." (Mr. J.)

"I don't really mind about the gender of the child. But it would be nice if I had a boy and a girl. Why would I deny my feelings for the sake of being modern? It is not a problem if it is a girl and it is not a big honor to have a boy. You may have a boy, but he may be a rebel, an idler. I saw many like those, you know? Mine is perhaps emotional. I have a nephew two year older than my daughter. They went to the movies last evening. I liked watching them going to movies together, a boy and a girl." (Mr. J.)

"*Eşim çok üzüldü ondan sonra hani. Ya bir de şeyi istiyordu yani hem her eş erkek evladı ister ya, ya normalde onun da şeyi oydu. Hani "Bir kız olsun, bir oğlan olsun." diye. Şeyi oydu yani. Amacı, yani isteği... en*

"My husband got so upset afterwards. He wanted to have a boy, as all men want. He wanted both to have a boy and a girl. It was his desire, his wish… We were going to learn the gender when I had a miscarriage. I

son düşürdüğümde zaten şeyi öğrenecektik, cinsiyeti öğrenecektik bebeğin cinsiyetini. Hani erkek olunca da eşime hani en son düştüğünde hani böyle olmasaydı da öyle haber verseydim diye, onu çok istedim. Hani işte böyle müjdeyi verseydim, hani "Oğlan çocuğu olacak." diye. "Bir erkek çocuğu olacak." diye. Yani işte onun sevinmesini, o anı yaşamayı çok isterdim. O şeyi yaşamayı çok isterdim." (Mrs. D.)

wish I could have given him the good news instead of this. I wanted so bad to tell him 'it is a boy! We are going to have a boy.' I wanted to live that moment, his surprise. I would have loved to live that." (Mrs. D.)

4.1.2.3. Personality

In this sub-theme, how personality factors affected the participants' decision to have a baby were presented. 7 of the participants (5 women and 2 men) talked about their personal characteristics that lead their child-making decision such as caring attitude toward children, ability to have responsibility of a child, nurturing characteristics developed throughout one's history, motherhood instincts and so on. Not only women, but also men talked about their positive relationships with the children that affected their decision to have a baby.

"*Yani şöyle ben uzun süreden beri zaten, kendi kendimi bildim bileli zaten bebekleri severim. Çocukları severim*." (Mrs. C.)

"I always love babies, ever since I could remember I love babies and children." (Mrs. C.)

"*Yani böyle hani bende şey kuvvetli hani annelik içgüdüsü. Hani bir şeye bakayım, koruyayım, onu eğiteyim, yetiştireyim, onunla ilgili bir şeyler yapayım. Bu hani ben doğduğumdan beri var. Sonuçta benim küçük kardeşim de var. Ondan da bildiğim şeyler var. Böyle bir annelik, bir korumacılık, ablayım, iki tane erkek kardeşim var. Böyle yetiştirildiğim için belki de hani böyle bu hissiyat bende oldu, bilmiyorum burcumdan kaynaklı mı ama (gülüyor). Çocukluğumdan beri var yani o anaç içgüdüsü. Ondan dolayı da hani birinin bakımını üstlenmeyi istedim yani*." (Mrs. A.)

"My maternal instinct is very strong. I always have the desire to take care of something, to protect, to educate, to raise, to do things about that. Ever since I was born, it is there in me. I also have little brothers. I know these things because of that. I am an elder sister, I have two little brothers. Maybe that's how I grew up, I don't' know if it is because of my zodiac sign (laughing). The maternal instinct was there since I was a kid. That's why I wanted to undertake someone's responsibility." (Mrs. A.)

4.1.2.4. Experiencing Parenthood and Emotional Value of Child

Regardless of having a prior child or not, all participants talked about their wish to experience parenthood. In addition to other factors affecting their decision to have a baby, the most salient factor observed in all participants was this factor. When considering that all

pregnancies were voluntary, it was surprising to hear emotional bonds developed for the child.

"*Şöyle ailevi olarak umutlu olmanın önemli bir parçası da çocuk sahibi olmaktır. O duyguyu [baba olma duygusu] yaşamaktır. Benim için anlamı biraz o*." (Mr. G.)	"An important part of being hopeful as a family is having a child. To experience that feeling. For me it mostly means this." (Mr. G.)
"*Yani böyle hani ikinci anne duygusunu yani daha iyi şey yapmak, tatmak istedim. Hani kızımda tattığım için. Hani annemden sonra da etkilendim. Ondan sonra hani bir tane daha çocuğum olsun diye. Yani annelik duygum öyleydi*." (Mrs. D.)	"I wanted to better enjoy the motherhood in the second time. As I tasted it with my daughter. I also affected by my mother. I wanted to have another child after that. That was my maternal instinct" (Mrs. D.)

For just a few participants, child means more than raising a child, or taking a responsibility of a child or adjusting the social norms. For some participants, child had more emotional meaning. For some, it is a medication for his/her ache, for some baby means a friend to him/her, a person with whom they would have mutual dreams and goals.

"*Açıkçası çocuğum olursa, benim aynı zamanda bir de arkadaşım olacağını düşündüm... Hayalim şu anda işte mesela bir çocuğum olsa, neler yapacağımın hayallerini kurdum. İşte ne bileyim, tabii yaşıma bağlı olarak işte bu erkek de olabilir, kız da olabilir, farketmez, işte ona kitap okumak, onunla işte hani çocukça konuşmak, ne bileyim uçurtma uçurmak falan filan gibi böyle hani bu şeyleri yapabileceğimi, yapmayı istediğimin hayallerini kurdum.* "(Mr. C.)	"I thought having a child would be like having a friend, to be honest…I imagined what we would do together. It can be a boy or a girl, doesn't matter. Reading a book to a child, doing baby talk, or flying a kite together, things like that. I imagined I could do these things and want these things." (Mr. C.)

4.1.2.5. Raising a Child Who Carries the Parent's Values

Some participants (Mr. B., Mr. E., Mrs. F. and Mr. F., Mr. I and Mrs. I) (n=6) talked about how significant for them to raise a child who carries their values. They wanted to raise a child based on their religious, nationalist, or humanistic values. For instance, a child who helps the population of Turkey, population of people believing in Islam, serving his/her nation were some of the reasons expressed by the participants. For Mr. I and Mrs. I. in addition to national or religious values, humanistic values to transfer to the child were also important.

"*Ama eşim dışarıdan bakıldığında çocuklara böyle uzak duran, çok sevmeyen aman mıçmıç mıçmıç çocuk seven bir insan değil. Ha o biraz aile kurmak adına hani İslam, Müslümanlık adına çocuk sahibi hani, işte Peygamber efendimiz "Evlenin." İşte "Çocuklar dünyaya getirin. Onları Müslüman gibi yetiştirin." şeyinden yola çıkıyor eşim biraz*." (Mrs. F.)

"My husband is a distant man; not affectionate to children. He is more into it to be a family, in the name of Islam, you know, our prophet said 'get married, have children and raise them as Muslims'. My husband wants children because of this actually." (Mrs. F.)

"*Daha yani bizim geleneksel yapımızda, Türk toplumunun yapısında ailenin genişlemesi her zaman mutluluk verdiği için belki ondan. Ama İslami düşünce olduğu için bizde çoğunlukla biz de diyoruz ki yani Allah'ımızın emirleri gereği "Çoğalın, neslinizi işte nesil sahibi olun, onlara eğitim verin." Ondan dolayı daha çok istiyoruz yani*." (Mr. F.)

"It is because expansion of the family is always a happy event in our tradition, in Turkish society. But there is also the Islamic thought for us, it is God's order to reproduce, to multiply the generation, and educate the youth. We want his mostly because of this." (Mr. F.)

4.1.2.6. Age of Parent

Here, it should be mentioned that mean of the participants age was 35.5 with a range between 28 and 46. Even if none of the participants were that old that was an obstacle to their being a mother or a father. Still, age was an important factor for some participants (n=7). Not only women, but also men talked about having a baby before it was too late was a driving factor for them. 7 of the participants had anxiety regarding whether their age would be a limiting factor for them, so they wanted to have a baby as soon as possible. They mentioned not only biological clock, but also the psychological factor. For instance, for some participants, the earlier the decision for a child is made means more time to spend together with the child.

"*İşte benim de yaşım geçiyor, eşimin de yaşı geçiyor. Kızım büyüyor bir taraftan. O yüzden bir tane daha evladım olsun istiyorum yani*." (Mr. J.)

"I am getting old, you know, my wife is aging too. And my daughter is growing up. That's why I want to have another child, you know." (Mr. J.)

"*Artık vaktinin geldiğini, yaşımızın belli bir seviyeye geldiğini düşündüğümüz için*" (Mr. A.)

"Because we are thinking it is the time, we have come to a certain age." (Mr. A.)

With these motivations to have a baby, all couples experienced involuntary pregnancy losses. The experienced losses occurred at different gestational periods. Of 10 pregnancy losses, 9 of them could be defined as miscarriage, while only one of them was

stillbirth based on the criterions set by Covington (2006). The table below summarizes the loss periods, frequency of losses and whether the loss was a miscarriage or a stillbirth.

Table 6: Participants' Loss Experiences and Time of the Loss

	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Gestational Age that Loss occurred	10 w	11 w	8 w	18 w	12 w	4 w ___ 9 w	10 w	8 mth	12 w	16 mth
Time Since the Loss	3 yrs	15 mth	4 mth	8 mth	1 yr	4 yrs ___ 2 yrs	4 yrs	2 yrs	6 yrs	6 mth
More than One loss					*	*				*
Miscarriage (M) or Stillbirth (S)	M	M	M	M	M	M	M	S	M	M

In the next themes, how participants experienced the pregnancy loss was presented. Because all losses were involuntary and unexpected, the reactions of the participants have some common features. Also, the responses the loss was individually and socially affected, there were different reactions expressed by the participants.

4. 2. Theme2: Short-Term Grief and Bereavement Responses

In this theme, how participants reacted the pregnancy loss within the first days and within the few months after the loss were presented. As Stroebe, Hansson, Stroebe, and Schut (2001) expressed that after loss, the bereaved individuals might have affective, behavioral, cognitive and physical /somatic symptoms. Even if we did not define these reactions as the themes, the reactions of bereaved participants were given under different themes in the following pages. Firstly, their psychological reactions including their emotions and first reactions regarding learning the bad news from their doctor were given. Secondly, how their hopes failed after the loss was given both from personal and family views. Thirdly, their anxiety for future pregnancies were explained. As the fourth category, how men and

women perceived the curettage operation were presented since for a few participants this hospital process had traumatic meanings. It should be mentioned that there was no question regarding this code in the interview protocol, and it was expressed by participants. Because there is a medical procedure for pregnancy losses, it was not abnormal for women or men to talk about this code, but because we did not aim to understand medical related experiences, their hospital experiences were asked with general questions, but the sub-theme was emerged within the data that sounded important in understanding the loss experiences of participants. So, emergence of this theme could explain how this medical procedure could have affected their psychology at that time and after the procedure. And lastly, how participants perceived this loss as a loss of part of oneself, that differentiated pregnancy loss from other losses they experienced and their increased attention to other pregnancies and other pregnancy losses were given.

Table 7: Short-Term Grief and Bereavement Responses

THEME 2: SHORT TERM GRIEF AND BEREAVEMENT RESPONSES
•Psychological Reactions •Failed Hopes •Anxiety Regarding Possible Future Pregnancies •Curettage Operation •Losing a Part of Oneself •Paying Attention to Other Pregnancies and Other Losses

4.2.1. Psychological Reactions

As can be observed in the following pages, even if the psychological reactions to pregnancy loss can be named similarly with other losses, such as denial, sadness, loneliness, anger, the content of the reactions and how these were experienced were different from other losses. Moreover, some reactions like anxiety for further pregnancies may be observed differently in other losses. For instance, after losing someone important, the anxiety for the possible losses might be observed but this anxiety for the "loss of relationship" with loved one. In pregnancy loss, however, the anxiety is for the person who was neither touched nor seen, only the mother may have felt the physical acts of the fetus during pregnancy. Or, for

the one who had lost someone important, there were memories left after the lost one, while for the pregnancy loss, what was lost was the hopes regarding the expected baby.

Table 8: Psychological Reactions

PSYCHOLOGICAL REACTIONS
•Denial •Sadness •Shock •Anger and Accusation of Others •Self-accusation •Loneliness •Panic •Withdrawal

4.2.1.1. Denial

Except two couples in the study, eight couples (n=16) expressed their first reactions after hearing that there was a problem with the baby as denial. This denial could be seen in their statements. Especially this denial was voiced with their unbelieving the doctor's statements who said that the baby's heartbeat was not heard, or with their decision of changing their doctor and desire to take another opinion from a different doctor even if the final words were spoken about the baby. And participants who did not took another opinion related to health of baby, had regrets that they should have asked to another doctor.

"*Hani böyle gitmesem sanki geri duracakmış gibi düşündüm. Hani "Acaba gitmesem mi kürtaj olmaya?" falan diye*."(Mrs. G.)	"I thought I could keep it If I didn't go. I wondered about the possibility of not going to the abortion." (Mrs. G.)

Below Mrs. I explained her desire to go to her own doctor since she was in the holiday when the doctor explained the situation, so she wanted to go back to Istanbul to her own doctor to be sure about the baby's situation.

"*Farklı bir doktordan öğrenmiştim hatta kendi doktorumdan öğrenmemiştim. O yüzden acil İstanbul'a dönüp hatta inanmak istemedim yani kendi doktoruma muayene olmadan aldırmadım mesela bebeği. Sonra kendi doktoruma gittim. Kendi doktorumla konuştuktan sonra bebeği aldırdık*. "(Mrs. I)

"I got the news from a different doctor, not from my own doctor. I didn't want to believe it, you know, I wanted to rush to Istanbul to see my own doctor. I didn't have the abortion before seeing my doctor. Then I went to my doctor, talked to him. I had the abortion afterwards." (Mrs. I.)

Mrs. B. who had another loss experience within two years, she lost her mother to cancer and she had a motivation of filling the emotional gap left with the lost of her mother with her baby. She expressed how she had difficulty in accepting the bad news.

"*Hafta sonuydu ben apar topar tekrar hastaneye gittim, kendi doktorum yoktu, nöbetçi doktor baktı bana. Dedi ki " Bu bebeğin gelişiminde problem var. Bu bebeği kaybedeceksin." dedi. Tabii ben o doktora bağırdım, çağırdım, hakaretler ettim falan. Çıktım gittim hastaneden bir şey bilmiyor bu falan diye. Ertesi gün hafta içi kendi doktoruma gittim, o baktı, dedi ki "Sorun yok. Devam et hani. Hiçbir sorun yok." "Sen" dedi "Bir ay sonra normal rutin kontrolüne gel." dedi. Bir ay sonra gittiğimde de zaten bebeğin kaybını hani öldüğünü öğrendik. Hâlbuki benim o hani sinir olduğum doktor doğru söylemiş yani. ...Ama işte ben tabii ki de kabullenemedim*." (Mrs. B)

"It was on a weekend, my own doctor was not there, another doctor saw me. And he said 'There is a problem in the development of this baby. You will lose it.' Of course I got mad, shouted at him, insulted him. And rushed out of the hospital thinking that he does not know anything. A day after that, on a weekday, I went to my own doctor who said that there was no problem and I could come for the routine control next month. When I went the following month, we heard of the baby's death. I saw that the doctor I shouted at was actually telling the truth…. But of course I couldn't accept it." (Mrs. B.)

Not only women in the study, but also men talked about their decisions to get a second opinion. For instance, Mr. A. talked about his need for reassurance before making a final decision regarding the baby.

"*Çocuğumuz işte 8 haftayı geçmişti kalp atışlarını işte duymuştuk. Onu takip ediyorduk. İşte rutin kontrol için gitmiştik. Yani rutin kontrol için gittiğimizde hani kalbinin atmadığını öğrendik. Ya pek bize şey gelmedi o zaman işte inanmak istemedik. Tekrar, özel bir hastaneye gitmiştik, hani eşim doktor olduğu için bir de eşimin çalıştığı hastaneye gittik. Orada başka makinelerle bakılsın, başka doktorlar da şey yapsın çünkü hani kayıp, insan inanmak istemiyor ve hani ilk defa bir çocuk beklentisiyle çocuk sahibi olma*

"It was after the 8th week of the pregnancy, we had already heard the heart beats. We went to hospital for the routine control. We learned that the heart was not beating on a routine control. It didn't seem true, we didn't want to believe it. We went to a private hospital, as my wife is also a doctor, we wanted to the hospital she was working in. We wanted to check once again with different doctors, different equipment. Because, you know, it is a loss, you don't want to believe it. And it was our first time expecting a child, no matter how good a

şeyinde gerçekten hani onu çok iyi bir uzman bile olsa, çok iyi bir makinede bakılsa da inanmak istemiyor insan. Yani inanmak istemediği için tekrar tekrar bakmaya şey yapma ihtiyacı hissediyorsun." (Mr. A)	doctor is, how advanced the equipment is, you don't want to believe it. That's why you feel the need to check again and again." (Mr. A.)

4.2.1.2. Sadness

Most of the participants (n=18) talked about their sadness after their pregnancy loss experience. Especially within first months, this sadness was present. While all women expressed their sadness with words, only a few men used the feeling word "sad" during the conversation when talking about their experience. For some participants, this sadness lasted a few days, for some for weeks and for some, whenever they remember the loss, they still experience this sadness. There were times that trigger this sadness such as when seeing a pregnant woman, or a newborn baby, even a baby product commercial. For some participants, explaining this loss to another person or seeing the baby staff they bought for the baby was a source that triggered their sadness.

For the ones who did not mention sadness, it might not mean that they did not experience sadness; but they might have reacted with different emotions since even the ones who did not express sadness, expressed emotion of shock, since they were waiting for a wanted baby.

"*İlk zamanlarda çok üzüldüm hani çok çok üzüldüm*." (Mrs. G.)	"At the beginning, I got so upset. So so so much upset." (Mrs. G.)
"*Tabii ben ondan sonra böyle çok üzgündüm, durup durup ağlıyordum falan..Ama o zaman böyle en ufak bir çocuk reklamına bile ağlıyorsun yani hani duygusala bağlıyorsun yani direkt. Ya yapacak bir şey yok onda da*." (Mrs. A.)	"I was so sad afterwards, I kept crying all the time. But then you cry even at an advertisement with children in it. You get very emotional. Nothing to do about it." (Mrs. A.)

This sadness was not limited to loss experience itself. For some participants, this loss might have long-term effects such as for further pregnancies, chance to get pregnant again. Mrs. F. said she did not cry a lot after her miscarriage but when she talked with her doctor and learned the other consequences of that loss, she was so sad.

"*Ama yoksa şey yapmadık, hani çok o gün böyle oturup hüngür, hüngür, hüngür, hüngür ağlamadım. Yani evet üzüldüm, suratım düştü, biraz birkaç damla gözyaşı da düştü ama o kadar...Pazartesi günü, tabii pazartesi günü doktora gittim. Bu "Tüp bebek düşün." dedi hani bir an böyle o an, o zaman kapıdan çıktım, ağlıyorum ama hani etraftan insanlar da çok böyle dikkat çekmesin diye kendimi sıktım ben o gece çok ağladım*." (Mrs. F.)

"That day I didn't cry a lot. Yes I was upset, my face changed, a few tears fell, but that's all. Then, on Monday, I went to the doctor who said "consider test-tube baby". That moment, when I walked out the door, I cried but there were people around. I didn't want to draw attention. I forced myself to stop. But I cried a lot that night." (Mrs. F.)

The partners felt so much pain notably within the first months after the loss. This pain was sometimes so much that they woke up from their sleeps. A few women talked about their lack of willingness to go out, to spend time with others because of the sadness they felt. For some participants, this pain was higher than any other loss. Thus, the feelings expressed by the participants might have also shown themselves in the behaviors or somatic symptoms.

" *"Anne" dedim "Sen nasıl dayandın ya bu acıya?" hani, inanılmaz yani hani. İğrenç bir şey. Çünkü hani sen o on haftalık bebeğe hani o kadar emek verdiğini düşünüyorsun içinde bir şey. Ama hiçbir şey yapmamışsın ki. Sadece hani şey biraz dikkat etmişsin beslenmene, biraz miden bulanmış falan filan. Hani doğurduktan sonra veya hani biraz daha ayı ilerledikten sonra veya hani doğduktan sonra canlı canlı evladını kaybetmek acısını tahayyül bile edemedim yani. Düşün ki on haftalık bir bebek. Hani bebek bile değil nerdeyse yani*." (Mrs. A.)

"I said 'Mom, how could you bear this pain?'. It was incredibly hard. It is an awful thing. You think you put so much effort to that ten-week baby. But in fact, you did nothing, just minding your diet a bit, a little nausea etc. I couldn't imagine the pain of losing a child after the birth or in the advanced stages of pregnancy. Let alone a ten-week baby, not nearly a baby…" (Mrs. A.)

"*Ben de acı çektim çünkü. Hani çocuğun düşmesiyle ben de acı çektim, onunla birlikte*." (Mrs. D.)

"Because I suffered too. I suffered with the child, on its loss." (Mrs. D.)

4.2.1.3. Shock

Shock was another reaction expressed by the participants (n=20). Because all participants experienced involuntary pregnancy loss, the decision for curettage or miscarriage was not decided by them and this led to feelings of shock by the participants. All participants' talking about the shock experience might result from the nature of loss. Sometimes the shock feelings expressed by the participants could be sensed from their

sentences, or their actions during the loss period such as in the case of Mr. E. or Mrs. H. whose quotes were given below.

"*Bir canlıyı kaybetmenin üzüntüsü çok zorlaştırdı. Hele de ilk günlerde. Böyle ilk birkaç gün böyle bir hafta iki hafta falan insan etkisinden kurtulamıyor. Yani "Ruh gibi işe gidip geliyorsunuz." derler ya aynen öyle*." (Mr. E.)	"The pain of losing a living thing worsened it so much. Especially in the first couple of days. You cannot overcome that feeling in the first week or two. You wander around like a ghost." (Mr. E.)
"*Uzatalım diye [tatili] rapor almak için başka bir doktora gitmişken, orada olmadık bir anda biz öğrendik. Çocuğumuzu kaybettiğimizi. O bizim için çok büyük bir vurgun olmuştu .Ya hayatımın ilk şoku buydu diyebilirim çünkü beklemiyorduk artık biz böyle bir şeyi. Çok büyük bir şok oldu bizim için yani. En büyük travmam odur herhalde*." (Mrs. I.)	"We learned it when we went to a doctor to get a report to extend the vacation. We learned that we lost our child in a very unexpected way. That was a great strike for us. I can say that was the first shock of my life because we were not scared of such a possibility anymore. That was a big blow to us. I guess that is my biggest trauma." (Mrs. I.)

Mrs. H. explanations sound that she was in a state of dissociation that was caused with the shock feelings of the unexpected loss.

"*Geliyorlar, gidiyorlar ama inan ki böyle sanki bir hayal gibi, bir perde gibi böyle gözünün önünden geçiyor. Bazen diyorsun "Ay bunlar niye gelmiş?" gibi hissetmeye çalışıyorsun ama olmuyor tabii*." (Mrs. H.)	"People come and go but they pass through my eyes like a dream. Sometimes you ask why they come. You try to feel, but of course it doesn't work." (Mrs. H.)

4.2.1.4. Anger and Accusation of Others

In this theme, feeling of anger toward others and oneself was shared by 6 of the participants (n=6). This anger was expressed by a few participants as accusation of others- their partner, their work, and the hospital personnel.

Especially men participants talked about their anger toward others, while women participants talked about the anger, they directed toward themselves. Specifically, a few men were angry toward the attitudes of the hospital personnel, in some cases they believed that the hospital personnel did not do the necessary procedures to make the baby alive, and in some cases, hospital personnel's communication style was not proper for them. Mr.D. accused the hospital because he thought that there were necessary health checks when he brought his wife to hospital that their baby was still alive at that point.

"..*Ve o hastanede ben o doktoru gördüm. Ve onunla bir tartışmamız olmuştu. Yani bırak motiveyi, ben direkt oradaki doktorla tartışmıştım. Hatta iki üç doktorlar gelmişti sonra. İşte "Herhangi bizim yaptığımız tetkiklerde herhangi bir şeylerde bir sakınca yok. Bu normal şeyler." diye öyle geçiştirdi meçiştirdi... Yani ben öyle bir rezalet hastane görmedim. Çünkü sen orada sonuçta ben oraya bir kanama için gidiyorum. Ki orada bir belirti var yani. Ben on iki buçukta gittiğimde belirti var. Sen o gittiğimde bunu anlaman lazımdı yani bunu bilmen lazımdı. Beni göndermemen lazımdı*.." (Mr. D.)	"…And I saw that doctor in that hospital. And we quarreled with him. Let alone motivating the patient, he quarreled with us. Then some other doctors also came. They said there was nothing wrong in the examinations they have made. They said it was all normal. I never saw a worse hospital. I go there upon a bleeding after all, there is a symptom there. There is a symptom at twelve thirty. You should have noticed it then, you should have known it. You shouldn't have sent us back. (Mr. D.)

Sometimes, past issues with the partner or previous child were opened and with the intense emotions caused with the loss, women may reflect negative emotions to family members. This kind of opening old issues after the loss was expressed only by women. While women were the ones who were more open to talk about their emotions with their husband, still they were the ones who talked about the unfinished past issues that were mostly related to their marriage or relationship.

"*Mesela ilk başta hani iş yoğunluğundan dolayı hani kızımı suçladım. Eşimi suçladım. "Sizin yüzünüzden diye."* (Mrs. J.)	"For instance; at the beginning I blamed my daughter, my partner due to his busy schedule. I told them it was their fault." (Mrs. J.)
"Ben o süreçte tabii ki hani her türlü, herkesi biraz daha suçlama eğilimindeydim. İşte şurada şu stresi yaşadım, o yüzden sebebi bu oldu. İşte atıyorum küçük bir şey bile yaşasam eşimle, ya da iş yerinde atıyorum biriyle bir şey yaşasam bile işte bunun sebebi o oldu filan" (Mrs. C.)	*"I tended to blame everyone in every way in that period. I was telling, for example, that I suffered this stress at one point and that caused this. I mean, for instance, even a small thing between me and my spouse or for example if something happened at work the reason was it." (Mrs. C.)*

4.2.1.5. Self-Accusation

Accompanying the anger feelings, men and women in the study were likely to accuse themselves because of what happened about the pregnancy. Especially women (n=5) accused themselves because of the thought that they might have not protected themselves for the baby as it should have been. For instance, physical activities like going to another place by using bus or working long hours have been considered as a possible reason for their pregnancy loss. Their doctors did not explain anything that claimed that their doubts were

true, but still as it seems that they are looking for an explanation for the loss. For some participants, not going to their monthly or weekly gynecologist visits was their reason for the self-accusation. These self-accusations or guilty feelings that result from the belief that they did not do the necessary things to protect the baby, were expressed by the five women (Mrs. D, Mrs. E., Mrs. G., Mrs. H. and Mrs. J.) in the study.

"*Ya o kayıp döneminde ben bir ara memlekete gittim geldim. Sonra dedim ki "Acaba gidip gelmese miydim?" Memleketten geldim, üç hafta sonra zaten bebeğimi kaybettim. "On gün içimde ölü durduğuna göre." diyorum, "Memleketten gelmişim, bir hafta falan daha durmuş, diğer on günü de ölü geçirmişiz. Acaba gidip gelmese miydim?" diye kendi kendime sordum yani. Acaba bu yolculuk mu beni etkiledi? Acaba oraya gittim, geldim, böyle nazara mı geldim? Hani "İkinciyi de doğuruyor." falan, göze mi geldim? İşte bir onu çok düşünmüşümdür. O kadar yani. "Gitmeseydim, durur muydu çocuk?" diye düşündüm. Öyle*." (Mrs. E.)

"I visited my hometown in that period. Then I thought if I shouldn't have done it. I lost my baby in three weeks after I came back from the visit. As it stayed dead in me for ten days… After I came back, it must have been alive for another week, and been dead for the last ten days. I asked myself again and again if I shouldn't have taken the trip. If the trip had an effect on me. I wondered if they jinxed it, by thinking "wow, she is pregnant with the second", you know, if I had been affected by the evil eye. I gave a lot of thought to that. I wondered if I could have kept the baby, if I hadn't taken that trip. That's all." (Mrs. E.)

Two men in the study talked about that they may not pay attention their wife's health as much, and they were sorry about this.

"*Biraz daha yani her gün yaşayabilirdim onunla. Yani onun hamilelik dönemini, her gününde, onunla her gün yaşayabilirdim. Ama işte bir haftayı yedi güne böldüğümüz zaman, ben onun hamileliğiyle hani üç gün ilgiliysem, dört gün ilgisiz gibiydim. Onu biraz daha motive edebilirdim. Biraz daha fiziki şartlardan etkilenmemesi için dikkatli olabilirdim. Onu da dikkatli olması için uyarabilirdim. Onun da benim ona bu yaklaşımımdan dolayı daha sorumluluk çerçevesinde bir şey, hassas olabileceğini düşünürdüm. Bunlardan dolayı pişman oldum, evet*." (Mr. H.)

"I could have been with her a bit more, I mean, everyday. I mean, I could have been with her on each day of her pregnancy. But when you look at the seven days of a week, I was there with her on three, away on four. I could have better motivated her. I could have paid more attention for her to be not affected by physical conditions. I could have also warned her to be more careful. I thought she was more sensitive because of my attitude. I regret these, yes." (Mr. H.)

Participants talked about the regrets they experienced related to baby loss. These regrets were related to their actions or reasons to get pregnant. For instance, some participants felt regret of making a decision to have a baby again in a later age, some

participant felt regret for their bus ride, for some it was related to rituals after the loss that were not fulfilled.

"*Ama çok pişman oldum, keşke daha erken [yaşta] yapsaydım. Çünkü benim tahlillerim de iyi çıkmamıştı. Düşük çıkmıştı yani*." (Mrs. H.)	"I regretted that so much. I wish I had done it at an earlier age. Because my medical test results were not okay. They were low." (Mrs. H.)

4.2.1.6. Loneliness

Three couples (n=6) in the study talked about their loneliness feeling, specifically after the curettage operation in the hospital. Two couples were already living away from their core families, and first a few days, they had to spend their time together as a couple. One couple (couple I) was in the holiday when they learned that the fetus was dead.

"*Bir de dedim ya yine ameliyattan hemen sonrasında yine bir yalnızlık. Hani işte ailemizin olmaması yanımızda ya da bir biz tektik sonuçta. O eşimi daha çok üzdü yani. O olay sonrası, o şey yani o operasyon sonrasında*." (Mr. G.)	"And as I said, a sense of loneliness after the operation. Our families were away, we were on our own. That had upset my wife more, after that thing, that operation." (Mr. G.)

4.2.1.7 Panic

Panic feeling was related to unexpectedness of the loss and was expressed by 4 participants in the study. Even there was a problem diagnosed in the previous doctor visits, the men and women still kept their hopes. When the participants were talked about the loss of the baby, they were panicked since they did not know what to do.

"*Gittik hani iki hastane arasında belki 5 km yoktu ama biz o sürecin nasıl geçtiğini hatırlamıyoruz hani çok ben ömrü hayatımda mesela araba kullanırken o kadar hani dikkatsiz, o kadar ayaklarımın titrediğini şey yaptığımı hatırlamıyorum*." (Mr. A.)	"There was not even 5 kilometers between the two hospitals, but we don't remember how we went through that road. I hadn't been that inattentive while driving a car before in my life, with all that shaking feet and nervousness." (Mr. A.)

Couple D. experienced the miscarriage in their homes in a very late time of the night. Mr. D. had to help his wife in this difficult situation. He expressed his panic when he first saw the fetus.

"*Ama tabii ki ilk gördüğümde çok paniklemiştim, çok korkmuştum. Bir o an için iki- üç günlük bir üzüntüsünü yaşadım.*	"Of course, I was so panicked and scared when I first saw it. I went through a strong despair for the first couple of days. But of

Ama uzun süreli bir üzüntü olmadı tabii ki." (Mr. D.)	course, it was not permanent." (Mr. D.)
"*Hem panik içindeydik, hem üzüldük*" (Mrs. D.)	"We were both so panicked and so upset." (Mrs. D.)

4.2.1.8. Withdrawal

A few participants (n=4) talked about their need to stay alone after the loss experience, within the first days after the event. As the following quotations exemplified, this staying away from others was not related to need to stay away from their own family, extended family members or close friends.

"*Çünkü o süreçte [kayıptan sonra] iş arkadaşlarımdan kimseyi de görmek istemedim ben, hiç kimseyle de görüşmek istemedim. Telefonlarını açmadım*" (Mrs. I.)	"Because I didn't want to see anyone from my colleagues in that period [after the loss], didn't want to talk to them. I didn't pick up their calls." (Mrs. I.)
"*Ben zaten iki üç gün falan işe gitmedim. İzin almıştım. Bende böyle bir durumlarda yalnız kalıp böyle şey yapıyorum. Öyle kendimi teselli etmeye çalışıyorum*." (Mr. E.)	"I didn't go to work for a couple of days. I took days off. I cope with it alone in such situations. I try to console myself that way." (Mr. E.)

4.2.2. Failed Hopes

In this theme, lost dreams related to baby was shared by the participants (n=12). Those dreams were related to their own dreams, or the expected child's position in the larger family, previous child's failed hopes for the expected sibling. For the participants who had a previous child, pregnancy loss reminded them they would be lonely when their first child is grown up and leave the home. A few participants talked about their disappointment feelings that resulted from their unfulfilled desires related to having a baby.

"*Beklentilerimi öteleyen ya da engelleyen bir kayıp oldu. Yani iki tane çocuğum olsun istiyordum. Çünkü sonuçta neredeyse liseye gidecek bir kızım var. Bir gün yuvadan uçup gidecek yani evin içerisinde başladığımız günkü noktaya geri döneceğiz. Elbette ekonomik olarak da kendimi hazırladım, ona da bakma gücüm vardı Allah izin verdiği sürece. Bu manada beklentilerimi engelledi ya da erteledi diyebilirim. Erteledi diyorum çünkü bir tane daha inşallah bir tane daha çocuğum olur. İstiyorum yani*." (Mrs. J.)	"The loss postponed or hindered my expectations. I desired having two children. Because I have a daughter who will soon start high school. She will leave the home someday and we will return to the point where we first began in the home. I also had made financial preparations. I was ready for the expenses of raising another child, as long as God allows. In this sense, I can say that the loss postponed or hindered my hopes. I say 'postponed' because I still wish to have another child. I do want it." (Mrs. J.)

"*Hayal kırıklıkları oldu. Yani bazı kafamda kurmuş olduğum planların gerçekleşmeyeceğini ya da en azından ötelendiğini bilmek. Yani ben şu koltukta oturup da şey yaptığımı hatırlıyorum, işte bugün şu anda şu kadarlıksa işte şu zamanlarda doğar gibi hesaplar yaptığımı hatırlıyorum. O yüzden herhangi bir şey günlük hayatımda sadece kendi içimde bu hayal kırklığını yaşadım*." (Mr. C.)

"I was disappointed. I mean, to see that the things I planned out would not happen. I mean I remember sitting on this armchair and making calculations about the birth date. That's why I went through these disappointments in my daily life." (Mr. C.)

In the study, participants who had a previous child have a girl and all of them wanted their second baby to be a boy. For some partners, this had not such an important role, but as seemed to me that there were some participants who really wanted to have their second child be a boy. This situation may have created burden for the women, while for men the loss meant their desires would be postponed.

"*En son düşürdüğümde zaten şeyi öğrenecektik, cinsiyeti öğrenecektik bebeğin cinsiyetini. Hani erkek olunca da eşime hani en son düştüğünde hani böyle olmasaydı da öyle haber verseydim diye, onu çok istedim. Hani işte böyle müjdeyi verseydim, hani "Oğlan çocuğu olacak." diye. "Bir erkek çocuğu olacak." diye. Yani işte onun sevinmesini, o anı yaşamayı çok isterdim. O şeyi yaşamayı çok isterdim*." (Mrs. D.)

"We were going to learn the gender when I had that miscarriage. I wish I could have given him the good news instead of this. I wanted so bad to tell him 'it is a boy! We are going to have a boy.' I wanted to live that moment, his surprise. I would have loved to live that." (Mrs. D.)

"*Ve eşimin gözlerinde zaten bir oğlan beklentisi vardı. Sağ olsun, o da oğlan olması için her deneyimi yaptı. Hani kız olacak korkusu çok fazlaydı bende zaten. Şu anda eşim yanımda, ilk defa açıklıyorum ben bunu söylüyorum. Kaç ay sonra. Yani bu korku hep içimde vardı zaten. Acaba kız mı olacak, oğlan mı? Kız olursa ne yaparım?*" (Mrs. J.)

"And I always saw in my husband's eyes that he was expecting a boy. He tried everything for this. I mean I was always afraid of the possibility of having a girl. My husband is here now, I confess it for the first time in front ot him. After months. I had always have this fear in me. I was wondering what the gender would be, and I thought what would I do if it were a girl." (Mrs. J.)

For Mr. C. and Mrs. B. child had another importance, they wanted to fill the gap left with their mother loss. So, their loss was another resource for disappointment.

"*Kayıptan sonraki ilk anneler günüde ben zaten annemden sonra her anneler gününde kötü oluyordum yani. Hamile olduğumu öğrenince şey dedim "Tamam, bu seneki*

"I was already getting upset on every mother's day after I lost my mother. I said to myself that this mother's day would be a happy one for me. Then I got depressed

anneler gününde mutlu olacağım." Dedim. "Mutlu geçireceğim anneler gününü artık." Dedim. Sonra çifte kötü geçirdim. Yani daha da kötü oldum çünkü böyle bakıyorum mesela, ben önceden hiç dikkat etmezdim böyle şeylere. Hiç özen göstermezdim yani mesela anneler gününde atıyorum Facebook'ta Instagram'da falan kutlardım. Fotoğraf koyardım, ama sonradan hani kendi başıma gelince anladım ki birilerini incitebiliyoruz yani biz oralarda fotoğraf koyarken, kutlama yaparken. O gün baktım, ya işte herkes annesiyle fotoğraf koyuyor işte "Canım annem." türünden şeyler. Ya da çocuğuyla koyuyor işte "Beni anne yaptığın için teşekkürler." gibi şeyler yazıyor falan. Ama hani benim annem de gitti, çocuğum da gitti. Böyle çok kötü olmuştum yani. O bayağı kötüydü yani o anneler günü benim için." (Mrs. B.)

twice as much. It was much worse. Because, I noticed that I used to not pay attention to such things, I was so inconsiderate. For example I used to post photographs on Facebook or Instagram on mother's day. Then after I went through this, I realized that we could hurt some people by posting those photographs, by celebrating. That mother's day I saw that everyone was posting photograph with their mothers, with captions like 'my dear mother', or photographs with their children and writing things like 'thank you for making me a mother'. But I lost both my mother and my child… I got really upset because of it. That mother's day was so difficult for me." (Mrs. B.)

4.2.3. Anxiety Regarding Possible Future Pregnancies

All women (n=10) and most of the men (n=7) in the study talked about the anxiety regarding the next pregnancy. In the literature, having a prior pregnancy loss experience was found to affect the opinions of partners in the future pregnancies, even it was discussed that previous loss experience would affect the relationship of parents with the subsequent children. In this study, participants talked about their anxiety, fears related to experiencing pregnancy again. For the participants, having a prior child was a source for finding solace, but for participants who did not have a child, future is darker.

"*Çünkü 'Tekrar düşer mi bu çocuk' korkusu hep yaşandı*." (Mrs. I.)

"Because, there is always the fear of another possible miscarriage." (Mrs. I.)

"*Hamilelik süreci biraz daha şey geçiyor yani rahat bir hamilelik geçiremiyorsun çünkü önceden yaşamış olduğun bir şey var. Bu süreçte hani anne daha titizleniyor, duygusallaşıyor çünkü önceki yaşadığı olayın daha sonra tekrar etme şeyi düşüncesi, bir şey olacak şeyleri hani gebelik sürecinde daha şey ortam. Ama belli bir süreci geçtikten sonra, ilk riskli dönemleri geçtikten sonra altıncı yedinci aydan sonra anne artık rahatlayıp da hamilelik sürecini hani daha verimli daha tatlı daha düzgün geçmesi oluştu. İlk 4-5 ayı*

"The period of pregnancy becomes a bit different, it cannot be an easy process as you had a difficult experience before. The mother gets more nervous and emotional due to the thought of the repetition of the past experience, the feeling of 'something will happen'. But after a certain time, after the first risky period. When you come to the sixth or seventh month, the mother gets relaxed and the period gets easier. It was of course hard for us in the first 4-5 months until the baby settled safely in the womb." (Mr. A.)

bu süreç oluşana kadar tam gebelik rayına girip de çocuğun rahime tutunması süreci bizim için biraz daha tabii sancılı geçti." (Mr. A.)

There were participants who had subsequent pregnancies with live births. Even if they remembered the anxiety they felt during their pregnancy, they still wanted to have a baby.

"*Oldu. Evet. Oldu ama yine de yani hani yine de istedim. Hemen istedim yani ben. Doktor "İki ay yapma." dedi. "İki ay bekle." dedi. O iki ayın bile geçmesi benim için böyle iki sene gibiydi yani. Hani yine aynı şeyi yaşayabilirim korkusu olsa bile yine de yeni bebek istedim yani. Ama şeyde mesela Vera'nın haberini alır almaz direkt böyle hani problem olmayacakmış gibi aradım, ilk dakikada herkese söyledim. "Hamileyim, doğacak bu sefer." gibi hani. Çok emin oldum yani o sefer. Çünkü hani o kadar da şanssız olamam herhalde diye düşündüm*." (Mrs. B.)

"Yes, it happened. But I still wanted it, despite of that. I wanted to make another child at once. The doctor told me to wait two months. Those two months were like two years for me. I wanted a new baby in spite of the fear of going through the same thing again. But I called everyone immediately when I heard the news of Vera, as if nothing would happen this time. I said 'I am pregnant, this time I will give birth.' I was so sure. Because I thought I couldn't be so unlucky." (Mrs. B.)

4.2.4. Curettage Operation

For a few women in the study (n=3), the worst part of the pregnancy loss was the curettage operation. For Mrs. E. the operation desk reminded her like she was dead. Maybe this curettage operation was concretely proving them that their pregnancy was over.

"*Sürekli kürtaj masasına yatmak zaten bir insanı mahvediyor resmen ölmüşsün gibi. Hayatın bitmiş gibi o kürtaj masasına çıkarken. O bir kere çok zor. E kürtaj olup eve geliyorsun, bütün hayal kurdukların bitti, ikinci çocuğa göre hayal kurdun. Veya üçüncüye. Ondan sonra bitmiş oluyor ya. Artık hayal kurmana da gerek kalmıyor. Sanki hayalsiz gibi yaşıyorsun. Hayal kurmana gerek kalmıyor, kürtaj oldun, bitti. Bütün hayallerin suya düştü. Öyle geçiyor o dönem...Çok kötü bir şey yani. Bebeğin ölmüş, ölüsünü aldırıyorsun, çok kötü bir şey o masaya yatıp da ölü bebek aldırmak. O bir kere başlı başına çok kötü bir olay. Yani benim en korktuğum ve etkilendiğim şey zaten o. O masayı görür görmez zaten, ben şu anda sağlık ocağında bile öyle bir*

"Being on that curettage table devastates a person, it's like being dead. It's like your life is ended when you are on that table. That's very difficult. Then you come home after that, all your dreams are gone. You were dreaming about the second child. Or the third. Then it is all over, no need to dream. You live a dreamless life. No need to dream, you had the abortion, it is over. All your dreams have failed. That period was like this. That's so hard. Your baby is dead, they take the corpse. It is a terrible thing to lie on that table and let them take the dead baby. That's a terrible thing on its own. That's what affects me worst. I get uneasy whenever I see that table now in the hospital, it reminds me of that day. I don't want to see that table when I go to a

masa var onu bile görür görmez bir tuhaf oluyorum, o gün geliyor aklıma. Tabii o masayı görür görmez hep o anlar aklıma geliyor ki hastanelere ya da sağlık ocağına gittiğimde öylesi masa görmek istemiyorum. Görürsem çok kötü oluyorum" (Mrs. E.)

hospital or a clinic. I get devastated when I see them." (Mrs. E.)

Only one man in the study talked about their partner's curettage operation. How male participants were affected with this curettage operation was not mentioned by any male participants. It seems that partners talked about the curettage operation, but women were the ones who disclosed their experiences. Similar to other themes, men did not talk about their experiences with their wives, i.e. what they experienced, thought, felt about the operation. We could have understood this from the lack of any expression related to men's experiences. The following quotation was just one of the sample quotations in which men talked about women's experiences. Neither the quotations that exemplified their experiences from their own words nor men's experiences from women's perspectives were given in any interview.

"*Ya o eşim aslında en çok hani böyle yani travmatik mi diyeyim bilmiyorum ama daha böyle ağır, daha böyle zorluk çektiği aslında o ameliyat ve sonrası. Çünkü öncelikle eşimin anlattığı kadarıyla hani nasıl olur da bir parçamın alındığı ve artık olmaması. O vücudumun bir uzvu gibi...Hani eşimin o hastanedeyken işte ameliyattayken yaşadıkları ve sonrasında aslında en o ameliyattan sonraki bir saat. O inanılmaz bir travmatik bir durum yani eşim açısından*" (Mr. G.)

"The most traumatic part for my wife was actually that operation and the period after that. Because, as far as my wife told me, that shock of having taken a part of one's body, that loss of one's own part…. That one hour after the operation was the worst for my wife. That was an incredibly traumatic experience for my wife." (Mr. G.)

4.2.5. Losing a Part of Oneself

Contrary to other losses people experience in their lives such as death of parents, friends, pets, colleagues; child loss means more than losing the relationship between the dead one. This loss also was the death of one part of herself/himself. A few participants (n=3) in this study talked about this very sentimental dimension of the loss.

"*Evet yani bir farklı oldu, nasıl söyleyeyim aileden hani babaannem ve işte anneannemi kaybettiğimde onun hani bir eksiklik hissediyorsunuz yani çok yakınınızdan gittiği zaman sizi derinden etkiliyor. Ama bu sanki sizden bir parça kopmuş gibi hissediyorsunuz*." (Mr. G.)

"Yes, it was different actually. How can I say, I felt the lack when I lost my grandmother, a loss from your close circle. But this is like losing a part of yourself." (Mr. G.)

4.2.6. Paying Attention to Other Pregnancies and Other Losses

After the loss occurred, some participants (n=7, 5 of them were women) paid attention to other pregnant women, or other pregnancy loss experiences. Women paid attention to both pregnant women and losses in their environment, while men paid more attention to losses. For some participants, realizing those losses was a sign that their loss was normal.

"*Bana da normal geldi. Dedim ki "Demek ki." dedim, "Var bir şeyler." dedim, yediklerimiz mi dokunuyor, hormonlu mu yiyoruz? Veya ne bileyim, bünyemiz mi hassas? "Benim gibi." dedim "Ne çok düşüren var." Benimle birlikte sadece on tane düşüren vardı benim hastanemde, düşün yani. "Demek ki." dedim, "Düşüyormuş çocuklar." Bana da normal geldi. "Olabiliyormuş demek ki." dedim. Demek ki "Bünyemiz sağlıklı falan değil." dedim. Annelerimiz gibi hani sağlıklı yaşamamışız biz. Yediklerimiz falan dokundu diye düşündüm ben. Hani hormonlu yiyecekler, hazır gıdalar, ben bunlara bağladım biraz*." (Mrs. E.)

"It seemed normal to me. I thought that there must be a reason, maybe the food we eat, is it the GMO foods? Or, I don't know, are we too weak? I realized that there were many women who had miscarriage. There were ten women in my hospital including me, you know? That looked normal to me. I thought that it could happen. I thought that we were unhealthy, we didn't live healthy lives as our mothers did. It seemed to be about the food we eat to me. You know, fast food, the GMO foods, I thought that was the reason." (Mrs. E.)

"*Wolksvagen Passat bir araba alırsınız, beyaz renktir. Aldıktan sonra "Ya bu mahallede ne kadar beyaz Passat varmış." dersiniz ya. Bu ona benzer.Yani o zaman fark edersiniz. Yani sende de böyle bir olayla karşılaştıktan sonra belki beş altı ay içerisinde yani sanki bütün çocuklar düşmüş gibi geldi bana. Ondan duyuyorum, ondan duyuyorum, ondan duyuyorum halbuki daha önce de duyuyorduk da*." (Mr. H.)

"You buy a white Volkswagen Passat, then you realized every white Passat in your neighborhood. It is like that. You realize then. After experiencing this, it seemed to be that everyone losing their babies in the next 5-6 months. I heard the same thing from everyone. But actually we were hearing this before as well." (Mr. H.)

4. 3. Theme 3: Factors Affecting the Grief Resolution

In this theme, factors identified from the data and explained by the participants that seem to affect the participants' grief resolution were presented. Based on the data from 20 participants, partner support, socio-cultural support, gestational age of the lost baby, having a subsequent child or prior child that born before the loss experience, having hope for future fertility, other stress factors in the life, having involuntary loss, coping with the loss, views

on the normalcy of grief after the pregnancy loss, and self-changes will be explained in detail and participants' quotations will be given as examples for the themes and sub-themes.

Table 9: Factors Affecting the Grief Resolution

THEME 3: FACTORS AFFECTING THE GRIEF RESOLUTION
•Partner Support •Gestational Age •Coping with the Loss •Having a Subsequent Child or Already Having a Child •Hope for Future Fertility •Other Stress Factors •Lack of Control •Views on Normalcy of Grief Process •Self-Changes

4.3.1. Partner Support

In this sub-theme partner support given or non-given by the partners to each other and how participants perceived this support was presented. Also, relationship issues and gender roles expressed by men and women during their grief process and their opinions regarding those roles were shared.

4. 3.1.1. Communication and Support between Partners

In order to learn about the support and communication between the partners, they were asked directly in the interviews. The interesting thing was all men answered this question from "their supportive role" perspective, meaning that they expressed that their wives were the ones who needed support and that is why, they gave the support to bereaved women. When looking at the frequencies of participants who expressed whether they got support or not, 8 of 10 participants (all of them were women) expressed that they got the necessary and sufficient support from their partners. 2 of 10 women expressed that they did not have the support from their husbands, but one of them said that these non-supportive behaviors lasted in the first times after the loss; her husband supported her afterwards. And remaining 10 male participants stated that they could have gave the support for their bereaved wives. Therefore, while women perceived themselves as "support-receiver", men perceived themselves as "support-giver" after their loss experience. Even if the loss was a

shared experience between men and women, men kept their supportive role during the grief process.

The support from the partner was so important that, for some participants this support was more precious than other people's support (i.e. friends, family members, mother or fathers etc.).

"*Asıl önemli olan eşinizin sizin yanınızda olup, sizinle vakit geçirmesi size destek olması. Yani diğerleri çok da demin söylediğim kadar kısmı yeterli oluyordu yani bence, bana göre... hani gerçekten eş, bunun tek ilacı eşler yani*" (Mrs. I.)	"The essential thing is your partner's being with you, spending time with you, his support. For others, the things I said before was enough to me. Really, the partner is the best solace for this." (Mrs. I.)
"*Başka bir önerim, birbirlerini kesinlikle desteklemeleri.*" (Mr. G.)	"My other advice for partners is absolutely to support each other." (Mr. G.)

When the expected support from the partner was not received, as the participants expressed, they might have felt lonely. Sometimes partners' divergence from each other led to withdrawal of emotions especially the positive ones, while the negative emotions were expressed behaviorally rather than verbally. These emotional barriers between partners may affect the relationship between them. This loneliness expressed by Mrs. B., and Mrs. J., specifically. Like other sub-themes in the study, this theme was only voiced by the women. Men in this study, as it seems, did not express any loneliness resulted from the lack of support from their partner. But it should be remembered that from their perspectives, women were the ones who needed support, not them. That may be the reason that they did not need support, so they did not evaluate the lack of support from their partner as a reason to feel lonely.

"*Yani ikimiz de üzüntüden herhalde biraz böyle negatifleştik. İlk birkaç gün, birkaç hafta falan bayağı kötüydük yani ikimiz de. Birbirimize karşı da kötüydük, kendi içimizde de kötüydük. Ondan sonra eşim baktı ben daha kötüyüm herhalde, hani o biraz kendini toparladı artık. Yani o bana sonradan destek olmaya başladı hani rahatlatmaya başladı beni. Konuşarak falan. Başlarda kötüydük yani destek olamadık maalesef.*" (Mrs. B.)	"We were both very negative, perhaps because of sadness. We were very aggressive in the first couple of days or weeks, both to each other and in ourselves. Then my husband realized that I was perhaps worse than him. He recovered himself. I mean, he began supporting me later on, he began comforting me., by talking etc. At first things were bad, we couldn't support unfortunately." (Mrs. B.)

Only a few participants (Mrs. I. and Mrs. G.) talked about the importance of physical contact as a kind of support given by their partners.

"*Ya şeyi hatırlıyorum mesela doktor ilk söylediği zaman eşim hemen elimi tutmuştu filan.*" (Mrs. I).

"I remember, for example, that my husband held my hand instantly when the doctor first told me." (Mrs. I.)

Sometimes, rather than the psychological or physical support given by the partner, partner's not-accusation of the woman may be perceived as a kind of support. Women were likely to accuse themselves with the loss, so how their husbands approached the women's self-accusations could be a supportive or unsupportive attitude for the women. This code was also expressed by some men, but similarly to women they expressed that they did not accuse the women with the consequence of the pregnancy and according to them, this was a kind of support they showed to their wives.

"*[Eşimin] Destek olduğunu düşünüyorum. Yani öyle hani kimisi der işte ondan sonra hani "Niye olmadın? Bir bebeğe sahip çıkamadın. Bir çocuğa sahip çıkamadın." Hani "Niye böyle yaptın da düşürdün?" Normalde Allah'tan gelen bir şey. Ya eşim de bana hep böyle destek oldu. Hep bu açıdan destek oldu yani. Ya onun için eşinin böyle birbirine destek olması lazım. Eğer destek olmazsa tek başına atlatılamaz yani. Yani bu süreçler atlatılamaz. Ona destek olmak lazım. Öyle düşünüyorum*." (Mrs. D.)

"I think my husband is supportive. You know, some men blames the woman saying 'you couldn't keep a baby, what did you do to miscarry it' etc. It is in fact God's wish. My husband supported me in this. It is important for partners to support each other. It is impossible to overcome this without support. These periods require support. That's what I think." (Mrs. D.)

"*Yani ki bu burada eşimin şeyini yadırgayamam (yadsıyamam) yani o da hani mesela şimdi ben istiyorum, düşüyor, üzülüyorum. Ama bir de karşı tarafta mesela hani eş tarafından yani "Bir çocuk doğurmayı beceremedin. Sana hareket etme demedim mi?" Böyle bir tepkiler gelse o zaman insan ruhsal olarak çok daha fazla çöker. Ama sağ olsun eşim hiçbir zaman öyle bir tepkide bulunmadı. Hep destek oldu. Hiç bunu dile getirmedi yani. Böyle şeyleri dile hiç getirmedi. Onun için, onun için daha çabuk atlattığımı düşünüyorum*." (Mrs. F.)

"I can't deny my husband's support in this. I want the baby, I lose it, I get upset. But when you look at the husband's perspective, if he says 'you couldn't make it, didn't I tell you not to move?' or things like that, then one gets more devastated psychologically. But fortunately he never reacted that way. He always supported me and never mentioned these things. I think that's why I have overcame sooner." (Mrs. F.)

"*Ama o bana bu konularda hep olumlu yaklaşmıştır. E ben de elimden geldiğince ona olumlu yaklaşmışımdır. Şey değilimdir yani işte baskı kurmam yani. "İlla bizim de bir çocuğumuz olsun, sen işte şöyle yaptın, böyle oldu." hiç dememişimdir*." (Mr. F.)

"But she always acted positively about these things. I am also acting positively as much as I can. I am not pressuring her. I never said 'we have to have a child' or 'it is your fault we lost it' etc. (Mr. F.)

Especially almost all men withhold their emotions, thus they did not reflect their emotions to their partners. From outside, their emotions could be understood and named but within their relationship, except a few couples (i.e. G. H. and I.), partners were not aware of each other's feelings. According to men, their behavior was for the protection of their wives, in order not to upset the women, they looked at the events more rationally. Protection and supporting women was a source for coping from men's point of view. Men, who withhold their emotion to protect their wives were also cautious about the consequences of their actions. From their point of view, reasons behind their not-focusing on the details of the pregnancy loss too much and acting more rationally were to support women.

"*Ben olaylara biraz daha şey bakarım, bu konularda özellikle böyle konularda çok soğuk kanlıyımdır. Hani ne bileyim, biri ölür işte bir kaza olur işte böyle kötü olaylarda genelde soğukkanlıyımdır yani böyle duygusal tepkileri kolay kolay vermem. Artık ne zaman veririz? Yaşlanınca mı veririz onu da bilmiyorum ama. E tabii haliyle eşim benden daha duygusal olduğu için ben genelde onu daha motive ediyorum... çünkü bu konu ne kadar çok uzatılırsa özellikle yine dediğim gibi toplumdan mütevellit bayanların daha çok üzüldüğünü düşündüğümden ötürü bu konunun çok uzatılmaması gerektiğini, yani "Olan olmuş, kısmet değilmiş." dedik. Kapatılması gerektiğini düşündük*." (Mr. F.)

"I am very cold-blooded about these things. I can't easily react emotionally when someone dies, or in case of an accident etc. When do people react more easily? At old age? I don't know. As my wife is naturally more emotional than me, I motivate her usually. Because I think this issue should not be prolonged as women get more depressed due to the social pressure. We said 'what's gone is gone, nothing to do'. We thought it was better to drop the subject." (Mr. F.)

"*Valla ben hanım üzülmesin diye biraz daha içime kapanık davranışlar, aslında içine kapanmak iyi değildir belki ama daha böyle at gözlüğüyle gittim olayların kenarından, sağından, solundan geçtim*." (Mr. J.)

"I got more reserved, being reserved is not good for you perhaps but I closed my perception and passed through the sideways of the events in order not to hurt my wife more." (Mr. J.)

In Turkish families, importance of the spouse's family could not be denied. The relationships with the mother-in-laws and father-in-laws or with the husband's sisters have been always given importance. If there is a relational problems with these people, somehow this affects the relationship between spouses. Therefore, while talking about pregnancy, pregnancy loss experiences, child expectations, it would be surprising if there was no subject opened up by the participants related to spouse's family. Mrs. D., Mrs. F., Mrs. G. talked about their problems with their mother-in-laws regarding their loss and how their partners reacted to conflicts with the mother-in-laws. In the following example, Mrs. F. talked about

her feeling pleased with her husband's protection of her from the critics of his family. How men reacted to their families regarding the pregnancy loss was important for these three women.

"*Ama işte mesela şu çok hoşuma gitmişti, ablası arıyor, işte bir yer bebek konusu açılınca benim suratım düşmüş güya. İşte "Niye?" gibi bir şeyler sordu. O da ablasına tepki veriyor. "Bir daha bu kıza çocukla ilgili kimse bir şey söylemeyecek. Herkesi uyar, bir daha bu kıza çocukla ilgili kimse ağzını açıp bir şey söylemeyecek." diyor. Bu benim hoşuma gitti*." (Mrs. F.)

"But something my husband did had really pleased me. His sister called one day, asking him why I dropped my face when someone brought the subject up. Then he reacted to her sister saying 'From now on, no one will say anything about the subject to her. Warn everyone, no one will ever say anything related to children to her.' It really pleased me." (Mrs. F.)

One interesting conversation was done with Mr. A. He pointed out something important that was also mentioned in the literature. He mentioned that he could gave support to his wife after their pregnancy loss experience by staying calm. However, as he mentioned that, he could not have stayed calm or rational as he did in this pregnancy loss, in a loss that occurred after a longer pregnancy period or in a loss that they would lose their child. Mr. B. also talked about similar things. He stated that as a father it was at a later time to get the father role and feel oneself as a father, because he thought that the baby was living in the body of women, they could feel the baby so they were more ready for their mother role and they had higher levels of emotions and emotional investments for the baby. Therefore, the men's support to their partners might be affected not only from relational factors but also from their psychological well-being that have been affected by the gestational age.

"*Bizim hani kendi adıma söyleyeyim ben soğukkanlı kalması gereken taraf olduğum için daha çok destek şeyinde hani bağ kurma olayında Melike'ye nazaran daha geride kaldığım için orada; ama şu an baktığımızda mesela ikinci çocuğumuzda Melike'den daha az bağım var, daha az tepki gösteririm şeklinde bir şey diyemem. Hani öyle bir durum Allah göstermesin olsa bilemiyorum yani nasıl bir tepki veririm, eşime destek olabilir miyim, o bana destek olabilir mi, hani çok büyük bir kopukluk olur*." (Mr. A.)

"To be honest, I am the one who needs to be calm and supportive because I am behind Melike in bonding with the baby. But I cannot say the same thing for our second child, I can't say that I have a weaker bond with the child than Melike. God forbid, I don't know how I would react if something happened, if I could support my wife, if she could support me, but I know that a huge break would happen." (Mr. A.)

"*Ben normalde duygusal bir insanım ama çocuğumu kaybetmiş olarak tam algılayamadım yani. Baba olarak bilmiyorum her baba aynısını mı yapıyor,*

"I am an emotional person normally but I couldn't perceive the loss as losing a child. I don't know if every father feels the same but I think you can't feel too strong until

onu bilmiyorum ama hani doğana kadar aşırı bir hissiyat olmuyor veya [annenin] karnı çok büyüyene kadar bir şeyi hissiyat olmadığını düşünüyorum ben, çocuğum doğana kadar [subsequent child] onu hissettim. Daha çok eşimin endişeleri, üzüntüleri işte onları teselli etmeye uğraştım yani." (Mr. B.)

the birth, or until the tummy gets real big. I felt like this until my [subsequent] child was born. I was more interested in comforting the worries of my wife." (Mr.B.)

In a few couples (Couple J., couple B., couple C.), the discrepancy between what was told between partners was very clear. Because of the lack of communication between the partners, they did not know each other's emotions and thoughts regarding the loss or their partner. Or the couples mentioned (B.,C. and J.) did not know exactly how their partners handled with the loss, since there was not open communication between them.

"*Valla ben hanım üzülmesin diye biraz daha içime kapanık davranışlar, aslında içine kapanmak iyi değildir belki ama daha böyle at gözlüğüyle gittim olayların kenarından, sağından, solundan geçtim… Çok fazla konuşmuyorum çünkü acı tazeliyor. Tazeleyecek bir şeyi de uzak tutmaya çalışıyorum. Yani bu benim fikrim ama yani psikolojik olarak doğru bir yaklaşım mıdır? Eğri bir yaklaşım mıdır? Onun üzerinde çok fazla kafa yormadım açıkçası. Böyle düşündüm yani "Boş ver ya." falan deyip, öteleyerek yani başka konulara geçip. Çünkü o ağlayacak, sızlayacak. Biliyorum yani. Ama geri gelmiyor giden. Başka bir nedeni yok yani, tamamen yine destek olmak amaçlı ama belki psikolojik olarak negatif etki yaratıyordur, belki pozitif etki yaratıyordur, bilmiyorum o konuda*." (Mr. J.)

"I got more reserved, being reserved is not good for you perhaps but I closed my perception and passed through the sideways of the events in order not to hurt my wife more. I don't talk much, because it freshens up the pain. I try to keep away everything that can freshen this up. It is my opinion but is it a correct attitude psychologically? Or a wrong attitude? I didn't think much on it, to be honest. I tried to change subject, I said 'let it go'. Because I knew she was going to cry a lot, I know this. But those passed away do not come back. There is no other reason, my sole aim is to support her but maybe it affects her negatively, or positively. I don't know about it, but this is my approach." (Mr. J.)

"*Sonra ikinci de eş, aile çok önemli. Eş, çocuk onlar çok önemli. Hani buna dikkat etsinler. Konuşsunlar. Hani aileyle de eşle konuşsunlar yani. Çünkü konuşulmadan atlatılmıyor. İçine kapandığın zaman sadece kendine ait işlerine odaklanıyorsun. Çünkü içinde bastırıyorsun o duyguları. Bir yerden sonra o patlak veriyor zaten patlıyor ama yine ağlayarak patlatıyorsun ama yine bir faydası olmuyor. Ama eşinle paylaştığın zaman daha farklı oluyor. Hani bana sorarsan hani eşim keşke hani ben açtığım*

"The family, the partner is very important. They should talk to each other. They should speak to the family, to the spouse. Because you can't get over it without speaking. If you withdraw into yourself, you just focus about your own things. You repress those feelings. At some point it bursts out, you burst into tears, but it still doesn't help. But it is different when you share your feelings with your spouse. If you ask me, I really wish my husband would talk respectfully to me when I

zaman konuyu hani şöyle olsa, merak etme, hani bana saygılı sözler konuşsaydı. Ki onu sorsan hani "Ben yapıyorum." der ama bana demek ki yeterli gelmiyor. İşte öyle." (Mrs. J.)

brought the subject up. He would say he did it if you ask him. But obviously it was not enough for me." (Mrs. J.)

On the other hand, there were couples whose grief process might be defined as shared since both partners were aware of his/her spouse's emotions, thoughts related to loss; they shared more time together.

"*Ya tabii ki o beni etkilendiğimi görünce daha çok destek oldu. Daha çok birlikte zaman geçirir olduk. Destek oldu yani, "Üzülmeyelim." diye. Daha çok bağlandı. İyi geçti yani günlerimiz. Öyle çok zor geçirmedim o süreci. Daha iyi geçirdim*." (Mrs. E.)

"Of course when he saw how affected I was, he got more supportive. We began spending more time together. He tried to heal our sadness. Wr bonded stronger. Our days were good. I overcame the period more easily." (Mrs. E.)

"*Birbirimizi teselli ettik tabii ki. Üzüldük sonuçta. Beraber üzüldük. Ne bileyim. O bizim öfkemizi, o benim öfkemi yendi, ben onun öfkesini yendim. Birbirimize teselli olduk tabii ki. Ha olduğumuz yerde bizi tabii ki tatmin etmedi ama içimiz kan ağladı illa ki*." (Mr. D).

"We certainly comforted each other. After all it upset us both. I don't know, we calmed each other's anger. We consolidated each other. But of course it didn't satisfy us, we had still too much pain." (Mr. D.)

When I asked the participants about their feelings after the interview, how they felt after talking about their loss; some of them expressed that talking about the loss was good for them, even they realized that they should have talked with their spouses, too. Below, Mr. C. talked about his understanding of the importance of talking about their pregnancy loss experience after participating in this study. His wife, Mrs. C. also mentioned about their lack of talk, sharing of their emotions after the loss. She also mentioned how her husband might have misunderstood her actions because of the communication barrier between them.

"*Ama biraz düşünürsem, belki evet yani paylaşmak. Şimdi biz çok üzerinde konuşmadık. Paylaşmak bunun iyi bir yöntemi olurdu. Yani şu anda belki bu seninle yaptığımız konuşma bile beni biraz rahatlattığını hissediyorum. Demek ki bunu yapmak daha şeydi. Yani şöyle, hani dedim ya hayallerimden bahsettim, o hayalleri birilerine anlatmak gerçekten güzel olduğunu hissettim şu anda açıkçası...Bundan dolayı bu şeyde hani bu konuşulması bu şeylerin üzerinde iyi*

"When I think about it, yes, perhaps, to share… We never talked much on it. Sharing could be a good way to cope with it. Even this talk with you made me feel better. It means that to share could be better. I mean, you know I told about my dreams a moment ago, I feel that telling about those dreams is really a good thing. That's why I think it could have been better if we had talked about it. We should have done this I think." (Mr. C.)

olabilirdi. Bunları yapmamız gerekirdi diye düşünüyorum" (Mr. C.)

"*Mesela bazen eşimle konuşurken o şey diyor, bazen yani sonrasında yine bunlar tabii açılıyor, başka bir şeyden konuşurken de açılıyor. O benim belki de çok üzülmediğimi mi düşünüyor bilmiyorum. Çünkü ben hani insan içinde, yanında çok ağlamam ya da çok belli etmem. O yüzden de daha hafif geçirdiğimi düşünüyor bana göre, bana kalırsa*." (Mrs. C.)

"These subjects are brought up afterwards, even when we talk about something else. I don't know but perhaps he thinks that it doesn't make me so sad. Because I don't cry or express myself in front of people. I think he is thinking that I get over it easily." (Mrs. C.)

Even if participants were talking more about their pregnancy loss experience, their devoted time for sharing was getting less both because of the time passed by as well as having a subsequent child. All partners who had a subsequent child (couple A., E., G., and Ö.) talked about this lessening of conversation about the lost baby in the home after the birth of the subsequent child. This sub-theme was expressed by both men and women.

"*E tabii şu an sonuçta Deniz faktörü var. Deniz geldikten sonra bu hususta konuşulmayan konular şeyine çünkü bu tamamen seni kaplıyor. Acı da olsa bir yaşanmışlık var orada. Hani konuşsan da çok fazla derine inip de hani şeyini konuşmuyorsun. Hani böyle oldu, şey oldu, çok fazla konuştuğumuzu söyleyemem*." (Mr. A.)

"Now, there is Deniz. The things that were gone untold on this subject remain untold because it covers all of you. There is something lived there, though it is painful. Even when you talk, you don't go deep enough. I can't say we talk much about it." (Mr. A.)

In addition to talking about the event, sharing emotions with each other, there were other ways partners supported each other. Especially they supported each other by spending more time together, visiting new places together, or making different activities. In this sample of participants, all activities done together were planned by the men. Maybe this supports the statements above, men saw their role as supportive to their partners. For instance, buying flowers for his wife, making small jests were some signs that the men showed their support to women.

"*Eşim. her şekilde yani çok iyi destek oldu. Hem o süreçte, öğrendiğimiz anda hem sonrasında. Hatta ondan sonrasında böyle hani hastaneden bana izin verdiler on gün hani biraz şey yap dinlen gel diye. Mr. A. da izin aldı o dönem, yıllık izninden. Beraber işte Çanakkale'ye falan götürdü beni kafamız dağılsın diye. Öyle her akşam*

"My husband supported me in every way. Both when we first learned it, and afterwards. When they gave me some days off from the hospital to recover, Mr. A. also got days off from his work. We went to Çanakkale together, to distract ourselves. We used to go out every night to wander around. He was always with him. We

çıkıyorduk dışarı geziyorduk geziyorduk geziyorduk geliyorduk falan. Sağ olsun yani o konuda hiç şey yapmadı yani hep yanımdaydı. Gayet iyi geçti yani." (Mrs. A.)

passed through it easily." (Mrs. A.)

"*Yani o beni çok motive etmeye çalıştı ben gece böyle bazen ağlayıp hani sıçrayarak uyandığım çok oldu benim. Okulda bile olsa teneffüste beni kontrol etmeye geliyordu, yani ne bileyim insanın eşinin bir kere hani böyle sarılarak onun o sıcaklığını hissetmeniz yetiyor zaten. Böyle sarılarak yanımda saatlerce durduğunu bile bilirim mesela kendimi iyi hissetmediğim zamanlarda arayıp bir dersliğine bile olsa yerine başka öğretmeni koyup hani yanımdan ayrılmadığını bile biliyorum hani. Hani eşim elinden geldiği her, ne geliyorsa benim için yapmaya çalışmıştır hani hiç ummadığınız zamanlarda bir yere götürmek istemiştir kafam dağılsın diye. Ya da hiç ummadığım zamanlarda ne bileyim bir çiçek bile yaptırıp getirmiştir ya da böyle mutfağa girip bir meyve tabağı hazırlayıp getirmiştir işte benim için çay kahve demleyip getirmiştir. Yani böyle hani zamanımı dolu geçirmem için elinden geleni yapıyordu.*" (Mrs. G.)

"He tried to motivate me. I used to wake up crying at nights. He used to come check me even if he was in the school. I don't know, I think even a warm hug from your partner is enough. He used to stay with me hugging for hours without going anywhere. He even arranged another teacher for his class to be with me when I was not okay. He did everything he could for me. He took me to places in unexpected times to distract me. Or brought me flowers when I least expected it. He prepared fruit plates in the kitchen or brought me tea/coffee. I mean he tried to do anything he could to keep me occupied." (Mrs. G.)

4. 3.1.2. Men vs. Women's Gender Roles

Gender roles expressed by most of the participants (n=16) that affected the grief process were explained in this sub-theme. How they perceived gender roles was important in their grief process and this influenced how they reacted to their spouse's needs. In addition, participants' perspectives and evaluations regarding those roles were presented.

All male participants (n=10) and some of the female (n=6) participants talked about the gender roles. Specifically, they mentioned the differences between men and women (i.e. women are more emotional, women and men differ in their grieving styles, they have different support systems), between being a mother and a father during their grief. For instance, there was a shared belief among all participants that motherhood starts earlier than fatherhood and that was the reason that women were affected more negatively with the pregnancy loss than men. They also talked about the need for men to stay calmer compared to women in order to keep the family balance after a negative life experience, as loss after the pregnancy.

How men and women perceived their gender roles affected the other partner's motivation for asking for support. For instance, when man was reluctant to talk about the loss, the woman was likely to withdraw herself and experience the grief on her own even if the loss was a shared one.

"*Ya tabii o kadar paylaştık yani, ya baş etti, kendi kendine. Ağladığını düşünüyorum. İçinden ağladığını düşünüyorum. Yani ilk zamanlar. Ama orada analık psikolojisi ya, normal bir şey. Çünkü ben ilk çocuğumdan biliyorum, babalık sonradan kazanılan bir şey. Analık hep o içinde olan bir şey. Babalık sonra sonra gelişiyor. Yani ilk gün doğuyor ya çocuk, eline alıyorsun aslında baba falan değilsin o anda. O hikâye onlar. Sadece seviliyor. Duygu gelişimleri zamanla oluşuyor... Babalık sonra kendi halinde gelişiyor. Hani çekirdeksiz bir şey. Hazır fidan olarak alıyorsunuz. Analık tohum olarak gelişiyor. O toprağı çapalama, fidanı atma, su dökme, güneşi görme, yok yani oksijen falan yok. Babalık hazır fidan. Toprak üzerinde, hazır paket halinde geliyor, size veriliyor. Ama analık öyle bir şey değil. Analık boz bir tarla. Yani fidanı da o, pardon çekirdeği de o, güneşi de oksijeni de o, suyu da o. Toprağı da o*." (Mr. J.)

"Of course, we shared to a certain extent. I think she could cope with it on her own. I think she cried inside. I mean at the beginning. But that's motherhood psychology, that's normal. I knew from my first child that fatherhood is something that comes later on. Motherhood is developed inside but fatherhood comes afterwards. When you hold your newborn infant, you are not a father yet. It is fiction. You just love the baby but the emotions develop later. Fatherhood comes later by its own. It is something that lacks a core. You take it as a young tree. Motherhood however developed from the seed. Toiling the soil, seeding, watering, sunlight, and oxygen, none of it…. Fatherhood is ready made tree. It comes to you as a ready package on the surface of the soil. But motherhood is something else. Motherhood is a field. It is both the core and the sun and the oxygen and the water. It is the soil." (Mr. J.)

"*Hani bir taraftan da şey yapman gerekiyor hani eşimin o anki ruh hali durumu şeyinde birimizin daha metanetli olması gerekiyor ve ya erkek olarak hani senin o görevi yerine getirmen gerekiyor. Hani duygunu, hissiyatını, şeyini minimumda yaşaman gerekiyor ki bir şekilde yanındaki eşine destek olabilmen için yani orada birimiz zaten tamamen yıkılmış ikimiz birden yıkıldığı zaman orada çünkü yok etrafında kimse ikinizsin, baş başasın hani gidip kimseye nu söyleyebilme, paylaşabilme çünkü daha kendini inandıramıyorsun…Ya orada hani destek olunacak kişi ben değil eşimdi. Hani sonuçta çocukla ilk duygusal bağı kuran, o varlığı hisseden, onunla hani yaklaşım kuran kişi eşimdi. Çünkü hani hep söylerler ya babalık doğumdan sonra başlıyor. Annelik hani hamilelik sürecinde başlıyor.*" (Mr. A.)

"On the other hand, you need to stay calm in that state of my wife, one of us needs to be calmer, stronger and as a man you need to fulfill that mission. You have to live your emotions at the minimum in order to support your wife there. Because one of us is already destroyed, what would happen if the other also gives in. because there is no one else, we are on our own, and you cannot share this with anyone else because you don't believe it yourself yet. The person who needed support there was not me, it was my wife. Because the one who first bonded with the baby, the one who felt the existence of it was my wife. As they always say, fatherhood begins after the birth, motherhood begins with the pregnancy." (Mr. A.)

Once Mrs. G. realized that, her husband was crying but still he tried to seem calmer. She thinks that his behavior was related to gender roles.

"*Aslında erkekler biraz daha yani genelde erkeklerin genel halidir hani onlar çok fazla paylaşmadan, hani içlerinde yaşıyorlar. Ben sadece hani onun bazen böyle bazen onu böyle ağlarken görüyordum. O dönemde, çok yakın hani zamanda. O dönemde onu ağlarken görüyordum. Sonrasında mesela diyorum ya ben üzülmeyeyim diye o bunun muhabbetini hiç etmedi*." (Mrs. G.)

"Actually, men are like that, they go through it without sharing their emotions. I just saw him crying sometimes in that period, right after it. Then he never mentioned it not to upset me." (Mrs. G.)

Sometimes women were the ones who demanded more attention and support. In these kinds of situations, men were willing to support women. So, the reason behind the women's getting more support from their spouses and their social environment may result from their gender roles, too, from the ideas that " women need more support, since the men are more powerful, or women are more emotional" and so on.

"*Valla eşimin aslında kendi bir anne olarak daha çok yüzde yüz kendine destek istedi. İşte biz de elimden geldiğince ona destek olmaya çalıştım*." (Mr. B.)

"My wife demanded hundred percent support as a mother. So I tried my best to support her." (Mr. B.)

One of the male participants talked directly about how social perceptions affected men's grief after pregnancy loss, even if they were affected by this loss, they were subjected to belief that they should not show their grief. His acceptance of the gender roles shows might show they were emotionally affected by the loss even if they did not give an emotional hint to their environment or did not talk about the loss as their spouses did.

"*Ya dediğim gibi aslında biraz hani bu tür durumlarda hani siz de bilirsiniz belki, şöyle söyleyeyim, anne daha çok etkileniyor. Aslında baba da etkilenir ama toplumda böyle bir algı var aslında. Anne daha çok etkilenir, biraz baba duygularını daha çok bastırır ya da duygularına daha fazla hakim olur diye. Ha eşim yani tabii kendisi de o durumu birebir yaşadığı için onun daha fazla aslında desteğe ihtiyacı vardı*." (Mr. G.)

"As I said, perhaps you know this too, in these situations mothers are more affected. In fact, fathers are also affected, but there is such a perception in the society that mother is more affected, father represses his emotions more. But as my wife experienced the loss first hand, she need more support." (Mr. G.)

Participants also expressed their opinions regarding how societal gender roles give extra burden to women after the loss experience or pregnancy issues in general. As the following quotations show that women were subject to criticisms and questions of their environment that sometimes implied that women did something wrong and the baby was lost. Even when they do not have a problem with the reproductive issues, the women's reproductive capacities are generally under the scrutiny. These societal pressures for women could have been observed in couple E., F., and G.

"*Çünkü bu konularda özellikle Türkiye Cumhuriyeti'nde, toplumumuzda kadınlarda bir baskı oluyor...Çünkü eğer bir sorun yoksa, yani bu çevreden dolayı, "Acaba kadında sıkıntı mı var?" Hiç kimse erkeğe toz kondurmaz. O da yanlış bir durum. Toplum açısından ama durum bu. Yani benim çevremde bana o konuda çok şey yapan yok. Ha bazen söylüyorlar, e haliyle eşler görüştüğü için, eşler vasıtasıyla işte bir dolaylı yoldan söylemeler oluyor ama öyle benim benim üstümde pek bir baskı yok yani. Durum bu.*" (Mr. F.)

“Because there is a pressure on women especially in our society in Turkey. If there is a problem, they ask whether the problem is in the woman. No one blames men. That’s not right. But that’s how our society is. There is no one from my circle who does that to me. They tell sometimes, as our partners see each other, they know through their wives and they imply this to me. But I don’t feel any pressure on me to be honest. That’s how it is.” (Mr. F.)

"*Bir tek o an hani ben kürtajdan yeni çıkmışım ve yataktayım, o an hani kayın validem arayıp güya "Geçmiş olsun" ben demesini beklerken bana hani "Ne yaptın da bebe düştü?" gibisinden bir tepki vermesi mesela o an beni çok üzdü. Hani sanki o bebeği ben düşürmek istedim de düştü gibi. Hani "Bir şey, kesin bir şey yapmışsındır ki." diyor, yani "Düşük yapmışsın." diyor, yoksa hani "Nasıl kendi kendine düştü?" diyor. Hani mesela ben o an onun için çok ağlamıştım. Yani inanın bebeğimi kaybetmenin yanında hani kayın validemin bu cümlesi beni o gün hem de çok çok üzmüştü yani acayip derecede üzülüp ağlamıştım ben o gün bu söz için*." (Mrs. G.)

“Only the moment after the operation when I was still in bed, my mother-in-law called. I was expecting that she would say something like “get well soon” or something. But she said ‘what did you do so that the baby is gone?’. That upset me so much. As if I wanted to get rid of the baby. She said ‘you certainly did something or how it happened on its own’. I cried so much at the moment. Besides losing my baby, the things my mother-in-law said upset me very very much that day. I cried so much for this remark that day.” (Mrs. G.)

In addition to gender roles regarding how much emotional expression was preferred, men and women in the study also expressed that men and women were also different in terms of the communication styles that were affected by the gender roles. It was mentioned that women were more likely to talk about their inner experiences with their female friends, while in men’s friendships these issues did not have such an importance. Even if men talked

with their friends, the issues were more practical ones such as to which hospital they should go, who is the best doctor in those kinds of issues and so on.

"*Şimdi erkek olmamızdan dolayı şöyle bir şey de olabiliyor, erkekler birbirleriyle bu gibi durumları pek paylaşmazlar. Yani iki veya üç kişi*." (Mr. H)	"There is also the impact of being a man. Men do not share these things with each other. I mean, two or three people." (Mr. H.)
"*Benimle alakalı yani bana özellikle benim için gelen yok. Tabii insanlar soruyor ama, tabii erkekler arasında bu konular çok fazla konuşulmaz*." (Mr. F.)	"They don't come especially for me. Of course people ask but these issues are not shared among men." (Mr. F.)

Mr. A. also made comments on the lived experiences with his wife. According to him, women had more emotional up-and-downs and women were more likely to ruminate over events, so they were more likely to open up old issues when they were overwhelmed.

"*Biz erkeklerde o duygusal açlık şeyi çok o kadar dibe vurmadığı için daha kolay toparlanabiliyor ama kadınlarda hani kadınsal yapı olarak o tarz travmatik yaşanan şeylerde kayıplarda duygusal çöküşler çok fazla oluyor. Ve bu duygusal çöküşler hani belli bir dönem içerisinde kalmıyor, yıllara yayılabiliyor. Aradan üç yıl geçmiş, beş yıl geçmiş, birdenbire aklına gelip bir anda hani "Sen şöyle yapmadın, bana şöyle davranabilirdin."...Erkeklerde bu şey olmuyor, hani geriye dönük patlamalar, şeyler ama kadınlarda hani yıllar sonra da o anda bir şeyi hatırlayıp o anki duygu şeyini bugünkü şartlarla düşünüp duygusal travmalar çıkabiliyor*." (Mr. A.)	"We as men can get over it more easily as we don't have that emotional hunger. But that emotional breakdown happens more frequently in women in such traumatic losses due to their female nature. And these breakdowns do not always happen in a certain period, it may expand to the years. Three years has passed, five years has passed, she still can burst out saying 'you didn't do this, you could have done that.' This doesn't happen to men., these retrospective explosions. But women can remember something years later and relive its trauma all over again." (Mr. A.)

4.3.2. Gestational Age

In the literature, it was examined whether the gestational age that the pregnancy ended has an impact the outcome of the loss, or grief process of the bereaved parents. The interview protocol of this study did not have a direct question examining the gestational age, but almost every participant mentioned about the gestational age and its relations to its results in their lives.

4.3.2.1. Religious Ceremonies Based on Gestational Age

Participants linked the gestational age and its relation to religious ceremonies conducted for the baby. A few participants (i.e. couple D., E., J.) stated that the legal issues regarding the pregnancy losses did not let them make a religious ceremony for the baby since they could not have got the remainings of the baby. Or for some participants, the period of pregnancy's ending was not suitable for a religious ceremony based on their own beliefs and what they read on the religious resources.

As understood from the expressions of participants, there was a confusion in all participants regarding the proper time for burying, or dıing religious ceremonies for the baby. Because they did not find the information in the hospitals or because when they asked the religious officials, they could not have standard information, they acted based on their own beliefs. Each individual in the study made comments regarding the confusion in the society when is the proper time to bury for whom.

In the only stillbirth case (couple H.), the baby was buried because in Turkey, babies who weigh over than 500gr. were allowed for burial.

"*Hani biz de o anda belki aklımıza gelmedi. O an yapılabilir miydi, hani sonuçta şey daha şey olarak hani beden olarak oluşmadığı ve gelişmediği için bizim de o hususta bir talebimiz olmadı. Hastaneden de böyle bir teklif gelmedi... Patolojik incelemeden sonra da zaten bize herhangi bir şekilde cenini alabilirsiniz gibi bir süreç olmadığı için biz de çok peşine düşmedik*." (Mr. A.)

"It didn't occur to us. We didn't know if we could have taken it, as it had not formed bodily yet, we didn't demand it. The hospital didn't offer it also. They didn't say we could take it after the pathological examinations, so we didn't pursue it." (Mr. A.)

"*Ama hastane görevlileri yani "Et parçası olduğu için." dediler, "Çocuk tam gelişmediği için." zaten bize vermediler çocuğu patolojiden sonra. Ben istedim bizzat. Hatta hocayla da falan görüştüm. İşte herhangi bir cenaze gömme, toprağa gömme falan filan sizin dediğiniz gibi "Öyle bir şey yapacak mıyız hocam?" diye, "Gerek yok." dediler. Hastanede et parçası olduğu için o zaten onu kesmişler patolojide. Çocuğu test etmişler. Onun için "Gerek yok." dediler. Yani "Veremeyiz." dediler derken öyle kaldı*." (Mr. D.)

"But the hospital staff told us that it was only a piece of flesh that it had not developed fully. That's why they didn't give it to us after the pathological exams. I wanted it, I even talked to the hodja, I asked him if we would do burial, funeral etc. He said, 'no need'. In the hospital they already had cut it in the pathology, to examine. That's why they said they couldn't give it." (Mr. D.)

In the literature, even if there is a controversy over whether touching or seeing the baby was harmful or not, there were studies that supported seeing, touching, holding the baby were related to less psychiatric symptom, to less chance for complicated grief, (Forrest, Standish, Baum, 1982; Kirkley-Best & Kellner, 1982). In this sample, almost all participants expressed that they would not prefer to see or touch the baby. For instance, Mrs. D. and Mrs. J. who saw the fetus were not comfortable with talking about how it looked like and contrary to studies in the literature, for them not-seeing was healthier, as they said.

"*Çok kötü [bebeği görmek]. Oraya dönüyorsun yine. Hani doğum ettiğin zaman, onun kavanozla, gözünün önünde kavanozun içine dolduruyorlar ya. Hani eli kolu olmuşmuş, ağzı burnu oluşmuş bir de gözünün önünde onu koydukları zaman onu hatırlıyorsun zaten. Konuştuğun zaman direkman onu hatırlıyorsun. Mesela televizyonda birisini gördüğün zaman onu hatırlıyorsun*" (Mrs. J.)	"It is awful [to see the baby]. You turn back to that moment, when they take it and fill in a jar in front of your eyes. You know, it has developed hand and arms, mouth and nose. You remember that moment when they put it in front of your eyes. You remember that when you talk about it, or even see something like that on TV." (Mrs. J.)
"*Ya sonuçta elimize almadık, tabii hani hissediyorsunuz vs. ama, elimize almadık, dokunmadık. Hani bir yere koyup onu maddeleştirmek daha sonrası için daha yaralayıcı olabilirdi yani*." (Mr. I.)	"After all we never hold it in our hands. Of course, you feel it, but we didn't hold it, didn't touch it. To materialize it by putting it somewhere would be much more hurting later." (Mr. I.)

4.3.2.2. Seeing the Baby in Ultrasound

Ultrasound during the weekly or monthly visits might have affected the attachment developed between baby and parents. As our participants (n=3) exemplified below, seeing the organs of the baby showed them it was a real baby. Hearing the heartbeats even once might have affected their attachment to baby.

"*Şöyle, onu da şöyle çok sahiplendik açıkçası. istesem kol ve bacak tomurcukları çıkmıştı yani hani böyle şeyleri uzuvları yavaş yavaş ortaya çıkmaya başlamıştı. Çok hani böyle fasulye gibi bir şey değildi yani. onları görmüştük*." (Mrs. I.)	"We developed a sense of possession actually. It had developed the beginnings of arms and feet. It began developing body members. It was not a shapeless fetus. We saw them." (Mrs. I.)
"*Bir sonrakinde mesela çok heyecanlıydım yani gerçekten "Bir şey görecek miyiz şu an?" diye. Ve onu [bebeğin bulunduğu kese] gördük ve hakikaten gözlerimin yaşardığını hatırlıyorum*."(Mr. C.)	"In the next visit; I was so excited wondering if we could see anything else. And we saw it [the gestational sac] and I remember my eyes were filled tears." (Mr. C.)

4.3.2.3. The Attachment between Parent and Baby

All participants (n=20) shared the same opinion that the longer the pregnancy would mean more grief reactions to loss. 12 of the participants expressed that losing the baby even in the pregnancy affected them, some of them believed that because the baby was a part of themselves, it was not abnormal to grieve after her/him. 7 women and 5 men in the study expressed that their sadness was related to their attachment developed for the baby.

"*Tabii şeyle de alakalı var kaybın sekiz-dokuz haftalık bir cenin olmasıyla altı-yedi aylık bir hani artık belli bir şeye ulaşmış olması arasında çok büyük fark var. Biz belki daha hafif, daha kolay atlattık süreci. Ama eğer cenin daha büyük belki daha şey olsaydı, belli bir bağ kurulmuş olsaydı daha zor olurdu, daha acı olurdu*." (Mr. A.)	"It's also about the stage of the pregnancy. There is a huge difference between a 8-9 weeks embryo and a fully grown baby of 6-7 month. We perhaps overcame the period more easily. But if the baby had been bigger, if an attachment had been developed, it would be harder, and more painful." (Mr. A.)
"*Çünkü hani sen o on haftalık bebeğe hani o kadar emek verdiğini düşünüyorsun içinde bir şey. Ama hiçbir şey yapmamışsın ki. Sadece hani şey biraz dikkat etmişsin beslenmene, biraz miden bulanmış falan filan. Hani doğurduktan sonra veya hani biraz daha ayı ilerledikten sonra veya hani doğduktan sonra canlı canlı evladını kaybetmek acısını tahayyül bile edemedim yani. Düşün ki on haftalık bir bebek. Hani bebek bile değil nerdeyse yani hani*." (Mrs. A.)	"Because, you know, you think you put so much effort to that ten-week baby. But in fact, you did nothing, just minding your diet a bit, a little nausea etc. I couldn't imagine the pain of losing a child after the birth or in the advanced stages of pregnancy. Let alone a ten-week baby, not nearly a baby…" (Mrs. A.)
"*Daha önce de bir düşük yaşamıştım zaten, bu kızdan önce. Aynı bu şekilde yaşadım, ama o daha da küçüktü o yüzden hissetmemiştim. Bu daha bir hissedilir bir şekilde oldu*." (Mrs. J.)	"I had another miscarriage, before this girl. It was the same, but it was smaller, that's why I didn't feel it this much. This felt more real." (Mrs. J.)

Similarly, some participants thought that if they had lost a child who died after living a period of time, such as losing a child who is at school age, then the loss would be devastating because there were more livings, more attachment developed with the child.

"*Ama mesela doğmuş olsaydı, kucağıma almış olsaydım şu an Allah korusun hani oğlumda yaşasam bambaşka olur yani. Böyle olmaz. Ama hani böyle çok şeyi yok yani. Hani etkilerinin azalmaya başladığını fark ettiriyor. Fark ediyorum zaten epey zaman geçti yani. Yani o zaman bilmiyorum*	"But if it had been born, If I had hold it in my arms, God forbid if I experience it with my son, it would be totally different. But now it is not a huge impact. I realize that its impacts are fading. A great deal of time has passed. If I had counted the days, life would be, I don't know, very difficult I guess."

ya çok zor olurdu herhalde yaşam, o günleri saysaydım," (Mrs. I.) (Mrs. I.)

All participants agreed that because the women carry the baby in the whole process of pregnancy, their attachment to the child was more than their attachment. The physical sensation felt by the mother was an important factor in developing better attachment with the baby/fetus from participants' perspectives. The longer the mother carried the baby, the more she had hopes for the child.

"*Yani işte konuşmuştur onunla şakalaşmıştır onu duyduğunu sanmıştır. İşte yiyecekleri şey besini alırken gecikme durumunda işte "Bugün aç kaldın mı?" demiştir yani konuşmuştur mutlaka. E olmaması neticesinde daha da üzülmüştür tabii, o [anne] üzülmüştür*." (Mr. H.)

"I think she must have talked to the baby or joked with it. For example, when she was late eating her meal, she must have said 'are you hungry?', she certainly must have talked. Then when it didn't happen, she naturally got upset, after all." (Mr. H.)

"*Ben normalde duygusal bir insanım ama çocuğumu kaybetmiş olarak tam algılayamadım yani. Baba olarak bilmiyorum her baba aynısını mı yapıyor, onu bilmiyorum ama hani doğana kadar aşırı bir hissiyat olmuyor veya karnı çok büyüyene kadar bir şeyi hissiyat olmadığını düşünüyorum ben, çocuğum doğana kadar onu hissettim*" (Mr. B.)

"I am an emotional person normally, but I couldn't perceive the loss as losing a child. I don't know if every father feels the same, but I think you can't feel too strong until the birth, or until the tummy gets real big. I felt like this until my [subsequent] child was born." (Mr. B.)

"*Yani keşke daha erken haberimiz olsaymış. Çünkü hani üç hafta, dört hafta falan ben o ölü bebekle yaşamışım. Belki üç- dört hafta önce öğrenmiş olsaydım o üç dört haftalık ümidi beslememiş olacaktım içimde. Daha erken öğrenseydim daha iyi olurdu tabii*." (Mrs. B.)

"I wish I had known it earlier. Because I lived with the dead embryo for three or four weeks. If I had learned it three-four weeks earlier, I wouldn't have feed those hopes for three-four weeks. It would have been better if I had learned it sooner." (Mrs. B.)

4.3.2.4. Gender Reveal

For the two couples, gender of the baby was important (for couples D. and J.). Both couple had already living a girl who was studying in the secondary school. Especially Mr. D. and Mr. J. expected to have a boy. When they lost the baby, two couples knew that the baby lost was a boy. As Mrs. J. explained below, learning the gender of the baby was another factor increased her regrets since in her opinion her husband would have desired to have a boy. However, as it will be explained in the couple analysis, Mr. J. and Mrs. J. did not talk face to face about this gender issue of the baby. While Mrs. J. Thought that her husband wanted to have a boy so much, Mr. J. expressed that because he had a girl already, he would

have preferred a boy, but it was not a big problem whether the baby was a boy a girl, as long as the baby was healthy. Apart from this two couples, for Mr. A. and Mrs. G., gender reveal meant that they would have developed more attachment to the child. So, in total for 6 of the participants, gender reveal has important aspects in the increased development of attachment, thus in their increased grief.

"*İşte o zaman bilmiyorsun ki hani, cinsiyetini bilmiyorsun. Hani o yüzden pişmanlıklar yaşıyorsun hani kız olursa, oğlan olursa, kız mı olur oğlan mı diye ama şimdi öldükten sonra oğlan olduğunu bildiğin zaman daha fazla artıyor*." (Mrs. J.)	"We didn't know then, we didn't know the gender. That's why you experience regrets, if it had been a girl, if it had been boy etc. But now that we know it was a boy when it is dead, it became more difficult." (Mrs. J.)

Even if the gender of the baby was non-important for some participants, knowing the gender seems a factor affecting the attachment between baby and the parent.

"*Ama bu düşündüklerini hani Mrs.A. ile pek hani konuşma şeyimiz olmadı öyle bunları, hani çünkü belli bir seviyeye gelmemiş bile olsa hani gebelik, belki daha ileri seviyede olsaydı daha hani cinsiyetini öğrenseydik, hani daha fazla anne-çocuk ilişkisi yaşasa belki daha acı daha ruhsal olarak şey olacaktı, travmatik, daha ağır bir durum oluşacaktı*." (Mr. A.)	"But we didn't talked about our thoughts on this with Mrs. A.. Because if the pregnancy had come to an advanced stage, if we had learned the gender, if a more close bond between the baby and the mother had been developed, it would have been more traumatic, more difficult." (Mr. A.)
"*Çok şükür bir de belki de hani kısa bir dönemdi ya hani üç aylık bir süreçti. Bir de bebek küçüktü ya hani böyle bebek olarak da görmedik. Böyle hani cinsiyetini de öğrenmedik*." (Mrs. G.)	"Thank God it was a short period, for three months. The baby was so small that we couldn't perceive it as a baby that much. That's why we didn't learn the gender of it." (Mrs. G.)

4.3.3. Coping with the Loss

Table 10: Coping with the Loss

COPING WITH THE LOSS
•Social Based Coping •Cultural and Religion Based Coping •Cognitive Based Coping

4.3.3.1. Social Based Coping

In this sub-theme, how participants got social support from which resources in the family, friends, or expert people in the hospital (hospital personnel) and how participants perceived this support were presented. Not everything said or done for the participants were accepted as a helpful support by the participants, some of them were perceived as aggravating comments, words that hampered their grief process.

4.3.3.1.1. Social Support

Perceived positive support regarding the immediate social environment was so important after the pregnancy loss that having or not-having a positive social environment might have affected the grief experiences of participants. As you will read the upcoming paragraphs, all participants' have visitors who came to say "get well soon" wishes or to express their condolence. However, how those people expressed themselves affected the bereaved participants differently.

Because the pregnancy loss experience was a shared experience among the couples, the loss might have affected each partner so much, that they could not have supported each other. In these kinds of situations, that neither couple had more emotional resilience, support from outside might have additional importance for the couple. For the couple B. and I., this importance of outside support was expressed.

"*Ya daha çok ikimiz de aynı durumdaydık, bizi başkalarının telkin etmesi daha iyi olmuştur diye düşünüyorum. Hani birbirimizi ne kadar telkin edebiliriz? Yani. Karşılıklı oturur ağlarız en kötü yani*." (Mr. I.)	"We were both in the same state. Other's comforting us was better, I think. How could we comfort each other? I mean, we could at best sit and cry together." (Mr. I.)

Even if there were no psychological professional support given to those bereaved participants, having social support may be a mediating factor affecting the grief process. This support can be supportive attitude toward the bereaved, or even small physical contacts like hugging. In the following quotation, Mr. G. explained how the family of Mrs. G. supported her after the loss that affected her psychological well-being positively. For Mrs. G., even this social support may have taken place of professional support.

"*Yani en azından şeyi o duyguyu birebir yaşayan anne adayı şey yapamıyor yani, nasıl söyleyeyim, söylediklerinizle biraz o travmayı atlatamıyor yani. Biraz sanki*	"The expecting mother who experienced this first hand cannot get better with what you say. You feel that she needs something else. A support, a help. My wife was with

farklı bir şey gerekiyormuş gibi hissediyorsunuz. Bir destek, bir yardım gerçi ailesiyle kalınca yani ailesiyle eşim ailesiyle kaldı birkaç ay ben askere gittikten sonra, o esnada ha biraz iyi geldi aslında. Hani annesinin desteği, kardeşinin desteğiyle. Biraz iyi oldu, ya o olmasaydı belki daha sıkıntılı bir durum olurdu." (Mr. G.)

her family when I was in the army that helped her though. The support of her mother and sister. That was helpful. If it hadn't happened, it would have been a more troubled period." (Mr. G.)

"*Hani bir sarılsa bile yeterdi mesela. Hani konuşmadan bir sarılsa bile yeter yani. Çünkü herkes kendi acısını, gelen kişi kendi yaşadıklarını anlatınca, hani tamam onlar da bir şekilde bir şey anlatmaya çalışıyor ama benimkisiyle pekiştiği zaman kafa karışıyor. O yüzden bence bu durumda olan insanların yanında bence bir sarılması bile yeterli yani diye düşünüyorum kendi açımdan*." (Mrs. J.)

"A hug was enough actually, a hug without any talk. Because when everyone shares what they have experienced, okay they try to tell you, but it gets confusing. That's why those who want to help people in my situation should only hug, that's what I think." (Mrs. J.)

Some reactions of their social system may have made them feel upset, angry, think rejected, unsuccessful, or misunderstood. The interesting thing was all participants who talked about negative comments from the social environment were women, none of the men in the study had problems related to social environment's comments after the loss.

"*Öyle yani yoksa şey yapmadık, hani zaten dışarıdan gelen tepkiler olmasa insan bu yaşadığı üzüntünün daha azını yaşar...işte laf sokmalar, onlar, bunlar, şunlar olmasa çok daha az üzülürsün. Ama onlar, dışarıdan gelen tepkiler biraz daha insanın canını bazen sıkabiliyor*." (Mrs. F.)

"You would be less upset if the people around you didn't react that way. Without those comments and implications, you would feel better. But those comments and reactions from the circle may upset you sometimes." (Mrs. F.)"

"*Ya tabii kaynanamla biraz sorunlarımız oldu o dönemde. İşte bu ilk bebeğimi kaybettim, işte sonra boşandım falan kaynanam şey demişti "Sen çocuk düşürmeye alışıksın zaten." Bu kelimesi yani mahvetmişti. Yani resmen "Çocuk katilisin." dedi suratıma*." (Mrs. E.)

"We had problems with my mother-in-law in that period. I lost my first baby then I divorced, and my mother-in-law said 'you are already used to miscarry babies'. That sentence devastated me. She officially called me a baby killer to my face." (Mrs. E.)

Similar to what Mrs. E. talked about non-empathic responses from the social environment, Mrs. G. experienced a very similar thing that made her upset too much. While with the visit of her mother-in-law, expectation was mother-in-law's support or her expression of condolence; what was heard was completely different one for Mrs. E. and the comment of mother-in-law was blaming her with the ending of the pregnancy. She was not

alone with her problem with her mother-in-law, there were other women in the study who expressed similar negative comments from especially mother-in-law.

"*Bir tek o an hani ben kürtajdan yeni çıkmışım ve yataktayım, o an hani kayın validem arayıp güya "Geçmiş olsun" ben demesini beklerken bana hani "Ne yaptın da bebe düştü?" gibisinden bir tepki vermesi mesela o an beni çok üzdü. Hani sanki o bebeği ben düşürmek istedim de düştü gibi. Hani "Bir şey, kesin bir şey yapmışsındır ki." diyor, yani "Düşük yapmışsın." diyor, yoksa hani "Nasıl kendi kendine düştü?" diyor. Hani mesela ben o an onun için çok ağlamıştım. Yani inanın bebeğimi kaybetmenin yanında hani kayın validemin bu cümlesi beni o gün hem de çok çok üzmüştü yani acayip derecede üzülüp ağlamıştım ben o gün bu söz için*." (Mrs. G.)

"Only the moment after the operation when I was still in bed, my mother-in-law called. I was expecting that she would say something like "get well soon" or something. But she said, 'what did you do so that the baby is gone?' That upset me so much. As if I wanted to get rid of the baby. She said, 'you certainly did something or how it happened on its own'. I cried so much at the moment. Besides losing my baby, the things my mother-in-law said upset me very very much that day. I cried so much for this remark that day." (Mrs. G.)

For some participants, support from their friends were more important than family members. There were many reasons behind this. Firstly, some participants believed that especially old people could not have understand them, their friends who were almost at the same age with the participants were more understanding. Secondly, culturally in a family talking about emotions with mothers, fathers were not accomplished. Parents gave suggestions to their children, but generally they do not listen. When old people visited the bereaved couple, this was for the "Get well soon wishes", while young people were better in talking about emotions. Another reason might be that general suggestions or comments might not have been helpful, they might not have given any perspective to bereaved ones, and sometimes they may have wanted to hear different things that might have helped them approach the problem differently.

"*Tabii genç arkadaşlar da işte üzüntüye ortak oluyorlar*." (Mr. B.)

"Young friends surely share our sadness." (Mr. B.)

"*Var tabii yani birkaç arkadaşım var yani. Onlarla konuştum yani samimi bulduklarım. En azından benim derdimle dertleşebilecek yapıda*." (Mr. J.)

"Of course, I do, I have some friends. I talked with them, the close ones. At least they have the ability to share my trouble." (Mr. J.)

"*Yani sonuçta genel sonuçta senin yaşadığını, senin hissettiğini onların anlayabilmesi, onların birebir empati kurup*

"It is more difficult for them to understand what you feel, to empathize with you. And families, of course they get sad, they say

bu hususu şey yapması daha zor. Bir de hani bir kişinin hani tabii aileler üzülüyorlar hani seni de şey yapıyorlar "Üzülmeyin, gençsiniz." hani "Daha çocuk sahibi olmanız için önünüzde zaman var, hani bunlar olası şeyler gebelikte, bunlar risk dahilinde olan şeyler." dediler." (Mr. A.)

things like 'don't worry, you are still young, you have a great deal of time in front of you to have a child, these are normal risks in pregnancy." (Mr. A.)

" *"Bir daha olur.", "Niye böyle hani dikkatli olsaydın." "Şunu yapmasaydın." "Bunu yapmasaydın.", keşkeler filan orada hani onlar zaten benim bildiğim bir şeyler olduğu için direkt karşıdan, karşı kişilerden duyduğum zaman çok zor bir süreç oluyor. Hani duymak istemiyorsun. Yani. Hani bunları duymaktansa farklı şeyleri duymak ister insan*." (Mrs. J.)

"They say: 'You can have again', 'Why did it happen?', 'You should have been careful', 'You should have done this, and shouldn't have done that'. These are the things I already know, I cannot stand it when I hear these from outside. I don't want to hear. I want to hear other things instead of these." (Mrs. J.)

As Mr. B. and G. exemplified that how perceptions of other people regarding the pregnancy loss have changed with the time, so the reactions of people to these losses have changed. Both of them thought that old people were more accustomed to pregnancy losses. Mr. G. stated that because society saw this death as normal, they do not think that there is a grief after this loss, so their grief is disenfranchised, socially not-acceptable from Mr. G.'s viewpoint. Only men's talking about this issue might have resulted from their own grief process' being influenced by the societal expectations regarding the gender roles.

"*Ya şöyle hani demin de belirttim, biraz toplumun hani sizi anlamaması, ya da işte bu böyle bir durumun normal karşılanması. Sonuçta hani şimdi siz anne baba olarak yani ben artık o dönem için anne-baba olduğumu kabul ediyorum, bir kayıp oluyor. Ama o kayıp hani sanki bir canlı hani yitirilmemiş gibi düşünülmesi sizi biraz -ben kendi açımdan söyleyeyim- babayı biraz üzüyor. Yani nasıl olur da hani normal kayıplarda insanlar üzülürken, tüm işte sıkıntılarınızı paylaşırken bu tür durumda sanki çok normal bir şeymiş gibi algılanması açıkçası biraz üzüntü verici. Ya bu durum değişse, değişmesi sanki iyi olur yani. Böyle bir şey yaşarsam daha doğrusu, ya da çevrem tarafından, ben bu durumun açıkçası bir kayıp olarak düşünürüm. Çünkü çevre bunu kayıp olarak görmüyor açıkçası. Öyle söyleyeyim*." (Mr. G.)

"As I said earlier, the society doesn't understand you, they consider it is normal. After all it is a loss for the parents, I regard us as parents in this period. But when people don't see this as a loss of a living being, it upsets you, it upsets the father, to speak for myself. How come they regard it as a normal thing while you can share your grief in other losses. It needs to change, it would be better if it changed. I see it as a loss when I experience it. But the society doesn't see it as a loss to be honest. That's what I'm saying." (Mr. G.)

"*Ya şimdi bizim akrabalar açısından düşündüğünüzde tabii kadınlar geldi, onlar daha böyle bu tür şeyler, çocuk aldırmalar, çocuk kayıpları daha çok yaşadıkları için yani daha yaşlı oldukları için Türkiye şartları daha eskiden daha elverişli olmadığı için, işte şimdi her kontrolde her çocuğun her aşamasında doktorla birliktesin, ne olacağını biliyorsun. Onlar bunları yaşamadığı için daha normal karşılıyor tabii onlar açısından*." (Mr. B.)

"When you look at it from the perspective of our relatives, the women who came, they think it is normal as they experienced many things like this, abortions, miscarriages etc. in the poor conditions of the old time Turkey. But now you are with the doctor in every stage of the pregnancy, you know what will happen. As they didn't experience it in today's conditions, they consider it normal." (Mr. B.)

For some participants, especially men, talking with others was harder because personally they did not like sharing their emotions, as in the cases of Mr. A., F. and B. For instance, Mr. F. preferred to talk with friends he called as "family friend-aile dostu" who were older than him and who had experience in pregnancy loss, since he believed that practical help was more important in these kinds of issues, so he did not like questions coming from his friends about their experience. Even if his family asked too many questions, especially to his wife, he was the one who had arguments with them to stop their questions.

Participants such as Mrs. C. and Mrs. I. stressed that even if the social support was important, i.e. hearing from others that they cared, getting messages from them; the most important support actually came from the person's own family (mother, father and siblings).

"*Çevrem için, tabii ki en yakınlarımdan atıyorum annem, kardeşim daha böyle birebir, o insanlardan belki biraz daha beklentim olabilir ama, bir başkasından çok, yani çünkü olan gerçekliği değiştirmiyor onların aramış olması. Hani tabii ki o anda destek oluyorlar kendilerince. Yani sadece ben olayı hep, her defasında anlatmış oldum, baştan sona baştan sona anlatmış oldum. Bu. Ama tabii ki insanların yine arayıp sorması da, belki hiç aramasalardı, o zaman da şey de diyebilirdim, "Kimse aramadı." da diyebilirdim. Bilmiyorum şu an onu yaşamadığım için. O konuda bir değerlendirme yapamıyorum. Ama birçok kişi destek oldu. O sırada yani*." (Mrs. C.)

"The support of my mother, my sister mattered actually, more than the others. Because their phone calls don't change the reality of what I experienced. Of course, they try to help in their way. I just re-told them what happened again and again, from beginning to end. But maybe if they hadn't called, I would now say 'nobody called'. I don't know, I cannot assume as it didn't happen. But many people supported in that period." (Mrs. C.)

4.3.3.1.2. Hospital and Hospital Personnel Related Experiences

It was observed that this was an important subject for the participants since from the moment that they heard the bad news from the doctors to their post-loss screening (examination of reproductive ability, determining the reasons of the loss etc.) in the hospital, they talked with the hospital personnel. While the pregnancy loss was already a stressful and painful experience for most of the participants, attitudes of the hospital personnel who were the first people encountering the bereaved individuals had an important impact on their psychological well-being after the loss experience. Facing with negative attitudes from the personnel might have added extra stress for these bereaved people.

Some of the participants attributed the helpfulness of the hospital personnel to their working in a private hospital. They assumed that hospital personnel in the state hospitals would not be so understanding.

"*Hepsi çok iyiydi. Çok anlayışlılardı. Hatta ilk şeye girdik işte kürtaj olacak odaya girdik. Anestezi için hazırlıyorlardı beni, takıyorlardı orama burama bir şeyler falan. O sırada böyle bana bir şey mi verdiler, yoksa korkudan mı böyle acayip saçmaladım yani. Gelene gidene kızdım, ağladım, bir şeyler söyledim, saçma saçma konuştum falan. Ama hepsine katlandılar hani "Ne diyorsun sen?" demedi kimse dönüp. Herkes alttan aldı falan. Tabii özel hastane olmasının da etkisi var. Devlet hastanesinde olsa çekmezlerdi o kadar beni yani*." (Mrs. B.)

"They were all very nice, very tolerant. We went into the abortion room, they were preparing me for the anaesthesia, putting things on my body. I babbled things out of fear or out of the anaesthesia. I shouted at everyone there, I cried, talked nonsense. They endured it all. No one said 'what are you saying?'. Everyone tolerated me. But of course, it was partly because it was a private hospital. They wouldn't care about me that much in a public hospital." (Mrs. B.)

"*Ya şey mesela şöyle beni tekerlekli sandalyeye kıyafetlerimle oturttular kürtaja götürdü hasta bakıcılar. Doktor onlara "Biz hastayı böyle kıyafetle mi istiyoruz? Neden önlüğünü falan giydirmediniz, soyundurmadınız? diye hasta bakıcıya biraz kızdı. Hasta bakıcının özür dileyerek "Canım benim." diye soyundurarak giydirmesi çok hoşuma gitmişti mesela. "Ben seni böyle getirmeme gerekiyordu, benim hatam." O hoşuma gitti, yani öyle hiç hani kötü bir şey yaşamadım hastanede. Böyle sevecendi, zaten özel hastane hani. Belki devlet hastanesi olsa çok azarlıyorlar, kötü davranıyorlar*." (Mrs. E.)

"For example, they put me on the wheelchair with my clothes on and drove me to the abortion room. The doctor got mad at them saying 'do we want the patient with all her clothes on like this? Why didn't you make her wear the apron?'. The nurse apologized and undressed me gently. She said: 'it is my fault, I shouldn't have taken you here like this.' I mean I don't have a bad experience in the hospital. Everyone was affectionate. It is a private hospital though. Perhaps in the public hospitals, they would not be so nice." (Mrs. E.)

Only 3 couples (couples A, D and H.) preferred to go public hospital. Because Mrs. A. has been working as a doctor in a state hospital, they preferred to go to hospital where Mrs. A. has been working. As her husband expressed that going to a pre-known hospital, knowing the hospital personnel was comforting for Mrs.A. and himself.

"Hani sonuçta yabancı olmadığımız bir ortamdı. Hani ortama girdiğin, orada kayıp döneminde, operasyon öncesinde ve sonrasında oradaki tüm yüzler tanıdık yüzler. Hani onların beraber çalıştığı arkadaşlarının olması sana yardımları, bakışları daha farklı oluyor. Herkes gelip destekliyor, konuşuyor. Hani sonuçta biraz da Melike'nin mesleğinin hani doktorluk olması, hastane içerisinde bu tarz ortamları bilmesi, daha önce doğumlara girmiş olması, görmüş olması hani oluşabilecek endikasyonları, durum sonuçlarını daha karşılayabilir olmasını sağladı. Hani ben de tabii onunla beraber artık belli bir seviyede hastane şeyine bir şekilde doktor çevresinde olduğum için hani daha rahat geçti diyebiliriz." (Mr. A.)

"It was a familiar atmosphere after all. You see familiar faces everywhere during the period of loss, before and after the operation. The fact that they are your colleagues, their helps, their looks are different. Everyone comes to talk to you, to support you. Melike's being a doctor, her familiarity with the atmosphere in the hospital, with the birth and its complications made her strong against the resulted events. As I was also acquainted with the hospital atmosphere, and be a part of the circle of doctors, I can say that it was easier for us" (Mr. A.)

While couple H. did not express any problem with the state hospital where their operation was completed, Mr. H. thought that the private hospital where his wife had been visiting for the eight months could not have realized the problem of the baby. That is why, after they were referred to state hospital, Mr. H. argued with the doctors in the private hospital. A similar argument was experienced by Mr. D. As they explained, Mrs. D. went to state hospital in the night when she had bleedings, and the doctors stated that there was no problem with the baby and everything was ok, then Mrs. D. was discharged from the hospital. That night in a later time, when she was at home, she had so much pain, and the baby was lost, and Mrs. D. had to be taken to hospital's emergency room.

"*Eşimin ufak kanaması vardı. On iki gibi. Tabii korktuk, panikledik. On iki buçuk gibi, tabii, Şişli Etfal'e gittik, gece. Üç buçuğa kadar orada kontrol altında kaldı. İşte kan tahlili falan filan. Bilmiyorum eşim anlattı mı bunları. Üç buçuk, tabii dörde geliyordu hastaneden çıktık. "Herhangi bir sakınca yok." dediler. "Bir sıkıntı yok." dediler. Sabah yedi buçuk, sekiz gibi de çocuğu düşürdü. Bu beni çok üzdü. Hatta ben de*

"My wife had a little bleeding at twelve o'clock. We were of course panicked and scared. We went to Şişli Etfal at twelve thirty. She was kept under control there till three thirty. We went out of the hospital between three thirty and four. They said everything was normal, there was no problem. She miscarried the baby at seven thirty-eight in the morning. That upset me so much. Then we called an ambulance

çocuk düştüğünde zaten biz apar topar çocuğun paniğiyle sonra ambulans çağırdık. Ondan sonra tekrar aynı hastaneye gittik. Ve o hastanede ben o doktoru gördüm. Ve onunla bir tartışmamız olmuştu. Yani bırak motiveyi, ben direkt oradaki doktorla tartışmıştım." (Mr. D.)

with great panic and went back to the same hospital. And I saw that doctor in that hospital. And we quarreled with him. Let alone motivating the patient, he quarreled with us there." (Mr. D.)

So, whether it was a private or state hospital may not make a big difference but how good the attitudes of the hospital personnel toward these bereaved parents may made the difference. For the bereaved participants, whether their privacy was given importance, whether the doctors made the necessary explanations regarding their loss (i.e. why it occurred), how they were cared in the hospital, what interventions should be done after the miscarriage or stillbirth, or giving information about how partners should support each other had more importance. Another important thing from the participants' view was whether the hospital personnel was responsive to emotional situation of the participants.

"*Hani doktorun gerçekten tanıması şey yapması, yormadan, psikolojisini anlaması ve hasta-doktor ilişkisi güvene dayalı olması çok önemli. Ben doktoruma çok inanmıştım çünkü. Çok şey yapmıştı. O bağın kurulması çok önemli yani anneler bence böyle elektrik alamadığı bir doktora çok yanaşmasınlar. Güvende hissetmek çok önemli*." (Mrs. I.)

"The fact that your doctor know you, understands you, and your relationships based on trust is of great importance. I trusted my doctor very much. That bond is really important. Mothers shouldn't go on with doctors whom they don't trust. Feeling safe is very important." (Mrs. I.)

"*Mesela bir tane doktor "Bu çocuğu zaten kaybedersiniz." "Kaybedeceksiniz zaten çünkü olağan gitmiyor her şey." demişti. Ama diğer doktor problem olmadığını söylemişti. Öyle bir tek işte orada şey yaşadık, gayet rahat söylenilmesi bizi şey yapmıştı, üzmüştü. O kadar*." (Mr. B.)

"For example, a doctor said: 'you will definitely lose this child. Because things don't go well." But another doctor told us there was no problem. To say that so confident, that upset us. That's all." (Mr. B.)

Couple D. talked about the negative manner of the hospital when they asked whether they could got the baby' bods to make a funeral for him [the baby's gender was learned during miscarriage]. Based on this couple's experience, how the hospital personnel reacted to baby's funeral/remainings may also have an important role for the parents. In Turkey, babies who do not weight over than 500 gr and who were not over 22 weeks are not given to the families. Maybe parents should have informed about this legal practice by also showing their empathic understanding for the parents.

"*Ya et demesi tabii benim için et değildi. Benim için et değildi. Benim için resmen çocuktu yani. Gerçekten küçük küçük bir bebekti yani. Hani küçük de olsa bir bebekti*." (Mrs. D.)

"They called it flesh, but it was not flesh for me. It was officially a child for me. A very very small baby. A baby no matter how small it is." (Mrs. D.)

Some participants, i.e. Mr.I., Mr. E. and Mr. B. viewed the attitudes of the hospital personnel very normal because they thought that their professional identity requires them to get accustomed to clients and their problems, so while the doctors had many clients, paying attention to just one patient may have been unrealistic.

"*Yani farklı olarak yani farklı şeyler illa beklenebilir ama hani ya ben ekstra yapabilecekleri bir şey olduğunu düşünmüyorum..O yoğunluğun içinde yeterince de ilgilendi diye düşünüyorum yani. Ekstra başka bir şey beklenemezdi sanırım*." (Mr. I.)

"Of course you can expect different things but I don't think there are many things they can do. I think they spared enough time for me in the middle of that busy atmosphere. I don't think any other thing can be expected." (Mr. I.)

Even the ones who stated that they were cared by the hospital personnel, expressed that they did not got any professional psychological help even if there were some suggestions given to couples. As understood from the participants' sayings, hospital personnel were helpful in explaining when is the right time for the next pregnancy, what kind of preventions can partners have for the next baby and other medical-related practical information.

A few participants expressed that there should be some psychological help for these bereaved parents. As the above quotation shows that because there is not such a help in the hospitals, they could not ask even think about the existence of such an assistance even if they had needed it.

"*Yani Türkiye şartlarında biz herhangi bir şeyi aklımıza gelmedi o şekilde bir şey, destek mestek..Olmadığı için, olmayan bir şeyi görmüyorsun*." (Mr. B.)

"We didn't think about it in the conditions of Turkey. Professional support and etc. It doesn't exist, that's why you cannot consider it." (Mr. B.)

"*Şöyle hani devletin sosyal devlet anlamında yaptığı hani bu tür kayıp yaşayan kişilere hiçbir şey yok. Yani bence ne bileyim hani iki seans, üç seans, beş seans neyse, anne ve babaya her şekilde bir şey sağlamalılar. Ya da hani ne bileyim zorunlu kılmalılar. Her ne kadar etkilemedi desek de bir şekilde bu bizim hayatımızı etkileyen bir şey. Büyük bir travma*

"The government, as a social state, does nothing to the people who go through this. I think they should provide support for the parents at least a couple of sessions. Or they should make it compulsory. Even though we say we are not affected, actually we are affected. It is a great truma in our life." (Mrs. I.)

hayatımızda." (Mrs. I.)

4.3.3.1.3. Talking with Other People with Similar Loss Experience

Talking with other people who had similar pregnancy loss experience made some participants feel understood. As stated above, even if family members and social environment gave support the partners, some of them were not helpful at all. However, none of the participants who expressed that they talked with similar experiences found the talks with them as unhelpful, hurtful and so on. It seemed that the participants tried to learn from others' experiences.

"*Yani aynı gün içinde kaybettiği için annesi daha o konuda eşim ile empati kurup hani daha destek olabildiğini düşünüyorum*." (Mr. A.)	"As she lost her baby after the baby' birth, her mother was very supportive to my wife by empathizing with her I think." (Mr. A.)
"*Yani şimdi destek olmak veya şu manada soruş tarzlarına göre olay değişir. Yani mesela kardeşim Yasin, onunla konuşuyoruz. Kendisinin de böyle bir vakası olduğundan mütevellit. Kendisiyle konuşuyoruz*."(Mr. F.)	"In terms of support, it depends on their way of asking. For example, my brother Yasin, I talk to him because he has had the same experience." (Mr. F.)
"*Bizimki çünkü benim bunları konuştuğum arkadaşlarım içinde ilk çocuklarından önce iki kez düşük yapan, eşi iki kere düşük yapan vardı. İşte onunla biraz bilgi almaya çalıştım, hani "Sizin böyle." hatırlıyorum, biliyorum çünkü onu da. "Sizin böyle ne olmuştu, neydi?" bilmem ne diye sordum. Onun dışında hani bu sadece "Geçmiş olsun." ve işte onların deneyimlerini, deneyim derken hani psikolojik olarak ne yaşadığı, deneyimi değil de. İşte "Ne yaptınız?" işte, "Hangi doktora gittiniz?" gibi bu tarz şeyler.*" (Mr. C.)	"There was a friend among the ones I shared my experience with who had two miscarriages before their first child. I tried to get information from him, I asked questions. Besides, I asked practical questions like 'what did you do? Which doctor did you go to?', not their psychological states in that period." (Mr. C.)

4.3.3.2. Cultural and Religion Based Coping

Cultural environment was so important in the lives of the bereaved individuals that affected their coping mechanisms, rituals completed after the loss, how people they knew reacted to pregnancy loss. The rationale of how individuals in different cultural backgrounds may have reacted to the same loss differently was explained by Mrs. G. vey well in the following quotation:

"*[kaynanasının tepkisi] Yani biraz kültürel. Yani biraz sanki böyle hani bebeği düşük yani biraz basit geliyor aslında. Hani böyle onların zamanında böyle şeyler çok yaşanmadığı için kayın validem dokuz tane doğurmuş maşallah hani böyle şeyler de çok yaşamamış o yüzden han böyle düşük, işte şu bu işte gebe bayan dinleniyor mesela bunlar basit geliyor. Hani dokuz ay geçti, doğur. Biraz o mantık var yani yaşlılarda özellikle...Biraz yaşam tarzıyla da alakalı bir şey. Yaşla da alakalı bir şey*." (Mrs. G.)

"It is a cultural thing [the reaction of her mother-in-law]. It seems simple to her. There were not many cases like this in their time. My mother-in-law gave birth to nine children. She had no experiences like this. She finds it weird when the pregnant women need rest now, for example. Her expectation is birth after nine months. This mentality is common among elder people. İt is partly about lifestyle partly about age." (Mrs. G.)

As exemplified above, in this subtheme how culture affected the grief process of individuals was shared. In addition, how religious beliefs, practices were used by couples and whether they were found beneficial in their coping were examined from the participants' own words. Because religion affects the everyday life of people, rather than separating cultural and religious statements, they were given as an unite in order to make the reader the understand the socio-cultural environment of the bereaved people that also included the religious beliefs and practices.

Firstly, how people in the social-environment gave support, or suggestions for the participants' getting pregnant again or how the socio-cultural environment explained the reasons of the loss based on their own beliefs were given with quotations of participants. As the following examples showed that independent of where the participants lived, especially women heard the cultural suggestions by other people. These cultural statements were not found helpful at all by the bereaved women. Even some statements frightened them, they were afraid they would not have a subsequent child, or they did something wrong during their pregnancy.

For instance, Mrs. F. who experienced more than one pregnancy loss, was subjected to suggestions like eating specific things or putting a baby on her lap that constitutes the folk culture of the society regarding getting pregnant. She did not take these suggestions seriously. In a sense, she did not want other people to have an opinion about a very special issue and secondly, as I observed that, she was so overwhelmed because other people reflected the consequences of the loss like it was a failure. Her feelings of boredom and disgust from these cultural statements could be read in the following quotation.

"*İkincisinde tabii ki şey oldu, sürekli dışarıdan baskı geliyor işte hani insanlardan "Ay siz tedavi görüyorsunuz zannediyoruz." Hani "Çocuğunuz olmuyor*

"At the second time, people asked and commented a lot. They asked if we were under treatment or not, if we were impotent or not. You explain the same

mu?" İşte doktorla aynı şeyleri tekrar tekrar anlatıyorsun, tekrar tekrar anlatıyorsun, soruyorlar, anlatıyorsun. Sonra sanki hiç bunları anlatmamış gibi tekrar tekrar soruyorlar. İşte "Öyle bir karışım var, böyle bir karışım var. Onu ye, bunu iç, şunu yap." Çok fazlaca, ben herkesi, kimseyi kırmamak adına herkese "Tamam, tamam." diyorum ama hani "Uyguluyor musun?" desen, uygulamıyorum. Hani işte ben soğan suyu içmem arkadaşım. Soğan suyu nedir yani? İçemem yani soğan suyunu, soğanı kaynatacakmışım, suyunu içecekmişim. Bütün şeyi temizliyormuş vücuttan. Hamile kalabiliyormuşum. (Gülüyor)...Mevlütlere gidiyorsun, eline bir bebek tutuşturuyorlar, "Senin çocuğun yok al bebeği". Teyzem sürekli "Bal karıştır işte polen, onu ye. Hem o vücut sağlığına da çok iyi geliyormuş. Hem de belki bebeğin olmasına da faydası olur." diyor. Soğan suyu vücuttaki bütün mikrobu temizliyormuş.". Ya böyle şeyler çok bana göre değil." (Mrs. F.)

things again and again and they ask you again as if you never have explained them before. They come with suggestions like 'there is this mixture', or 'eat this', 'do that'. Too many suggestions. I say okay to everyone not to hurt their feelings but if you ask me if I apply those suggestions, no I don't. I can't drink onion juice, my friend. What is onion juice? I can't drink that, they want me to boil the onion and drink the broth of it. They say it cleans everything in the body, and then I could get pregnant again. (laughing)… You go to prayer gatherings, they put a baby on your lap. They say: 'you have no children, take the baby'. My aunt always advised me to eat honey with pollen. She says it is also beneficial to my health. Or onions juice cleans all the bacteria from the body. This kind of stuff is not for me." (Mrs. F.)

According to Mr. F. especially the old people gave suggestions like his wife said, but they were not helpful for them at all.

"*En fazla işte koca karı ilacı verir. İşte "Şunu yap, bunu yap, şuraya git." İşte "Şu hamama git. Şuraya git." Yani bilmediği için.*" (Mr. F.)

"At most, they give folk remedy. They say: 'do this', 'do that', 'go to this place', 'go to that bath'. As they don't know… (Mr. F.)

In the following example, the socio-cultural environment of the participant Mrs. E. tried to explain the loss from their perspectives by linking the behaviors of Mrs. E. and the loss as a consequence of these behaviors that included eating specific things (like in the case of Mrs. F.) or lifting heavy things or making heavy housework at home. Mrs. E. also talked about a very cultural statement told to her by the visitors who came to her home to wish her get well soon.In total, three women in the study were accused with their behaviors, these accusations came from their mother-in-laws.

"*"En azından oldu da düştü." "Düşüğün kıçı içinde." diye bir laf var. "Hemen olur peşinden." dediler.. Önüne gelen vay efendim "Ağır iş görüyorsun sen." işte "Sen hiç dikkat etmiyorsun." "Sen Burcu'yu çok kucağına aldın da düşürdün." diyen oldu.*

" 'At least you had it.' they said to me: 'You will get pregnant again straight away'. Everyone tells me that I did heavy housework, they blamed me for not being careful enough. One of them said 'you hold Burcu on your laps too often, that was the

Ondan sonra "Sen işte" ne bileyim, her türlü akıl geliyor ya, ummadığın şeyler geliyor. İşte "Şunu mu yedin de düşürdün?" yemeğe bile bağlıyorlar... Canını mı sıktın?" yok "Stresten mi düştü?" yok "Şunu mu kaldırdın? Ağır mı kaldırdın?" yok bilmem ne. Ya saçma sapan şeyler." (Mrs. E.)

cause.' The opinions come in every way,they even linked it to food, they asked 'did it happen because you ate that?' they say 'was it the stress? did you think too much?, did you lift heavy weights?'. They are all nonsense." (Mrs. E.)

Mrs. G. talked about a different tradition in her region. Even though she lost her baby through miscarriage, she was expected to experience the puerperium/postpartum period (loğusalık dönemi) as though she gave a live birth.

"*Doğum yapan bayan için "Kırklı." denir ya bilir misiniz?" Hani kırk gün bitene kadar hanı kırklıdır bebek de anne de "Kırklı." derler. Sadece kürtajdan sonra da ben "Mümkün mertebe çok fazla işte dışarı çıkmamaya özen göster." falan dediler. Bebeği sonuçta senden, rahimden aldıkları için doğum yapmış gibi oluyorsun. Hani kırklı bir kadınsın. Hani o yüzden çok fazla dışarı çıkmamaya çalış hani muhabbeti oldu da ben bunu çok önemsemedim zaten*." (Mrs. G.)

"A woman who has given birth is called "kırklı" for the first forty days after the birth, do you know that? After the operation they told me not to go out too much as they considered me 'kırklı' as well. As they have taken the baby from your womb, you are considered to be in your postpartum period. You are a 'kırklı' woman. That's why they told me not to go out too often, but I didn't care much about it." (Mrs. G.)

Mrs. G. also talked about the cultural beliefs she witnessed after her loss regarding the curettage operation.

"*Çünkü ben o kürtajdan sonra o kadar çok şey duydum ki olumlu birçok olumsuz birçok şey bayanlar o kadar gelip anlatıyorlar ki hiç o anki ruh halini bile düşünmüyorlar. Kimi geliyor işte diyor "Kürtajdan sonra." diyor "Hamile kalmak çok zor." diyor, kimi geliyor diyor "Kürtajdan sonra" diyor "Kadının rahmini almışlardı." diyor. Güya bana geçmiş olsuna gelmişler ama hani her türlü şeyi duyuyorsun. O an ve ben o andan sonra çok kötü oldum hani ben acaba bir daha hamile kalabilecek miyim? Hani bunu bile, o korkuyu bile yaşadım yani*." (Mrs. G.)

"Because I heard so many things after the operation, positive and negative things. Those ladies come and tell you things without considering your psychological state. Some says: 'it is too difficult to get pregnant again after the operation.' Some says: 'they have taken the womb of a woman after the operation'. They came to wish me to get well soon on the appearance, but they tell me all kind of things. I got worse after that, I doubted if I could get pregnant again. I even experienced that fear." (Mrs. G.)

While other people's cultural comments on their loss or pregnancy were not helpful for neither of the participants, their own beliefs might have helped them to cope with the loss. These beliefs, as it seems, helped them give meaning to their experiences. How they

conceptualized this loss was affected by their religious beliefs, too. Almost all couples talked about how they conceptualized the loss based on their religious, and sometimes spiritual beliefs.

"*Yani yaradan "Ol." derse oluyorsun, "Olma." deyince olmuyorsun. Yani senin elinde olan bir şey yok. Sonuç olarak bunu kabul edeceksin, kabulleneceksin*." (Mr. J.)	"If the creator tells you to exist you exist, if the creator tells you not to exist, you don't exist. There is nothing you can do about it. You will accept it, acknowledge it." (Mr. J.)
"*Hani şimdi "Allah da onun ecelini öyle ayarlamış." diye düşündüm. Yani bizim de ne zaman öleceğimiz belli değil. "Onun da." dedim "Nasibi bu kadarmış." falan diye düşündüm*." (Mr. E.)	"I thought that God determined its lifespan. We don't know when we will die either. I thought that was its fate." (Mr. E.)

The belief that the lost baby will wait for them in the heaven was shared by some of the participants (i.e. Mrs. C. and Mrs. I., Mr. E.). Even Mrs. C. believed that the lost baby was for her own father who died when she was a small kid, and for her husband's mother who died a few years ago; and surviving people such as her own mother and her husband's (Mrs. C.) father will be the grandmother and grandfather of the upcoming healthy child.

"*Mesela şu anda diyorum aslında "İşte benim bebeğim de dedesiyle babaannesinin yanına gitti." Yani orada aslında tek değil. İşte benim babam da torununu göremedi ya da eşimin annesi de yani babaanne olarak o da torununu göremedi ama orada gördü en azından. Hani onlar için bir tane şu anda ben bir tane daha bebek doğursam onlar bunu göremeyecek. Şu anda benim annem hayatta, yani anneannesi görecek. Eşimin babası hayatta, yani diğer dedesi görecek...Ama onlar için [ölen ebeveynler] onların orada gördüğü torunları gibi düşünüyorum. O yüzden, yani işte o iç konuşmalarımda bu var. Yani onların yanına gideceği ne bileyim, ya da o hani tek hissetmeyeceğini filan o tarz şeyler*." (Mrs. C.)	"I say to myself that my baby is with its grandmother and grandfather who has passed away. It is not there alone. My father couldn't see his grandchild, or my mother-in-law couldn't also see her grandchild as a grandma. But they saw at least over there. If I give birth to another child now, they could not see it. My mother is alive, its grandmother will see and the father of my husband will also see. But I consider my lost child as a grandchild for them [parents who passed away]. That's why I reason myself like this. I mean the fact that it will go to them and not feel alone, that kind of stuff." (Mrs. C.)
"*Yani tabii ki en büyük insana dini olarak destek geliyor. İşte okuduğumuz hadislerde falan anne karnında ölen çocuğun işte cennete gideceği falan işte çocukların cennetlik olduğu falan, onları duydukça o da bir teselli oluyor insana*." (Mr. E.)	"The biggest support comes from the religion. We read in the hadiths that the dead children will go to heaven. That consolidates us." (Mr. E.)

Participants had religious beliefs that were related to "destiny". This belief of "destiny" was expressed a lot, especially regarding the destiny of having a child or not, having a retarded child.

"*Ama dediğim gibi Allah'tan gelen bir şeye bir şey yapamıyorsun. Sonuçta o çocuk dünyaya gelecekse her türlü gelirdi yani bir şekilde. Bunu düşünerekten kendimizi teselli ettik yani*." (Mr. D.)

"But as I said, you can't do anything against God's will. After all, if that child would come to the world, it would come in all manner. We've been consoling ourselves by thinking this." (Mr. D.)

"*Ha bence, bana sorarsanız her şey nasip kısmet. Ben öyle şeyler tabii ki etkiliyordur, hani doktorların tavsiyelerini tabii ki dinliyoruz. Ama yaşayacak ömrü olsaydı ne yaparsan yap yaşardı diye düşünüyorum her zaman...Ama dediğim gibi hani tevekkül ettiğiniz zaman daha çabuk atlatıyorsunuz*." (Mrs. F.)

"If you ask me, it is destiny. Of course there are factors, you should listen to the advices of the doctor. But I always think that if it had the life to live, it would live no matter what you do. But as I said, you overcome more easily if you have faith." (Mrs. F.)

Parallel to this "destiny" belief, some participants were relieved with thought that even if the baby was lost, at least they did not have a retarded child that may have impacted their psychology more negatively. Both men and women in the study talked about their relief related to not-having a retarded child. Participants' thoughts related to risk of retarded child were related to their talks with the doctors after the loss since as all participants expressed that, after the pregnancy loss, in the hospital the genetic tests were applied in order to understand the reason of the loss and all doctors explained that there was a risk for retarded child, and because of the genetic problems in the child, the baby was lost. Although the exact reason of the loss could not have been explained by the doctors, the explanations were found to be useful for all the participants.

"*Her şeyin içinde vardır bir hayır. Hani normalde zaten engelli çocuklar var. Hani özürlü çocuklar var. Acaba öyle şey olsaydı daha mı şey olurdu? Yani bizim için hayırlısı böyleymiş." dedi yani. "Böyleymiş." dedi, ondan sonra öyle yani*." (Mrs. D.)

"Every yin has a yang. Normally, there are retarded children. Would it be better if we had one? I think that was the best for us. That was our destiny." (Mrs. D.)

Therefore, as it was observed that different participants witnessed and were subjected to different cultural and religious beliefs regarding their loss experience. Some of them heard the suggestions from their social environment regarding their newx pregnancy, some heard about their curettage operation and some heard things about the destiny. Based

on their own belief systems, some of these beliefs were helpful in their meaning making and conceptualization of the grief. However, some of them did not work and even some harmed them psychologically. Thus, the socio-cultural elements, as seems, have both positive effects as well as negative effects on the participants based on whether these elements were in harmony with the participants' own views or they were conflicted.

At the end, which religious practices were used by the participants were shared in this sub-theme. Not all participants performed religious practices after their loss experiences. There were personal reasons behind not-fulfilling any religious practice after the loss such as believing that fulfilling religious practices might have increased their grief reactions more, or their personal grief beliefs that there should be religious practices for a baby that was lost during the pregnancy.

Some participants (i.e. couple A, B, C) did not follow any religious ritual because the baby was lost at an earlier time. When looking at the laws and legislations in Turkey, for the pregnancy losses that ended after the 22 weeks of gestation and where babies who are borned over than 500 gr, the legislations allow parents to take the body of the baby, otherwise there are no strict rules for the remainings of the baby as told by Mrs. A. who was a doctor. Therefore, because of either the doctors did not talk about what to do with the remainings of the baby or the parents could not have thoughts about what to do with that; they did not make any religious ceremony including praying or reading Mevlüd for the baby.

"*Dini duygular yoğunsa o alabileceğiniz desteğin bir parçası gibi düşünebilirsiniz aslında dini duyguyla hani dinin kişinin üzerindeki etkisi bu olayla ilgili. Din sanki biraz o rahatlatıyor yani öyle söyleyeyim. O inanç noktasında biraz sizi rahatlatıyor. Ama böyle bir dua falan filan çok fazla eşim ediyor ama ben kendim etmiyorum*." (Mr. G.)

"If you have a strong religious belief, you can think of it as a part of the support you can get. That is the effect of the religion on the individual. I guess religion comforts you a bit. It comforts you on that point of belief. But I don't pray, my wife does, but I don't." (Mr. G.)

People who followed some religious rituals generally read some parts of the Quran.

"*Kendim dua falan ettim ama o sırada biraz da kafa da bulanık olduğu için, aslında böyle bir şeyde cenaze namazı olur mu diye o sıra pek düşünemedim. Bir de dünyaya gelmediği için, hani bazı çocuklar dünyaya geliyor, sonra ölüyor falan onlara cenaze namazı falan yapıyorlar. O sıra pek onu da düşünemedim ama kendim belli dualar ettim tabii*." (Mr. E.)

"I prayed on my own, but as I was confused at the moment I couldn't think if a funeral ritual would be suitable or not. And as it didn't come alive, some children come to the world then they die, they can make funeral rituals for them. But I couldn't think about it at the moment. I just prayed on my own." (Mr. E.)

"*Yani tam detaylı büyük bir Kuran okumadık ama, mevlit açısından öyle evde bir ya da camide öyle bir şey yapmadık ama evin içinde bir Kuran Yasin okuttuk*." (Mr. D.)

"We didn't make a complete and detailed reading of Quran, or any prayer gatherings at home or in the mosque. But we made reading of Yasin at home." (Mr. D.)

The only baby who was buried in the cemetery for the children who died at birth belonged to Mr. and Mrs. H. Both of them did not participated in the funeral of their baby. Firstly, Mrs. H. was in the hospital at that time. And secondly, they did not want to see the baby.

"*Çocuğu görmedim. "Benim için bir hayal gibi olsun." dedim. Bir rüya gibi olsun. "Böyle bir şey, bir şaka gibi olsun." dedim. Ama benim bilinçaltımda var tabii bilinçaltımda ister istemez var. O zaman da böyle oldu. Şey yapmak istemedim böyle somutlaştırmak istemedim. Yani fiili bir olay yaşamak istemedim. Kendimce yaşamak istemedim. Ben o olayın [defnedilmesi] ortasında olmak istemedim*." (Mr. H.)

"I didn't see the child. I wanted it to stay as a dream, as a joke. But it stays in my subconscious, no matter what. I didn't want to materialize it. I didn't want to live an actual thing. I didn't want it to happen. İ didn't want to be in the middle of it [the burial]." (Mr. H.)

4.3.3.3. Cognitive Based Coping

Some participants used some cognitive strategies to cope with the loss. For instance, thinking about the risk of having a retarded child, the rate or prevalence of pregnancy loss was very common among the participants. Or thinking about that they did not lose their reproductive ability, they could have a baby in the future was cognitive coping for some participants.

"*Ya olumluları da görüyorsunuz, olumsuzları da görüyorsunuz, hayatta neler. Mesela benim bir müşterim vardı. Çocuğu doğuştan otizmliydi. ...Hani özellikle mesela onu gördüğüm zaman ha bu arada adamla mesela bu kadar olumsuzluklara rağmen hep bir hayat enerjisi vardı adamda. "Olsun." derdi, yani "Onun yürümesi beni mutlu ediyor." derdi en azından mesela bunları bile gördüğümüz zaman ne yapıyorsunuz? Yani yani diyorsunuz ki ben hanım da sağlıklı yani olmama ihtimali yok. Bugün olmaz, on yıl sonra olur hani buna takılmıyorsunuz. Ya bir de belki de bundan dolayı soğukkanlı oluyoruz*." (Mr. F.)

"You see the good and you see the bad too, there are many things in life. For example, a client of mine had a son with autism. Whenever I saw him, I felt his energy of life despite so many negative things. 'So be it.' he used to say, 'I feel happy just by watching him walk'. When I see these, I realize that we are a healthy couple and we still have the chance. If not today, ten years later. That's why you get calmer." (Mr. F.)

"*Yani insan ne olursa olsun o hani annelik şeyi, bir kere hani yerleşince evet ben hamileyim, anne olacağım şeyi oturunca kafaya onun elinden alınması insana böyle bir anda koyuyor yani veya hani hiç hamile olmadığını düşün, birden hani -bebek sahibi olmayacağım diyorsun- ama doktora gidiyorsun. Hormon tetkikleri falan yapıyor, menopoza girmişsin, erken menopoz. O hissiyat bile kötü hani istemiyorsun ama bir şeyi istememekle, ona sahip olabilitenin elinden alınması farklı bir şey. O hissiyat hep orada kalsın istiyorsun yani o ihtimal. Ama o ihtimal de elinden alınınca hiçbir şeyin kalmıyor yani. Onun gibi bir şey o da. Hani anne olabilme ihtimalinin alınıyor gibi bir şey oluyor, annelik hani. Farklı bir şey yani. Yani hani, ama o olmuyor yani düşükten sonra da hayat devam ediyor ve hani senin rahmin duruyor vs. Hani tekrar çocuk sahibi olabileceksin ve hani tekrar çocuğun olduğu zaman bunları unutuyorsun bile yani belki hatırlamıyorsun bile. Gerçekten de öyle oluyor. Ama tabii o ilk yaşadığın şeyler yani yaşanacak yani. Ama geçecek. Yapacak bir şey yok, her kayıpta olduğu gibi yani*." (Mrs. A)

"No matter what, when that sense of motherhood settles in you, losing it strikes you bad. Imagine a woman who does not want to have a child, but then she does to a doctor, test her hormones and the result is early menopause. That feeling is terrible. You don't want it but not wanting is very different from losing the possibility of it. You want to keep that possibility. But when you lose it, there is nothing left in your hands. It's like that. It's like losing the ability to be a mother. I mean, motherhood, is something else. Your life still goes on after the miscarriage if you keep your womb, and the ability to conceive again. If you have another child, you can forget it all. It really happens. But those you go through are going to be experienced. Nothing to do about it, as it is in any loss." (Mrs. A.)

"*Hani yol yakınken dönülmüş. Yani sonuçta bu dünyanın sonu değil. Hayat devam ediyor. Daha da eğer hamile kalabiliyorsak daha sonra da hamile kalabiliriz..Artık olabileceğini düşünerek onu atlattık. Yani olumlu yönleri de var can kaybının ötesinde*." (Mr. I.)

"We gave up before it was too late. It's not the end of the world after all. Life goes on. I can still get pregnant. We got over it by thinking that we can still do it. There are also positive ways beyond the loss." (Mr. I.)

"*Psikolojik anlamda yani bu bir kayıptı evet. Ama hani bu kayıp bittikten sonra ben bir daha hamile kalabilirim. Hani sonuçta ben bir kadınım. Eğer ki benim böyle bir hakkım varsa bir sağlık sorunum yoksa hani ben bir daha hamile kalabilirim. Kendini körü körüne o kayıp şeyine bağlamaması gerekir kadının da*." (Mrs. G.)

"Psychologically, yes, this was a loss. But after this loss I can get pregnant again. I'm a woman after all. If I have this right and don't have any health problems, I can get pregnant again. The woman shouldn't let herself get lost in the loss." (Mrs. G.)

4.3.4. Having a Subsequent Child or Already Having a Child

Among the participants, 4 couples had already child (couples D, E, H and J.) and 5 couples had child after their pregnancy loss experience (couples A, B, E, G, and I.), couple E. had a previous and a subsequent child. Only two couples (C and F) did not experience any surviving child's parenthood.

Participants, who already had a child, consoled themselves with the first child. On the other hand, for the participants who had a subsequent child after the loss, grief was not complicated, and it did not lat long. Five of the couples in the study expressed that they did not thought as much about the loss after their subsequent child's birth as it was immediately after the loss event. Having a subsequent child became the reason to stay strong for the bereaved parents. Without having a child, the loss experience would be traumatic for some participants.

"*Şimdi bir tane daha çocuk kaybettik. Ne oldu şimdi? Acımız büyüdü değil mi? Ama elde var bir tane, cepte bir tane var. Hiç çocuğu olmayan ne yapsın? Şimdi orada senin erkek ya da kız deme şansın var mı? Senin erkek istiyorum, kız istemiyorum deme şansın var mı? Ya da tam tersini düşünelim, yani hiç çocuğu olmayan 45-50 yaşında bir bay bayana, bir çifte, "Ya sizin bir çocuğunuz olacak ama, istediğiniz cinsiyet olmasın. Olmayacak." dediğinizde "Yok ben bunu istemiyorum." derler mi sizce?*" (Mr. J.)

"Now we lost another child. What then? Our grief increased, didn't it? But we have already one, we have a child. What about those who have no children? Do you have a chance to want a specific gender then? Or let's think about the other way around, if you tell a couple of 45-50 years of ages with no children that they are going to have a child but not the gender you want. Do you think they can say 'we don't want the child then.'? (Mr. J.)

"*Hani sınırdan belki de travmanın sınırından bir geçiş oldu, daha sonra eşimin tekrar hamile kalması ve o sürece geçmemesi belki de bizim için daha travma dönemlerine girmeden daha hızlı atlatmamıza vesile oldu*." (Mr. A.)

"We passed through the border of trauma but my wife's having another pregnancy made us overcome the period without getting into a big trauma." (Mr. A.)

"*Vera'ya hamile kalana kadar. Yani bir üç ay falan. Yani hamile kalamasaydım muhtemelen daha uzun sürecekti. Yeni haberi alınca artık eskisini unuttum... Yani tabii Vera'nın gelmesi de unutturdu bize hani. Gelmeseydi, şu ana kadar bebeğimiz olmamış olsaydı muhtemelen konuşurduk hala. Muhtemelen ben hala bunalımda olurdum falan filan. Ama nasıl olsa yenisi oldu diye hiç konuşmuyoruz onu, bahsi*

"Until I got pregnant with Vera. For about three months. It would probably last longer if I haven't got pregnant. I mean I forgot the previous one when I got the news. Of course, Vera's birth also made us forget. If she hadn't come, if we had no child now, we would probably be still talking about it. I would still be in depression now. But as we have a new baby, we don't talk about it, the subject isn't brought about." (Mrs. B.)

açılmıyor." (Mrs. B.)

On the other side of the coin, between the time they lost their baby during pregnancy and time that their subsequent child was born, they had emotional reactions resulted from the loss. After their loss experience in pregnancy, participants were more anxious during their pregnancy. After the child born alive, all the problems they experienced faded away but until that point, they followed the specific dates very firmly (i.e. the month that the baby was lost), they paid attention more to their physical activities, to what they ate and so on. This anxiousness was expressed by both men and women in the study.

"*Hamilelik süreci biraz daha şey geçiyor yani rahat bir hamilelik geçiremiyorsun çünkü önceden yaşamış olduğun bir şey var. Bu süreçte hani anne daha titizleniyor, duygusallaşıyor çünkü önceki yaşadığı olayın daha sonra tekrar etme şeyi düşüncesi*." (Mr. A.)

"The period of pregnancy becomes a bit different, it cannot be an easy process as you had a difficult experience before. The mother gets more nervous and emotional due to the thought of the repetition of the past experience" (Mr. A.)

"*Hani şimdi bile mesela ben ikinciyi düşünüyorum bu sefer. Bu bile şimdi tedirgin ediyor. Artık düşük olayını bir yana bıraktım. Bu sefer ben bir daha gebelik zehirlenmesi yaşarsam, çünkü gebelik zehirlenmesinin bile belli dereceleri var. Hani ben yine orta seviyede bir şey yaşadım. Hani Allah korusun, beyin kanamasına kadar gidiyor. Çok kötü durumda sonlandıranlar bile oluyor. Bir de onu düşünüyorum hani. Bu bile ayrı bir korkutuyor yani*." (Mrs. G.)

"Even now I am thinking about the second this time. Even this makes me nervous. I set aside the miscarriage, I am now anxious about the probability of pregnancy toxemia. Because it has degrees, I passed through a moderate one. God forbid, it may as well result in cerebral bleeding. There are even worse cases than that. I am thinking about that and it makes me scared." (Mrs. G.)

Even if they did not experience more than one pregnancy loss, some participants expressed that it would be harder if they experienced this loss more than once.

"*Ama düşünsenize bunu iki kere, üç kere, dört kere yaşayan anneler var. Ve beş-altıncı ayında bebeği canlanmış, artık bebeğini şekil olarak görüp kaybeden anneler de var. Hani onlarda çok soğukkanlı böyle hani sağduyulu anneler var. O yüzden diyorum. Yaşandı ve bitti*." (Mrs. G.)

"But think about it, there are mothers who lived through the same thing three or four times. Or there are mothers who lose their baby after they see the form of it in fifth or sixth month of pregnancy. Some of them still stay strong. That's why I say it is lived and gone." (Mrs. G.)

4.3.5. Hope for Future Fertility

14 of the 20 (8 women, and 6 men) participants expressed that they consoled themselves with the idea that they could have baby in the pregnancy since they did not have a genetic or reproductive problem. After the loss experience, while it was hard for the participants to accept the finality of their pregnancy, one of the factors that helped them to cope with the loss was their chance of future pregnancies. That is why, what was heard from the doctors after the loss related to partners' reproductive system affected their grief process. If the doctors did not find any problem related to man or woman's reproductive system, then they kept their hope for future fertility that was an important positive factor affecting their grief. However, when the doctors suggested other interventions such as the possibility of tube baby, or adoption, losing the chance of future pregnancies might have added extra stress and sadness for the participants.

"*Yani insan ne olursa olsun o hani annelik şeyi, bir kere hani yerleşince evet ben hamileyim, anne olacağım şeyi oturunca kafaya onun elinden alınması insana böyle bir anda koyuyor yani veya hani hiç hamile olmadığını düşün, birden hani -bebek sahibi olmayacağım diyorsun- ama doktora gidiyorsun. Hormon tetkikleri falan yapıyor, menopoza girmişsin, erken menopoz. O hissiyat bile kötü hani istemiyorsun ama bir şeyi istememekle, ona sahip olabilitenin elinden alınması farklı bir şey. O hissiyat hep orada kalsın istiyorsun yani o ihtimal. Ama o ihtimal de elinden alınınca hiçbir şeyin kalmıyor yani. Onun gibi bir şey o da. Hani anne olabilme ihtimalinin alınıyor gibi bir şey oluyor, annelik hani. Farklı bir şey yani. Yani hani, ama o olmuyor yani düşükten sonra da hayat devam ediyor ve hani senin rahmin duruyor vs. Hani tekrar çocuk sahibi olabileceksin ve hani tekrar çocuğun olduğu zaman bunları unutuyorsun bile yani belki hatırlamıyorsun bile. Gerçekten de öyle oluyor. Ama tabii o ilk yaşadığın şeyler yani yaşanacak yani. Ama geçecek. Yapacak bir şey yok, her kayıpta olduğu gibi yani*." (Mrs. A.)

"No matter what, when that sense of motherhood settles in you, losing it strikes you bad. Imagine a woman who does not want to have a child, but then she does to a doctor, test her hormones and the result is early menopause. That feeling is terrible. You don't want it but not wanting is very different from losing the possibility of it. You want to keep that possibility. But when you lose it, there is nothing left in your hands. It's like that. It's like losing the ability to be a mother. I mean, motherhood, is something else. Your life still goes on after the miscarriage if you keep your womb, and the ability to conceive again. If you have another child, you can forget it all. It really happens. But those you go through are going to be experienced. Nothing to do about it, as it is in any loss." (Mrs. A.)

One of the dimensions that creates stress and sadness in couples was that their fear regarding not-having a future pregnancy. Participants who already had a child knew that they did not have a reproductive problem, but for the couples who did not have a previous child and especially for the ones who experienced more than one pregnancy loss, unpredictable future creates extra emotional burden.

"*Bir de şu da var, yani hani bir de çocuk sahibi olmanın o istek o şey zaman içerisinde bir de şey oldu başka bir çocuğumuz da olabilir ya da olacak hissiyatı biraz bizi rahatlattı açıkçası yani olabilir, özellikle doktor hani şunu "Üç ay daha doğrusu dört beş ay sonra çocuk sahibi olmak isteyebilirsiniz." şeklindeki şeyleri bizi biraz açıkçası rahatlattı*." (Mr. G.)

"And there is also this, wishing to have another child, or the possibility of it comforted us to be honest. Especially when the doctor said 'you can wish to have another child in four or five months", we felt better." (Mr. G.)

As Mrs. F. exemplified below, having a child in natural ways sometimes desired for men or women. Doctor's suggestions regarding the possibility of having a baby via tube baby treatment made Mrs. F. feel so sad. She may think these suggestions as the doctors' confirmation of their reproductive problem they had in the pregnancy loss experiences.

"*Pazartesi günü, tabii pazartesi günü doktora gittim. Bu "Tüp bebek düşün." dedi hani bir an böyle o an, o zaman kapıdan çıktım, ağlıyorum ama hani etraftan insanlar da çok böyle dikkat çekmesin diye kendimi sıktım ben o gece çok ağladım*." (Mrs. F.)

"Then, on Monday, I went to the doctor who said, "consider test-tube baby". That moment, when I walked out the door, I cried but there were people around. I didn't want to draw attention. I forced myself to stop. But I cried a lot that night." (Mrs. F.)

People who tried to support the bereaved participants, neighbors or family members who came to visit the couple, talked about their being young and having many options in the future. For some participants, even hearing that they would have another chance in the future to have a child was comforting. While in other studies these kinds of suggestions were found be non-effective and sometimes harmful for the bereaved parents, in this sample these comments were helpful. none of the participants had regrets over these comments.

"*Ara sıra burada çalışan bir teyze vardı, şey demişti bana, o beni çok etkilemişti, hala hatırlarım. "Kızım çok üzülme, yani üzülürsün, bir şey olur. Ama Allah eşine sağlık versin.Hani birbirinizi seven bir çiftsiniz. Allah eşine sağlık versin. Tekrar*

"There was a woman who worked here occasionally. Once she said 'Don't worry my dear, may God give your husband health. You are a loving couple. You can have it later.' that was so comforting. I still remember it." (Mrs. I.)

olur." demişti. O beni öyle bir rahatlatmıştı. Hala hatırlıyorum mesela." (Mrs. I.)

4.3.6. Other Stress Factors

Other negative life events may have affected the grief experiences of participants. Three of the participants had experienced their mother's loss (Mrs. B., Mrs. D. and Mr. C.). For Mrs. D. and Mr. C., their loss affected them so much that during our interviews, the subject the person was talking about changed a lot. For these 3 participants, the stress was higher during the grief. Moreover, these participants' spouses knew that their stress after the loss was higher since they experienced other losses in their lives in close times.

"*Biz evlenmeden önce, daha nişanlıyken annesini kaybetti eşim ve annesine inanılmaz bağlı, ikisi de birbirini çok seven sayan insanlardı anne oğul olarak. Ben eşimin daha bu kaybı da atlattığını düşünmüyorum…şimdi bu bebeğin düşmesi yani "İkinci bir Fatma öldü." kafasında da böyle şeyleri düşündüğünü biliyorum. Zaten annesi de öldü, e bebek de adı aynı olacaktı, yani kız olup olmayacağını bilmiyoruz ama biz kız diye düşünüyorduk, o sebeple yani ikinci bir ölümmüş gibi, daha şey olmuş oldu. Diğerini tetiklemiş oldu bir daha. Tabii bu anlamda bence biraz daha da etkiledi onu*." (Mrs. C.)

"My husband had lost his mother before we got married, when we were engaged. And my husband was so close to his mother, the two of them were loving and respecting each other a lot as a mother-son. I don't think my husband got over it even now. The loss of this baby now seemed to him as the death of another Fatma. Her mother had already died, and the name of our baby will be her name. we didn't know the gender, but we always felt it was a girl. That's why it hit him as a second loss. It triggered the previous grief. In this sense, he was more affected." (Mrs. C.)

Mrs. D. was the one who had more intense reactions to pregnancy loss, and one of the factors increased her stress was her experiencing other losses. She went to a psychiatrist after her mother's death, but still her some of the symptoms still continue.

"*Ölüm korkusu vardı. Hani ben de ölecekmişim gibi, ben hani hatta onu doktora da söyledim. Dedim "Doktor Hanım böyle böyle." dedim. Hani "Benim ölüm korkum var." dedim. "Hani her an bir şey olacak hani ben de ölecekmişim gibi." dedim. Ha doktor hanım da dedi ki "İşte böyle." dedi, "Kayıplar yaşadığın için." dedi, "Çok etkilenmişsin." dedi. "Etkilendiğin için." dedi, "Sana öyle bir korku oluşmuş üstünde." dedi. Ondan sonra, işte ondan sonra kendim böyle şeyden destek almak istedim işte*." (Mrs. D.)

"I had a fear of death. It seemed to me as if I, too, was going to die. I told it to my doctor. I said 'doctor, I have this fear of death. I feel as if something will happen in any moment and I will die.' Then the doctor said 'you are affected by your losses, that's why you have developed this fear.' Then I wanted to have this support. (Mrs. D.)

In addition, having economic problems after the loss (n=6), being away from the support systems (n=2) was also stress factors expressed by participants.

"*Diyorum ya hani biraz şartlar elvermediği için belki de biraz da dönem olarak yanlış bir yani böyle doğru bir zamanlama olmadı. Hem bebeğimi kaybettiğim dönem, sonrası eşimin askere gitme dönemi ve o dönemde de Diyarbakır'ın ben Diyarbakır'a geldim ailemin yanına eşim hani askere gitti diye. Belki hatırlarsınız o dönem de Diyarbakır'da çok kötü olayların olduğu bir dönemdi. Böyle yani dışarıya çıkma yasağı anonsları yapılıyordu falan. Hani böyle bildiğiniz ben hem eşimi askere gönderme, hem bebeğimi kaybetme hem de böyle bir eve kitlenme psikolojisi içerisindeydim hani her an böyle bir şey atılsa sanki ev havaya uçacak modundaydık. Çünkü çok kötü olayların olduğu bir dönemdi...O dönem hiç böyle daha doğrusu psikolojimi rahatlatmanın tam tersi psikolojik anlamda çok berbat bir döneme denk geldim yani. O yüzden şey kötü bir dönemdi yani hiç unutamıyorum zaten*." (Mrs. G.)

"As I said, the conditions were bad, and the timing was so bad. Both the period of this loss, and then my husband went to his military mission. I came to my family house in Diyarbakır while my husband was in the army. Perhaps you remember, those days terrible things were happening in Diyarbakır. There were curfew announces. I was shut in a psychological state of both the loss, and my husband's being in the army and this atmosphere in Diyarbakır. We were in a state of constant danger, we could explode instantly if somebody throw a bomb to the house. Because it was a terrible period there. I could find no way of easing my psychological state, on the contrary, it happened to be an awful period. That's why it was a really bad period, I cannot even forget it." (Mrs. G.)

4.3.7. Lack of Control

In this sub-theme participants statements (n=8) regarding making decisions rapidly without having time to think about details of their experience and their perceptions of lack of control over their decisions in terms of hospital, baby related issues were presented.

All participants experienced pregnancy loss involuntarily, so the result of their pregnancy was not expected. That is why, they had to decide for the curettage operation rapidly. Because the mother's health was also in danger, in addition to shock experienced with the pregnancy loss, the participants also had to think about the health of the mother. Also, that rapid process in the hospital did not let participants to think about the details of the hospital process. For instance, they did not have a chance to get opinions of doctors about the remainings of the baby, whether they could have done a funeral for the baby.

"*İnsan hiç beklemiyorsun ya, hazırlıksız yakalanınca hiç de bir şey aklına gelmiyor. Ne kadar doktor da olsan. Yani birileri bir şey söylüyor sen onu yapıyorsun yani o an. Başka hiçbir şey düşünmüyorsun*." (Mrs. A.)

"As you don't expect it at the moment, you don't know what to do. Even if you are a doctor. I mean you do what they tell you to do. You can't think of any other thing." (Mrs. A.)

"*Gerçekten kaybettiğimizi anladığımız zaman hızlı bir şekilde karar vermemiz gerekiyordu yapılacak şeye çünkü artık vücutta ölü bir cenin vardı, hani anneye de zarar verebilirdi ve test edilen o anki şey daha sonra eğer düzgün bir müdahalede bulunulmazsa daha sonraki gebeliklerde de hani anne için gebelik riskini düşüren hani kanser olma şeyi eğer iyi temizlenmezse oluşturabilecek bir şey vardı çünkü*" (Mr. A.)

"We had to decide what to do when we learned about the loss. As there was a dead embryo in the body , it could damage the mother. And the thing they tested could result in decreased fertility in subsequent pregnancies if not intervened immediately or cancer if not cleaned completely." (Mr. A.)

Mrs. E. was the only one who expressed that making decision rapidly made her begin to suspect about the decisions made related to baby.

"*Ya şöyle düşündüm acaba ben bir doktora gittim, o direkt "On gün olmuş, ölmüş, hemen kürtaja alalım." dedi. Ben direkt "Alın." dedim. Acaba başka doktorlara gitse miydim? Hep kafamda bu var. İki üç dört beş doktora daha görünse miydim? Farklı hastanelere gitse miydim? Acaba yaşıyor muydu? Ya da kurtarılabilir miydi? Ya da başka doktorlar daha başka bir çözüm verir miydi? Durdurabilirler miydi? Hep bu soruları sormuşumdur kendime. Hep böyle düşüncelerim oldu yani*." (Mrs. E.)

"I went to a doctor and he directly said 'it's been dead for ten days, we have to take it immediately.' And I said okay. But should I have seen other doctors? There is always this question in my mind. Should I have seen two three four more doctors? Should I have gone to other hospitals? Was it rescuable? Was it alive? Or could other doctors have given different aadvices? Could they have stopped it? I have always asked these questions to myself. I have always had these thoughts." (Mrs. E.)

4.3.8. Views on Normalcy of Grief Process

Participants experienced many feelings after their loss experience and there were many things changed with this loss, they faced with the reality that their plans would be postponed at least within the near future. While society had some rituals for the loss of older people, what are the rituals for the pregnancy loss was not known and this affected the participants to question whether their grief was normal. Or they worried about whether their feelings for this loss was normal or not.

"*Hani aslında bu tür durumlarda hani üzüntünüzü de çok fazla yansıtmıyorsunuz, daha çok yani kendi adıma söyleyeyim çevreye. Çevre de bunun normal bir şey olduğunu söylüyor. Hani üzüntüyle alakalı çok fazla biliyorsunuz hani toplumumuzda çok fazla çevremize yansıtmayabiliyorsunuz özellikle baba adayısınız. Normal bir şey gibi karşılanıyor yani, öyle söyleyeyim.*

"You don't reveal your sadness to others in such situations. They say this is something normal. You know, in our society if you are an expecting father you can't reveal your sadness. It is regarded as normal by society and the others." (Mr. G.)

Toplum tarafından. Çevre tarafından." (Mr. G.)

"*Yok, öyle bakılmıyor da. "Olur." diyorlar, yok normal sayıyorlar aslında. "Düşer." diyorlar. "Sanki düştüğüne şükret. Hiç olmasa ne yapardın?" diyorlar. "En azından oldu da düştü." "Düşüğün kıçı içinde." diye bir laf var. "Hemen olur peşinden." dediler. Yani normal sayıyor, hani kimle karşılaşsam, "Olsun ya düşsün. Yaşınız genç, yine olur." diyorlar. Öyle, şey yapmıyorlar yani ters karşılamıyor. Çünkü ben şu anda bile bak yan komşumuz falan hep çocuk düşürmeler çoğaldı. Benim zamanım, benim kürtaj olduğum dönemde düşün yani o ay içerisinde on tane çocuk düşüren vardı benimle beraber. Çok çocuk düşüren vardı, hepsi de benim gibi, iki aylık, üç aylık düşüren. O hepsi de benimkinin sıkıntısı, gelişmemiş. Bebek gelişmemiş. Ya da direkt bebek rahminden düşüyor. Yani o dönem çok çoğaldığı için herkese normal gelmişti*." (Mrs. E.)

“No, they don’t look at that way. ‘It happens’, they say, they view it as normal. ‘Miscarriage happens’, they say. ‘Be thankful you had a miscarriage, what would you do if you didn’t even have it? At least you had it.’ They told me: ‘You get pregnant again straight away’. Anyone I talk to says: ‘Nevermind, you are young, you will have another.’ It is not perceived negatively. Miscarriages are increased nowadays. During the time I had abortion, there were ten other miscarriages in that month. There were so many miscarriages, all of them were like me, miscarriage during the second or third month of the pregnancy. The same issue as I had, the baby was not developed. It seemed normal to everybody during that time because there were many miscarriages.” (Mrs. E.)

Below, Mrs. C. talked about how her loss was denied by most of the people in her life. According to her, "get well soon" wishes were not so proper for the pregnancy loss because these statements implied that there was an illness rather than a loss. She expressed the instant when she felt being understood by another person regarding her loss.

"*Bu konuda sadece farkındalığım biraz daha şöyle oldu, herkes tabii “Geçmiş olsun, geçmiş olsun.” İşte “Şifa dileriz.” vs. vs. diyordu. Yani kimle konuşursam. Ama benim bir eğitim durumum vardı işte doğum psikologluğuna dair bir eğitim grubu. Bununla ilgili bir oranın işte hocasıyla görüşmeye gitmiştim. Öncesinde tabii ki bir kendi durumumuzu, geçmişimizi, doğumla ilgili, doğum psikologluğu olduğu için kendi aile ilk doğum hikayemizden biz bir bebek doğurduysak bu hikayeye kadar her türlü şeyi öncesinde istemişlerdi bizden bilgi olarak. Yani oraya gittiğimde kadın gayet benle ilgili şeyleri biliyordu. Mesela lafa şey diyerek başladı “Bilgilerinizi okudum. Öncelikle baş sağlığı diliyorum, başınız sağ olsun. Bir kayıp yaşamışsınız.” şeklinde başladı. Gerçekten mesela işte onu*

“My awareness about this was developed as follows; everybody told me ‘Get better soon’, ‘Wish you a speedy recovery’ etc. Everybody. But I was in an educative group about birth psychology. I went to see the instructor of the group. They have requested background information about us beforehand about our personal situation, our past, our first birth story if we had a baby before, everything. When I got there the instructor already knew a lot about me. For example, she started by saying: ‘I read about your background. First of all, my condolences. You experienced a loss.’ Then when I thought about it, I told myself: ‘This is a loss too. It doesn’t have to be one or two years old to be considered as loss.’ Until that day nobody had offered condolences before. The fact that the

sonrasında düşündüğümde bunu diyorum yani "Bu da bir kayıp. İlla bir bir yaşına, iki yaşında olup bebeğin ölmüş olması gerekmiyor." Yani o güne kadar kimse baş sağlığı dilememişti mesela. O kadın orada "Başınız sağ olsun, gerçekten bir kayıp yaşamışsınız." demesi çok başka bir şeye götürdü yani beni. Hani o anda gerçekten evet, bu öyle bir şey aslında. Önemli bir kayıp, yani bir ölüm neticede. Yani bu hastalık değil "Geçmiş olsun." denilebilecek. Aslında bu bir kayıp. O yüzden baş sağlığı bence çok uygun. Ve tek diyen o kadındı. Çok da iyi gelmişti orada." (Mrs. C.)

instructor told me: 'My condolences, you really experienced a loss.' was something else. It is an important loss, it is death after all. It is not a sickness that you can just say 'Get better soon.' This is a loss. And offering condolences is very suitable. The instructor was the only one to say that. And it was comforting." (Mrs. C.)

Sometimes participants had questioned their grief reactions, whether they overreacted or underreacted, what were the normally accepted reactions of parents from the society's viewpoint.

"*Hani öyle mi normal? Ben mi anormalim acaba?" diyorum. Ya ben atlatmaya çalışıyorum "Sen iyisin, valla iyisin, maşallah." diyor bana hani iyi niyetle yaklaşıyor ama. Ben kendimi sorguluyorum mesela diyorum yani "Allah Allah bu daha mı kıymetli yani, bunun çocuğu daha mı kıymetli ki bu kafayı yiyor da ben atlatıyorum." diyorum*." (Mrs. H.)

"'Is it normal? Or am I abnormal then?' I say. I'm trying to get over it, they tell me 'You are fine, really fine, god bless.', albeit with good intentions. I question myself: 'Is her child more precious than mine since she is going crazy while I'm getting over it?'" (Mrs. H.)

"*Bazen öyle düşünüyorum. "Acaba hani gerektiği kadar o özeni vermedik mi? diyorum. Bazen de "Ne yapılabilirdi ki?" diyorum. "Yani bunun üzerine ben tabii ki üzüldüm, aylarca yataklara mı düşmeliydim? İşte aylarca işe gitmemeli miydim? Ya da sürekli ağlamalı mıydım? Bu muydu standardı?" diyorum. Ama yani hani bunun bir standardı yok. O yüzden ben de karışık, daha çelişkili duygular ara ara tabii ki düşünüyorum."* (Mr. C.)

"Sometimes I think that way. 'Didn't we take enough care?' I wonder. 'What could be done?' 'Of course, I grieved, was I supposed to be sick in bed for weeks? Was I supposed to leave work for months? Or cried nonstop? Is that the standard?' But there is no standard. Therefore of course I have complicated, contrasting feelings from time to time." (Mr. C.)

4.3.9. Self-Changes

After the loss experience, some participants had new awareness in their lives regarding changed life philosophy, values, beliefs, relationship changes. For instance, some participants talked (n=7, 4 of them were women and 3 of them were men) about changes in

their opinions such as appreciating what they already had, the need to accept that not everything could be controlled, and humans could not have power over everything.

"*İnsanı biraz durgunlaştırıyor tabii. İnsanın aklına ölümü getiriyor sürekli. Bir gün bizim de öleceğimiz, bu yüzden de hareketlerimize şeylerimize böyle daha kırıcı değil yapıcı olarak davranmamız gerektiği, her an ölümle baş başa olduğumuzu hissettiriyor tabii ki*." (Mr. E.)

"It calms you down, of course. It reminds you about death all the time. It makes you feel that you will die one day too and therefore you should act constructive instead of destructive and you face death all the time." (Mr. E.)

"*Hani kendim adıma şunu fark ettim. Biz hani çocuk olsa da olur, olmasa da olur görüşündeydik diye zannediyorduk ama o kaybı yaşayınca biz gerçekten çocuk istiyormuşuz ve onu kaybedince bunun şeyini çok daha net anladığımızı düşünüyorum, daha net gördüğümüzü fark ettim yani. Yani hani olsa da olur olmasa da olur şeyinde bakarken evliliğin ilk yıllarında, acaba olmasa mı? Sonra hani baktık gördük olmuyor, uğraştırıyor, sonra olunca çok sevindik, kaybedince inanılmaz bir şey olmuştu yani çöküş olmuştu bizim için*" (Mrs. I.)

"I realized this: We had thought that we would be happy with having a child or not but I think we understood it more clearly that we really wanted to have a child when we experienced the loss. I realized that we saw it more clearly. You see it like you can be fine with having a child or not during the first years of marriage, you may even think 'maybe we shouldn't'. Then we realized it is difficult and takes too much effort. Then we were so happy when it happened, and it was unbelievably bad when we lost it, it was a disaster for us." (Mrs. I.)

"*Hani bazı şeylere isyan etmememe sebep oldu. Olan bir şeyi değiştirmememe. Onu da kabullenmem gerektiğini, hani bunu anladım, yani. Bu başıma gelmiş, bu olmuş. Keşke şu olsaydı da hani ben çünkü bunları hep irdeledim durdum. Yani mesela kız olursa tepkisi nasıl olur? Bunları şimdiki aklım olsaydı düşünmezdim. Bunları düşünmezdim, irdelemezdim*." (Mrs. J.)

"It had made me not cry out against things, not to change what has happened. I learnt that I should accept it. This happened, or that. Because I kept analyzing like 'wish it happened this way', or 'how would it be like if it was a girl?'. If I knew then what I know now, I wouldn't have dwelt on it so much. I wouldn't analyze, wouldn't think about it so much." (Mrs. J.)

"*Varsa şansın yeni alternatifler deneyeceksin. Yoksa da kabuğuna çekilip oturacaksın yani. Çünkü farklı bir şey bu. İnsanın kendisinin doğması bile bir şans. Hani milyonlarca sperm gidiyor, sen en önden gidiyorsun, içeriye giriyorsun. Kapıları kapatıyorsun ve dünyaya geliyorsun. Yani bir sıra geride olsan sen yoksun. Anlatabiliyor muyum? Aslında hepimiz doğduğumuz için şampiyonuz. Anlatabiliyor muyum? Hepimiz şampiyonuz aslında. Onun için yani olacaksa oluyor, olmayacaksa olmuyor*." (Mr. J.)

"If you have the chance, you should try alternatives. Or you will withdraw into your shell. Because this is something different. Being born is already a chance itself. You know, millions of sperms race each other, you come first, go inside, close the door and born into this World. You know I mean? Actually, we are all champions for being born. Therefore, if it's meant to be, it happens." (Mr. J.)

"*Ya şeyi düşünüyorsun mesela birincisi bir çocuğun, bir çocuğa sahip olmanın kolay bir şey olmadığını, hani etrafına baktığında insanların çocuklarına davranışlarını şeylerini görüyorsun ya da hamilelik süreçlerini görüyorsun. Ya diyorsun bir çocuk kolay sahip olunmuyor. Nasıl süreçlerden geçiliyor, kayıplar oluyor, hani insanların çocuklara davranışlarının şeylerinin o çok mesela bende o süreci geçtikten sonra o çok farklı oldu. Çünkü çocuk sahibi olmak gerçekten aslında kolay bir şey değil. Hani yaptım oldu, o süreçleri yine bu kayıp sürecini, ondan sonra hamilelikteki süreçleri görüyorsun çünkü onun etkileri, ondan dolayı yaşadığın şeyler, hani bir mucize olarak görüyorsun o çocuğu, etrafındaki çocukları, onların hani o mucizeye nasıl davranıldığını, nasıl yetiştirildiğini gördüğün zaman biraz hani canın sıkılabiliyor, biraz insanların davranışlarını, çocuk yetiştirme şeylerini görüyorsun. Eskiden mesela daha şey olan hususlar şimdi daha çok dikkatimi çekiyor. Yani o çocuklara davranışlar hamilelik sürecindeki, yaşıyorsun, görüyorsun. Hani kolay bir şey olmadığını o kayıpla kazanç arasındaki ince çizgiyi gördüğün için hani o aslında o kayıp şeyinden geçmiş o kazanmış yani. Aslında orada bir piyango çekilişi olmuş ve o çekilişi aslında kazanmış ama kazandığının farkında değil*." (Mr. A.)

"First of all, it makes you think that having a child is not easy. When you look around you see how other people treat their children, or their pregnancy process. You say, it's not easy to have a child. What does one go through, the losses? After I went through that process, I looked at it differently. Because having a child is really not easy. You see the loss, the phases in pregnancy and you start to see the child as a miracle. And then it bothers you to see how people treat that miracle, how it is raised. You start to notice the behaviours of the people, their way of raising the child. Since you see the thin line between the gain and the loss, you see actually the loss has come out. There had been a lottery and the loss won it but it's not aware of it." (Mr. A.)

"*İstediğim bir şeyi hani elde edemeyince hani sadece her şey senin elinde değil yani hani. Hani böyle her şeyi kendin planlayabilirsin. Evliliğini, şeyini falan, her şey tıkır tıkır gider ama hani bu şeyinde de hani mesela parsiyel mol gebelik binde bir kişinin başına gelebilen bir şeymiş. Mesela atıyorum hani benim hiç öyle risk faktörüm yoktu mesela hani. Yaşlı olmak diyor hani, daha önce mol gebelik geçirmiş olmak bilmem ne olmak falan filan hani hiçbiri yoktu. Ama hani olması gerekiyorsa oluyor gibisinden hani demek ki vakti değilmiş diyorsun yani biraz daha böyle şey*." (Mrs. A.)

"When you can't get what you want, you realize not everything is in your control. You can plan everything yourself. Your marriage and so on, everything would go as planned but, in this case, partial molar pregnancy occurs once every 1.000 pregnancies. I didn't have any risk factors either. Being old, having molar pregnancy before, I didn't have any of these. But it happens, you think perhaps it was not the right time." (Mrs. A.)

Mrs. B. had started to be more careful about what she shares in her social-media accounts after the loss experience, since she realized that while people celebrate the mother's day in the internet, they do not realize that there might some people who lost their babies or their own mothers.

"*Ama hani benim annem de gitti, çocuğum da gitti. Böyle çok kötü olmuştum yani. O bayağı kötüydü yani o anneler günü benim için. Ondan sonra da zaten hiçbir özel günü kutlamıyorum şeyde yani sosyal medyada kutlamıyorum. Çünkü hani birilerinin babası yok, birilerinin annesi yok. Birilerinin çocuğu yok. Yani biz bu insanları bilmeden kendimizi mutlu etmek ya da gösteriş yapmak adına o insanları kırıyoruz. Ondan sonra hiç kutlamıyorum ben sosyal medyada*." (Mrs.B.)

"I lost my mother, I lost my child too. I was devastated. That Mother's Day was very difficult for me. Since then I don't post anything related to special days on social media, I don't celebrate them. Some people do not have a mother, some do not have a father. Some people do not have a child. We hurt these people by showing of or trying to make ourselves happy. Since then I don't post anything on social media." (Mrs. B.)

5 of the participants (n=5; Mr. and Mrs. A., Mrs. I. and Mr. and Mrs. G.) talked about their changed relationship with the subsequent child, how they viewed as a chance to have a baby was expressed by them Mr. A. and Mrs. A. stated that they became more patient after their loss experience since they appreciate the difficulty of having a healthy child more.

"*Ve şimdiki mesela Deniz'in böyle bazen hani katlanamadığım şeyleri olduğunda diyorum ki hani veya hani başkası başkasının hani ben bunu hani ne kadar zor emeklerle sahip oldum hani böyle yapmaya hakkım yok hani biraz daha hani şey gösterip daha çok sakinliğimi koruyordum. Eğer ilk gebelikte direkt çocuk sahibi olsaydım bu kadar belki sabır gösteremezdim çocuğuma*." (Mrs. A.)

"When Deniz does things I can't stand, I reminded myself of how much effort I made to have her and I didn't have any right to behave like this and kept calm. If I had a child the first time, I was pregnant, maybe I wouldn't have been so patient with my child. (Mrs. A.)

4. 4. Theme 4: Long -Term Grief and Bereavement Responses

Table 11: Long-Term Grief and Bereavement Responses

THEME 4: LONG-TERM GRIEF AND BEREAVEMENT RESPONSES
•Suggestions for Men and Women with Similar Experience •Time Heals the Wounds •Oscillatory Process of Grief •Professional Support •Anniversaries •"What If the Child Would Live" Thoughts

4.4.1. Suggestions for Men and Women with Similar Experience

Based on their own coping mechanisms, participants of the study gave some suggestions to couples who have similar experiences. Giving suggestions based on their own experiences enabled them a chance to reflect on their experiences and by conceptualizing their coping mechanisms, they might have reached new awarenesses.

Most of the participants (n=15) talked about the importance of spousal support after their loss experience. Rather than criticizing or blaming each other with the consequence of pregnancy, supporting each other and looking for new possibilities in the future were suggested. Within these 15 participants, there were also the ones who did not have the support they needed from their spouses, but they thought that would be helpful such as in the case of Mrs. B., Mrs. J.

"*Kayıp sonrası birbirlerine destek olsunlar. Yani çünkü ben bunu birebir yaşadım. Yani birbirlerine bahane edip, birbirlerini suçlamasınlar. Çünkü bunun sonu yok yani suçlamayla işte birbirinize bağırmakla, çağırmakla, kavgayla bu iş olmuyor*." (Mr. D.)

"They should support each other after the loss. I personally experienced this. They shouldn't use this as an excuse to blame each other. You won't get anywhere by fighting and shouting at each other." (Mr. D.)

"*Çünkü yani yaşayan bile olsa o duyguyu yani o bağı yaşayan insanlar olması lazım. Bu bağı yaşayan da biri annedir, biri de babadır. Yani ikisinden birisi bu duyguyu yaşadıkları için böyle bir sendrom yaşadıklarında kurtulacak olanlar da*

"Because it should be between the ones who felt those feelings and share the bond. And the ones who share this bond is the mother and the father. Since they are the ones who experienced this, it is themselves who will save each other. Nobody can tell

kendileridir. Buna kimse "Şöyle yapın, böyle yapın." diyemez." (Mr. H.)	them "do this, do that." (Mr. H.)
"*Hani aileyle de eşle konuşsunlar yani. Çünkü konuşulmadan atlatılmıyor. İçine kapandığın zaman sadece kendine ait işlerine odaklanıyorsun. Çünkü içinde bastırıyorsun o duyguları. Bir yerden sonra o patlak veriyor zaten patlıyor ama yine ağlayarak patlatıyorsun ama yine bir faydası olmuyor. Ama eşinle paylaştığın zaman daha farklı oluyor*." (Mrs. J.)	"They should speak to the family, to the spouse. Because you can't get over it without speaking. If you withdraw into yourself, you just focus about your own things. You repress those feelings. At some point it bursts out, you burst into tears, but it still doesn't help. But it is different when you share your feelings with your spouse." (Mrs. J.)

Almost all participants (n=16) also talked about their personal coping mechanisms such as going out, spending time with friends, doing things that calm them down, not-focusing on the negative comments from the environment, enjoying the time spent with the previous child and so on.

"*Ağlamak istedikleri zaman ağlasınlar. Bunu öneririm. Çünkü çok rahatlatıyor. Başka bebekleri sevmeye devam etsinler. Hoşlandıkları şeyleri yapsınlar ya. Her zaman hoşlandıkları şeyleri yapsınlar. Hani özellikle o birkaç ay böyle sevdikleri şeyleri yapsınlar. Sevdikleri insanlarla görüşsünler. Biraz yalnız kalsınlar. Kafalarını dağıtsınlar bir şeylerle*." (Mrs. F.)	"They should cry whenever feel like crying. I recommend this. Because it is so comforting. They should keep loving other babies, do whatever they enjoy doing. Always. Especially the first few months. They should see people they love, stay alone for a bit, distract themselves with various things." (Mrs. F.)
"*Valla, dışarıdan kimseyi dinlemesinler. Kafaya kimseyi takmasınlar. Gezip tozup, takmasınlar. Evde eğer bir çocukları varsa sırf ona odaklansınlar. "En azından bir tane çocuğum var." diye kendilerini teselli etsinler. Ha hiç çocuğu yoktur, kaybetmiştir hamilelik döneminde, "Olsun, yaşım genç, bir daha olur." havasına takılsınlar...Doktor ne diyorsa onu yapsınlar.Başkalarının dediklerine göre yapmasınlar yani hiçbir şeyi*." (Mrs. E.)	"Actually, I advise them not to listen to anybody else, not care about anybody. I advise them to concentrate on their child if they have one, console themselves by thinking 'At least I have a child'. They may not have any or had a miscarriage during pregnancy, in that case they should think 'It happens, I'm young, I can have a child again.' They should listen to what the doctor says, not anybody else." (Mrs. E.)

4.4.2. Time Heals the Wounds

There was an agreement between participants (expressed by 15 men and women) regarding that grief reactions would lessen with the time. Even the ones who lost their baby within the last 6 months (i.e. Mr. and Mrs. J.) were believing that with the time, they could have re-focus on their lives, they would find a way to cope with the loss. Even though they

might have thought about the loss from time to time, at least the loss did not affect them as much as within first months after the loss.

"*Zaman zaten hafifletiyor..Hani etkilerinin azalmaya başladığını fark ettiriyor. Fark ediyorum zaten epey zaman geçti yani. Yani o zaman bilmiyorum ya çok zor olurdu herhalde yaşam, o günleri saysaydım, şey yapsaydım. Alışmamış olsaydım. Zaman zaman aklıma geliyor yani hani böyle sürekli aklımda değil... Yani etkiliyor, şey yapıyor hani böyle iç acıtıyor vs. filan ama hayat bir şekilde devam ediyor yani hani.* " (Mrs. I.)	"It subsides with time anyway. It makes you notice that the effects start to reduce. I already notice lots of time passed since. I don't know, it would be very difficult back then if I counted the days. If I couldn't get used to it. It comes into my head from time to time, but you know, it's not always in my mind. It affects you, hurts you but life goes on somehow." (Mrs. I.)
"*Zaman geçtikçe tabii hani "Ölenle de ölünmüyor." diyorlar ya, bir de o da var tabii. "Zaman herşeyin ilacıdır." diyorlar ya bizim de öyle oldu biraz. Bir de bu yeni çocuk olunca daha da düzeldi*." (Mr. E.)	"As time passes, you know, as they say: 'You should let it go'." It was a case of 'Time heals all wounds' for us. And also, it got better with our new child too." (Mr. E.)

4.4.3. Oscillatory Process of Grief

Stroebe and Schut (1999) defined two styles of coping: loss-oriented and restoration-oriented coping. Loss orientation was the bereaved person's thinking about the loss, yearning for the lost one and other behaviors that were mostly grief work for the bereaved. On the contrary, in the restoration-oriented coping, the bereaved person attends to life changes, s/may be distracted from her/his loss experience, new roles and identities after the loss has been adopted by the bereaved. This second coping was mostly related to bereaved one's adaptation of her/himself to secondary stressors resulted from the loss (Stroebe & Schut, 1999). The oscillatory process, the distinctive concept of their Dual Process Model of Bereavement, was used to refer to alternation of the bereaved person between loss and restoration-oriented coping, meaning that the bereaved person might confront the loss at times, and s/he may avoid or distract her/himself from the loss issues at other times. According to Stroebe and Schut (1999), this dynamic back-and-forth process of grief was healthy behavior for the griever, for the optimal adjustment this oscillation has to occur.

In this study, most of the participants (n= 13) expressed that they thought about the loss from time to time. But especially the ones who did not have a child yet, thought about their losses such as Mrs. F. and Mrs. C., and Mr. C.

"*Bilmiyorum hani insanın bir kayıptır yani çocuğu olsun, köpeği olsun aklına illa ki gelir. Hani aman aman düşüneyim, üzüleyim şeyinde değilim ama aklıma gelince böyle sohbeti geçince bir şekilde insan üzülüyor*." (Mrs. I.)	"I don't know, any loss, whether a child or a dog, comes back to you for sure. I don't tend to specifically think or grieve about it but when I'm reminded of it or talk about it, it makes me sad." (Mrs. I.)
"*Yani yine etkisi şeyi yani her zaman oturup düşündüğün zaman hani aklına gelen, şey yapan, insanı rahatsız edici, bazen düşünüyorsun hani doğum gerçekleşseydi hani cinsiyeti ne olurdu, ne isim verirdik, nasıl olurdu, kime benzerdi hani bunları düşünüyorsun.. Her zaman konuşulan ve dile getirilen bir şey değil yani sonuçta o zaman yaşadıklarımızı, şeylerimizi şey yaptığımız zaman insan buruklaşıyor. O sürece gidiyorsun, yaşıyorsun*." (Mr. A.)	"You know, when you sit and think about it, it bothers you, you think what the gender would be, what name we would give, whom it would resemble and so on, if the pregnancy went through. It's not something you talk about or mention all the time but when we do things we were doing at that time it makes us upset. You go travel back to that time, live the same things once more." (Mr. A.)
"*Sonra unutuyorsun ama bir an geliyor, bir patlıyorsun o birikmişlerin hepsi bir anda patlak veriyor. Aklına geldiği zaman için yanıyor*." (Mrs. J.)	"Then you forget, but a time comes, and you explode, everything that's been accumulated just explodes. It tears your heart out when you remember." (Mrs. J.)

4.4.4. Professional Support

6 women and 3 men (n=9) talked about the importance of the professional support after the pregnancy loss. There were participants who expressed that they needed professional support after their pregnancy loss experience (Mrs. B., Mrs. D., Mrs. E., Mrs. G., and Mrs. J.), but none of them went to a professional for support. There were reasons behind their decisions.

Mrs. B. believed that since she experienced two losses (her mother and her pregnancy loss) that occured one after another, she believed that her reactions were normal and they would decrease with the time.

Mrs. D. asked for a professional support from the psychiatrist when her mother died, but she thought that medical treatments were not helpful for her psychological well-being and she quitted the medicine subscribed by psychiatrist and because she believed that same medical treatment would be suggested to her, she did not want to a doctor again. However, her psychological problems have had its effects on her life such as she could not stay in the closed places a very long time; or she could not spend time with others frequently, she needed to be alone from time to time. When the interview with Mrs. D. was ended, she asked for a referral and the researcher suggested a psychiatrist she have knew, who also had experience in EMDR treatment.

Mrs. E. would have desired to get professional psychological support but not because she had psychological issues that need to be resolved, but because she believed that there were no close friends, or family members of her so she could not have talked about her loss experience with someone special for her. Thus, she wanted to have a kind of social environment in which she could have talked about her experience. Because of their home's being away from the central and her economical problems, she could not have gone to a psychiatrist. When she was asked whether she needed psychological assistance then she could have been referred, she said she did not need after the born of her subsequent child because she likes spending time with her children and the loss did not bother her that much.

"*Aslında alsam çok iyi olurdu ama şey yapmak istemedim. Kim götürüp getirecek? Araba yok. Her yer hastaneler uzak. Bir bunu düşündüm. Bir de eşime şey yapmak, zorlamak istemedim yani. Desem belki o götürür getirirdi. "Aman." dedim, "Kendi kendime atlatırım." Aslında alsam çok iyi olurdu*." (Mrs. E.)	"Actually, it would be very good if I received support, but I didn't want to push. Who would take me there and back? I don't have a car. Hospitals are far from here. I thought about these. I didn't want to force my spouse too. If I asked, maybe he would have given me a lift. "Anyway", I said. "I can get over it myself." Actually, it would be very helpful if I got professional support." (Mrs. E.)

Mrs. G. also had a similar motivation with Mrs. E. She wanted to talk about her loss experience even if her psychological symptoms did not last long (i.e. awaking from the sleep crying, having nightmares, crying spells, negative cognitions etc.) after her baby was born. She could not have gone to an expert due to fact that where she was living was away from the city center where there were professional people.

And lastly, Mrs. J. who was the one who had loss experience in a nearest time, expressed her need to get psychological help, but she did not apply to anyone at that time.

Some participants talked about the importance of getting psychological help from the professionals since not in every family or social context, this loss was accepted as a significant loss to be mourned. Also, people might have not shared their very personal issues or emotions, even with their spouses.

"*Ya aileler için aslında biraz da hani sanki bir uzmanlık desteği şart olduğunu düşünüyorum yani çünkü dedim ya çevre ve toplum tarafından biraz çok normal bir durummuş gibi. Sadece o o duyguyu, o kaybı yaşayanlar baş etmeye çalışıyor. Bu biraz yani açıkçası zorluyor. Ha bizi çok derinden etkilemedi ama bazı yani*	"I think it is a must for families to receive professional support because as I said it is regarded as a completely normal situation by the society and the close circle. Only the ones who experience the loss are trying to cope with these feeling. It is difficult. It did not affect us deeply but from what I heard some people, especially mothers, find it

duyduğum kadarıyla bazı insanlar bunu daha ağır bir şekilde, özellikle anne bunu daha ağır bir şekilde atlatıyor ya da atlatamayan, zor atlatanlar da var. O konuda uzman desteği sanki biraz şart gibi. Ya bunu önerebilirim." (Mr. G.)

much more difficult to get over it and some of them can't get over it at all. Therefore, professional support is a must. I can recommend it." (Mr. G.)

4.4.5. Anniversaries

Anniversaries were commented on by 8 of the participants (5 women and 3 men). Except one male participant within this group of participants, all of them expressed that there were important dates in their lives after their pregnancy loss experience. Anniversaries after the loss might have special meanings for these participants.

When their reactions to anniversary of the death or the time when the baby was expected to be born was asked to participants, they expressed different emotions and reactions. For some participants, these anniversaries did not come yet (i.e. they lost their baby 4 months, 6 months ago), but they expressed that they have expectations about their behaviors or emotions during the anniversaries coming up.

"*Yani 10 Marttaydı. Doğum olarak, evet sonuçta benim için artık hani standart bir ritüele dönüşür diye düşünüyorum. Çok büyük bir şey tabii olmaz ama kendi içimde mini bir şey her 10 Martta olur diye düşünüyorum*." (Mrs. C.)

"It was on the 10th of March. Yes, I think it would become a standard ritual for me eventually. It would not be a big thing of course but I think I will feel something inside on the every 10th of March." (Mrs. C.)

Not men, but all women who talked about the anniversaries (n=5) expressed that the day the child was lost or the day that they would expect their child would be born was important in their lives. They may think about "what happened if the child would live", the important dates might have reminded them the reality of their loss and their sadness

"*Ekim ayı geldiğinde ben hatırlıyorum düşük yaptığımı. Hiçbir şey yapmıyoruz ama insan bir buruk oluyor yani. Hani mesela Ekim ayında ben düşük yaptım, hani şu anda doğsaydı ondan sonra bir yaşında olurdu. Şöyle olurdu, işte hani şunu yapardı gibisinden. O tür şeyler aklıma geliyor yani. Ekim ayında geliyor*." (Mrs. D.)

"I remember my miscarriage when October comes. We don't do anything, but you feel sad about it. Like, I had a miscarriage in October, the baby would be one year old now, would do this, would be like that. Such things come to my mind in October." (Mrs. D.)

For some participants who had a subsequent child after the loss, even if they remember the important days (i.e. the curettage day, the day the lost baby was expected to be born), they appreciate the having their subsequent baby with whom their sadness was lessened.

"*10 Mayısta geçtiğimiz yıl kürtaj oldum. Bu 10 Mayıs geldiğinde Şengül bir aylıktı. Dedim ki "Allah'ın takdiri." dedim. Geçen 10 Mayıs'ta çok üzülüyordum, ağlıyordum. Bu 10 Mayıs'ta seviniyorum...Öyle yani insan o tarihlerde çok kötü oluyor. O tarihler çok koyuyor insana, doktorun verdiği tarihler. Onun için bu Mayıs 10 diyorum ya şey olacaktı, kürtaj olduğum gün. Buna sevindim. Diyorum eşime "Bak geçen yıl bugün üzülüyorduk, ağlıyorduk." diyorum. Ama bugün seviniyoruz. "Çünkü Şengül var." diyorum*." (Mrs. E.)

"I had abortion on the 10th of May last year. This year on the 10th of May Şengül was one-month old. 'God's will', I said. I was so sad on last May 10, I was crying. I'm happy on this May 10...You feel so bad on these dates. They bother you a lot, the dates the doctor gave you. You know, this May 10 was originally going to be the date I had my abortion. I tell my spouse, "See, this day last year we were so sad and crying. But we are happy today. Because Şengül is here." (Mrs. E.)

There were also religious memorial rituals done by a few participants such as praying after the baby, reading some passages of the Quran.

"*Üç İhlas bir Fatiha falan okuyorum. Yasin suresi okuyorum arada sırada. Öyle okuyorum yani. Üstünden de bir yıl geçti tabii*." (Mr. E.)

"I read Al-Ikhlas, Al-Fatiha. Sometimes I read Surah Ya-Sin. I read such passages. It has been one year since then." (Mr. E.)

4.4.6. "What If the Child Would Live" Thoughts

This theme was completely created based on the accounts of the participants. Almost every participant had a thought regarding "what would happen if their child would be alive, his/her gender?". Sometimes these thoughts came around the anniversary of the loss or the time when the baby was expected to be 1,2 etc. years old. Thinking about the loss and what would happen if the loss did not occur was not an abnormal behavior since this was a normal period before moving on with the life.

"*İnsanı rahatsız edici, bazen düşünüyorsun hani doğum gerçekleşseydi hani cinsiyeti ne olurdu, ne isim verirdik, nasıl olurdu, kime benzerdi hani bunları düşünüyorsun*." (Mr. A.)

"It bothers you. You sometimes think what the gender would be if the pregnancy went through, which name we would give, how would it be like, resembled whom. I mean, you think about these." (Mr. A.)

"*Ekim ayı geldiğinde ben hatırlıyorum düşük yaptığımı. Hiçbir şey yapmıyoruz ama insan bir buruk oluyor yani. Hani*

"I remember my miscarriage when October comes. We don't do anything, you feel sad about it. Like, I had a miscarriage in

mesela Ekim ayında ben düşük yaptım, hani şu anda doğsaydı ondan sonra bir yaşında olurdu. Şöyle olurdu, işte hani şunu yapardı gibisinden. O tür şeyler aklıma geliyor yani. Ekim ayında geliyor." (Mrs. D.)	October, the baby would be one year old now, would do this, would be like that. Such things come to my mind in October." (Mrs. D.)

4.5. Summary of the Findings

As a qualitative research, this study wanted to make the experiences of the pregnancy loss of couples more visible in Turkish literature. Purpose of the study was to understand the grief experiences of prenatally grieved partners and how gender and socio-cultural factors affected their grief process. For this purpose, five research questions were set that were aimed to serve the research purposes. Because of the nature of the qualitative data, the answers for the research questions outstretched almost every theme that was given above. Here, the summary of the research findings were presented based on the research questions.

- How did partners experience prenatal loss?

As an inclusion criterion for the purposive sampling strategy of this study, only participants with involuntary pregnancy losses were accepted to the study. So, their experiences were based on a loss that was not expected. As the theme 1 (motivation to have a baby) showed that participants had personal as well as family, marriage and social related motivations to have a baby. This theme was important in understanding the context of the participants because when we understand the meaning attributed to child, we could understand the loss reactions of the participants.

As the short-term reactions of the participants showed that this bereaved people grief reactions that were expressed with similar terms in the literature: psychological reactions (i.e. denial, sadness, and accusation of others or oneself), cognitive reactions (i.e. decreases in socialization and time spent with others, loss of joy) or physical reactions (i.e. bodily remembering the operation). However, when looking at the content of these reactions, they were different from reactions occurred after other losses such as after losing someone adult.

They were also prenatal-loss specific reactions of bereaved participants. For instance, while in other losses, the person may grieve for the lost relationship with the dead one and remember the old good days together, in prenatal loss the bereaved parents grieved for the days that never lived together with the baby. Or, in prenatal loss, what was lost was also a part of her or his body. That is why, in order to examine the grief experiences of partners with prenatal loss, comprehending this loss-specific contextual factors has utmost importance.

Similarly, when the long-term grief and bereavement reactions of the participants were examined, the experiences regarding the anniversaries and oscillatıry process of grief could be observed in other losses, too. Also, bereaved parents had wondered about what would happen if their baby was alive. This was similar to other losses in a sense that in other losses bereaved people had fantasized about a life in which the person was alive. But here the difference was that prenatally bereaved parents experienced this for a child that they did not see or touched before (except the ultrasound images of the baby).

One of the most important finding for the counseling literature may be related to subtheme that addressed why these bereaved individuals did not have a psycholgocial support, even if some of them expressed their needs. As read in the findings, participants could not got psychological support because of practical (living away from the hospital) or economical reasons (i.e. not-wanting to spend money for the psychological help).

- How did partners affect each other's grief process?

Similar to findings in other studies, the bereaved mothers expressed more grief reactions to their pregnancy loss than their husbands. As the participants of this study explained that the physical bond between the mother and baby, or societal mother-child relationship expectations might have affected this attachment with the baby. While in the Western literature, non-shared grief, in other words, discordant grief was found to be related to more psychological problems, and more relationship problems, shared or concordant grief was found to be related to more growth experiences after their pregnancy loss (Buchi, Mörgeli, Schnyder et al., 2009). As explained in the following question, most of partners in this study got the support from their spouses, only 2 of them expressed that they could not got the necessary support.

Men and women in this study expressed some common and different coping mechanisms. While for women social environment was more important especially friends with whom they could share their emotions and experiences, for men friends was important because they could have asked practical things to their friends. Or while men preferred to do activities, spend more time in the work; women were more likely to focus on the grief and experience emotional reactions. For instance, while in couples G. H. and I. there was a communication of feelings between partners, in couple B., C., J. there was no communication of feelings. So, the misunderstandings between those partners without communication were common.

- How did partners support each other after the pregnancy loss?

In the literature, prenatal loss has been examined as a dyadic process meaning that the grief of one partner might have affected the grief of the other because the loss was a shared experience between the man and woman. When the participants were asked about how they, as couples, supported each other, all men answered this question by explaining their support-giving to their wives and all women answered this question as their husbands' giving support. So, contrary to research findings in literature, in this study's participants were not believing that men needed support. Men accepted their roles as support-giver and women accepted their roles as support-receiver. In this study, 8 of the women believed that they could get the support they needed from their husbands, while 2 of them did not believe that they could get the support needed. The interesting thing was all male participants believed that they could have given the necessary support to their wives, even the ones whose wives believed the contarty of this.

- How did men and women differ in terms of grieving process?

There were differences as well as similarities between men and women's grief. As explained their coping mechanisms, perceptions of social support, how they viewed their loss were different. If there was an open communication between partners, these differences were not problematic. But, as can be see in some couples, if partners did not talk about their different grief reactions, they may have misunderstood each other. For instance, in couple C., partners did not know whether the other partner was sad, grieving and so on, because even if both of them were aware that they did not talk much about their loss, they did not solve this problem in their communication.

- How did socio-cultural elements affect their loss experience?

Even if the prenatal loss was a loss for the parents, generally their social environment did not evaluate this as a loss, so when the parents got visitors after their loss, these were mostly "get well soon" wishes. Also, because there was no religious or cultural explanation for the prenatal loss, bereaved individuals had questions about what the normal way of grieving after the pregnancy loss was. While there was no formal support provided for this bereaved group, non-formal support from their social context has an important role. As the parents expressed that the most important support they got from their social environment came from their friends and people with similar experiences, especially the extended family members could not have understood their loss either because they thought that the loss was normal (since in their times, it was more prevalent), or on the contrary, they thought the loss as abnormal and questioned the behaviors of the bereaved mothers.

Consequently, while the social environment tried to give support to these bereaved individuals, the perceptions regarding the social support provided may not be always positive according to participants.

Below research questions and with which themes the research questions were answered were given:

Table 12: Research Questions and Related Themes

Research Questions	**Themes That Were Related to Research Question**
1. How did partners experience prenatal loss?	Theme 1 provided the context for the loss experiences of participants Theme 2, and 4 showed the short and long terms experiences after the loss Theme 3 showed that factors that affected the grief and bereavement experiences
2. How did partners affect each other's grief process?	In all themes, this question had some answers regarding the partners' grief, but specifically "Partner Support" sub-theme was related to this research question.
3. How did partners support each other after the pregnancy loss?	Like previous research question, this question was examined in all themes but specifically "partner support" gave information.
4. How did men and women differ in terms of grieving process?	Especially "men vs. women gender roles" sub-theme was related to this sub-theme, but how men and women differed in their grief could have been observed in other themes, too.
5. How did socio-cultural elements affect their loss experience?	This was mostly observed in "social support" and "cultural and religion-based coping" subtehems, but also socio-cultural elements could be examined in other themes.

CHAPTER 5

DISCUSSION AND CONCLUSION

The aim of the study was to understand a) the overall grief and bereavement experiences of couples with prenatal loss and b) whether gender roles and other sociocultural factors impact their experiences. The motivation of the study comes from the fact that this loss has been neglected in the national and international literature. In Turkey, pregnancy loss has been mostly examined in the medical sciences, while the psycho-social dimensions of the pregnancy loss have been largely ignored. Even though the literature exemplified the high number of occurrences of miscarriages and stillbirths (almost one fifth of the pregnancies end with losses) among the population, psycho-social needs of the partners with prenatal loss have not been documented with a qualitative study.

Therefore, to produce more knowledge about this topic, semi-structured interviews with 10 couples (20 participants) were completed and the transcribed audio-materials were analyzed by using thematic analysis method. The results from 20 individuals' data were presented under four themes. These themes were namely: motivation to have a baby, short-term grief and bereavement response to prenatal loss of the loss, factors affecting the grief resolution and lastly long-term grief and bereavement response to prenatal loss.

In this chapter of the study, those results were discussed based on the relevant literature. The implications for counselors, and conclusions drawn from the study were presented at the end of this chapter.

5.1. Discussion of Findings

Due to the improvements in medicine, it has been expected that babies live to the adulthood and they live longer than their parents (Stroebe & Schut, 1998). However, stillbirths or miscarriages still exist in the society and people who experience it have some reactions to this loss. Even if the grief after pregnancy loss has been a disenfranchised grief for many years, studies conducted with men and women with pregnancy loss experience show that these people grieve like other losses the society admits. The findings regarding the participants' grief reactions showed that their grief and loss experiences were similar to other people with loss experience. Participants of this study experienced the most stated grief reactions in affective, behavioral, and cognitive domains (Aksöz-Efe, 2015; Nolen-Hoeksema and Larson; 1999).

Parenthood as a step to adulthood begins with the idea of having a child. As Jaffe and Diamond (2011) expressed that "No matter what has gone wrong on the road to parenthood, the underlying psychological anguish is similar for all-it is traumatic" (p.10). As the participants of this study showed, parents grieved after their loss and some of them even had traumatic experiences.

Almost every participant talked about their own motivation to have a baby that had either personal or social foundations. Having a motivation to have a baby means that the pregnancy was a planned one. Only a few participants expressed that they wanted to have a kid because their spouse wanted so, but they were agreed with their spouses at the end. Each woman in the study got pregnant with natural ways, none of them had been treated for any reproductive problem, neither their husbands. Moreover, none of them had voluntary abortion. Nine women experienced miscarriage and 1 experienced stillbirth, all babies lost during the pregnancy were single babies (neither twin, nor triplet etc.).

In Turkish culture, it was commonly believed that the main reason behind the marriages is the idea of supporting the next generations, that is why, it is culturally expected from the couples to have a baby, and the most desired time for that is "as soon as possible" (Teke, 2005). Even though there are cultural reasons behind this idea, there have been also political statements in Turkey that support this culturally defined motivation for having a baby.

It is very interesting that the structure of the word "miscarriage" implies women's mis-carrying the baby, like it is the women's behaviors that lead to this result. As Örnek (2000) expressed that in Turkish culture, especially the women are the subject of the criticisms when the couple is childless. Women are expected to give birth for the dignity of the men's family, to experience motherhood and to prevent the extinction of family's ancestry. Especially women in the rural areas of Turkey have been marginalized, insulted and oppressed (Örnek, 2000, as cited in Topdemir-Koçyiğit, 2012). Similar to this comment on Turkish culture, in the sample of this study, even though not all participants experienced the social pressure for having a baby, those who experienced this pressure were mostly women. Accordingly, it was not unexpected that the social system's comments on the pregnancy loss were directed to women, rather than men as in the case of Mrs. F. Mrs. E, and Mrs. G.

The motivation for having a boy was expressed by two couples in the study that has a cultural explanation. However, it should be expressed that participants who expressed their desire to have a boy were the ones who already had a previous child. The previous children

were girls and based on their opinion, their desire to have a boy mostly related to their desire to have a child from each gender. According to Kagitcibasi and Ataca (2005), within the last three decades the changes in the society regarding the increased level of education and the increased financial resources of the family resulted in the changes in gender preferences of the society. While in a value of children study conducted in 1975, 84 % of the participants preferred boy (75 % of women preferred the child to be a boy), in 2003 more than half of the participants expressed their desire to have a girl. The gender preferences were especially apparent in the urban context (Kagitcibasi, & Ataca, 2005).

On the contrary, for the remaining eight couples, gender of the child was not important. So, for this sample we may infer that gender was not a primary motivating factor to have a baby. Raising a child who carries the parent's values, age of the parents, and the desire to experience parenthood, personality and personal history of the participants were other factors for the participants of the study to have a baby.

While all pregnancies were wanted, and participants had different dreams and motivations to have a baby, learning that the baby was lost without any prior sign would be expected to affect the participants. This involuntary loss had some short-term as well as long-term effects on the partners. Because their loss was involuntary, they had to give decisions fast because the health of the mother would have been in danger. Because of the shock and involuntary decision for ending the pregnancy, they expressed that they lacked the control over their acts. While almost all partners got another opinion before their medical decision, only couple E. did not ask for another opinion and they had regrets over this, even though asking to another doctor would not have changed anything.

The emotional and psychological reactions of the participants were revealed in the transcribed data and based on the sayings of the individuals, it could have been observed that they experienced psychological reactions that were parallel to what were mentioned in different theories and research. Even though a few participants were told about the abnormality in the baby during the pregnancy, most of them had difficulty in accepting this reality. Also, most of the participant's loss was sudden and unexpected that they were not ready for this experience at all. So, their feelings of shock, disbelief, sadness were normal and expected reactions to these kinds of losses (Murphy, 1998).

Denial was the most common psychological reaction of the bereaved individuals in this study. Denial, as a stage in Kubler-Ross' theory, was the first reaction of the surviving ones because of the paralysis and the numbness experienced with the suddenness of the loss.

This denial may help the bereaved to unconsciously manage his/her emotions by giving them time (Kübler-Ross, & Kessler, 2014).

Shock, as an accompanying feeling to denial, was expressed by the participants. This shock was related to unexpectedness of the loss. Most of the participants were not told anything about a health problem of their unborn baby. Also, because the loss was involuntary, their shock experience was not abnormal at all. In the literature, whether the partners' sudden loss was a factor for their increased grief reactions or not has been discussed. According to Kersting et al. (2005), unpreparedness for the loss was a significant factor for the experiencing the loss with traumatic reactions.

Sadness experienced by the participants was common between men and women. The sadness experienced was not only related to real loss of their baby, but also to their anticipated future pregnancies. Some women were afraid of losing their reproductive ability totally and this was a bigger problem for them, so their sadness was expressed with a different reason.

Anger, another emotion expressed by the participants either verbally or non-verbally, was shown to either to their partner or the hospital personnel by the participants. And generally, this anger went along with the accusations to other person (partner) for not supporting him/her, not providing the proper health service (in the case of hospital personnel). The participants were aware that they might have been affected by their prior relationship issues that were not resolved when disclosing their anger to the partner after the loss. According to Worden, anger has two sources: frustration and regression. Regression and frustration occur when the bereaved one understood that there was nothing to be done for the lost one (Worden, 2009). A similar finding was revealed in the study of Cimete and Kuğuoglu (2006), who commented that the person's realization of the loss as real might be turned to anger toward God, others, family members and the health care staff. In our sample, the participants did not talk about whether their loss caused changes in their belief system, whether they had questioned the God with the loss. This might have cultural and religious foundations in Turkish sample since in Islamic beliefs, accepting what was given by the God and trusting in the God's decisions (tevekkül etmek in Turkish) were expected from the believers. As was given in the finding section of the study, one of the most common coping mechanisms used by the participants in the study was their belief system that included the belief in destiny which is also related to trusting in God's decisions. Therefore, while the participants might not turn their anger to religious beliefs, or the God, the most proper target to which the anger can be directed might be their spouses, or the hospital personnel.

In this study, one of the most common feeling expressed by the women were guilt that was behaviorally related to "self-accusation". They felt guilty about making over-physical movements, having long-trips such as going to another city or working for many hours. According to their opinion, these physical movements may have harmed the baby and these thoughts made them feel guilty and responsible from what had occurred. Contrary to women, men's feelings of guilt were related to their regrets over the amount of support they gave to their spouses. So, while women accused themselves with not-protecting their children as it warranted, men accused themselves with their actions toward their wives after the loss. Women's feelings of guilt were common in the literature. The same issue was discovered in the Friedman and Gath's study (1989) in which the women were distressed by thoughts that their physical over activity might somehow have caused the miscarriage (Friedman & Gath, 1989). Guilty feelings were identified in other studies, too. For instance, women who had miscarriage experience (N=15) talked about their lack of information about the actions that may lead to miscarriage. Accompanying this feeling of guilt, anger toward oneself was also present (Adolfsson et al. 2004). In a qualitative study with 21 women with miscarriage experience, self-accusation and regrets were found to be the most common reactions of women (Tseng, Chen, & Wang, 2014). Adolfson and his friends supported that pregnant women should be informed about the possible harmful acts that may affect their pregnancy, thus women could have more rational expectations (2004). In this study, too, participants were not informed afterwards that which of their actions, behaviors, accustoms might have been harmful or not and that is why, they have kept the opinion that they did something wrong during pregnancy.

Especially mothers have instinctual desire to protect and care for their children. By presenting her physical warm and love to her child, she is biologically and mentally the protector of her offspring. Pregnancy is a time for preparation for the dreams related to having a baby (Stern, 1999). One of the reasons that pregnancy loss resulted in some traumatic experiences by some participants in this study may be related to losing a planned, desired baby. In a study conducted by Badem (2015) in a Turkish sample of women (N=382), a relationship was found between planned pregnancies and the degree of prenatal attachment. So, it might be a reason for the participants' developing more attachment with their unborn child, since even the ones, whose pregnancy was ended at an earlier time, grieved after their loss and all losses were involuntary with its nature.

Participants talked about their failed dreams related to baby after the loss such as not-experiencing parenthood, giving their care to a child. Contrary to other losses such as

losing a family member, or losing a child who was 5 years old, bereaved people after pregnancy loss mourn also for the days and experiences that were never lived together. Even if the parents might have some memories related to baby, such as seeing the baby for the first time, feeling the first movements, these memories mostly were created with an ideal child imagination. Therefore, what was felt or experienced related to baby was not stemmed from the experiences with a concrete reality, but rather they were based on the internalized representation of the baby by the parents. However, even losing the child before knowing/seeing him/her meant a lot to partners as stated by Murphy (1998) because of the lost hopes and expectations regarding having a baby. In this study, mothers talked about their sadness over the situation that after all dreams and hopes related to their baby, they went home with their hands empty. Explaining the loss with the metaphor of being "empty-handed" was observed also in Lindgren, Malm, & Radestad's study findings (2014). Then, while grief reactions of this bereaved sample with prenatal loss were like other loss experiences, this loss has also distinctive features that differentiate it from other losses such as losing of an anticipated relationship with the child; loss a of child who was neither touched nor seen.

The anxiety regarding future pregnancies of the both male and female participants in the study was demonstrated. The anxiety experienced by the parents was observed similarly in other studies (Cacciatore, 2010; Cuisinier, Janssen, Graauw, Bakker & Hoogduin, 1996; Swanson, Connor, Jolley, Pettinato, & Wang, 2007; Tseng, Chen, & Wang, 2014; Van, & Meleis, 2002). Also, two of the participants expressed their reluctance to have a further pregnancy. While Mrs. J. was still in her grief period, Mrs. H. had the same reluctance that resulted from her fear of experiencing another pregnancy loss even two years after the loss. Similar to anxiety regarding future pregnancies, the reluctance experienced by women was not rare in the literature. It has been pointed by the related literature that experiencing fear, worry, the sense of fragility and reluctance make them delay their future plans for pregnancy (Batool & Azam 2016; Côté-Arsenault, Bidlack, & Humm,2001; Maguire et al.,2015).

It has been discussed that whether anxiety for further pregnancy and the doubt that she may not experience another pregnancy would be expected to be higher in woman who did not have a previous children experience. These women without a child experience remarkably more depression and other mental health problems (Nikcevic, Tunkel, & Nicolaides, 1998; Tavoli et al., 2018). Since this study was not designed as a longitudinal one, we would not have a chance to observe future reactions of participants. However, based on the participants' expressions, especially the ones who did not have neither a previous nor

subsequent child (i.e. Mrs. C. and Mrs. F.), they might be more anxious in their future pregnancy plans. Especially, like in the case of Mrs. F., if there are other factors such as limited social pressures from the husband's family, more than having one pregnancy loss experience, it might be expected that further anxiety would be experienced by women because in addition to her own reasons such as the risk for further loss, or not having another chance to get pregnant; familial and other social factors might increase the anxiety of the women.

As seems that parents' anxiety feelings for the subsequent pregnancies might have affected their enjoyment of pregnancy process (Meaney, Corcoran, Spillane, & O' Donougue, 2016). They may want to learn every detail to protect their child and keep their pregnancy, by this way they might cope with the uncertainty and anxiety (Côté-Arsenault & Marshall, 2000). Another common behavior of the women in their subsequent pregnancy was their goal-setting that aims to exceed the gestational week their prenatal loss occurred (Meaney, Corcoran, Spillane, & O' Donougue, 2016). Even, it was documented that some parents who had subsequent pregnancy had lower attachment to their unborn baby, even denied the giving birth to baby (Van, and Meleis, 2002). So, helping those bereaved parents regarding how to handle with their anxiety emotions after the loss experience have a significant role because not only parents' psychological well-being but also next generation's well-being might have been affected with the loss experience.

Whether the parents' attachment to the subsequent child has changed after the loss was also another important point that has been discussed in different studies (Armstrong, 2002; Armstrong, & Hutti, 1998). In Badem's thesis (2015) women with prior pregnancy loss experience were found to have higher attachment to their subsequent child. Badem (2015) attributed this conclusion to participants losing of voluntary pregnancies. In this study, participants were relieved that they did not lose their reproductive ability, appreciated being a parent to a live-born child. Some participants even talked about the positive changes with their subsequent child that resulted from their loss experience. This kind of relational changes after losing someone important might be called as growth experiences by the post-traumatic growth literature. Therefore, after the birth of their subsequent child, participants' anxiety feelings disappeared. That’s why it can be said that having a child compensated their loss and having a further child helped them having growth experiences such as appreciating the ability to have a child or having more positive relationships with the child. Even if small in numbers, a few participants talked about self-changes they experienced after the loss. For instance, the thought that it was not possible to control everything, and the realization of the

importance of enjoying the moment were all related to posttraumatic growth experiences of parents as examined by Tedeschi and Calhoun's PTG theory (Tedeschi, & Calhoun, 1996; 2004) after the loss. For some participants, their awareness to pregnancy losses occurred around them, within their friends or close networks was also a growth factor since they could emphatize with them. Same growth-related findings that have been documented in the literature (i. e. Meaney, Corcoron, Spillane, & O'Donoughe, 2016) suggest that even if the pregnancy loss led them have grief reactions, they still could have growth experiences after that negative life experience which was very normal.

For the participants, the hope for future fertility was a very important factor affecting their grief processes. Knowing that nothing was wrong with their reproductive system and they would have further chances in the future comforted them. Since in addition to the actual loss experience, they would have anticipated future loss cases if the doctors had detected a problem related to their reproductive system.

A few participants talked about how curettage operation affected them negatively. For some, the memory related to this process was so vivid. The intense reactions to curettage may be interpreted as women's confrontation of the reality of the loss by the removal of the baby. While the pregnancy may be a proof of their reproduction capability and the provider of a new identity for the woman (van den Akker, 2011), the curettage operation may be a physical fact of the pregnancy loss. The reason that women were affected from this surgery maybe because they may have felt that their own body has failed them (Dunn, Goldbach, Lasker, & Toedter, 1991).

As participants talked about their hospital experiences, some of them also expressed the positive attitude from the hospital personnel during the curettage, such as paying attention to psychological and physical needs of the person. The interesting thing was the participants' paying more attention to hospital personnel rather than the physical conditions of the hospital. So, from the women's perspectives, maybe the most important factor affecting their psychological well-being after the operation was the hospital staff's attitudes toward them (Meaney, Corcoron, Spillane, and O'Donoughe, 2016). As Levy (1987) exemplified, the hospital process is very important after the pregnancy loss since mothers may be in danger of developing traumatic or other psychiatric symptoms after surgery.

Participants talked about their sadness over "losing a part of oneself" and the statement "feeling that like something was removed from your own body" was expressed by some participants. This expression of baby as "a part of one's own life" was a cultural statement. Similar expressions were identified in another study (Köneş, 2018) and the

comment of the author over this expression was that it showed the higher degree of ache felt by the bereaved parents. Maybe depicting the loss with somatic terms was a cultural explanation. As McWhirter (1983) stated that people in Turkey give so much importance to non-verbal communication, also because they are not very good at talking about their emotions; after a traumatic event, occurrence of somatic symptoms is expected. Therefore, explaining the deep sadness of the loss might be explained by using somatic terms. This theme was expressed by both men and women, so rather than physically carrying the baby during the pregnancy, baby's carrying cells from both parents might make them feel that the loss is a biological one for both.

Although not a commonly-voiced theme by the participants, some women in this study talked about their negative feelings regarding other pregnant women or women with a living birth experience, especially if those women's birth was close in time to the bereaved women's loss experience. The participants of the study did not precisely define their emotions, but based on the researcher's interpretations, their feelings were thought to be mostly resentment, and unfairness. The participants may have believed that those feelings were not socially acceptable, or maybe they unconsciously could not define the feelings they experienced for those pregnant women. These unvoiced feelings were also mentioned in some studies (i.e. Friedman & Gath, 1989; Meredith, Wilson Branjerdporn, Strong, & Desha, 2017).

When the woman lost her baby without knowing, her unfulfilled desire to be a mom has to be ceased. In this study, some women talked about the envy they felt to other mothers or babies, or how they found it difficult to be around of other pregnant women after their loss experience. This feeling of envy actually is not only voiced here. Similar studies found that many situations in their lives reminded their loss specifically when their friends are pregnant or when they meet with families with children (Adolfsson et al. 2004, Maguire et al. 2015). Sometimes, these women may consider their feelings of envy or staying away from other mothers as abnormal. Actually, this behavior is normal especially immediately after their loss because this keeping themselves away from mothers or children is a way for themselves to cope until a time when they could face their ache and sadness (Gerber-Epstein, Leichtentritt, & Benyamini, 2008).

Along with paying attention to other pregnancies and other losses, the participants' questions about whether grieving after the pregnancy loss normal or what kind of religious or cultural practices was were acceptable for such a loss might have shown their need to normalize their loss experience. Their curiosity over how many pregnancies were ended with

miscarriages or stillbirths or what were the reasons of the loss of others were related to their meaning-making of the loss.

As it was explained in the literature section, the grief after pregnancy losses has been defined as the "disenfranchised" or "silent" grief because the society does not evaluate this loss as other losses since they did not personally know the lost one. But the parents had a vision of their child; they had hopes for the baby, so even if they did not see or touch the baby, they may have developed a certain degree of attachment to the baby and that is why, their grief has been expected by the professionals. In the Islamic belief, unless the baby has a soul that was believed to happen during the gestation period of 120 days, there were no rituals as in a loss that occurred during infancy, adulthood etc. While in other losses there are condolence visits by family members, friend, and neighbors, after the pregnancy loss even if there were visits by family or other close ones, this is most like “get well soon" visits. Therefore, paying attention to other pregnancy losses might lead the participants think that they were not alone in their experience, that it was a more common experience among the pregnant women than the society expected.

In a doctoral study by Väısänen (1999) with 22 families and one focus group, a qualitative phenomenological method was used to understand the family grief and recovery process after perinatal death, sudden infant death syndrome or neonatal death. In this study, the similar theme was discovered from the data: the participants especially talked about how difficult for them to see babies around which reminds them they could not protect their child. For this study, seeing other babies did not lead the participants to think that way; but they were jealous of other mothers' having a baby.

While most of the participants expressed that they could have got the necessary support from their spouse, a few participants (i.e. Mrs. B., Mrs. C., and Mrs. J.) stated that they could not have got the support they desired from their spouses or even if they got physical or psychological support, they could not have shared their inner experiences with their partners. It was obvious from the statements of the participants that the pregnancy loss caused extra stress for the partners, especially the ones who had already problems in their relationships such as communication issues, or problems related to partners' own family.

According to Gold, Sen and Hayward (2010), the partners who had unstable relationships before the pregnancy loss might have further problems in their relationships after their stillbirth or miscarriage experience as this experience brings further distress for them. This loss experience brings further stress for the couples since from the perspectives of both partners; the loss has different meanings for them: for some the loss means the loss of

dreams related to having a baby, or it means further pressure from the social environment for others. If the partners' relationship has been built on open communication, empathy care and support, then they are more likely to comfort each other. Actually, the degree of problems between the partners may be a sign for their support seeking from each other (Corbet-Owen, 2003). Also, the degree of intimacy in the relationship was found to be related to the intensity of the grief after the loss (Hutti, Armstrong, Myers, & Hall, 2015).

In the past, pregnancy and birth issues had been thought to be only a woman issue. This conventional thought has changed a lot with the industrialization, and the knowledge in medicine and psychology increased. Now, it has been accepted that the father has also an important role before, during and after pregnancy both for the mother and for the baby (O'Learly & Thorwick, 2006). That is why, it was not surprising for the men in this study to know about the pregnancy issues; they have especially knowledge about the practical issues of the pregnancy such as hospital or doctor preferences. Even if not all women in the study talked about their emotions with their husbands, all men in the study could help their partners about the practical issues of pregnancy and loss; they asked their friends about the doctors, or they talked with the religious personnel in the mosques whether there was anything to be done about the loss regarding the religious rituals.

In accordance with the findings of this study, it could be observed that there were common reactions for both gender as well as gender-specific reactions to loss experience. These differences may be caused by the individual differences or socio-cultural effects on gender. While grieving differently, in general men and women have used different coping strategies in their dealing with the loss. For instance, in Avelin and his associates' study (2013) bereaved men's coping strategies were withdrawal or daily activities, a very similar finding with this study. In our study, men spent more time in their work, or they arranged activities that were mostly physical with their wives. On the other hand, women talked with their friends, cried, shared their loss with the family members.

Even if they had different styles of coping with the loss, partners who spent time together after the loss were more successful in their coping. So, it may be reached the conclusion that partners had different coping mechanisms, but if they also had some commonalities with their partner in dealing with the loss such as talking about the loss, spending time together, going vocation together, then they were more likely to support each other and have normal grief reactions. As Kersting and Wagner (2012) stated, the use of different coping styles might lead to decreased quality in a relationship, so they suggested that continuing communication among the partners should be flourished. So, as long as the

communication and support exist between the partners, the difference in their coping ways might not harm the relationship.

In Murphy's study (1998) men explained similar experiences regarding their views about the gender differences. Four of the five men in his study expressed that women were believed to be more emotional and to have more intense emotions after their pregnancy loss experience since men thought that women were physically and hormonally affected from their pregnancies, which in turn affected their grief reactions. In contrast, men were expected to be stronger and to support their partner, even if this means the suppression of their emotions (Murphy, 1998). This situation might not be always supported in the literature. In some studies, men were reluctant to accept the opinion that they did not grieve after their loss. They expressed that even though they were not affected physically, they were emotionally affected with their loss (Meaney, Corcoran, Spillane, & O'Donoughue, 2016).

The gender roles that affected the participants of the study were also observable in other cultures. In Dunn, Goldbach, Lasker and Toedter's study (1991) similar comments were made about the gender roles affecting the men and women. Because women were allowed to express their emotions more, their expression of emotions through crying, feeling sad or talking a lot about their loss experience was accepted as normal in the society, while men were not allowed to make such emotional expressions. They were expected to be strong compared to their partners, and to hide their emotions from the others (Dunn, Goldbach, Lasker, & Toedter, 1991). Avelin and his associates commented that the differences between men and women in the degree of their emotion expressiveness were also related to the degree of attachment expected between the baby and the parents. This expectation was also related to gender role expectation in which women as the carrier of the baby, were expected to have a deeper attachment than the father; so, women were expected to have more intense grief reactions that last longer (Avelin, Radestad, Saflund, Wredling, & Erlandsson, 2013). Then, the physically experiencing the pregnancy may be a visible reason for the women's having more grief reactions and the society's accepting these reactions as normal, while non-existent physical bond with the baby might affect both men's own beliefs regarding the normality of the degree for their grief responses and the society's expectations for them. Therefore, it is seen that cultural conditioning might affect the men and women's reactions (McCreight; Staudacher, 1991; Stinson et al. 1992; O'Leary, & Thorwick, 2006).

According to Beutel, Willner, Deckardt, Rad, and Weiner (1996)'s findings, the experience of the grief was affected by the partner's concern for each other. Women who showed depressive symptoms after their loss were the ones without social support, especially

from their partners. Women commented that because of the lack of communication with their partners about the miscarriage, they had more discussions in their relationships. Even if their partners were concerned about the women's depressive symptoms after the loss, they still felt burdened by the women's reactions and they coped with this situation by being away from home by working more or spending more time for vocational activities (Beutel, Willner, Deckardt, Rad, & Weiner, 1996).

When the participants were asked about their expectations of support from their partner, all women expressed their needs, regardless of whether those needs were met by their spouses or not. However, men answered this question from the perspective of women, meaning that they talked about how they met the needs of their wives. From the men's point of view, even they expressed that they were the ones who had to support their partners, they were not in a needy position because their wives were the ones who experienced the loss since they were the ones who carried the baby. This finding was very similar to findings of other studies in the literature. While in some studies men acknowledged that their needs were put aside (Miron, & Chapman; Murphy, 1998; Worth, 1997), for instance in Radestad and Segesten's study (2001) they expressed their needs to be recognized as mourners. In this study, however, men did not even talk about their own needs. This might be related to either they really may not be affected with the loss as their spouses because of the lack of physical contact with the baby or they may resist that they did not have psychological support from their wives because of the societal expectations and these expectations' effects on gender issues. If, the second hypothesis was true, then the men's reactions somehow may be delayed and, in this case, suppressed feelings might lead potential chronic grief reactions for men (Kamm, & Vandenberg, 2001). And if the second hypothesis was true, it also means they could not get the necessary support from their social environment because others, too, may not believe that they do not need any psychological support from their friends, family members and so on because of men's looking strong and capable of handling the grief (Murphy, 1998).

While the socio-cultural factors might have affected how men and women grieve after the pregnancy loss, there were no study that proved this proposed association as in cause-and-effect form. Therefore, there still might be other explanations for the differences between men and women. Another explanation in the literature to gender differences in pregnancy loss experience was that there might be more grief reactions than the studies so far determined; meaning that there might be multiple alternatives to loss that explains the

differences between men and women's grief styles (Vance, Boyle, Najman, & Thearle, 1995; Beutel, Willner, Deckardt, Rad, & Weiner, 1996).

Most of the men in this study talked about their comparatively less attachment to their baby during pregnancy compared to their wives. According to them, since the baby lives in the body of the mother, she is the one who feels the movements of the baby, and so she is the one with increased grief reactions. As they expressed, if the baby had died after birth, they would have had higher levels of grief since they also would have developed the attachment with the child. Women also believed that the longer the pregnancy, the higher their grief would be. In this study, only one couple experienced stillbirth, all other losses were miscarriages. However, when looking at the both men and women's reactions to stillbirth or miscarriage, there was no observation that the couple who experienced stillbirth had more grief reactions than couples with miscarriage experience. There were participants who lost their baby within the first trimester, but they grieved as much as the one who experienced stillbirth. Based on our observations, gestational age may not stand as the only factor affecting the degree of grief reactions. The motivational reasons to have a baby, person's coping mechanisms, partner support, how social environment reacted to this loss, all were interacting with each other. For instance, for the participant Mrs. F., all losses occurred at a very early time in her pregnancies; but rather than the gestational period, experiencing more than one loss was very distressing for her since not only she was losing her hopes in each loss, she also experienced family-related stress (questioning of her reproductive ability by Mr. F.'s family, suggestions given to her to get pregnant etc.).

Worth (1997) asserts that because of the pregnancy loss, fathers' unfulfilled contact with the baby leads to a fantasized relationship with the baby and the men loses the identity of the father before they gain it. However, the mother may have felt her motherhood, even after the loss. According to Lietar (1986), the mother develops attachment with the baby within the first trimester (as cited in Golbach, Dunn, Toedter, & Lasker, 1991). In order to test whether the affectional bond with the baby changed through time, Golbach, Dunn, Toedter and Lasker (1991), with 138 women and 56 of their partners the study was conducted by using Perinatal Grief Scale. Results revealed that the overall grief scores, subscales of active grief, difficulty coping, and despair have found to differ between the groups of participants who experienced pregnancy loss at different gestational periods. Participants whose loss occurred at a later time in the pregnancy had higher grief levels than participants whose gestational age was not that longer. Even after two years from the loss, participants whose loss occurred at a longer gestational period had higher grief scores.

These study findings were compatible with Meaney et al. findings (2016). They expressed in their study that participants who had a previous child could have reassured themselves with the opinion that they could have got pregnant and give a live birth to a baby; however, participants without a prior child and who experienced a miscarriage had concerns about their future fertility and health, too. Wong, Crawford, Gask and their associates (2003) supported this finding, asserting that women with children were less distressed. Therefore, having no child may be related to an increased desire to have a child and more distress related to future pregnancies (Brier, 2008).

Having a previous child was comforting for some participants; they spent time with them that made their coping easier. Then, having living children could encourage the bereaved parents regarding finding a new perspective to their loss experience since the child fosters her belief that she could have a child; she does not have reproductive problems (Van, & Meleis, 2002). In clinical studies, not-having a prior child was found to relate to pathological reactions of the bereaved parents (Horsch, Jacobs, & McKenzie-McHarg, 2015; Janssen, Cuisinier, de Graauw, & Hoogduin, 1997; Kennell, Slyter, & Kalus, 1970).

When thinking about the social context of the Turkish culture, it has been observed that while formal support provided was limited after the postpartum period, informal support by family members and friends were provided (Serçekus, & Mete, 2010). A similar emphasis was made in Kuscu, Akman and Karabekiroglu et al.'s study (2008) that emphasized the importance of the extended family as informal support networks. In this study, some participants talked about their feelings of loneliness occurred after the loss. Not only women but also men talked about this feeling. Especially being away from family members was a factor affecting their loneliness. Apparently, the expression of loneliness was mostly related to family members' physically being away from them. While women were the ones who got more support from their friends and social environment like their colleagues or neighbors, they were still in the same position with their husband who did not talk with their friends, even their boss about the loss; even the ones who were more talkative, did not share with others a lot about their experiences. This might show that the relationships with the family members especially relations with the men or women's family were so important for the partners after the loss that no one in the social environment could gave this support for the partners. Chodorow (1978) discussed the loneliness feelings of men and women after the child loss. He hypothesized that even though women got more support after losing their child, this support may have limited effect on their well-being after two months from the loss. Also, the differences between men and women might lead to differences in their

feelings of loneliness. While men may feel lonely because they prefer not to be connected with others, women may feel lonely because they spend more time in the home by isolating themselves from other people (Chodorw, 1978).

The impact of social support had always been searched in the psychology literature. For instance, in Van and Meleis ' study (2002) participants talked about the significance of talking with their family or friends who listen to them without judging and criticizing. That was also found reassuring and comforting by the bereaved women. When the family or friends were felt sufficient to share their emotions and experiences, women did not prefer to go out to seek help from counselors or support groups. (Van, & Meleis, 2002).

Similarly, social constraints such as not-having a supportive environment to talk about their emotions and thoughts regarding the loss might result in the inhibition of emotional and cognitive processing of the loss experience that affects the adjustment levels of individuals. In a community sample who experienced different kinds of losses (N=238), it was found that women, younger participants and those with economic problems had more social constraints and people with higher social constraints were found to have more depressive symptoms, more perceived stress, somatic symptoms and worse global health score (Juth, Smyth, Carey, & Lepore, 2015). Social support can be a protective factor for the mental health of the individuals even in stillbirth experience (Campbell-Jackson, & Horsch, 2014; Horsch, Jacobs, & McKenzie-McHarg, 2015).

Another reason of social constraint might be the society's not-having social responses to losses that were not defined by cultural norms, or religious rituals (Romanoff, 1998). Even if the neighbors, family members had "get well soon" visits to partner, this loss was different from other losses. For instance, in Turkey, all neighbors know at which home the loss has occurred, and the death of the person is announced by the religious personnel in the district where the lost person had been living. There was no such a ritual for the pregnancy losses, so it was a kind of "silent birth"; the bereaved people mourn in their homes with the limited social support from other people.

Bereaved mother did not find the suggestions by others who did not have a similar loss experience as much helpful as talking with people with similar experiences. Some women thought that people's non-supportive reactions were normal that other people could not know how to give support in this kind of situation. That is why, talking with bereaved parents with similar experiences has been found as more helpful.

In this study, men talked about how they supported their wives but neither they nor their wives talked about how men were supported. Men had reluctance about getting

emotional support from their wives as well their friends. They mentioned that they talked with their friends mostly about the practical issues after their pregnancy loss. Men who are not-getting emotional support from other people were also documented in other studies. Carroll and Schaefer (1993-1994) expressed a similar finding that men got less support from the outside of their marriage after their sudden infant death syndrome experience. Their reluctance for getting help from other might result from their gender roles or their assumptions regarding their responsibility for their bereaved situation (McCreight, 2004).

While women in the study turned the anger feelings toward themselves by accusing themselves with the results of their pregnancy, men turned their anger to outside sources, especially to the hospital personnel. In another study in Turkey (Cimete, & Kuguoglu, 2006), participants talked about their anger that resulted from non-sufficient support from the health personnel. The reason for the difference between men and women's anxiety source might be related to nature of the pregnancy. While woman carries the baby within her own body, she may assume the full responsibility for the child's well-being.

Like in other studies, most of the men and women in this study were satisfied with the physical help provided by the hospital personnel. However, while a few participants believed that the doctors' only giving physical help by ignoring the psychological needs of their patients were very normal because of their long and intense work hours. But there were also participants who as expressed that they needed emotional support from the health personnel. When looking at the literature, emotional needs of bereaved parents during their hospital processes have been highlighted. Explaining parents by health care professionals that their grief responses after their pregnancy loss even though they did not see or touch the baby, talking about normal and abnormal grief reactions in the following times, talking with them about their emotions and failed dreams regarding the baby have been suggested (Côté-Arsenault & Freije, 2004; Kersting et al., 2005; Meredith, Wilson Branjerdporn, Strong, & Desha, 2017).

In this study, participants expressed that they could not even think about the possibility of psychological help provided in the hospital. Cimete and Kuguoglu (2006) expressed in their papers that in Turkey families could got support from only health care staff. That is why, it was suggested that hospital care staff that are the first encounters with these bereaved sample should be trained about how to help emotionally to these bereaved parents.

In this study, almost none of the participants expressed their need for a religious ritual. Some participants were unsure about whether there was a necessity; others asked the

issue to an expert such as an older person, or a clergy. While the participants of this study did not have such a need, the need for acknowledgement of the loss by the rituals has been highly expressed in different studies (Meaney, Corcoron, Spillane, & O'Donoughe, 2016). Participants in those studies followed some rituals such as keeping a diary for the baby, having a funeral or another ceremony. It was found that these kinds of ceremonies made them acknowledge their loss (Meaney, Corcoron, Spillane, & O'Donoughe, 2016).

Similarly, anniversaries are important dates for the bereaved one since those days remind them their loss. In the grief counseling, bereaved person has been suggested to make some ceremonies, rituals for the lost one. In the literature, it was expressed that for some bereaved people anniversaries remind them the painful memories and experiences while others express that those days were similar to others (Worth, 1997).

In this study, most of the participants heard the comments like "you are young you can have another baby," or "you have already a child" and these comments calmed them down. However, this finding was contrary to what the other studies revealed. In other studies, men and women felt frustration when others made similar comments, because they seemed like underestimating their loss, by not accepting the reality of the baby (Worth, 1997).

Participants' trying to understand the reasons of the loss might be a way to get control over the negative event they experienced. By understanding those reasons and preventing any further risk factor in the future, somehow, they try to avoid further losses. This finding was supported by other studies (such as Côté-Arsenault & Freije, 2004).

Because of the reason that families and friends are sometimes unwilling or uncomfortable about talking about the loss and providing emotional support, either partner may feel isolation or anger (Reed, 1984). This was the case in our findings, as well. Some partners got the necessary emotional and practical support (help regarding the house chores, meeting the needs of other children in the home and so on); some participants talked about how indifferent some of their family members (like mother-in-law in Mrs. E's case or sister or father-in-law in Mrs. C.'s case) were after their pregnancy loss. Even Mrs. G. talked about her mother-in-law's statements that mean to blame her about the loss.

While bereaved parents were making meaning from their experiences, the people in the social environment of the couple also tried to give meaning to stillbirth or miscarriage based on their own knowledge. When talking with the bereaved men and women, it was realized that for some, time heals their wounds while for some, they still felt the ache. There were other factors mediating the relationship between loss and time, such as whether the

partners had a subsequent child after their loss experience, or whether there was sufficient social support for the partners. Similarly, in the longitudinal studies participants' recalling of their experiences, emotions even two or more years after their loss was documented (Murphy, 1998). Correspondingly, some participants expressed that with the passage of time, they were healed since the experience of loss were faded and they had a child after the loss. Tseng, Cheng, Chen, Yang, and Cheng (2017) documented a similar result that with the passage of time, grief scores have been lowered.

Because time was an important predictor for the grief, waiting for the next pregnancy (at least 12 months) has been suggested (Hughes, Turton, & Evans, 1999). In addition, talking with parents about the normal course of grief process and when is the right time to ask for a professional help if their grief is not resolved should have been suggested (Tseng, Cheng, Chen, Yang, and Cheng, 2017). According to DSM-V criterions (APA, 2013), 12 months could be accepted as normal grief period. However, as the participants of this study exemplified that even after a few years passed from their loss, and even they have a further pregnancy, they might remember the lost baby from time to time, especially at the important dates such as anniversary of the loss, or at times when the baby was supposed to born. Not only during anniversary dates, but also there might be other times that reminded their loss and they thought the idea of what would happen if their child was born. According to Stroebe and Schut (1999) this oscillation between dealing with the loss and being away from loss thoughts was very normal for the bereaved person; even this process was a part of healthy grief.

Even if this oscillation was normal for the bereaved parents, they might be confused about what was normal grief, even they might not be certain about whether they could grieve after the pregnancy loss since there were no agreed-upon decisions regarding the rituals and grief over the pregnancy loss in the society. While those bereaved parents did not know whether the grief was normal or not, some of them expressed that if they could get emotional support from professionals, they could have coped better. Some participants only needed to talk about their loss experience because they thought that they did not the necessary social support from their environment, and some thought that their grief might have been lesser if they had the professional psychological support.

5.2. Implications

In the following pages, implications for couple and family counselors, parents and couples, educators and supervisors, counseling programs, society, policy makers and further research was given. As mentioned throughout the study, pregnancy loss issue was a multi-dimensional issue affected by different factors that is why, in addition to individual interventions, more broad perspective and practical changes might be needed.

5.2.1. Implications for Couple and Family Counselors

Grief and bereavement are very personal experiences, and even though there is a time limit set by the theories and manuals like 6 months, 1 year; these partners' personal experience of loss should be evaluated, and mental health workers should support the partners in evaluating all the aspects of future pregnancies and help the partners grieve after their lost baby (Worden, 2009). On the other hand, some partners may delay their recurrent pregnancy, or their grief period is longer than what is accepted as normal, in these kinds of situations counseling services directed to understand the emotions of partners such as fear, guilt, anxiety (Meaney, Everard, Gallagher & O'Donoghue, 2016). In addition to understanding the emotional effects, counselors also should talk with the partners about the meaning of the pregnancy for them. What are their dreams of having a baby can give lots of information regarding the intervention.

Especially for the pregnancy losses like miscarriage, there are a few rituals that are important for making the loss more tangible, thus give a chance for the bereaved ones to express their grief. Counselors can encourage the bereaved men and women by creating some rituals like naming the fetus, preparing a memorial service, finding ways to express their dreams, hopes for the child such as by writing a letter to the lost baby (Worden, 2009).

Emotional support, specifically physical presence and listening, are supportive behaviors for bereaved parents. Health care professionals should advise family and friends to show the bereaved parents small gestures of kindness, such as sending a card, bringing over a meal, or assisting with other practical help. Providing written bereavement support booklets regarding advices to family and friends may be helpful tools for them (Kavanaugh, Trier & Korzec, 2004). Partners also can be supported by increasing the positive communication between them and also with other family members. Some men and women may restrain from asking for help from other family members. In order to resolve their grief in healthy ways, they need to express their emotions, needs openly to both their partners and

other family members, or friends. Otherwise, marital conflicts, psychosomatic symptoms, relational problems are very likely to occur after such an experience (Smith & Borgers, 1988).

Counselors should take into account individual, cultural and gender-role related differences between men and women's grief reactions. There might be a range of different reactions to loss and the grief period of the person might be different from partner to another even if they experienced the same loss (Vance, Boyle, Najman, & Thearle, 1995). If these differences between partners are not shared with each other and there is no open communication of feelings and thoughts, partners might not understand the reasons of their different grief styles, that in turn might give harm the relationship. That is why, both partners' involvement and providing a context in which there is a dialogue between partners after the pregnancy loss experience have been suggested (Avelin, Radestad, Saflund, Wredling, & Erlandsson, 2013; Beutel, Willner, Deckardt, Rad, & Weiner, 1996).

For the couple and family counselors, the following implications might be drawn from the data:

1. Partners should be explained that they might have different grief reactions and having different reactions to loss is normal. Here, the important thing is to enable the participants share their emotions, thoughts with each other. So, they also should be counseled about the healthy communication.
2. Similarly, the men and women might have also different coping styles, so counselors should also inform the couple about the normality of different coping styles.
3. Even if anxiety is a common feeling expressed by the bereaved parents, especially when they begin again thinking about a further pregnancy; sometimes they do not know how to handle with these anxiety feelings and they might reflect this emotion to their relationship with their partner. Similarly, there are other feelings that bereaved parents sometimes find it difficult to handle such as anger, intense sadness, or panic. The couple or family therapist might teach the couples about emotion regulation techniques, mindfulness strategies, stress management techniques. Overall, cognitive behavioral techniques that enable the person to control his/her thoughts, thus giving a chance to change his/her feelings might be useful.
4. As the results of this study showed that there might be some negative life memories in the bereaved life that might affect his/her negatively in the future. For instance, the curettage operation or seeing the fetus after miscarriage affected the participants of this study negatively. For these kinds of negative life experiences, EMDR technique might be helpful.

5. As can be observed in the data that partners had different attributions or meaning for having a child. Some partners shared their opinions with each other, but some did not. So, while counseling these bereaved group, creating opportunities for the couples to discuss each other meaning-making of the having baby as well as of the loss.
6. Partners should be also informed about the oscillatory process of grief as suggested by dual-process model of grief. When they hear from a professional that their having both loss-oriented as well as coping-oriented reactions were normal after the loss experience, might be helpful in making them understand that they could grieve as similar as other losses people experience.
7. Because Turkish culture has the elements of both collectivist and individualistic societies, in addition to personal elements, also socio-cultural and family related factors should be deal with during the couple or family counseling. For instance, as the study showed that extended family had an importance for the bereaved partners, so including the important family figures into the counseling sessions sometimes is necessary.

5.2.2. Implications for Couples and Families

One of the most important practical suggestions to those bereaved men and women is to recognize their loss because this loss is as much important as the loss of an older person or a child (Worden, 2009).

They might wonder why their partner does not have the same reactions to loss. It is necessary to keep in mind that even if partners experience the same loss, their reactions might be different. While a partner might have more internalized reactions, the other partner might have more externalized reactions. That is why, talking about emotions and experiences regarding the loss would be valuable for the partner.

5.2.3. Implications for Educators and Supervisors

Educators and supervisors of the counselors either in the universities, or in mental health associations might have counselors as their supervisees who have clients with pregnancy loss experience, so in addition to commonly used trainings, or courses for the counselors; education and training programs might include modules that focus on the needs of the bereaved partners with prenatal loss. Loss and couple or family therapy programs might give information about the differences and similarities of the prenatal loss experience people and other losses, how partners could have handle with the loss, what are the

intervention strategies for these bereaved partners. While supervising the counselors, socio-cultural context affecting the client's grief process should be mentioned.

5.2.4. Implications for Counseling Programs

Counseling programs in the universities have generally elective courses related to couple and family counseling or grief counseling. However, the issue of prenatal loss has been neglected in these courses. As this study showed that the prenatally bereaved partners might have counseling needs related to their grief process, coping mechanisms, social constraints or their family planning (such as anxiety regarding for future pregnancies), so the necessary skills to work with this population might be pointed in these elective courses.

5.2.5. Implications for Society

First, acceptance of the pregnancy loss might be achieved. Since as this and other similar studies showed that partners with prenatal loss experience grieve after their loss that emotional, cognitive, social and physical reactions were same. But how they experienced these reactions might be different.

Secondly, how to give beneficial support to those bereaved partners matter, since as in the findings showed that, not all kind of support given to partners were found as effective. While there were cultural myths regarding the pregnancy or loss exist in the society, how these myths affect the bereaved partners' well-being should be taken into consideration.

5.2.6. Implications for Policy Makers

Pregnancy loss has enduring effects on not only the person who experienced it, but also the partners, the larger family and the society at large. Based on the empirical findings, it is necessary to pinpoint the needs of the partners and families to make fundamental strategies (Heazell, Siassako, Blencowe et al., 2016). In a study, women who went through a pregnancy loss were asked about their needs, the need for information from doctors (54%), continuity of care (45%), sympathetic manners from health workers (26%), better medical help (21 %), increased family involvement (18%) and similar needs like support from friends, partner were expressed (Rajan & Oakley, 1993).

Helping those bereaved mothers after their pregnancy loss experience would be important both for the mother and the attachment she will develop with the subsequent child, since the healthy relationship between the bereaved mother and the new child would be possible after the mother's resolving her grief and psychological problems (Hughes, Turton,

Hopper, McGauley, & Fonagy, 2001). That is why, community health centers might be helpful in aiding these bereaved parents because the healthy society can be accomplished by healthy families and for healthy families, and healthy individuals are needed.

As the participants of this study showed that even the ones who had normal grief reactions to pregnancy loss experience might have needs for psychological help. However, as the participants talked about there were no formal support systems for these bereaved individuals after their pregnancy loss experience. Even if the women lose their babies in the hospital and this loss was recorded, these individuals are not given any kind of psychological support while they are in a position that they crave for any kind of support given to them such as information about what awaits them after their miscarriage or stillbirth, what are the normal reactions of the grief, and when to ask for further support. The policy makers may develop a program for these bereaved parents such as group counseling, or for the ones who needed more intense support, individual counseling and even psychiatric help.

5.2.7. Implications for Gender Issues

As the findings revealed that participants had some gender-related assumptions regarding how "motherhood" or fatherhood" should be, or how "men" or "women" should grieve after their loss. All these learned gender issues might have affect their well-being. For instance, men may have more psychological reactions, but because of the society's reinforcement of gender roles, they might have not grieved as they wanted. Or, the thought that "I should be strong and support my wife" may hinder their own grief process. For women, the same gender issues may create further problems such as women might believe that because they were the mother, they should be sad more and this might have created stress for them since the participants of the study were unsure about the normalcy of their grief. Therefore, gender roles that shape the identity of the person via motherhood or fatherhood, or "women" and "men" might affect the grief experiences of people that should be questioned.

5.2.8. Implications for Further Research

Theoretical implications of this study were related to presenting the grief and bereavement of participants with pregnancy loss experience and how gender and socio-cultural factors might have affected their grief resolution within the time.

Regarding the theoretical implications, this research showed that the existing grief theories were helpful in some degree, such as when explaining the grief Kubler-Ross' stage

theory was helpful, also in terms of meaning making of their loss and how their grief reactions were socio-culturally shaped could be explained by the social construction theories of grief. Also, participants' explained growth experiences might be the examples for growth literature. Still, it should be suggested that the unique characteristics of grief reactions present in a Turkish culture context.

For the further studies related to pregnancy loss experiences of partners or individuals; the concepts derived from this study might be helpful. Concepts such as the importance of social support, especially with regard to family members; the gestational period at that the loss occurred, motivations to have a child, short-term and long-term grief reactions of bereaved parents can be studied with quantitative methodologies. While this study gave in-depth data regarding the grief experiences of prenatal loss experienced partners, quantitative methods could explain the underlying mechanism between these concepts.

The differences between men and women's grief might be examined in further research by this study's giving perspective to especially gender roles, socio-culturally shaped behaviors of men and women, as well as parental behaviors.

Leaving the lack of formal support given to the bereaved parents after their prenatal loss experience, participants themselves did not asked for support after their pregnancy loss experience even if they wondered about whether grieving after this kind of loss was normal or not, or for some there was no social or partner support after the loss. In this study, there were participants who expressed that psychological support might be helpful for them to deal with their loss experience but none of them got psychological support. In addition to practical reasons addressed in the findings (such as living away from the city and so inability to reach the psychological help), there might be other factors affecting their help-seeking behaviors that were not mentioned in this study. Therefore, further studies are suggested to examine those variables influencing the help-seeking behaviors of the bereaved.

As mentioned above, having a subsequent child somehow affected their grief resolution. While the participants talked about their anxiety before their giving birth to alive child, they did not mention a lot about how their attachment with the child was affected by their previous loss experience. This might be an interesting topic for further studies.

As observed in this study, there were no differences in the grief reactions of participants who experienced miscarriage and with the ones who experienced stillbirth. This issue has been studied a lot in the foreign literature, but in Turkey this subject was not studied a lot. Therefore, controlled studies might explain the situation in Turkey.

REFERENCES

Adolfsson, A., Larsson, P. G., Wjima, B., & Bertero, C. (2004). Guilt and emptiness: Women's experiences of miscarriage. *Health Care for Women International*, 25, 543-560.

Albuquerque, S., Narciso, I. & Pereira, M. (2017). Posttraumatic growth in bereaved parents: A multidimensional model of associated factors. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1-9. doi: 10.1037/tra0000305.

Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A. & Tod, A. M. (2009). Ethical issues in the use of in-depth interviews: Literatüre review and discussion. *Research Ethics Review*, *5*(2), 48-54.

American Counseling Association. (2018). Retrieved September 8, 2018, from https://www.counseling.org/about-us/divisions-regions-and-branches/divisions

American Psychiatric Association.(2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.

American Psychological Association. (2013). *Diagnostic and statistical manual of mental Disorders (5th ed.).* Washington, D.C.: Author.

Armstrong, D. S. (2002). Emotional Distress and Prenatal Attachment in Pregnancy After Perinatal Loss. *Journal of Nursing Scholarship*, *34*(4), 339-345.

Armstrong, D., & Hutti, M. (1998). Pregnancy after perinatal loss: The relationship between anxiety and prenatal attachment. *JOGGN*, *27*, 183-189.

Avelin, P., Radestad, I., Saflund, K., Wredling, R., & Erlandsson, K. (2013). Parental grief and relationships after the loss of a stillborn baby. Midwifery, 29, 668- 673. doi: http://dx.doi.org/10.1016/j.midw.2012.06.007

Averill, J. R. (1968). Grief: Its nature and significance. *Psychological Bulletin*, *20*, 721-748.

Averill, J. R., & Nunley, E. P. (2003). Grief as an emotion and as a disease: A social constructionist perspective. In Stroebe, M. S., Stroebe, W., & Hansson, R. O. (Eds.). Handbook of bereavement: Theory, research and intervention. Cambridge: Cambridge University Press (pp. 77-90).

Badem, A. (2015). *Kadınların prenatal dönemde bebeklerine bağlanma düzeylerinin belirlenmesi*. Unpublished Master Thesis: Gaziantep University, Gaziantep.

Badenhorst, W. & Hughes, P. (2007).Psychological aspects of perinatal loss.*Best Practice &Research Clinical Obstetrics and Gynaecology*, *21*(2), 249- 259. doi:10.1016/j.bpobgyn.2006.11.004

Bağcaz, A. (2017). *Ankara'da Yakın Kaybı Sonrası Yas Belirtilerinin Yaygınlığı ve Yordayıcı Etmenler (Sosyodemografik Özellikler, Yakın Kaybının Özellikleri, Anksiyete Duyarlılığı ve Yetişkin Ayrılık Anksiyetesi ile İlişkisi).* Unpublished Doctoral Thesi. Hacettepe University: Ankara.

Barrows, P. (2004). Fathers and families: Locating the ghost in the nursery. *Infant Mental Health Journal, 25*, 408 – 423.

Batool, S. S. &Azam, H. (2016). Miscarriage: Emotional burden and social suffering for women in Pakistan. *Death Studies*, *40*(10), 638-647. doi:http://dx.doi.org/10.1080/07481187.2016.1203376

Başal, H. A. (2006). Türkiye'de doğum öncesi, doğum ve doğum sonrası çocuk gelişimi ve eğitimine ilişkin geleneki görenek ve inançlar. Eğitim Fakültesi Dergisi, XIX (1), 45-70.

Bayık, A., & Bahar, Z. (1985). Doğurgan Çağdaki Kadınların Geleneksel Uygulamalarına İlişkin bir Çalışma. Ege Üniversitesi Hemşirelik Yüksekokulu Dergisi, 1(1).

Becker, G., Xander, C. J. Blum, H. E., Lutterbach, J., Momm, F., Gysels, M., & Higginson, I.J. (2007).Do religious or spiritual beliefs influence bereavement? A systematic review. *Palliative Medicine, 21*, 207–217.

Benedek, T. (1959).Parenthood as a developmental phase.*Journal of the American Psychoanalytic Association*, *7*, 389-417.doi: 10.1177/000306515900700301

Benore, E. R., & Park, C. L. (2004). Death-specific religious beliefs and bereavement: Belief in an afterlife and continued attachment. *International Journal for thePsychology of Religion, 14*, 1-22.

Beutel, M., Deckardt, R, von Rad, M., & Weiner, H. (1995). Grief and depression after miscarriage: Their separation, antecedents, and course. *Psychosom Med*, *57*, 517–526.

Beutel, M., Willner, H., Deckardt, R., Rad, M. V., & Weiner, H. (1996). Similarities and differences in couples' grief reactions following a miscarriage: Results from a longitudinal study. *Journal of Psychosomatic Research, 40*(3), 245-253.

Bilgiç, D., Demirel, G., & Dağlar, G. (2018). Gebelerin Gebelik Dönemine ve Doğuma İlişkin Mitlerinin Belirlenmesi. *Zeynep Kamil Tıp Bülteni, 49*(1):59-64.

Birksted-Breen, D. (2001). The experience of having baby: A developmental view. In Raphael-Leff, J. (Eds.). *"Split milk": Perinatal loss & breakdown*. London: The Institute of Psycho-Analysis (pp. 17-27).

Bogdan, R. C. & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theory and methods* (5th ed.). Boston: Pearson Education.

Bonanno, G. (2004). Loss, trauma and resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59(1), 20-28.*

Bonanno, G. A., Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review, 21* (5), 705-734.

Bowlby, J. (1973). *Attachment and loss (Vol 2). Separation: Anxiety and Anger*. New York: Basic Books/London: Hogarth.

Bowlby, J. (1980). *Attachment and loss (Vol3).Loss, sadness and depression.*New York: Basic Books/ London: Hogarth.

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

Brier, N. (2008). Grief following miscarriage: a comprehensive review of the literature. *J Womens Health*, *17*, 451–464.

Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2006). Predictors of anxiety and depression following pregnancy termination: A longitudinal five-year follow-up study. *Acta Obstetricia et Gynecologica Scandinavica*, *85*, 317–323. doi:10.1080/00016340500438116

Büchi, S., Mörgeli, H. Schnyder, U. et al. (2007).Grief and post-traumatic growth in parents 2–6 years after the death of their extremely premature baby.*Psychother Psychosom* ,*76*,106–114. doi:10.1159/000097969.

Büchi, S., Mörgeli, H., Schnyder, U. et al. (2009). Shared or discordant grief in couples 2–6 years after the death of their premature baby: Effects on suffering and posttraumatic growth. *Psychosomatics*, *50*(2), 123-130.

Cacciatore, J. (2010). The unique experiences of women and their families after the death of a baby. *Soc Work Health Care*, *49*(2), 134–148.

Cacciatore, J., Blood, C. & Kurker, S. (2018). From ‘‘Silent Birth’’ to voices heard: Volunteering, meaning, and posttraumatic growth after stillbirth. *Illness, Crisis & Loss*, *26*(1), 23-39. doi: 10.1177/1054137317740799.

Cain, A. C. & Cain, B. S. (1964). On replacing a child. *Amer. Acad. Child Psychiat*, *3*, 443-455.

Calhoun, L. G. & Tedeschi, R. G. (1999). *Facilitating Posttraumatic Growth: A Clinician's Guide*. London: Lawrence Erlbaum Associates, Inc

Calhoun, L. G. & Tedeschi, R. G. (2006). The foundations of posttraumatic growth: An expanded framework. In Calhoun, L. G. & Tedesch, R. G. (Eds.). *Handbook of Posttraumatic Growth: Research and Practice* (pp. 3-23). New York and London: The Psychology Press Taylor & Francis Group.

Calhoun, L. G., Cann, A. & Tedeschi, R. G. (2010). The Posttraumatic Growth Model: Sociocultural Considerations. In Weiss, T. & Berger, R. (Eds.). *Posttraumatic Growth and Culturally Competent Practice: Lessons Learned from Around the Globe* (pp. 1-14). Hoboken, New Jersey: John Wiley & Sons, Inc.

Campbell- Jackson, L.& Horsch, A. (2014). The psychological impact of stillbirth on women: A systematic review. *Illness, Crisis & Loss*, *22*(3), 237-256. doi: http://dx.doi.org/10.2190/IL.22.3.d

Canevello, A., Michels, V. & Hilaire, N. (2016).Supporting close others' growth after trauma: The role of responsiveness in romantic partners' mutual posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy* , *8* (3), 334–342. doi:http://dx.doi.org/10.1037/tra0000084

Carroll, R., & Shaefer, S. (1993- 1994). Similarities and differences in spouse coping with SIDS. *Omega, 28*, 273 - 284.

Catlin, G. (1993). The role of culture in grief. *The Journal of Social Psychology, 133*(2), 173-184.http://dx.doi.org/10.1080/00224545.1993.9712135

Cecil, R. (1996). Memories of pregnancy loss: Recollections of elderly women in Northern Ireland. In Cecil, R. (Ed.). The anthropology of pregnancy loss (pp. 179-196). Oxford: Berg.

Chodorow., N, (1978). *The reproduction of mothering: Psychoanalysis and the sociology of gender*. Berkeley: University of Califomia Pres.

Cimete, G. & Kuguoglu, S. (2006). Grief responses of Turkish families after the death of their children from cancer. *Journal of Loss and Trauma, 11*, 31–51. doi: 10.1080/15325020500194455

Clower, C. E. (2003). Pregnancy loss: Disenfranchised grief and other psychological reactions. Unpublished Doctoral Thesis. University of North Texas.

Cohen, L., Manion, L., & Morrison, K. (2007).*Research methods in education (6thed.)*. New York: Routledge.

Compton-Lilly, C. (2013). Case studies.In Trainor, A. A., & Graue, E. (Eds.).*Reviewing Qualitative Research in the Social Sciences* (pp. 54-65). New York, NY: Routledge

Condon, J. T. (1985). The parental-foetal relationship-A comparison of male and female expectant parents. *Journal of Psychosomatic Obstetrics and Gynaecology, 4*, 271-284. Condon J. (2006). What about dad? Psychosocial and mental health issues for new fathers. *Aust Fam Physician, 35*, 690–692.

Cook, A. S. (1995). Ethical issues in bereavement research: An overview. *Death Studies*, 19, 103-122.

Cook, A. S. & Bosley, G.(1995). The experience of participating in bereavement research: Stressful or therapeutic? *Death Studies*, 19, 157- 170.

Cook, A. S. (2010). The dynamics of ethical decision making in bereavement research. In Stroebe, M. S., Hansson, R. O., Stroebe, W., and Schut, H. (Eds.), *Handbook of Bereavement Research: Consequences, Coping, and Care* (pp. 119-142). Washington: American Psychological Association.

Corbet-Owen, C. (2003). Women's perceptions of partner support in the context of pregnancy loss (es). *South African Journal of Psychology*, *33*(1), 19-27.

Côté-Arsenault, D., Bidlack, D., &Humm, A. (2001). Emotions and concerns of women in pregnancy after loss. *American Journal of Maternal-Child Health*, *26*, 128-134.

Côté-Arsenault, D. & Freije, M. M. (2004).Support groups helping women through pregnancies after loss. *Western Journal of Nursing Research, 26*(6), 650-670. doi: *10.1177/0193945904265817*

Côté-Arsenault, D., & Marshall, R. (2000). One foot in—one foot out: Weathering the storm of pregnancy after perinatal loss. *Research in Nursing and Health*, *23*, 473-485.

Coyne, I. T. (1997).Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, *26*, 623–630.

Covington, S. N. (2006). Pregnancy loss. In Covington, S. N. & Burns, L. H. (Eds.). *Infertility counseling: A comprehensive handbook for clinicians*. New York: Cambridge University Press (pp. 290-304).

Creswell, J. W. (1998). *Quality inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches.* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4rd ed.). Boston, MA: Pearson Education.

Cuisinier, M., Janssen, H., De Graauw, C., Bakker, S., Hoogduin, C. (1996). Pregnancy following miscarriage: Course of grief and some determining factors. *J Psychosom Obstet Gynecol*, *17*(3), 168–74. doi: 10.1089/jwh.2007.0505

Cuisinier, M. C. J., Kuijpers, J. C., Hoogduin, C. A. L., Graauw, C. P. H. M. & Janssen, H. J. E. M. (1993). Miscarriage and stillbirth: Time since the loss, grief intensity and satisfaction with care. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 52*, 1163-168.

Çakırer, N. & Çalışkan, Z. I. (2010). Nevşehir ili Ağıllı Köyünde gebelik, doğum ve lohusalığa ilişkin geleneksel inanç ve uygulamalar. *TAF Preventive Medicine Bulletin, 9*(4), 343-348.

Davis, D. L. (1986).*Perinatal loss: The mother's experience of grief, resolution and subsequent child*. Unpublished Doctoral Thesis. Massachusetts: University of Massachuets.

De Montigny, F., Beaudet, L. & Dumas, L. (1999). A baby has died: The impact of perinatal loss on family and social networks. *JOGNN Clinical Studies*, *28*, 151-156.

De Montigny, F., Verdon, C., Meunier, S. & Dubeau, D. (2017). Women's persistent depressive and perinatal grief symptoms following a miscarriage: the role of childlessness and satisfaction with healthcare services. *Arch Womens Ment Health, 20*:655–662. doi: 10.1007/s00737-017-0742-9

de Vries, B., Davis, C. G., Wortman, C. B., & Lehman, D. R. (1997). Long term psychological and somatic consequences of later life parental bereavement. Omega: Journal of Death and Dying, 35, 97–117.

Dey, I. (2005). *Qualitative data analysis: A user-friendly guide for social scientists*. New York: Routledge.

Dunn, D., Goldbach, K. R. C., Lasker, J., & Toedter, L. (1991).Explaining pregnancy loss. *Omega*, *25*, 13-23.

Duyan, V., Kapısız, S. G. & Yakut, H. İ. (2013). The adaptation of fetal attachment inventory to Turkish with a group of pregnant women. *The Journal of Gynecology-Obstetrics and Neonatology*, *10*(39), 1609-1614.

Düzen, A. (2016). *Tekrarlayan Düşük Yaşayan Kadınların Ruhsal Süreçlerinin İncelenmesi*. Unpublished Master Thesis. İstanbul: Okan University.

Dyregov, A., & Matthiesen, S. B. (1987). Similarities and differences in mothers' and fathers' grief following the death of an infant. *Scand J Psychol*, 28, 1-15.

Dyson, L., & While, A. (1998).The ‘‘long shadow’’ of perinatal bereavement. British Journal of Community Nursing, 3, 432–439. Retrieved from http://www. bjcn.co.uk

Elklit, A. & Gudmundsdottir, D.B. (2006).Assessment of guidelines for good psychosocial practice for parents who have lost an infant through perinatal or postnatal death. *Nordic Psychology*, 58, 315-330.doi: http://dx.doi.org/10.1027/1901-2276.58.4.315

Engel, G. L. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine, 23,* 18–22.

Engelkemeyer, S. M., & Marwit, S. J. (2008).Posttraumatic growth in bereaved parents. Journal of Traumatic Stress, 21(3), 344–346. doi:10.1002/jts.20338

Engin, R. & Pasinlioğlu, T. (2002). Erzurum ve yöresinde infertil kadınların infertilite ile ilgili geleneksel inanç ve uygulamaları. *Atatürk Üniv. Hemşirelik Yüksekokulu Dergisi, 5*(1), 1-10.

Ersoy, R. (2002). Death and dead body rites and rituals in Turkish culture. *Milli Folklor, 54,* 86-101.

Erikson, E. H. (1977). *Childhood and Society*. London: Paladin Grafton Books

Forrest, G. C. & Standish, E. & Baum, J. D. (1982). Support after perinatal death: a study of support and counseling after perinatal bereavement. *British Medical Journal (Clinical Research Edition), 285*(6353), 1475-1479.

Fraenkel, J. R., Wallen, N. E. & Hyun, H. H. (2011). *How to design and evaluate research in education* (8th Ed.). Boston: McGraw-Hill.

Freud, S. (1917). Mourning and Melancholia. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916): On the History of the Psycho-Analytic Movement, Papers on Metapsychology and Other Works*, 237-258

Friedman, T. & Gath, D. (1989).The psychiatric consequences of spontaneous abortion. *British Journal of Psychiatry*, 155, 810-813.

Frost, M., & Condon, J. T. (1996). The psychological sequelae of miscarriage: A critical review of the literature. *Australian & New Zealand Journal of Psychiatry, 30,* 54–62.

Gall, M. D., Gall, J. P. & Borg, W. R. (2003).*Educational Research: An Introduction* (7th Ed.). Boston: Pearson Education, Inc.

Gall, M. D., Gall, J. P. & Borg, W. R. (2010). *Applying Educational Research* (6th Ed.).Boston: Pearson Education, Inc.

Gerber-Epstein, P., Leichtentritt, R. D., & Benyamini, Y. (2008). The Experience of miscarriage in first pregnancy: The women's voices. *Death Studies, 33*(1), 1- 29.

Giblin, P., & Hug, A. (2006). The psychology of funeral rituals. *Liturgy, 21* (1), 11-19.

Gibson, W. J., & Brown, A. (2009). *Working with Qualitative Data*. London: Sage Publication.

Giddens, O. & Giddens, S. (2000). Coping with grieving and loss. New York, NY: The Rosen Publishing Group, Inc.

Gilbert, K. R. (1996). "We've had the same loss, why don't we have the same grief?" Loss and differential grief in families.*Death Studies, 20*, 263-283.

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

Gilson, G. J. (1976) Care of the family who has lost a newborn. *Postgraduate Medicine, 60*(6), 67-70, doi: 10.1080/00325481.1976.11708404

Gissler, M., Hemminki, E., & Lonnqvist, J. (1996). Suicides after pregnancy in Finland, 1987–94: Register linkage study. BMJ, 313, 1431–1434.

Glaser, B. G., & Strauss, A. L. (2006).*The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

Glesne, C. (2006). *Becoming qualitative researchers: An introduction* (3rd ed.). Boston: Pearson Education Inc.

Golbach, K. R. C., Dunn, D. S., Toedter, L. J., & Lasker, J. N. (1991). The effects of gestational age and gender on grief after pregnancy loss. *Amer. J. Orthopsychiat., 61*(3), 461-467.

Gold, K. J., Leon, I., Boggs, M. E., & Sen, A. (2016). Depression and posttraumatic stress symptoms after perinatal loss in a population-based sample. *Journal of Women's Health, 25* (3), 263-269. doi: 10.1089/jwh.2015.5284

Gold, K. J., Sen, A., & Hayward, R. A. (2010). Marriage and cohabitation outcomes after pregnancy loss. *Pediatrics*, *125*(5), 1202-1207. doi: 10.1542/peds.2009-3081

Göka, E. (2010). *Ölme: Ölümün ve geride kalanların psikolojisi*. İstanbul: Timaş Publishing.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ, 29*(2), 75-91.

Hacettepe University Institution of Population. (2014). *2013 Türkiye Nüfus ve Sağlık Araştırması.*Hacettepe University Institution of Population, Turkey Ministry of Development, TÜBİTAK. Ankara: Türkiye.

Halifax, J. (2008). *Being with dying: Cultivating compassion and fearlessness in the presence of death*. Boston: Shambhala Publications

Hamilton, S. M. (1989). Should follow-up be provided after miscarriage? *Br J Obstet Gynaecol*, 96,743–745.

Hansson, R. O., Carpenter, B. N. & Fairchild, S. K. (2003). In Stroebe, M. S., Stroebe, W. & Hansson, R. O. (Eds.). *Handbook of Bereavement: Theory, Research and Intervention* (pp. 62-74). Cambridge: Cambridge University Press.

Harker L. (1993). Emotional well-being following miscarriage. *Journal of Obstetrics and Gynaecology, 13*, 262–265.

Harper, M., O'Connor, R., Dickson, A. & O'Carroll, R. (2011). Mothers continuing bonds and ambivalence to personal mortality after the death of their child – An interpretative phenomenological analysis. *Psychology, Health & Medicine, 16*(2), 203–214. doi: 10.1080/13548506.2010.532558

Heazell, A., E., P., Siassakos, D., Blencowe, H., Burden, C., Bhutta, Z. A., Cacciatore, J., et al. (2017). Stillbirths: economic and psychosocial consequences. *Lancet* [internet]; 387, 604–616.doi: http://dx.doi.org/10.1016/S0140-6736(15)00836-3

Helstrom, L. & Victor, A. (1987). Information and emotional support for women after miscarriage.*Journal of Psychosomatic Obstetrics & Gynecology, 7*, 93-98.

Hendrickson, K. (2009). Morbidity, mortality, and parental grief: A review of the literature on the relationship between the death of a child and the subsequent health of parents. *Palliative and Supportive Care, 7*, 109–119.

Herman, J.L. (1992). *Trauma and recovery*. New York: Basic Books.

Horowitz, M. J., Wilner, N., Marmar, C., &, Krupnick, J. (1980). Pathological grief and the activation of latent self images. *American Journal of Psychiatry, 137,* 1157–1162.

Horowitz, M., Bonanno, G., & Holen, A. (1993). Pathological grief: Diagnosis and explanation. *Psychosomatic Medicine, 55*, 260–273.

Horsch, A., Jacobs, I. & McKenzie-McHarg, K. (2015). Cognitive predictors and risk factors of PTSD following stillbirth: A short-term longitudinal study. *Journal of Traumatic Stress, 28,*110–117. doi: 10.1002/jts.21997

Hotun, N. (1990). İstanbul İli Halkalı Yöresindeki Kadınların Gebelik ve Doğuma İlişkin Geleneksel İnanç ve Uygulamaları. İstanbul Üniversitesi: Yayınlanmamış Yüksek Lisans Tezi.

Houwert-De Jong, M.H., Bruinse, H. W., Eskes, T. K. A. B., Mantingh, A., Termijtelen, A. & Kooyman, C. D. (1990). Early recurrent miscarriage: Histology of conception products. *British Journal of Obstetrics & Gynecology, 97*,533–535.

Hughes, C. B. & Page-Lieberman, j. (1989).Fathers experiencing a perinatal loss.*Death Studies, 13*(6), 537-556.doi: 10.1080/07481188908252331

Hughes, P. M., Turton, P. & Evans, C. D. H. (1999). Stillbirth as risk factor for depression and anxiety in the subsequent pregnancy: Cohort Study. *BMJ: British Medical Journal, 318*, 1721-1724.

Hughes, P., Turton, P., Hopper,E., McGauley, G.,A., & Fonagy, P. (2001). Disorganised attachment behaviour among infants born subsequent to stillbirth.*J Child Psychol Psychiatry, 42*, 791–801.

Hunfeld, J.A., Taselaar-Kloos, A., K., Agterberg, G., Wladimiroff, J.W., & Passchier, J. (1997). Trait anxiety, negative emotions and the mothers' adaptation to an infant born subsequent to late pregnancy loss: Case-control study. *Prenat Diagn, 17,* 843–851.

Hutti, M. H. (1986). An exploratory study of the miscarriage experience. *Health Care for Women International*, *7*(5), 371-389. doi: 10.1080/07399338609515750

Hutti, M. H., Armstrong, D. S., Myers, J. A. & Hall, L. A. (2015). Grief intensity, psychological well-being, and the intimate partner relationship in the subsequent pregnancy after a perinatal loss. *JOGNN, 44,* 42-50.doi: 10.1111/1552-6909.12539

Imamoglu, E. O., & Gultekin, Y. Y. (1993). Problems of university youth in the light of recommended balanced society-individual model: Evaluation, comment and recommendation to the studies conducted in the period between 1982 1992 (in Turkish). *Turkish Journal of Psychology, 8*, 27-41.

Jaffe, J. & Diamond, M. O. (2011). Reproductive Trauma: Psychotherapy with Infertility and Pregnancy Loss Clients. Washington: American Psychological Association

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition, 7*, 113–136.

Janoff-Bulman, R. (1992). *Shattered Assumptions: Toward a New Psychology of Trauma.* New York: The Free Press.

Janoff-Bulman, R. (2006). Schema-changes perspectives on posttraumatic growth.In Calhoun, L. G. & Tedesch, R. G. (Eds.). *Handbook of Posttraumatic Growth: Research and Practice*. New York and London: The Psychology Press Taylor & Francis Group.

Janssen, H. J. E. M., Cuisinier, M. C. J. & Hoogduin, K. A. L. (1996). A critical review of the concept of pathological grief following loss. *Omega*, *33*(1), 21-42.

Jonker, G. (1997). The many facets of Islam: Death, dying and disposal between orthodox rule and historical convention. In Parkes, C. M., Laungani, P. & Young, B. (Eds.). *Death and Bereavement Across Cultures*. (pp. 147-165). London: Routledge.

Juth, V., Smyth, J. M., Carey, M. P. & Lepore, S. J. (2015). Social constraints are associated with negative psychological and physical adjustment in bereavement. *Applied Psychology: Health and Well- Being, 7* (2), 129–148.doi:10.1111/aphw.12041

Kagitcibasi, C. (1996). The autonomous-relational self: A new synthesis. *Europea Psychologist*, *1*, 180–186.

Kagitcibasi, C. & Ataca, B. (2005). Value of children and family change: A three-decade portrait from Turkey. *Applied Psychology: An International Review*, *54*(3), 317-337.

Kamm, S., & Vandenberg, B. (2001). Grief communication, grief reactions and marital satisfaction in bereaved parents. *Death Studies*, *25*, 569- 582. doi: 10.1080/07481180126576

Kavanaugh, K., Trier, D. & Korzec, M. (2004). Social support following perinatal loss. *J Fam Nurs*, *10* (1), 70–92.

Kersting, A., Dorsch, M., Kreulich, C., Reutemann, M., Ohrmann, P., Baez, E. & Arolt, V. (2005). Trauma and grief 2–7 years after termination of pregnancy because of fetal anomalies – A pilot study.*Journal of Psychosomatic Obstetrics & Gynecology*, *26*(1), 9–14.doi: 10.1080/01443610400022967

Kersting, A. & Wagner, B. (2012). Complicated grief after perinatal loss.*Dialogues in Clinical Neuroscience*,*14* (2),187-194.

Kimbre, D. L. (1991). Neonatal death: A descriptive study of fathers' experiences. *Neonatal Network,* 9(8), 45–50.

Kirkley-Best, E. & Kellner, K. R. (1982). The forgotten grief: A review of the psychology of stillbirth. *Amer. J. Orthopsychiat*, *52*(3), 420-429.

Klier, C. M., Geller, P. A. & Ritsher, J. B. (2002).Affective disorders in the aftermath of miscarriage: A comprehensive review. Arch Womens Ment Health, 5, 129–149. doi: 10.1007/s00737-002-0146-2

Koopmans, L., Wilson, T., Cacciatore, J., & Flenady, V. (2013). Support for mothers, fathers and families after perinatal death. *Cochrane Database Syst Rev*, 6. doi:10.1002/14651858.CD000452.pub3

Korkmaz, A., Aydın, Ş., Çamurdan, A. D., Okumuş, N., Onat, F. N., Özbaş, S. et al. (2013).Türkiye'de bebek ölüm nedenlerinin ve ulusal kayıt sisteminin değerlendirilmesi.*Çocuk Sağlığı ve Hastalıkları Dergisi*, *56*, 105-121.

Köneş, M. Ö. (2018). *Gebeliğin farklı dönemlerinde yaşanan perinatal kayıplarda kadınların deneyimledikleri keder düzeyi ve etkileyen faktörler*. Unpublished Doctorate Thesis: Marmara University, Istanbul.

Krosch, D. J. & Shakespeare-Finch, J. (2017). Grief, traumatic stress, and posttraumatic growth in women who have experienced pregnancy loss.*Psychological Trauma: Theory, Research, Practice, and Policy*, *9* (4), 425–433. doi: http://dx.doi.org/10.1037/tra0000183

Kunt-Işguder, C., Batmaz, S., Yıldız, M., Songur, E., Yilmaz-Dogru, H., Delibas, I. B. Et al. (2018). Relationship between miscarriage and dysfunctional cognitions about trauma, coping mechanisms, and posttraumatic growth. *J Rat-Emo Cognitive-Behav Ther*. doi: 10.1007/s10942-017-0276-0

Kuscu, M. K., Akman, I., Karabekiroglu, A., Yurdakul, Z., Orhan, L., Ozdemir, N. et al. (2008). Early adverse emotional response to childbirth in Turkey: The impact of maternal attachment styles and family support. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(1), 33–38. doi: 10.1080/01674820701535480

Kübler-Ross, E. & Kessler, D. (2014). *On grief and grieving: Finding the meaning of grief through the five stages of grief*. New York: Scribner.

Lafarge, C., Mitchell, K. & Fox, P. (2017). Posttraumatic growth following pregnancy termination for fetal abnormality: the predictive role of coping strategies and perinatal grief. *Anxiety, Stress & Coping*, *30*(5), 536-550. doi:https://doi.org/10.1080/10615806.2016.1278433.

Lalande, K.M., & Bonanno, G. A. (2006). Culture and continuing bonds: A prospective comparison of bereavement in the United States and the People's Republic of China. *Death Studies*, *30*(4): 303-324. doi: 10.1080/07481180500544708

Lasker, J. N. & Toedter, L. J. (1991). Acute versus chronic grief: The case of pregnancy loss. *Amer. J. Orthopsychiat*, *61*(4), 510-522.

Lee, C. (2012). "She was a persoon, she was here": The experience of late pregnancy loss in Australia. *Journal of Reproductive and Infant Psychology*, *30*(1), 62-76. 10.1080/02646838.2012.661849

Lee, C. & Rowlands, I. J. (2015). When mixed methods produce mixed results: Integrating disparate findings about miscarriage and women's wellbeing. *British Journal of Health Psychology*, *20*, 36-44. doi: 10.1111/bjhp.12121

Leifer, M. (1977). Psychological changes accompanying pregnancy and motherhood. *Genetic Psychology Monographs, 95,* 55–96.

Leon, I. G. (1990). *When a baby dies: Psychotherapy for Pregnancy and Newborn Loss*. Yale University Press.

Leon, I. G. (2018). Reproductive loss and its impact on the next pregnancy. In Muzik, M., & Rosenblum, K.L.(Eds.). *Motherhood in the face of trauma: Pathways toward healing and growth* (pp.69-81). Cham: Springer Publishing.

Li, Z., Zeki, R., Hilder, L. & Sullivan, E. A. (2013) *Australia's mothers and babies 2011*. Perinatal statistics series no. 28. Cat. no. PER 59. Canberra: AIHW National Perinatal Epidemiology and Statistics Unit.

Li, J., Precht, D. H., Mortensen, P. B., & Olsen, J. (2003). Mortality in parents after death of a child in Denmark: A nationwide follow-up study. *The Lancet, 361,* 363–367. http://dx.doi.org/10.1016/S0140- 6736(03)12387-2

Lin, S. X. & Lasker, J. N. (1996). Patterns of grief reaction after pregnancy loss.*American Journal of Orthopsychiatry*, *66*(2), 262- 271.

Lindemann, E. (1944). Symptomatology and management of acute grief.*American Journal of Psychiatry, 101, 186-201.*

Lindgren, H., Malm, M. C. & Radestad, I. (2014). You don't leave your baby: Mother's experiences after a stillbirth. *Omega*, *68*(4), 337-346.

Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17*(1), 1121. doi:10.1023/B:JOTS.0000014671.27856.7e.

Lune, H. & Berg, B. L. (2017). *Qualitaive research methods for the social sciences* (9thed.).London: Pearson Education.

Maguire, M., Light, A., Kuppermann, M., Dalton, V. K., Steinauer, J. E. & Kerns, J. L. (2015). Grief after second-trimester termination for fetal anomaly: A qualitative study. *Contraception*, 91, 234-239.

Maker, C., & Ogden, J. (2003). The miscarriage experience: More than just a trigger to psychological morbidity? *Psychology and Health, 18(3),* 403-415. doi: 10.1080/0887044031000069343.

Mander, R. (2006). *Loss and bereavement in childbearing* (2nded.). New York, NY: Routledge.

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R., & Bush, F. (2008). Predicting depressive symptoms and grief after pregnancy loss. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*, 1–6.

Martin, T. L., & Doka, K. J. (2000). Men don't cry, women do: Transcending Gender Stereotypes of Grief. New York, NY: Routledge.

Martin, T. L., & Doka, K. J. (2011).The influence of gender and socialization on grieving styles.In Neimeyer, R. A., Harris, D. L., Winokuer, H. R., & Thornton, G. F. (Eds.). Grief and bereavement in contemporary society: Bridging research and practice. New York, NY: Routledge.

Martincekova, L. & Klatt, J. (2017). Mothers' grief, forgiveness, and posttraumatic growth after the loss of a child.*OMEGA—Journal of Death and Dying*, *75*(3) 248–265.doi: 10.1177/0030222816652803

McWhirter, J. J. (1983). Cultural factors in guidance and counseling in Turkey: The experience of a Fulbright family. *The Personnel and Guidance Journal*, *61*, 504-507.

Meaney, S., Corcoran, P., Spillane, N. & O'Donoghue, K. (2016). Experience of miscarriage: An interpretative phenomenological analysis. *BMJ Open*, *7*, 1-7. doi: 10.1136/bmjopen-2016-011382

Meaney, S., Everard, C. M., Gallagher, S. & O'Donoghue, K. (2016). Parents' concerns about future pregnancy after stillbirth: A qualitative study. *Health Expectations*, *20*, 555-562. doi: 10.1111/hex.12480.

Meredith, P., Wilson, T., Branjerdporn, G., Strong, J. & Desha, L. (2017). "Not just a normal mum": A qualitative investigation of a support service for women who are pregnant subsequent to perinatal loss. *BMC Pregnancy and Childbirth*, *17*(6), 1-12. doi:10.1186/s12884-016-1200-9

Merriam, S. B. et al. (2002). Qualitative research in practice: Examples for discussion and analysis (1sted.). San Francisco, CA: Jossey-Bass.

McCreight, B. S. (2004). A grief ignored: Narratives of pregnancy loss from a male perspective. *Sociology of Health & Illness*, *26*(3), 326-350.

Middleton, W., Raphael, B., Martinek, N. & Misso, V. (2003). Pathological grief reactions. In Stroebe, M. S., Stroebe, W. & Hansson, R. O. (Eds.). *Handbook of Bereavement: Theory, Research and Intervention* (pp. 44-61). Cambridge: Cambridge Univeristy Press.

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

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260. doi: 10.1037/0022-0167.52.2.250

Murphy, F. A. (1998). The experience of early miscarriage from a male perspective. *Journal of Clinical Nursing, 7,* 325–332.

Murphy, S., Shevlin, M. & Elklit, A. (2014). Psychological consequences of pregnancy loss and infant death in a sample of bereaved parents.*Journal of Loss and Trauma*, *19*, 56-69.doi: 10.1080/15325024.2012.735531.

Najman, J. M., Vance, J. C., Boyle, F., Embleton, G., Foster, B., & Thearle, J. (1993). The impact of a child death on marital adjustment. *Soc Sci Med., 37*(8), 1005–1010.

Nansel, T. R., Doyle, F., Frederick, M. M., & Zhang, J. (2005). Quality of life in women undergoing medical treatment for early pregnancy failure. *J Obstet Gynecol Neonatal Nurs*, *34*(4), 473–481.

Neimeyer, R. A., Klass, D. & Dennis, M. R. (2014). A Social constructionist account of grief: Loss and the narration of meaning. *Death Studies*, 1–14. doi: 10.1080/07481187.2014.913454

Neimeyer, R. A., Prigerson, H: G. & Davies, B. (2002). Mourning and meaning. *American Behavioral Scientist*, *46*(2), 235- 251. doi: 10.1177/000276402236676

Neimeyer, R. A., & Sands, D. c. (2011). Meaning reconstruction in bereavement: From principles to practice. In Neimeyer, R. A. Harris, D. L., Winokuer, H. R., & Thornton, G. F. (Eds.). *Grief and Bereavement in Contemporary Society: Bridging Research and Practice* (pp. 9-22). New York: Routledge.

Newman, E., Risch, E., & Kassam-Adams, N. (2006). Ethical issues in trauma-related research: A review. *Journal of Empirical Research on Human Research Ethics: An International Journal, 1*(3), 29-46.

Nikcevic, A. V., Tunkel, S. A. & Nicolaides, K. H.(1998). Psychological outcomes following missed abortions and provision of follow-up care. *Ultrasound Obstet Gynecol*, 11,123–128.

Nolen-Hoeksema., & Larson, J. (1999). *Coping with loss*. New Jersey: Lawrence Erlbaum Associates, Inc.

Nuzum, D., Meaney, S. & O'Donoghue, K. (2018).The impact of stillbirth on bereaved parents: A qualitative study. PLoS ONE 13(1).doi: e0191635. https://doi.org/10.1371/journal.pone.0191635

O'Leary, J. & Thorwick, C. (2006). Fathers' perspectives during pregnancy after, postperinatal loss. *JOGNN, 35*(1), 78-86. doi: 10.1111/J.1552-6909.2006.00017.x

Özmen, O. (2014). Cultural characteristics of grief and coping in bereaved adult women: A phenomenological study with consensual qualitative research. Unpublished Doctorate Thesis: Middle East Technical University, Ankara

Parkes, C.M. (1995). Guidelines for conducting ethical bereavement research. *Death Studies*, 19, 171-181.

Parkes, C. M., Laungani, P. & Young, B. (1997). Introduction. In Parkes, C. M., Laungani, P. & Young, B. (Eds.). *Death and Bereavement Across Cultures*. (pp. 3-9). London: Routledge.

Parkes, C. M. (2011). Introduction: The historical landscape of loss: Development of bereavement studies. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer, G. F. Thornton (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 1-5). New York: Routledge.

Parkes, C. M. & Prigerson, H. G. (2010). *Bereavement: Studies of grief in adult life* (4th ed.). New York, NY: Routledge.

Patton, M., Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed). Newbury Park, California: Sage Publications.

Peppers, L. G. & Knapp, R. J. (1980). Maternal reactions to involuntary fetal/infant death.*Psychiatry, 43*(2), 155-159.

Pines, D. (1972). Pregnancy and motherhood: Interaction between fantasy and reality. *British Journal of Medical Psychology, 45*, 333–343.

Rajan, L. & Oakley, A. (1993). No pills for heartache: The importance of social support for women who suffer pregnancy loss. Journal of Reproductive and Infant Psychology, 11(2), 75-87. doi: 10.1080/02646839308403198

Reed, K. S. (1984). Involuntary pregnancy loss research and the implications for nursing. *Issues in Mental Health Nursing, 6*, 2019-217.

Reyes, G., Elhai, J. D., & Ford, J. D. (Eds.) (2008). *The encyclopedia of Psychological Trauma.*Hoboken, New Jersey: John Wiley & Sons, Inc.

Riley, L. P., LaMontagne, L. L., Hepworth, J. T., & Murphy, B. A. (2007).Parental grief responses and personal growth following the death of a child.*Death Studies*, *31*, 277–299. doi:10.1080/07481180601152591

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

Robben, A. C. G. M. (2004). Death and anthropology: An introduction. In Robben, A. C. G. M. (Ed.). *Death, mourning, and burial: A cross-cultural reader*. Malden, MA: Blackwell Publishing (pp. 1-16).

Robinson, G. E. (2011). Dilemmas related to pregnancy loss. *J Nerv Ment Dis*, *199*, 571-574.

Rogers, C. H., Floyd, F. J., Seltzer, M. M., Greenberg, J. & Hong, J. (2008). Long-term effects of the death of a child on parents' adjustment in midlife. *Journal of Family Psychology*, *22*(2), 203-211. doi: 10.1037/0893-3200.22.2.203

Romanoff, B. D. (1998). Rituals and the grieving process. *Death Studies*, *22*(8), 697-711. doi: 10.1080/074811898201227

Rosenblatt, P. C. (1995). Ethics of qualitative interviewing with grieving families. *Death Studies*, 19, 139-155.

Rosenblatt, P. C. (1998). Grief: The social context of private feelings. *Journal of Social Issues, 44*(3), 67-78.

Rosenblatt, P. C. (2010). A social constructionist perspective on cultural differences in grief. In Stroebe, M. S., Hansson, R. O., Stroebe, W., and Schut, H. (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 285- 300). Washington: American Psychological Association.

Rowe, J., Clyman, R., Green, C., Mikkelsen, C., Haight, J. & Ataide, L. (1978). Follow-up of families who experience a perinatal death.*Pediatrics, 62*, 166-170.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, *15*, 85-109. doi: 10.1177/1525822X02239569

Samuelsson, M., Radestad, I. & Segesten, K. (2001). A waste of life: Fathers' experience of losing a child before birth.*Birth*, *28*(2), 124-130.

Schaefer, J. A., & Moos, R. H. (1992).Life crises and personal growth. In B. N. Carpenter (Ed.), *Personal coping: Theory, research and application* (pp. 149−170). Westport, CT: Praeger.

Schut, H., Stroebe M., von den Bout J, and et al. (2001). The efficacy of bereavement interventions: determining who benefits. In Stroebe, M., (Ed.). Handbook of Bereavement: Consequences, Coping, and Care. (pp. 705–737).Washington, DC, American Psychological Assoc.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, NY: Teachers College Press.

Serçekuş¸ P., & Mete, S. (2010). Effects of antenatal education on maternal prenatal and postpartum adaptation. *Journal of Advanced Nursing*, *66*(5), 999–1010. doi: 10.1111/j.1365-2648.2009.05253.x

Shaw, A. (2014). Rituals of infant death: Defining life and Islamic personhood. *Bioethics*, *28*(2), 84-95.

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

Shojaa, M., Jouybari, L., & Sanagoo, A. (2009).The sexual activity during pregnancy among a group of Iranian women. *Arch Gynecol Obstet,* 279,353–356.

Shuchter, S. R. & Zisook, S. (2003). The course of normal grief. In Stroebe, M. S., Stroebe, W. & Hansson, R. O. (Eds.).*Handbook of Bereavement: Theory, Research and Intervention* (pp. 23-43). Cambridge: Cambridge University Press.

Shumaker, S. A., & Hill, D. R. (1991). Gender differences in social support and physical health. *Health Psychology, 10,* 102-111.

Silverman, P. R., &Worden, J. W. (1992).Children's reactions in the early months after the death of a parent.*American Journal of Orthopsychiatry, 62(1), 93-104.*

Smith, A. C. & Borgers, S. B. (1988).Parental grief response to perinatal death.*Omega, 19*(3), 203-214. doi: 10.2190/BV16-G1FD-6CYG-CVXF

Smith, J.A. & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative Psychology. A Practical Guide to Research Methods. (2nd ed.).* London: Sage

Stake, R. E. (2010).*Qualitative research: Studying how things work*. New York, NY: The Guilford Press.

Stern, N. B. (1999). Motherhood: The emotional awakening. *Journal of Pediatric Health Care, 13,* 8-12. doi: 10.1016/S0891-5245(99)90049-4

Stinson, K. M., Lasker, J. N., Lohman, J.,& Toedter, L. J. (1992). Parents' grief following pregnancy loss: A comparison of mothers and fathers. *Faro Relations,* 41, 218-223.

Stringham, J. G., Riley, J. H. & Ross, A. (1982). Silent birth: mourning a stillborn baby. *Social Work, 27*(4), 322- 327.

Stroebe, M. S., Hansson, R. O., Stroebe, W., & Schut, H. (2001). Introduction: Concepts and issues in contemporary research on bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 3-22). Washington, DC: American Psychological Association.

Stroebe, M., & Schut, H. (1998). Culture and grief. *Bereavement Care, 17*(1), 7-11.

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, *23*, 197-224.

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *Omega*, *61*(4), 273-289.

Stroebe, M. S., & Schut, H. (2001). Meaning making in the Dual Process Model of Coping with Bereavement. In R. A. Neimeyer (Ed.), *Meaning Reconstruction and the Experience of Loss* (pp. 55–73). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/10397-003

Stroebe, M., Stroebe, W. & Schut, H. (2003). Bereavement research: Methodological issues and ethical concerns. *Palliative Medicine, 17,* 235 /240.doi: 10.1191/0269216303pm768rr

Stroebe, M., van Son, M., Stroebe, W., Kleber, R., Schut, H. & van den Bout, J. (2000). On the classificatıon and diagnosis of pathological grief. *Clinical Psychology Review, 20*(1), 57–75.

Swanson, K. M. (2000). Predicting depressive symptoms after miscarriage: A path analysis based on the Lazarus paradigm.*Journal of Women's Health & Gender-Based Medicine*, *9*(2), 191- 206.

Swanson, K. M., Connor, S., Jolley, S. N., Pettinato, M., & Wang, T. J. (2007). Contexts and evolution of women's responses to miscarriage during the first year after loss. *Research in Nursing & Health*, *30*, 2–16. doi: 10.1002/nur.20175

Tavoli, Z., Mohammadi, M., Tavoli, A., Moini, A., Moini, A., Effatpanah, M., Khedmat, L., & Mantazeri, A. (2018). Quality of life and psychological distress in women with recurrent miscarriage: A comparative study. Health and Quality of Life Outcomes, 16(150). doi: 10.1186/s12955-018-0982-z

Teke, E. (2005). Osmaniye'de Doğumla İlgili İnanç ve Uygulamalar. Unpublished Master Thesis: Gaziantep University.

Thomadaki, O. (2012). How mothers experience personal growth after aperinatal loss. (Unpublished Doctoral thesis, City University London)

Thomadaki, O. (2017). Bereavement, post-traumatic stress and post-traumatic growth: Through the lenses of positive psychology. *European Journal of Psychotraumatology*, 8.doi:https://doi.org/10.1080/20008198.2017.1351220

Tedeschi, R. G. & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455–471.

Tedeschi, R. G., & Calhoun, L. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15,* 1-18.

Tedeschi, R. G. & Calhoun, L. (2004). Expert companions: Posttraumatic growth in clinical practice. In Calhoun, L. G. &Tedesch, R. G. (Eds.).*Handbook of Posttraumatic Growth: Research and Practice* (pp. 291-310). New York and London: The Psychology Press Taylor &Francis Group.

Tedeschi, R. G., Calhoun, L. G., & Cann, A. (2007).Evaluating resource gain: Understanding and misunderstanding posttraumatic growth.*Applied Psychology:An International Review, 56*(3), 396-406.doi: 10.1111/j.1464-0597.2007.00299.x

Topdemir-Koçyiğit, O. (2012). Infertilite and sosyo-kültürel etkileri. *İnsanbilim Dergisi*, *1*(1), 27-38.

Tseng, Y. F., Cheng, H. R., Chen, Y. P., Yang, S. F., & Cheng, P. T. (2017). Grief reactions of couples to perinatal loss: A one-year prospective follow-up. *J Clin Nurs*., *26*, 5133–5142. doi: 10.1111/jocn.14059

Tseng, Y-F., Chen, C-H., & Wang, H-H. (2014). Taiwanese women's process of recovery from stillbirth: A qualitative descriptive study. *Research in Nursing & Health*, *37*, 219–228. doi: 10.1002/nur.21594

Turton, P., Badenhorst, W., Hughes, P., Ward, J., Riches, S. & White, S. (2006). Psychological impact of stillbirth on fathers in the subsequent pregnancy and puerperium.*British Journal of Psychiatry*, 188, 165-172.

Turton, P., Hughes, P., Evans, C. D. H. & Fainman, D. (2001).Incidence, correlates & predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *British Journal of Psychiatry*, 178, 556 560.

Väısänen, L. (1999). Family grief and recovery process when a baby dies: A qualitative study of family grief and healing processes after fetal or baby loss. Unpublished Doctoral Thesis. Oulu: Oulu University.

Vaismoradi, M., Turunen, H. & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences, 15,* 398- 405. doi: 10.1111/nhs.12048

van den Aker, O. B. A. (2011). The psychological and social consequences of miscarriage. *Expert Rev. Obstet. Gynecol.,* 6(3), 295–304. doi: 10.1586/EOG.11.14

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

Van, P. & Meleis, A. I. (2002). Coping with grief after involuntary pregnancy loss: Perspectives of African American women. *JOGNN Clinical Research*, *32*(1), 28- 39.

Veevers, J. E. (1973). The social meanings of parenthood. *Psychiatry, 36*, 291–310.

Ventura, S. J., Curtin, S. C., Abma, J. C., & Henshaw, S. K. (2012). Estimated pregnancy rates and rates of pregnancy outcomes for the United States, 1990–2008. *National Vital Statistics Reports, 60*(7), 1–21.

Volkan, V. (1970).Typical findings in pathological grief.*Psychiatric Quarterly*, *44*, 231-250.

Volkan, V.D. & Zintl, E. (2008).*Kayıptan Sonra Yaşam* (3rd Ed.).Izmir: Odağ Psikanaliz ve Psikoterapi Eğitim hizmetleri, Org. Ltd. Şt.

Walsh, K., King, M., Jones, L. Tookman, A., & Blizard, R. (2001). Spiritual beliefs may affect outcome of bereavement: Prospective study. *British Medical Journal*, *324* (7353), 1551-1554.

Walsh, F., McGoldrick, M. (Eds.). (2004). Living beyond loss: Death in the family (2nd ed.). New York: WW. Norton & Company.

Walter, T. (1999).*On bereavement: The culture of grief*. Buckkinghan: Open University.

Weiss, R. S. (1995). *Learning from strangers: the Art and method of qualitative interview studies.* New York: The Free Press.

Wender, E., & the Committee on Psychosocial Aspects of Child and Family Health. (2012). Supporting the family after the death of a child. American Academy of Pediatrics, 130(6), 1164-1169. doi: 10.1542/peds.2012-2772.

Werner-Lin, A. & Moro, T. (2004). Unacknowledged and stigmatized losses.In Walsh, F. & McGoldrick, M. (Eds.). Living Beyond Loss: Death in the Family (2nd Ed.)(pp. 247-271). New York, London: W. W. Norton & Company, Inc.

Wertz, F. J., Charmaz, K., McMullen, L. M., Josselson, R., Anderson, R. & McSpadden, E. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. New York: The Guilford Press.

Wild, N. D. & Paivio, S. C. (2003).Psychological adjustment, coping, and emotion regulation as predictors of posttraumatic growth.*Journal of Aggression, Maltreatment & Trauma, 8*(4), 97-122, doi: 10.1300/J146v8n04_05.

Wong, M. K. Y., Crawford, T. J., Gask, L., et al. (2003). A qualitative investigation into women's experiences after a miscarriage: Implications for the primary healthcare team. *Br J Gen Pract, 53*, 697–702.

Wong, O., Nguyen, T., Thomas, N., Thomson-Salo, F., Handrinos, D., & Judd, F. (2016). Perinatal mental health: Fathers – the (mostly) forgotten parent. *Asia-Pacific Psychiatry, 8*, 247-255. doi: 10.1111/appy.12204

Worden, J. W. (2009). *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner* (4th Ed.). New York: Springer Publishing Company.

Worth, N. J. (1997). Becoming a father to a stillborn child. *Clinical Nursing Research, 6*(1), 71-89.

Wright, P. M. (2011). Barriers to a comprehensive understanding of pregnancy loss. Journal of Loss and Trauma, 16, 1-12. doi: 10.1080/15325024.2010.519298

Wright, P. M., Limbo, R. & Black, B P. (2016). My absent child: Cultural and theoretical considerations of bereavement when a child dies. In Black, B. P., Wright, P. M. & Limbo, R. (Eds.).*Perinatal and Pediatric Bereavement in Nursing and Other Health Professions* (pp. 3-16). New York: Springer Publishing Company.

Yalçın, H. & Koçak, N. (2013). Gebelikle İlgili Geleneksel İnanç ve Uygulamaları ve Karaman Örneği. Journal of Urban Academy, 6(1), 18-34.

Yetim, U. (2003). The impacts of individualism/collectivism, self-esteem, and feeling of mastery on life satisfaction among the Turkish university students and academicians. *Social Indicators Research, 61*(3), 297-317.

Yıldız, H. & Cimete, G. (2017).The effect of a grief support program on Turkish parents whose babies have died.*Death Studies.* doi:10.1080/07481187.2017.1326541

Yılmaz, S. (2010).*Perinatal Kayıp Deneyiminin Sonraki Gebelik Üzerine Etkileri*. Unpublished Doctoral Thesis. İstanbul: İstanbul Üniversitesi

Yıldırım, Ş. (2003). *Parental Grief Reactıons after an Infant Death*. Unpublished Master Thesis. Ankara: Middle East Technical University.

Yıldırım, A. & Şimşek, H. (2016).*Sosyal bilimlerde nitel araştırma yöntemleri* (10th ed.). Ankara: Seçkin Yayıncılık.

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed). London: Sage Publication.

Yin, R. K. (2016). *Qualitaive research from start to finish* (2nded.). New York: The Guilford Press.

Zara, A. (2011). Kayıplar, yas tepkiler ve yas süreci. In Zara, A. (Eds.). *Yaşadıkça: Psikolojik sorunlar ve başa çıkma yolları* (pp. 73-90). Ankara: İmge Publishing.

APPENDICES

Appendix A: Approval Letter from Middle East Technical University Human Subjects Ethics Committee

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

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06 Haziran 2018

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof. Dr. Özgür Erdur BAKER

Danışmanlığını yaptığınız doktora öğrencisi Betül TANACIOĞLU'nun **"Gebelik Döneminde Kayıp Sonrası Çiftlerin Farklı Kayıp ve Yas Tepkileri Göstermelerine Sebep Olan Sosyo-Kültürel Etmenleri Anlamak: Niteliksel Bir Çalışmada Çiftlerin Bakış Açıları"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2018-EGT-082** protokol numarası ile **08.06.2018 - 30.12.2018** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Doç. Dr. Emre SELÇUK
Üye

Dr. Öğr. Üyesi Pınar KAYGAN
Üye

AppendixB: Informed Consent Form

GEBELİK DÖNEMİNDE KAYIP YAŞAMIŞ ÇİFTLERİN YAS VE MATEM TECRÜBELERİ: NİTELİKSEL FENOMENOLOJİK BİR ÇALIŞMADA PSİKO-SOSYAL ETMENLERİN İNCELENMESİ

Sayın Katılımcı

Bu tez çalışması, Prof. Dr. Özgür ERDUR-BAKER danışmanlığında Orta Doğu Teknik Üniversitesi Eğitim Bilimleri Bölümü Rehberlik ve Psikolojik Danışmanlık doktora programı kapsamında Betül TANACIOĞLU tarafından yürütülmektedir.

Amacı, hamilelik döneminde bebek kaybı sonrası çiftlerin tecrübeleri; kayıp, yas ve matem süreçleri; bu kayıpla nasıl baş ettikleri, sosyo-kültürel etmenlerin yas sürecini nasıl etkilediğini anlamaya çalışmaktır.Çalışmanın etik çerçevede gerçekleştirildiğine dair ODTÜ İnsan Araştırmaları Etik Kurulu' ndan gerekli izin alınmıştır.

Çalışmanın amacı doğrultusunda yapılan görüşmelerde yarı-yapılandırılmış sorular kullanılacak olup, katılımcılarla bir görüşme yapılması planlanmıştır.Yalnızca, ihtiyaç olması durumunda, katılımcıların da onayıyla ek görüşmeler yapılabilir. Sizinle gerçekleştirilen bu yüz-yüze görüşmenin yaklaşık 1- 1,5 saat süreceği tahmin edilmektedir.

Görüşmede sizin ve eşinizin hamilelik döneminde yaşadığınız kayıp ve bu kayıpla nasıl baş ettiğinizle ilgili sorular sorulacak olup, görüşme sırasında ses kaydı alınacaktır. Alınan bu ses kayıtları sadece araştırmacı Betül Tanacıoğlu ve bazı durumlarda tez danışmanı tarafından dinlenecektir ve çalışmanın bitiminde bu kayıtlar kesinlikle yok edilecektir.

Bu araştırmada isminiz, sizi çağrıştırma olanağı olan her türlü bilginin tarafımızca gizli tutulacağını bilmenizi isteriz.Araştırmanın katılımcılarına ait gerçek bilgiler sadece araştırmacı tarafından bilinecek, çalışmada isim kullanılması gerektiği durumlar olduğunda ise isminizin yerine takma isim kullanılacaktır.

Bu çalışmaya katılım gönüllülük esasına göre yapılmaktadır. Araştırmanın herhangi bir aşamasında katılımcıyı rahatsız eden bir durumda, katılımcı kendi isteğiyle herhangi bir kısıtlama olmaksızın çalışmadan ayrılabilecektir. Ayrıca, katılımcı görüşme sürecinde fikrini, ya da duygularını açıklamak istemediği bir durum olduğunda, istediği soruya cevap vermeme hakkına da sahiptir.

Görüşmede duygu ve düşüncelerinizi samimi bir şekilde anlatmanız ve soruları içinizden geldiği gibi cevaplamanız sonuçların geçerli olması açısından önemlidir.

Araştırmanın raporlaştırılmasından sonra, katılımcıların talebi doğrultusunda araştırmanın sonuçları hakkında katılımcılara bilgi verilebilecektir.

Araştırmayla ilgili merak ettiğiniz her türlü bilgiye, aşağıda yazılı iletişim bilgilerini kullanarak ulaşabilirsiniz.

Yukarıda yer alanaçıklamaları okudum.Bu bilgilerin içeriği ve anlamı, yazılı ve sözlü olarak bana açıklandı.Bu koşullar altında, bu araştırmaya kendi isteğimle gönüllü olmayı istiyorum.

Bu formun imzalı bir kopyası bana verildi.

(**Aşağıdaki bilgiler sadece araştırmacının sizinle iletişim kurabilmesi içindir, yukarda da belirtildiği gibi araştırma raporunda isminiz de dâhil olmak üzere <u>hiçbir kişisel bilginiz kullanılmayacaktır</u>**)

Katılımcının Adı- Soyadı:
Yaşı:
İmzası:
Adresi:
Tel:
Tarih:

Betül Tanacıoğlu İletişim Bilgileri
Orta Doğu Teknik Üniversitesi Eğitim Bilimleri- Psikolojik Danışmanlık ve Rehberlik Doktora Programı
Tel: (0XXX) XXX XX XX
e-mail: betul.tanacioglu@gmail.com

Appendix C: Online Support Groups, Social Media Announcement Text

Merhaba,

Doktora tez araştırmam için yürütmekte olduğum bir araştırma kapsamında hamilelik döneminde bebek kaybı yaşamış çiftlere ulaşmaya çalışıyorum. Bu çalışmanın amacı, hamilelik döneminde bebek kaybı yaşamış çiftlern kayıp tecrübelerini anlamaya çalışmaktır. Ayrıca, sosyo-kültürel etmenlerin kadın ve erkeklerin kayıp tecrübelerini nasıl farklılaştırdığı, bu kayıpla baş etmelerinde sosyo-kültürel faktörlerin etkileri, kayıp sonrası oluşan yeni sisteme çiftlelerin nasıl uyum sağladıklarını anlamaktır. Bu çalışma kapsamında hamilelik dönemince bebek kaybı yaşamış çiftlerle birebir görüşme yapmak istiyorum. Araştırmayla ilgili ODTÜ İnsan Araştırmaları Etik Kurulu' ndan alınmış olan araştırma izin belgesini ekte görebilirsiniz.

Bilgilendirilmiş onam formunda da belirtildiği gibi, katılımcılar istedikleri takdirde araştırmanın herhangi bir aşamasında araştırmadan ayrılabilirler.

Araştırmaya katılacak olan kişilere deneyimlerini paylaşma ve konuşma ortamının yaratılması, bu araştırmanın katılımcılara sağlayacağı olası bir faydadır.

Bu çalışmaya katılmaya gönüllü olmak ister misiniz? Araştırmaya katılımda gönüllü iseniz bana aşağıda belirttiğim iletişim yolları ile ulaşabiliriniz.

Çevrenizde hamilelik döneminde bebek kaybı yaşadığını bildiğiniz kişilere çalışma hakkında bilgi verebilirseniz, onlar da belki çalışmaya istekli olabilirler.

Araştırmaya olan ilginiz için teşekkür ederim.

Betül TANACIOĞLU

İletişim bilgileri (araştırmayla ilgili bir sorunuz olduğunda lütfen danışmaktan çekinmeyin)

E-posta: betul.tanacioglu @gmail.com

Tel: 05XX-XXX-XX-XX

Appendix D: The Interview Protocol (Turkish Form)

GEBELİK DÖNEMİNDE KAYIP YAŞAMIŞ ÇİFTLERİN YAS VE MATEM TECRÜBELERİ: NİTELİKSEL FENOMENOLOJİK BİR ÇALIŞMADA PSİKO-SOSYAL ETMENLERİN İNCELENMESİ
GÖRÜŞME PROTOKOLÜ

Tarih:
Başlangıç Saati:
Bitiş Saati:
Görüşmenin Gerçekleştirildiği Yer:
"Araştırmanın herhangi bir aşamasında sizi rahatsız eden bir durum olduğunda, kendi isteğinizle herhangi bir kısıtlama olmaksızın çalışmadan ayrılabilirsiniz. Soracağım sorular duygusal olarak yoğun gelebilir, görüşme sürecinde fikrinizi ya da duygularınızı açıklamak istemediğiniz bir durum olduğunda, istediğiniz soruya cevap vermeme hakkına da sahipsiniz.
GÖRÜŞME SORULARI:

1. **KİŞİSEL BİLGİLER**

"Öncelikle sizinle ve yaşadığınız kayıpla ilgili bazı sorular sormak istiyorum. "

1) Yaşınızı öğrenebilir miyim?
2) Öğrenim durumunuz nedir?
3) Çalışma durumunuz nedir?
4) Sosyo-ekonomik seviyenizi nasıl tanımlarsınız?
5) Şu an çocuğunuz var mı?
    - Evet ise, sayısı:
6) Ölen bebekten önce/sonra doğan çocuklarınız var mı?
7) Bebeğinizi kaybettiğinizden bugüne kadar geçen süre?
8) Bu yaşantınızın dışında başka hamilelik dönemi bebek kaybınız oldu mu? Olduysa kaç kez?
9) Hayatınızda sevdiğiniz başka insanların kaybını yaşadınız mı?
    - Evet ise, size bu kişinin size olan yakınlığı nedir?
10) Bu kayıp ne zaman gerçekleşti?
    - Bebek kaybınızdan önce mi sonra mı?
11) Birinin kaybı dışında olumsuz yaşantılarınız oldu mu? Doğal felaket, kaza, ağır hastalık, şiddet gibi...
    - Evet ise bu olay ne zaman gerçekleşti? Bebek kaybınızdan önce mi sonra mı?

2. **KAYIP ÖNCESİ**

"Şimdi kayıptan önceki hayatınızla ilgili bilgi almak istiyorum"

- Kaybettiğiniz bebekten önce, çocuk sahibi olmayı denemiş miydiniz?
    - Çocuk sahibi olmaya sizi ne motive etmişti?
    - Çocuk sahibi olmanın sizin, eşiniz ve çevreniz için önemi neydi?
- Hamileliğiniz planlı mıydı? Hamile kalma zamanınızı siz mi belirlediniz?

3. KAYIP DÖNEMİ

"Şimdi kaybın gerçekleştiği ilk bir yıl hakkında bazı sorular soracağım.Bu sorular sizin için duygusal olarak yoğun gelebilir.Bir kez daha hatırlatmak istiyorum, yanıt vermek istemediğiniz sorular olursa, cevap vermeme hakkında sahipsiniz. Nasıl rahat ediyorsanız öyle cevaplayabilirsiniz"

- Bebeği hamileliğinizin kaçıncı ayında kaybettiniz? Bebeğin kaybı bekleniyor muydu?
    - Doktorların kontroller sırasında fark ettiği normal olmayan bir durum var mıydı?
- Kayıp döneminde hastane personelinden psikolojik destek gördünüz mü?
    - Doktorlar bebeğin ölüm nedeni hakkında size bir açıklama yaptı mı?
    - Hastane personelinin size karşı tavrı nasıldı?
    - Sağlık çalışanlarının size farklı bir desteği olmasını beklediniz mi?

- Çift olarak birbirinize nasıl destek oldunuz?
    - Bu destek sizin için yeterli miydi?
    - Eşinizin daha faklı yapmasını istediğiniz bir şey var mıydı? Varsa nelerdi?
- Ailenizin, arkadaşlarınızın, sosyal çevrenizin yaşadığınız kayba tepkileri neler oldu?
    - Beklediğiniz tepkiler miydi?
    - Farklı bir tepki almayı bekler miydiniz?
- Ailenizin, arkadaşlarınızın, sosyal çevrenizin yaşadığınız kayba nasıl destek oldu?

- Bebeğiniz için bir cenaze töreni ya da dini bir ritüel yapıldı mı?
    - Evet ise, tecrübeleriniz neler oldu?
    - Hayır ise, ister miydiniz? Beklentiniz ne yönde olurdu?
- Sizce kayıp yaşadığınız dönemde yaşadıklarınızı atlatmanıza yardımcı olan sosyal, kültürel, dini uygulamalar nelerdi?
    - Yaşadıklarınızı atlatmanızı zorlaştıran sosyal-kültürel-dini uygulamalar nelerdi?

4. KAYIP SONRASI

"Şimdi yaşadığınız kayıpla ilgili uzun vadede neler yaşadığınızla ilgili sorular soracağım. Bu sorularda da sizi rahatsız eden bir soru olduğunda cevap vermeme hakkınız var."

- Bu kayıptan sonra hayatınızda değişiklik oldu mu?
    - Bu değişiklikler nelerdir?
    - Yaşadığınız bu bebek kaybı kendinize, çevrenize, yaşadıklarınıza, ilişkilerinize, değerlerinize olan bakış açınızda bir değişiklik yarattı mı? Yarattıysa neler?

- Kaybınızdan sonraki bu değişikliklerle baş etmede ne gibi yöntemler kullandınız?
    - Baş etmenizi zorlaştıran neler oldu?
- Çift olarak birbirinize nasıl destek oluyorsunuz?
    - Bu destek sizin için yeterli mi? Eğer yeterli değilse, eşinizin neyi farklı yapmasını istersiniz?
    - Eşinizle bebeğinizin ölümü hakkında konuşur musunuz?

    - Sizin gözlemlerinize göre eşinizin bu kayıpla başa çıkma sürecini nasıl değerlendirirsiniz?
- Geriye dönüp baktığınıza, kayıp sonrasında değiştirmek istediğiniz bir şey var mı? Eğer varsa, bu değişiklikler nelerdir?
- Yas süreci devam ederken profesyonel yardım almayı düşündünüz mü?
    - Evetse/Hayırsa nedenleri nelerdir?
- (Bebeğin kaybından sonra geçen yıla bağlı olarak)bir/İki..../altı yıl öncesine dönseniz yas sürecinde farklı yapacağınız bir şey olur muydu?
- Arkadaşlarınızdan, ailenizden, akrabalardan vb. aldığınız desteği nasıl tanımlarsınız?
- Kayıp sonrası ne gibi ritüeller gerçekleştiriliyor? dini, sosyal?
    - Örneğin, kaybın yıldönümünde yapılan bir anma var mı? Kaybın yıldönümlerinde neler yapıyorsunuz?
    - Bu ritüellerle ilgili olarak ne düşünüyorsunuz? Ne hissediyorsunuz?
    - Gerçekleştirilmesini istediğiniz ritüel var mı?
- Benzer bir kayıp yaşamış ailelere ne gibi önerileriniz var?

5. KAPANIŞ

- Tüm bu sorular sonrasında kendinizi nasıl hissediyorsunuz?

Konu ile ilgili sorularda size sorulmamış ancak size göre önemli olup da paylaşmak istediğiniz bir şey varsa dinlemeye hazırım.

Çalışmaya katılıp zaman ayırdığınız için çok teşekkür ederim.Aklınıza takılan bir soru olursa, ya da araştırmayla ilgili merak ettikleriniz için size verdiğim iletişim bilgilerinden bana ulaşmaya çekinmeyin lütfen.

Appendix E: Demographic Characteristics of Participants

	Age	Education Level	SES	Gestational age at the time of the loss	Time Since The Loss	Other Reproductive Traumas	Child Before the Loss	Child After the Loss	Bereavement Counselling or support	Psychiatric Diagnosis Before/ After Loss
Mr. A	35	University	High	10th week	3 years	None	None	1	None	None
Mrs.A	28	Doctorate	High	10th week	3 years	None	None	1	None	None
Mr. B	46	University	Middle	11th week	15 months	None	None	1	None	None
Mrs. B	33	University	Middle	11th week	15 months	None	None	1	None	None
Mr.C	36	PhD	Middle	8th week	4 months	None	None	None	None	None
Mrs.C	36	Master	Middle	8th week	4 months	None	None	None	None	Grief counseling after losing her own mother- before pregnancy loss
Mr. D	33	High school	Middle	18th week	8 months	None	1	None	None	None
Mrs D	31	Middle school	Middle	18th week	8 months	None	1	None	None	Depression- after the pregnancy loss
Mr. E	36	University	Low	12th week	1 year	None	1	1	None	None
Mrs E	29	Middle school	Low	12th week	1 year	Another pregnancy loss	1	1	None	None

	Age	Education Level	SES	Gestational age at the time of the loss	Time Since The Loss	Other Reproductive Traumas	Child Before the Loss	Child After the Loss	Bereavement Counselling or support	Psychiatric Diagnosis Before/ After Loss
Mr. F	34	University	Middle	4th week 9th week	4 years 2 years	More than one loss	None	None	None	None
Mrs F	36	University	Middle	4th week 9th week	4 years 2 years	More than one loss	None	None	None	None
Mr. G	32	University	Middle	10thweek	4 years	None	None	1	None	None
Mrs.G	31	University	Middle	10th week	4 years	None	None	1	None	None
Mr. H	46	High school	Middle	8th months	2 years	None	1	None	None	None
Mrs.H	37	Middle school	Middle	8thmonths	2 yars	None	1	None	None	None
Mr. I	34	Master	High	12th week	6 years	None	None	2	None	None
Mrs.I	34	University	High	12th week	6 years	None	None	2	None	None
Mr. J	43	Primary School	Middle	4th months	6 months	1 (before the first-born child)	1	None	None	None
MrsJ	40	Primary School	Middle	4th months	6 months	1 (before the first-born child)	1	None	None	None

Appendix F: Curriculum Vitae

PERSONAL INFORMATION

Surname, Name: Tanacıoğlu, Betül
Nationality: Turkish (TC)
Date and Place of Birth: 4 March 1988, Kayseri
e-mail: betul.tanacioglu@gmail.com

EDUCATION

Degree	Institution	Year of Graduation
MS	Boğaziçi University, Psychological Counseling and Guidance	2015
BS	Boğaziçi University, Psychological Counseling and Guidance	2010
High School	Antalya Konyaaltı High School	2005

WORK EXPERIENCE

Year	Place	Enrollment
2010- 2015	Turkish Ministry of Education, İstanbul, Turkey	Psychological Counselor at Primary and Secondary School
2015-Present	Turkish Ministry of Education, İstanbul, Turkey	Psychological Counselor at Guidance and Researh Center

PROFESSIONAL TRAININGS

Denver II Developmental Screening Test, EMDR, Play Therapy, Family and Couple Thereapy, Creative Drama, Rorschach and TAT

FOREIGN LANGUAGES

Advanced English, Beginner Spanish

PUBLICATIONS

1. Tanacıoğlu, B. (2017, 2018). Çocuk ve Ergenlerde Kriz Değerlendirmesi ve Vaka Formülasyonu (Crisis Assessment in Children and Adolescents and Case Conceptualization). In Erdur-Baker, Ö & Doğan, T. (Eds.) Kriz Danışmanlığı (Crisis Counseling), (pp. 75-110). Ankara: Pegem Akademi.
2. Kurşuncu, M. A., Padir, M. A. & Tanacıoğlu, B. (2018). Okullarda Krize Müdahale: Bir Vaka Örneği (Crisis Intervention in Schools: A Case Example). In Erdur-Baker, Ö & Doğan, T. (Eds.) Kriz Danışmanlığı (Crisis Counseling), (pp. 509-528). Ankara: Pegem Akademi.

HOBBIES

Trekking, badminton, cinema, theatre, camping, cycling, tennis, traveling.

Appendix G: Turkish Summary/Türkçe Özet

1. GİRİŞ

Doğum yeni bir hayatın başlangıcı ve ölüm ise bir hayatın sona erişinin işareti olarak varsayılır. Bununla birlikte, bu varsayım bazı yaşam tecrübeleri neticesinde tamamen değişebilir (Janoff-Bulman, 1992), bazen beklenen bir bebekle ilgili umutlar bebeğin kaybıyla bitebilir. İlgili alan yazını incelendiğinde, gebeliklerin yaklaşık olarak beşte birinin hamilelik döneminde bebek kaybıyla bittiği belirtilmektedir (Covington, 2006). Her ne kadar farklı kaynak ve araştırmalarda, hamileliğin farklı dönemlerinde tecrübe edilen kayıpların farklı tanımları olsa da, genel olarak hamileliğin 20 haftasından önce oluşan kayıplar için düşük (İngilizce'de "miscarriage") ve 20 haftalıktan sonra oluşan kayıplar için ölü doğum (İngilizce'de "stillbirth") terimleri kullanılmaktadır (Covington, 2006), ve yine bazı kaynaklarda ölü doğum olarak kabul edilmesi için bebeğin 500gr. ve üstünde bir kiloda olması da gerekli gerekçelerden sayılmaktadır (Kersting ve Wagner, 2012).

Genel olarak istatistiklere baktığımızca düşük oranının %15, ölü doğum oranının ise %1 olarak saptandığı belirtilmektedir (Maker & Ogden, 2003; Reed, 1984; Ridaura, Penelo & Raich, 2017). Türkiye'de Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü tarafından 2013'te yapılan, 2014'te yayınlanan rapora göre bu oranlar Türkiye'deki oranlara yakındır.

Doğumlar kutlanır ve ölümlerin yası tutulurken, çocuk kaybı ebeveynler için olumsuz bir yaşam tecrübesidir. Çünkü bu kayıp, çocukların ebeveynlerinden daha fazla yaşayacağı sanısını yıkmaktadır (Wright, Limbo ve Black, 2016; Janoff-Bulman, 1992; Wender ve ark., 2012). Kaybedilen çocuğun yaşından bağımsız olarak, çocuğunu kaybeden ebeveynler için bu yaşam tecrübesi, uzun dönem etkileri olan bir olaydır, öyle ki çocuğunu hiç görmemiş ya da ona hiç dokunmamış yaslı ebeveynler için bile bu kaybın olumsuz etkilerinden bahsedilebilir (Leon, 2018; Riley, LaMontagne, Hepworth ve Murphy, 2007). Ebeveynler beklediği çocuğun kaybı sonrası, sadece kendileri için önemli olan bir ilişkinin kaybını değil, gelecekteki "ebeveyn" olma durumlarının kaybını da yaşarlar (Jaffe ve Diamond, 2011). Çoğu zaman çocuk kaybının, suçluluk hissiyle komplike hale geldiği gözlemlenebilir çünkü kayıp yaşamış ebeveyn yapılacak hiçbir şey olmamasına rağmen, her ne olursa olsun bebeği/çocuğu korumuş olması gerektiğine dair inanca sahip olabilmektedir (Volkan ve Zintl, 2008).

Yukarda da belirtildiği gibi, hamilelik döneminde bebek kayıpları azımsanmayacak kadar yaygındır. Fakat, özellikle psikolojik danışmanlık alanında bu konuyla ilgili yapılan

çalışmalar yok denecek kadar azdır. Özellikle Türkiye'de hamilelik döneminde bebek kaybını ve etkilerini araştıran araştırmaların çoğunun tıp ya da hemşirelik alanlarında olduğu fark edilmiştir. Ruh sağlığı alanında yapılan az sayıda çalışma ise (örneğin Yıldırım, 2003; Düzen, 2016) daha çok bu kayıp sonrası yaşanan sorunlara odaklanmıştır. Hamilelik döneminde bebek kaybı yaşamış çiftlerin kayıp tecrübelerinin neler olduğunu araştıran, özellikle de psikolojik danışmanlık alanında Türkiye'de yapılan çalışmalar yetersiz görünmektedir. Nitekim, hamilelik döneminde bebek kaybı yaşamış çiftler için yapılabilecek önleme ve müdahale programları için, öncelikle bu kaybı yaşamış kişilerin tecrübelerini anlaşılması, kayıp sonrası verilen tepkileri etkileyen risk ve koruyucu faktörlerin belirlenmesi gerekmektedir.

Bazen ailenin, toplumun, hatta kaybı yaşayan kadın ve erkeklerin hamilelik dönemindeki bebek kaybını önemsiz bir kayıp olarak algıladıklarına ilişkin çalışmalar mevcuttur. Alan yazınında, "kabul edilmemiş", "unutulmuş" "anlaşılmaz" "görmezden gelinmiş" yas olarak adlandırılan yas süreçlerinden biri de hamilelik döneminde bebek kayıplarından sonraki yas sürecidir (Kirkley-Best ve Kellner; 1982; McCreight, 2004; Martin ve Doka, 2000; Martin ve Doka, 2011). Halbuki, hamilelik döneminde bebek kaybeden kadın ve erkeklerin, bu kayıptan nasıl etkilendiklerini anlatan çalışmalar, bu kaybın kadın ve erkekleri psikolojik, fizyolojik ve sosyal olarak etkilediğini saptamışlardır (Engelkemeyer ve Marwit, 2008; Heazell, Siassakos ve ark., 2017; Helstrom ve Victor, 1987; Rowe, Clyman ve ark., 1978; Li, Precht, Mortensen ve Olsen, 2003). Örneğin, Finlandiya'da 1987 ve 1994 yılları arasında düşük tecrübesi olan kadınların, sağlıklı bir bebek dünyaya getiren kadınlar ve toplumdaki genel kadın popülasyonuna kıyasla, önemli derecede daha fazla intihar riski olduğu saptanmıştır (Gissler, Hemminki ve Lonnqvist, 1996). Ebeveynler ve anne karnındaki bebek arasında gelişen bağlanmanın, özellikle dışardan hamilelik sürecini gözlemleyen kişiler tarafından anlaşılamaması, hamilelik döneminde yaşanan yasın toplumsal çevre tarafından anlaşılamamasının nedenlerinden biridir (Kirkley-Best ve Kellner, 1982).Fakat, hiç doğmadığı için ebeveynleri üzerinde ölümünün etki bırakmayacağına inanıldığı, hamilelik dönemindeki bebek kayıpları aslında hem annenin hem de babanın ruhsal sağlığını etkileme gücüne sahip önemli bir yaşam olayıdır. Profesyonellerin, arkadaşların, aile üyelerinin hatta kaybı yaşayan kişilerin bu kaybı hiç olmamış gibi düşünmesi, kayıp sonrası yas sürecinin daha zor atlatılmasına neden olabilir (Clower, 2003; Reed, 1984).

Hamilelik dönemindeki kayıp, her iki partnerin ortak kaybı olmasına rağmen, yasın daha çok "annesel" ya da "kadınsal" bir konu olarak düşünüldüğü ve erkeklerin bu kayıp sonrası nasıl etkilendiğinin araştırıldığı çalışmaların, kadınların yas süreciyle ilgili yapılan

çalışmalara kıyasla daha az sayıda olduğu göze çarpmaktadır (Beutel, Willner, Deckardt, Rad ve Weiner, 1996; McCreight, 2004; Murphy, 1998). Her iki partnerden de veri toplanması, hem hamilelik dönemindeki bebek kaybına kadın ve erkeklerin nasıl tepki verdiğini hem de bu kaybın ilişkisel olarak nasıl tecrübe edildiğini (birbirlerine nasıl destek verdiler, yas süreçleri birbirinden nasıl etkilendi) anlamada önemli bilgiler verebilir.

Yas ve kayıp alan yazınında, kişi için önemli olan birinin beklenmedik kaybı sonrasında kişinin verebileceği üç farklı kayıp tecrübesi türü tartışılmaktadır: normal, anormal/komplike ve travma sonrası gelişim. Alan yazınında normal ve anormal yası ayırt etmede, çoğunlukla Amerika Psikoloji Derneği (American Psychological Association)'nin sürekli olarak güncellediği tanı kriterlerinin yer aldığı DSM kullanılmaktadır. DSM-V'te yetişkin bir bireyin, normal yas süreci için altı ay kriter olarak belirtilmiştir (APA, 2013).

Travma sonrası gelişim ise özellikle son yıllarda çok araştırılan bir konu olarak, travmatik olaylara farklı bir yaklaşım getirmiştir. Travma sonrası gelişim yaklaşımına göre, bir olayın kişiler üzerinde bıraktığı olumsuz ve travmatik sonuçlara odaklanmak, aslında sadece tek yönlü bir durumdur. Travma sonrası gelişim yaklaşımı, insan tecrübesinin doğasını anlayabilmek için, travmatik olayların kişiler üzerinde bıraktığı olumsuz tepkiler kadar olumlu tepkileri de anlamak gerektiğini savunur (Linley ve Joseph, 2004). Olumsuz yaşam tecrübelerine rağmen, bu olay sonrasında psikolojik sağlıklarını koruyan, hatta olumlu yaşam tecrübeleri yaşadığını söyleyen kişilerin tecrübelerini görmezden gelmek, travmanın tüm perspektiflerden anlaşılmasını engellemektedir. Olumsuz yaşam olaylarından biri olarak, sevilen kişinin kaybı da her ne kadar matem tutan kişi için acılı ve zor geçse de bu tecrübe kişinin gizil kaynaklarını ve gücünü ortaya çıkarabilme potansiyeline de sahiptir (Shuchter ve Zisook, 2003).

Birey için önemli kayıp tecrübelerinden biri olarak, hamilelik dönemindeki bebek kayıplarından sonra hem kadın hem de erkeklerle yapılan çalışmalar, negatif etkileri kadar kaybın kişilerin gelişimleri üzerinde de olumlu etkileri olduğunu bulmuştur (Batool ve Azam, 2016; Cacciatore, Blood ve Kurker, 2018; Kunt-İşgüder, Batmaz, Yıldız ve ark., 2018; Krosch ve Shakespeare-Finch 2017). Sonuç olarak, kişinin baş etme becerileri üzerinde önemli bir etkisi olan kayıp tecrübesi, kişilerin aynı zamanda "savunmasız fakat daha güçlü" (vulnerable but stronger) olduklarına dair inanç geliştirmelerini de sağlayabilir. Bu bakış açısı, olumsuz yaşam tecrübelerinin olumsuz sonuçlarını görmezden gelmeyip, kayıp sonrası normal olmayan tepkiler vermek yerine, baş etme becerilerini, olaylara bakış açısını geliştirmiş, ya da çevresindeki insanlarla olan ilişkilerini daha sağlıklı yaşamaya

başlamış kişilerin, kayıp tecrübeleriyle nasıl dönüşüm yaşadıklarının araştırılması gerektiğini vurgular (Tedeschi ve Calhoun, 2004; Thomadaki, 2017).

Kayıp ve yas sürecini etkileyen önemli faktörlerden birisi de kişinin içinde bulunduğu sosyo-kültürel ortamdır. Yas süreci bireysel olduğu gibi, aynı zamanda sosyo-kültürel bir durumdur ve kişinin içinde bulunduğu sosyo-kültürel ortam hakkında bilgi sahibi olmadan kişinin verdiği tepkilerin normal ya da anormal olduğu noktasında yapılacak yorumlar eksik kalacaktır (Walsh ve McGoldrick, 2004). DSM-V de (2013) kişinin sosyo-kültürel çevresinin de yas sürecini değerlendirmede dikkate alınması gerektiği vurgulanmıştır. Kültür sadece normal ve anormal yasın ne olduğunu anlamamızda değil yas sonrası gerçekleştirilen ritüellerin yapısını, amacını ve kişi üzerindeki etkisini anlamamıza, ayrıca kültürün etkisiyle yas tutan kişiye verilen sosyal desteğin yapısı ve amacını anlamamıza da yardımcı olmaktadır. Buna ek olarak, kültürün etkilediği ritüeller toplumdaki cinsiyet rollerini, sosyal statü ve sosyal kuralları kayıp ve yas çerçevesinde anlamamıza da katkı sağlamaktadır (Rosenblatt, 2010). Bu sebeple, kayıp ve yas süreçlerinin sosyo-kültürel bağlamının da incelenmesi gerektiği alan yazınında önerilmektedir.

Özetlemek gerekirse, gebeliklerin yaklaşık beşte biri hamilelik döneminde bebek kayıplarıyla sonuçlanırken, bu kaybın çiftler üzerindeki etkilerini araştırmak önemlidir çünkü yukarda da bahsedildiği üzere, bu kaybın daha çok kadınlar üzerinden anlaşılmaya çalışılması ve erkeklerin yaşadığı tecrübelerin görmezden gelinmesi alan yazınındaki eksiklerden biridir. Halbuki, hamilelik dönemindeki kayıp baba adayı olarak, erkeği de etkileyebilmektedir. Ayrıca, yabancı literatürde sosyo-kültürel etmenlerin de dikkate alınması gereken bir konu olarak kayıp ve yas konusunda yapılan çalışmalar, Türkiye'de yapılan çalışmalar için temel oluşturmakla birlikte, sosyo-kültürel yapının farklı olmasından dolayı, Türkiye'de kayıp yaşamış bir çiftin yas süreçlerini anlamamızda yeterli olmayabilir. Kayıp ve yas sonrası gerçekleştirilen ritüeller kadar, sosyal ilişkiler, toplumsal cinsiyet rolleri kültürden kültüre farklılık göstermektedir. Türkiye' de gerçekleştirilen hamilelik dönemindeki bebek kaybı ile ilgili çalışmaların, daha çok tıp ve hemşirelik alanında olması, kayıp ve yas tecrübesi olan bu çiftler için yapılacak olan önleyici ve müdahaleye yönelik çalışmalar için gerekli bilgiyi sağlamamaktadır. Hamilelik döneminde kayıp yaşamış çiftlerin tecrübelerini anlayarak, bu tecrübeleri etkileyen sosyo-kültürel ve cinsiyet faktörlerinin anlaşılması, bu kişilere yönelik olarak gerçekleştirilecek müdahale ve önleme programlarının başarısını arttırabilir.

1.1. Araştırmanın Amacı

Bu çalışmanın amacı, hamilelik döneminde bebek kaybı yaşamış çiftlerin yas ve matem tecrübelerini, cinsiyet rollerinin ve diğer sosyo-kültürel etmenlerin kayıp tecrübelerini etkileyip etkilemediğini anlamaktır.

1.2. Araştırmanın Önemi

Öncelikle, hamilelik dönemindeki bebek kayıpları beklenenden daha yaygın bir durum olmasına rağmen, bu kaybı tecrübe etmiş kişilerin psiko-sosyal ihtiyaçları hem profesyoneller hem de toplum tarafından karşılanamamaktadır. Bu çalışmanın sonucunda, hamilelik döneminde bebek kaybı yaşamış çiftlerin tecrübelerini anlayarak, araştırmaya ait bulguların hem çift ve aile danışmanlığı alan yazınına, hem alanda çalışan danışmanlara ve bu alanda eğitim veren eğitimci ve süpervizörler için çıkarımlar sağlayacağı düşünülmektedir. Bunun yanında, elde edilen verilerin, hamilelik döneminde bebek kaybı yaşamış çiftler için oluşturulacak önleme ve müdahale programlarına, bu programları hayata geçirecek politikaları oluşturan kişilere ve özellikle de toplumla ilgili çıkarımlara yönelik bilgi verecektir.

Hamilelik döneminde bebek kaybı yaşamış kişilerle ilgili yapılan çalışmalar incelendiğinde, bu kaybı yaşayan kişilerin tecrübelerini anlayabilmek için yapılan çalışmaların çoğunun niceliksel metot kullanılarak, online anketlerle gerçekleştirildiği fark edilmektedir (Heazell, Siassakos, Blencowe ve ark., 2017; Nuzum, Meaney ve O'Donoghue, 2018). Bu çalışmada, daha derinlemesine verinin toplanabilmesini sağlayan niteliksel metodoloji kullanılmıştır.

Kayıp ve yasla ilgili teoriler incelendiğinde, teorilerin daha çok batı toplumlarındaki bilgi birikiminden yola çıkılarak geliştirildiği göze çarpmaktadır. Halbuki, yas sürecinin nasıl yaşandığı, süresi, bu yasla başa çıkmak için kişinin kullandığı baş etme becerileri gibi konuların tümü kişinin içinde yaşadığı kültürden etkilenmektedir (Kavanaugh, Trier ve Korzec, 2004; Stroebe ve Schut, 1998). Bu sebeple de Türkiye'de kayıp ve yas konusunda yapılan çalışmaların sosyo-kültürel etmenlerin de dikkate alındığı daha geniş bir perspektiften süreci değerlendirmeleri, yasla ilgili alınyazının gelişmesine katkıda bulunabilir. Bu ihtiyaçtan yola çıkarak, bu çalışmanın sosyo-kültürel etmenlerin hamilelik döneminde bebek kaybı yaşamış bireyler, çiftler ve aileler üzerindeki etkileri konusunda alan yazınına katkıda bulunacağı düşünülmektedir.

Bu araştırmada, verilerin toplanması için çiftlerden data toplanmıştır. Böylece, bireysel, ilişkisel ya da daha geniş perspektiften toplumsal olarak, hangi etmenlerin kişilerin normal, anormal yas ya da travma sonrası gelişimi tecrübe ettikleri anlaşılmaya çalışılmıştır. Bu açıdan, bu çalışmanın yas danışmanlığı literatürüne, içsel ve ilişkisel etmenlerin incelenmesiyle katkıda bulunduğu söylenebilir. Gillbert (1996)'in de belirttiği gibi, bireyler bir aile içerisinde yas tutsalar bile, farklı tepkilere sahiptirler, bu durum da hem kişisel hem de kişilerarası etmenlerin araştırılmasını gerekli kılar.

Aynı kaybı yaşamış çiftlerin tepkilerinin hangi noktalarda benzeştiğini ve farklılaştığını inceleyen bu çalışma, alan yazınında eksikliği hissedilen yasın cinsiyetler arası farklılaşması (Beutel, Willner, Deckardt, Rad, & Weiner, 1996; McCreight, 2004; Rinehart & Kiselica, 2010) konusuna da katkıda bulunacaktır.

Bu çalışmanın verileri neticesinde, bireylerin çocuk sahibi olmaya verdikleri anlam ve beklenmeyen bir kayıp sonrası yaslarını anlamlandırmaları, derinlemesine görüşmelerin analizi sonrası betimlenmiştir. Ailede kayıp öncesinde ya da kayıp sonrasında çocuk sahibi olmanın, geniş aileyle ve sosyal çevreyle olan ilişkilerin, eşle olan iletişim ve desteğin, sosyo-kültürel etmenlerin yas sürecindeki rolleri hakkında bilgi verilmektedir (De Montigny, Beaudet ve Dumas, 1999; Martincekova ve Klatt, 2017; Plagge ve Antick, 2009

Hamilelik dönemindeki bebek kaybı sonrası, tecrübeler ya da duygular hakkında konuşmamak, kişilerin yas süreçlerini olumsuz etkileyen bir durumdur. Toplumun görmezden geldiği bir yas olarak, hamilelik dönemindeki bebek kaybı yaşamış kişilerle gerçekleştirilen bu çalışma, bu kaybı yaşamış kişilerin tecrübeleri ve duyguları hakkında konuşmaları, bu tecrübelerin bilinç seviyesine getirilmesini sağlamıştır (Jaffe ve Diamond, 2011) k bu daçalışmanın katılımcılarına sağladığı bir katkıdır.

Niteliksel bir çalışma olarak, bu çalışmanın hamilelik döneminde kayıp tecrübesiyle ilgili alan yazınına genellenebilir sonuçlar vermesi gibi bir amacı yoktur. Fakat, fenomenolojik bir çalışma olarak 20 katılımcı, katılımcı sayısı olarak yüksek bir sayıdır. Farklı sosyo-ekonomik seviyelerden gelen ve hamileliğin farklı dönemlerinde bebek kaybı yaşamış çiftlerin, katılımcı olarak çalışmada bulunmaları, farklı yas tecrübelerin derinlemesine çalışılmasına olanak sağlamıştır. Böylece, hamilelik döneminde kayıp yaşamış çiftlerde olası koruyucu ve risk faktörleri hakkında bakış açısı sunmaktadır. Bu bakış açısı , danışmanlık alanında bu kişilere yönelik önleme ve müdahale programlarının hazırlanmasına ön bilgi sağlayabilir (Kavanaugh &Hershberger, 2005; Peppers & Knapp, 1980). Ayrıca, derinlemesine bilgi vermeyi amaçlayan bu çalışmanın verilerinde ortaya çıkarılan kavramlar ileride yapılabilecek niceliksel çalışmalara da katkı sağlayabilir (Weiss, 1995).

Amerika Psikolojik Danışmanlık Derneği (American Counseling Association)'nce kabul edilen 19 danışmanlık alanından biri olan, evlilik ve aile danışmanlığı açısından bu çalışmanın, alanda eksik bırakılmış olan bir konu olarak hamilelik döneminde bebek kaybı yaşamış çiftler ve ailelerle ilgili bir eksikliği kapatma noktasında yardımcı olacağı düşünülmektedir. Nitekim, hamilelik döneminde kayıp yaşamış çiftlerin danışmanlık ihtiyaçlarının anlaşılabilmesi için, öncelikle bu kişilerin tecrübelerinin neler olduğunun tespit edilmesi gerekmektedir. Bu çalışmanın, kayıp tecrübesi olan çiftlerle ilgili yapılacak çalışmalar için teorik, araştırma ve pratiğe yönelik bilgiler vermesi çalışmanın güçlü yönlerinden biridir.

Özetlemek gerekirse, araştırmacının bilgisi dahilinde, bu çalışma hamilelik döneminde bebek kaybı yaşamış çiftlerle ilgili yapılan çalışmalar içerisinde derinlemesine görüşmelerin her iki çiftle de gerçekleştirilmesi, yasın kişilerarası yönüne de odaklanması ve danışmanlık alanındaki önemli bir eksikliği gidermesi noktasında farklı bir konuma sahiptir. Bireysel ve kişilerarası süreçler kadar, hamilelik dönemindeki bebek kaybı sonrası tecrübe edilen yasın sosyo-kültürel boyutu da bu çalışmayla incelenmiştir.

1.3. Araştırma Soruları

Araştırmanın amacına bağlı olarak, bu çalışmada aşağıdaki araştırma soruları belirlenmiştir:

1. Partnerler/eşler hamilelik dönemi bebek kaybını nasıl tecrübe ettiler?
2. Partnerler/eşler birbirlerinin yas sürecini nasıl etkiledi?
3. Partnerler/eşler hamilelik döneminde bebek kaybından sonra birbirlerini nasıl destekledi?
4. Erkekler ve kadınlar yas tutma süreci açısından nasıl farklılıklar gösterdi?
5. Sosyo-kültürel etmenler partnerlerin/eşlerin kayıp sürecini nasıl etkiledi?

1.4. Araştırmanın Sınırlılıkları

Sosyal bilimlerde gerçekleştirilen diğer çalışmalarda olduğu gibi, bu çalışmanın da önlenememiş bazı sınırlılıkları mevcuttur. Öncelikle, araştırma metodunun niteliksel olmasından doğan bazı sınırlılıklardan bahsedebiliriz. Nicel araştırmalara kıyasla daha az katılımcıya ihtiyaç duyan niteliksel araştırmaların sonuçlarının, güvenirlik ve geçerliğini sağlamak için sağlanan önlemlere rağmen, genellenebilir olmasından söz edilemez. Ayrıca, amaçlı örneklem yönteminin katılımcılara ulaşmak için kullanılması da araştırma sonuçlarının genellenebilmesini engelleyen sebeplerden biridir.

Araştırmanın katılımcılarına kilit noktaları tutan kişiler (gatekeepers) ve sosyal medya araçları ile ulaşılmıştır. Stroebe, Stroebe ve Schut (2013) kayıp ve yas çalışmalarına katılan katılımcıların bazı motivasyonlarından (örneğin, başka kayıp tecrübesi olan kişilere yardım etme isteği, tecrübelerini paylaşma isteği gibi) bahsetmişlerdir. Ayrıca, bazı kişiler kayıp ve yas süreçleri hakkında konuşmanın kendilerini çok üzeceğini veya kendilerine daha fazla stres yaratacağını düşünebilirler, bu sebeple de katılımcı olmayı reddetmiş olabilirler. Sonuç olarak, katılımcı olmayı kabul eden çiftlerin farklı motivasyonları çalışmanın bulgularını şekillendirmiş olabilir.

Standardize edilmiş ölçme araçlarının tersine, görüşmeler çalışmanın yürütülmesi, sonuçların açıklanması, sonuçların değerlendirilmesi ve yorumlanması aşamalarında görüşmecinin olası etkilerine açıktır. Veri toplama ile ilgili objektifliği sağlamak amacıyla yarı-yapılandırılmış sorular tercih edilmiştir. Ayrıca, alanda çalışan uzman ve akademisyenlerden katılımcılara ulaşma, görüşme sorularının oluşturulması gibi konularda görüş alınmasından objektifliğin sağlanması açısından yararlanılmıştır. Deşifre edilen görüşmelerden ulaşılan kod ve temalar hakkında da akademisyenler ve alanda çalışan uzmanlardan fikir alınmıştır.

2. YÖNTEM

2.1. Araştırmanın Deseni

Araştırma metodolojileri temel olarak nicel ve nitel araştırmalar olarak ikiye ayrılmaktadır ve bu iki metod birbirinden varsayımları, amaçları, kullanılan metodlar, araştırmacının rolü, araştırma sonuçlarının genellenebilir olması ya da olmaması yönlerinden farklılaşırlar (Fraenkel, Wallen ve Hyun, 2011; Merriam ve ark., 2002; Gall, Gall ve Borg, 2010). Nitel araştırmalar, "nasıl" ve "neden" sorularının cevaplanmaya çalışıldığı, katılımcılardan daha doğal yöntemlerle verinin toplandığı (görüşmeler, odak grup görüşmeleri, gözlem gibi) ve araştırma sonucunda ortaya çıkan raporun daha derinlemesine bilgi verdiği araştırmalardır (Creswell, 1998; Merriam ve ark., 2002).

Niteliksel metodoloji içerisinde fenomenoloji, diğer adıyla olgu bilim, kişilerin yaşantılarına verdiği anlam, değer ve kültürleri inceleyen nitel araştırma yöntemidir. Bu çalışmada, hamilelik döneminde bebek kaybı yaşamış çiftlerin kayıp ve yas tecrübelerini, aynı zamanda da yas süreçlerini etkileyen cinsiyet rollerini ve diğer sosyo-kültürel etmenleri anlamak amaçlanmıştır. Çalışmanın amacı bu yaşantının kişilerin kendi bakış açılarından nasıl tecrübe edildiğini anlamak olduğu fenomenoloji yöntemi kullanılmıştır (Bogdan ve Biklen, 2007; van Manen, 1990). Yıldırım ve Şimşek (2016), bu yaklaşımın herkesin aslında

farkında olduğu, fakat hakkında detaylı bir anlamlandırmanın olmadığı olgular için kullanıldığını ifade etmişlerdir. Fenomenoloji, her gün karşımıza çıkabilecek tecrübeleri "Bu ne tür, nasıl bir tecrübedir?" sorusunu sorarak anlamlandırmaya çalışır (van Manen, 1990). Tüm nitel çalışmalarda olduğu gibi, fenomenolojik yaklaşımda da amaç o konuyla ilgili her şeyi açıklamak değildir, amaç o olguyu tecrübe etmiş kişilerin tecrübeleri hakkında iç görü kazanmaktır ki bu da aslında hem pratikte hem de teoride o konuyla ilgili önemli bir adımdır (van Manen, 1990; Yıldırım ve Öztürk, 2016).

Kayıp ve yas literatüründe, en çok kullanılan araştırma yöntemlerinden biri fenomenolojiyi temel alan araştırmalardır (ör. Aksöz-Efe, Erdur-Baker ve Servaty-Seib; 2018; Harper, O'Connor, Dickson ve O'Carroll, 2011; Meaney, Everard, Gallagher ve O'Donoghue, 2016; Özmen, 2014). Bu araştırmada, araştırmanın odağında olan olgu "hamilelik döneminde bebek kaybı tecrübesi" dir.

2.2. Örneklem ve Veri Toplama İşlemi

Araştırmanın amacına yönelik olarak, örnekleme ulaşmak amacıyla amaçlı örneklem yöntemi kullanılmıştır. Amaçlı örneklem yöntemine uygun olarak, araştırmanın amacı ve araştırma soruları doğrultusunda, araştırmaya dahil olma kriterleri belirlenmiştir. Katılımcılara ulaşmak için kullanılan kriterler şunlardır:

1. Katılımcının 18 yaşından büyük olması,
2. Katılımcı olacak çiftin, hamilelik dönemindeki bebek kaybının kişinin isteği doğrultusunda gerçekleşmemiş olması (ör. kendi isteğiyle kürtajı tercih etmiş çiftler dahil edilmemiştir),
3. Yaşanan kaybın, çalışmanın başlamasından en fazla 6 sene içinde olması,
4. Her iki partnerin de çalışmaya katılmaya gönüllü olması (partner/çiftler/eşlerden sadece birinin çalışmaya katılmaya gönüllü olmadığı kişiler dahil edilmemiştir).

Fenomenolojik bir çalışma olarak bu çalışmada, veri doyumuna 10 çiftle (20 kişi) ulaşılmış ve veri toplanmasına son verilmiştir. Niceliksel bir çalışmayla kıyaslandığında, 20 katılımcı çok az gibi görünse de niteliksel bir çalışma için katılımcı sayısı derinlemesine bilgi alabilmeyi olanaklı kılacak kadar büyük bir sayıdır. Alanda gerçekleştirilen niteliksel çalışmalara baktığımızda, katılımcı sayısının yeterli olduğu da fark edilebilir. Örneğin, Nuzum, Meaney ve O' Donoghue'ın çalışmasında (2018) katılımcı sayısı 17'dir, O' Leary ve Thorwick'in çalışmasında (2005) katılımcı sayısı 10'dur. Nitekim, niteliksel çalışmalarda sayıdan çok, toplanan verinin niteliği ve derinliği daha ön planda olan bir kriterdir.

2.3. Görüşme Formu

Araştırmada kullanılmış olan yarı-yapılandırılmış görüşme formu kullanılmıştır. Sorular açık uçlu olarak sorulmuştur. Görüşme sorularının geliştirilmesi aşamasında verilere dahil edilmeyen bir çiftle soruların yapısı, sayısı hakkında görüş alınmıştır. Ayrıca, alanda çalışan uzmanlar ve akademisyenlerden görüşme sorularıyla ilgili dönüt alınmış ve gerekli düzeltmeler yapılmıştır. Gerçekleştirilen görüşmelerde, araştırmayla ilgili sorulardan önce katılımcılara demografik bilgileri ile ilgili sorular sorulmuştur.

Soruların içeriğine bakıldığında, hamilelikle ilgili çiftlerin motivasyonları; kayıpla ilgili tecrübeleri, eşten, aileden, sosyal çevreden alınan destek ve bu desteğin nasıl algılandığı, kayıpla nasıl baş ettikleri, kayıptan sonra hayatlarında meydana gelen değişikliklerle ilgili sorular sorulmuştur. Görüşmede kullanılan soruların tamamına Ek D'de ulaşabilirsiniz.

2.4. Verilerin Analizi

Bu çalışmada 20 kişiyle yapılan ve kayıt altına alınan görüşmeler, öncelikle deşifre edilmiş daha sonra her bir katılımcının verisi bireysel olarak analiz edilmiştir. Verilerin analiz edilmesinde MAXQDA 10 programından yararlanılmıştır. Program kullanılmasının nedeni kod ve temaların organize edilmesine kolaylık sağlamasıdır.

Verilerin analizi için tematik analiz yöntemi kullanılmıştır. Tema tanım olarak, veride araştırma sorularıyla ilgili olarak önemli görülen örüntüleri ifade etmektedir (Braun ve Clarke, 2006). Tematik analizde ise veri içerisindeki tema ya da örüntülerin bulunması, analiz edilmesi ve raporlaştırılması kast edilmektedir (Braun ve Clarke, 2006).

Temalara ulaşabilmek için öncelikle, verinin içerisinde oluşturulan kodlar birbirleri arasındaki benzerlik, farklılık ve ilişkilerin değerlendirilmesi neticesinde bir araya getirilir ve kodların bir araya getirilmesiyle temalar oluşturulur (Gibson ve Brown, 2009; Yıldırım ve Şimşek, 2016). Bu çalışmada tematik analize kullanılan tümevarım ve tümden gelim kullanılmıştır. Bir başka söyleyişle hem verinin kendisinden çıkarılan temalar hem de ilgili alan yazınından çıkarılan temalar vardır (Ryan ve Bernard, 2003).

3. BULGULAR

Araştırma verilerinin, MAXQDA 10 programı kullanılarak yapılan tematik analizi sonucunda 4 temel tema belirlenmiştir. Bu temalar aşağıdaki şekilde isimlendirilmiştir:

- **Tema 1: Bebek Sahibi Olma Motivasyonu**

Bu tema özellikle, partnerlerin yas sürecinin bağlamını anlamada önemli bilgiler vermektedir. Hamilelik döneminde bebek kaybı sonrası, yaşadıkları kayıp ve yas sürecini, verdikleri tepkilerin derecesini ve türünü, sosyo-kültürel ortamlarını anlamak için, bu kişilerin kayıp yaşanmadan önce bebek sahibi olma kararlarını hangi etmenlerin etkilediğini anlamak önemlidir. Nitekim, her ne kadar diğer kayıp durumlarında verilen tepkilere benzer tepkiler verilse de hamilelik döneminde bebek kaybı yaşayan bireylerin tepkilerinin içeriği farklılaşmaktadır ve bu farklılığı anlamada yardımcı bağlamsal durumlardan birisi de çiftlerin bebeğe sahip olma motivasyonlarıdır.

Bu temanın altında iki alt tema açıklanmıştır: aile, evlilik ve sosyal çevre ile ilgili motivasyon ve kişisel motivasyon. Kağıtçıbası (1996)'nın da belirttiği gibi her ne kadar bireysel özellikler toplumda artmış olsa da kolektivizm halen toplumda devam etmektedir. Dolayısıyla hem ailevi, toplumsal faktörler hem de bireysel faktörler çocuk sahibi olma kararlarını etkilemiştir. Bu çalışmada, katılımcıların kayıp ve yas süreçleri kadar, bebek sahibi olma motivasyonlarını etkileyen sosyal çevrenin varlığı bu açıdan değerlendirilebilir. Birinci alt tema altında, partnerin bebek sahibi olma isteğini kabul etme (n=2), ekonomik sebepler (n=4), sosyal sistemin baskısı (n=11), ailenin tamamlayıcı bir figürü olarak çocuk (n=7) ve evliliğin belli bir noktaya ulaşması (n=10) katılımcılar tarafından bahsedilen sebeplerdir. İkinci alt tema olan bireysel motivasyon sebepleri olarak, kişisel tarih (n=5), cinsiyet temelli nedenler (n=4), kişilik (n=7), ebeveynliğin tecrübe edilmesi ve çocuğun duygusal değeri (n=20), ebeveynlerin değerlerini taşıyan/yaşatan bir çocuğa sahip olma isteği (n=6), ve ebeveynin yaşı (n=7) katılımcılar tarafından çocuk sahibi olma sebepleri olarak belirtilmiştir.

- **Tema 2: Kısa Dönemde Verilen Kayıp ve Yas Tepkileri**

Bu temada, katılımcıların kayıp tecrübelerine verdikleri kayıp ve yas tepkilerinin ilk günler ve aylarda neler olduğu açıklanmıştır. Stroebe, Hansson, Stroebe ve Schut (2001)'un da belirttiği gibi, kişiler kayıp yaşantıları sonucunda duygusal, davranışsal, bilişsel, fiziksel/somatic semptomlar göstermektedir. Bu çalışmanın katılımcıları, bu tepkilere benzer tepkiler vermişlerdir fakat alt-temalar bu tepkiler üzerinden oluşturulmamıştır. Her alt temada, bu tepkileri gözlemlemek mümkündür.

İlk alt tema psikolojik tepkilerdir ve katılımcıların verdiği reddetme (n=16), üzüntü (n=18), şok (n=20), kızgınlık ve başkasını suçlama (n=6), kendini suçlama (n=5), yalnızlık (n=6), panik (n=4) ve içine kapanma (n=4) tepkileri açıklanmıştır.

İkinci alt tema, katılımcıların kaybolan umutlarını içermektedir ve katılımcıların 12'si tarafından dile getirilmiştir. Kaybolan umutların içeriğine bakıldığında, çocukla ilgili kendi hayalleri, ailedeki önceki çocuğun kardeş sahibi olma ile ilgili hayalleri, geniş ailenin beklenen çocukla ilgili hayalleri bu alt temayı oluşturduğu görülmektedir.

Üçüncü alt tema, katılımcıların gelecekte tecrübe edecekleri olası hamilelik süreciyle ilgili yaşadıkları anksiyete ile ilgilidir. 17 katılımcı, gelecekteki olası hamilelik dönemi için benzer bir kaybı yaşayacağı endişesini duymaktadır. Alan yazınında bu konu ile ilgili yapılan çalışmalarda da benzer bir anksiyetenin varlığı bulunmuş, hatta hamilelik döneminde bebek kaybı yaşamış çiftlerin kayıptan sonra doğan çocukla olan ilişkilerinin etkilendiğini saptayan araştırmalar da mevcuttur. Katılımcılar arasında, kayıptan önce çocuk sahibi olanlar için, bu anksiyetenin daha az olduğu, daha önce çocuk sahibi olmayan çiftlerde ise daha yoğun olduğu katılımcıların tecrübelerinden ulaşılan sonuçtur.

Bu üç temanın dışında, katılımcıların kürtajla ilgili tecrübeleri, bebek kaybını kendi bedenlerinden bir parçanın ölümü olarak adlandırmaları, ve kayıp sonrası çevrelerindeki hamile ya da kayıp yaşamış kişilere daha fazla dikkat etmeleri farklı alt temalar altında açıklanmıştır.

- **Tema 3: Yas Sürecini Etkileyen Faktörler**

Bu temada, katılımcıların yas süreçlerini etkileyen etmenler incelenmiştir. Bu faktörlerden ilki eşler arasındaki destek süreci ve iletişimleridir. Eşlerin birbirine desteğini anlayabilmek adına, görüşme protokolüne "Çift olarak birbirinize nasıl destek oldunuz?" ve buna benzer sorular eklenmiştir. İlginç olan, katılımcı erkeklerin tamamının bu soruda, eşlerine verdikleri desteği tanımlamaları ve kendilerinin ihtiyacı olması gibi bir durumun olamayacağını belirtmiş olmalarıdır. Yani, erkekler hamilelik dönemindeki bebek kaybını fiziksel olarak yaşayan annenin, eş desteğine ihtiyacı olduğunu düşünmektedir.

Kadınların, eşlerinden gördüğü "kendilerini kayıpla ilgili suçlamama" ile ilgili durumu, destek olarak algıladıkları gözlemlenmiştir. Kadınlar, kayıp durumuyla ilgili kendilerini suçlarken, eşlerinin bu durumun onlarla ilgili olmadığını söylemesi onları rahatlatmıştır. Ayrıca, eşlerle geçirilen zamanın artması, birlikte yapılan etkinlikler de erkeklerden görülen ve olumlu algılanan desteğin formlarıdır.

Eşler arasındaki iletişime bakıldığında ise, kadın katılımcıların daha çok kayıplarıyla ilgili konuşma ihtiyaçlarının olduğu ve duygu kelimelerini daha sık kullandıkları görülmüştür. Erkekler, eşlerinin kayıp hakkında konuşmalardan rahatsız olacağına ilişkin inançları sebebiyle, duyguları ve yaşadıkları hakkında konuşmayı tercih etmemişlerdir. Bu durum eşler arasında yaşanan önemli iletişim sorunlarından biridir.

Kültürel olarak, büyük aileyle ilişkilerin önemli olduğu bir ortamda, büyük aileden gelen tepkilerin çiftlerin ilişkisine de yansıdığı bazı çiftlerde gözlemlenmiştir. Partnerlerden erkek bireyin, eşini savunması, eşi hakkında konuşulmasını engellemesi gibi davranışları kadınlar tarafından kendilerine yönelik bir destek olarak görülmüştür.

Üçüncü temanın önemli bir alt temasında, katılımcıların bebek kaybının hamilelik döneminde oluşma zamanının yas ve kayıp süreçlerini nasıl etkilediği verilmiştir. Örneğin, katılımcıların tamamı ebeveyn ve bebek arasındaki bağlanmanın, hamilelik döneminin ilerlemesiyle artacağını ve artan bağlanmanın daha çok yas tepkisi vermelerine neden olacağı hakkında hemfikirdirler. Bebeğin ultrasoundda görülmesi ya da sesinin duyulması bebek için geliştirilen bağlanmanın daha çok olmasını sağlamaktadır. Yabancı literatürden farklı olarak, bu çalışmada kayıp yaşamış çiftlerde bebek için ritüel gerçekleştirmemekten dolayı rahatsızlık hissetme yoğun değildir, fakat dini ya da sosyal bir ritüel gerçekleştirip gerçekleştirmeme noktasında kafa karışıklığı yaşayan katılımcılar vardır, nitekim toplumda bu tür kayıplar sonrası ne gibi ritüellerin gerçekleştirileceği konusunda kesin bilgiler yoktur. İnanca, sosyo-kültürel yapıya göre ritüellerin yapılıp yapılmayacağı, yapılacaksa neler olacağı ile ilgili kararlar değişmektedir.

Baş etme temasında sosyal temelli baş etme, kültürel ve dini öğelerin kullanımıyla baş etme ve bilişsel baş etme mekanizmaları hakkında bilgi verilmiştir. Sosyal baş etme mekanizmalarına bakıldığında sosyal çevreden gelen destek, hastane personelinden alınan destek ve benzer kayıp yaşamış kişilerle konuşmanın katılımcılara verdiği destekten bahsedilmiştir.

Katılımcıların sosyal destek sistemlerine bakıldığında, neredeyse tüm katılımcıların kayıp sonrası evlerine, aile ya da arkadaşları tarafından ziyaret gerçekleştirilmiştir. Fakat, bu ziyaretlerde çoğunlukla "geçmiş olsun" mesajları verilmiştir ki bazı katılımcılar için bu olumlu bir durum olarak algılanmamıştır çünkü bu sözler kaybı yaşayan bireyde kaybın küçümsendiği, bir kayıp olarak algılanmadığı gibi bir algı yaratmıştır. Sosyal çevreden aldıkları desteğin, kendi değerlendirmelerine göre negatif olduğunu ve aslında yas süreçlerini olumsuz etkilediğini söyleyenlerin tamamı kadındır, erkeklere göre sosyal çevreden alınan destek yeterli ve olumlu yöndedir.

Sosyal desteğin ne tür bir destek olduğu erkek ve kadın katılımcılar arasında farklılık göstermektedir. Kadın katılımcılar yakın arkadaşlarıyla, yakın aile üyeleriyle kayıp ve duyguları hakkında konuşmak isterken, erkek katılımcıların en yakın arkadaş ya ada aile üyeleriyle bile bu kaybın içeriği ya da kendi duyguları hakkında konuşmadığı, daha çok pratik konular hakkında konuştukları gözlemlenmiştir. Örneğin, erkekler daha çok hangi

doktor ya da hastaneye gidilmeli, bu aşamada nasıl bir yol izlenmeli gibi konularda destek ararken, kadınlar fiziksel ve duygusal olarak yanında olan kişilerle yaptıkları duygusal paylaşımları destek olarak algılamaktadır.

Kaybın öğrenildiği ilk andan, kayıp sonrası alınan desteğe kadar hastane personelinin kayıp yaşamış çiftlerle olan iletişimi ve hastane personelinden alınan desteğin önemi katılımcılar tarafından belirtilmiştir. Hastane personeliyle olan iletişimin olumlu olmaması dahi katılımcıları olumsuz etkileyebilmiştir. Hastane personelinin eşlerin mahremiyetine verdiği önem, hastanede gösterilen ilgi, kayıptan sonra çiftlere kayıpla ilgili ve kayıptan sonra yapılacaklarla ilgili yapılan açıklamalar, duygusal tepkilerine hastane personelinin verdiği tepkiler katılımcılar tarafından olumlu olarak algılanmıştır.

Katılımcıların kültürel çevreden aldıkları tepkiler ve dini inançlarının baş etmelerini nasıl etkilediği ile ilgili alt temada, özellikle kadınların sosyo-kültürel yorumlara maruz kaldığı görülmüştür. Bebeğin nasıl ve neden düştüğü ile ilgili bazen suçlamaya dönüşen, özellikle de geniş aileden gelen yorumların tamamı kadına yönlendirilmiştir. Ayrıca, kayıp sonrası yapılan yorumlardan bazıları, gelecekteki hamilelikleri için zaten kaygı yaşayan katılımcıların daha fazla kaygılanmasına neden olmuştur. Bu alt temada, farklı coğrafyalarda farklı kültürel gruplarda gözlemlenen hamilelik öncesi, hamilelik dönemi ve hamilelik sonrası dönemle ilgili mitlerle karşılaşılmıştır. Örneğin, hamile kalmayı kolaylaştırdığı düşünülen soğan suyu, bal, değişik baharatların içilmesinin önerilmesi, ya da "En azından oldu da düştü." "Düşüğün kıçı içinde.", "Hemen olur peşinden." gibi mitler, kırklı olanın mümkün olduğu kadar dışarı çıkmamasını öğütleyen inanışlar bazı katılımcılar tarafından dile getirilmiştir. Daha çok yaşlı aile üyeleri tarafından kadın katılımcılara yansıtılan bu mitleri, kadın katılımcılar faydalı bulmamaktadır. Başkaları tarafından önerilen inanç ya mitler, yararlı bulunmazken, kişilerin kendi geliştirdikleri inançları (çoğu dinsel inançları da yansıtan) vardır. Örneğin, kaybedilen çocuğun engelli bir çocuk olmasındansa doğmamış olması, pek çok katılımcı için kader kavramını yansıtmaktadır ve onları rahatlatan bir düşüncedir. Ya da bazı katılımcıların, ölen bebeğin cennette olduğu inancı onları olumlu etkilemiştir. Katılımcılar bebeğin çok küçükken anne karnında ölmesinden dolayı dini bir tören gerçekleştirmemiştir, ölü doğum tecrübesi olan tek çift olan, H. çifti ise yapılan törene katılmamıştır ve bundan pişmanlık yaşamamaktadırlar. Katılımcılara göre, ölen bebek için bir tören yapılmamış olması, yaşadıkları üzgünlüğün daha az olmasını sağlamıştır çünkü tören yapılması kaybın daha büyük olduğu anlamına gelecektir. Katılımcılardan birkaçı, bebeğin ölümünden sonra bebek için dua ettiklerini, Mevlüd okuduklarını ve bu ritüelin onlara iyi geldiğinden bahsetmiştir.

Katılımcıların bilişsel baş etme olarak kullandıkları yöntemler ise şunlardır: bebek kaybının yaygın olduğu ve bu yüzden yaşadıkları kaybın anormal bir kayıp olamadığını ve kendilerini suçlamanın gereksiz olduğunu düşünme, engelli olma riski sebebiyle bebeğin düşmüş olduğu bilgisinin doktorlar tarafından verilmiş olması, gelecekte tekrar çocuk sahibi olabilme ihtimallerinin olması.

Katılımcılar içerisinde daha önceden çocuk sahibi olan çiftler (D, E, H ve J çiftleri) ve sonradan bebek sahibi olan çiftler (A, B, E, Gve I çiftleri), hiç bebek sahibi olmamış çiftlerden farklı tepkilere sahiptir (C ve F çiftleri). Daha önce çocuğu olan katılımcılar kendilerini en azından çocuk sahibi oldukları için teselli etmişlerdir. Kayıp sonrası bebek sahibi olanların yas süreci ise uzamamış ve komplike duruma gelmemiştir. 5 çift, kayıp sonrası tekrar çocuk sahibi olduklarından kayıp hakkında artık çok fazla düşünmediklerini belirtmişlerdir çünkü yaşayan bebek için güçlü kalma istekleri oluşmuştur.

Kayıp öncesi ya da sonrası bebek sahibi olmak gibi, gelecekteki hamilelik dönemleri için umudun korunması da katılımcıların yas sürecini etkilemiştir. Doktorların kayıp sonrası hamile kalıp kalamayacaklarına ilişkin yaptığı açıklamalar, genetik ya da üremeyle ilgili sorunların varlığı ya da yokluğu bu ümidin oluşmasına ya da oluşmamasını etkilemiştir. Örneğin, F kodlu kadın katılımcının doktoru tarafından tüp bebek düşünebileceği hakkında yaptığı açıklama, katılımcıyı bebeği kaybettiğini öğrendiği günden daha fazla üzmüştür.

Bu çalışmadaki tüm kayıplar, eşlerin isteği dışında gerçekleşmiştir yani kayıplardan hiçbiri istemli düşük, gebeliğin sonlandırılması durumu değildir. Bu durum katılımcıların kendi bedenleri üzerinde kontrol sahibi olmadıkları düşüncesine neden olmuştur. Hamilelik döneminin sonlandırılması gerektiği doktorlar tarafından kendilerine açıklandıktan sonra, katılımcıların çok hızlı bir karar vermeleri gerekmiştir. Farklı doktorlardan fikir almadan ya da bu durum üzerine düşünmelerine fırsat bile olmadan, gebeliğin istemsiz bir şekilde sonlandırılması durumu 8 katılımcı tarafından rahatsız edici bulunmuştur.

Bir diğer alt-tema olan yasın normalliği üzerine düşünme temasında ise, katılımcıların kendi kayıp ve yaslarını sorguladıkları görülmüştür. Toplumun diğer kayıplar (yaşlı birinin kaybı ya da 3 yaşında bir çocuğun kaybı) için bir açıklama, ya da ritüeli mevcutken, hamilelik döneminde bebek kaybı sonrası verilen hangi tepkilerin normal, kabul edilebilir olduğu ya da hangi ritüel ve törenlerin gerçekleştirilebileceği ile ilgili çok farklı fikirler vardır. Bu net olmayan durum ise, katılımcıların kendilerini ve yas süreçlerini sorgulamalarına neden olmuştur. Örneğin, bir katılımcı (kadın katılımcı H) kendi yas sürecinin kısa sürmesi fakat tanıdığı başka bir kadının uzun süre yas tutmasını karşılaştırmış ve kendisinin normal olup olmadığı ile ilgili kafa karışıklığını paylaşmıştır.

Araştırmanın giriş bölümünde de ifade edildiği gibi, kişinin bir kayıp tecrübesi olması, anormal tepkiler vereceği ve bu tepkilerin her zaman uzun süreceği anlamına gelmemektedir. Kişilerin bireysel ve sosyal kaynaklarının derecesi ve olumlu olma durumuna göre, her kişi yaşadığı kayba farklı tepkiler verebilir. Bu tepkilerden birisi de bu tür olumsuz yaşam tecrübeleri sonrasında kişilerin yaşadığı olumlu değişim ya da gelişimlerdir. Bu çalışmada da bazı katılımcıların (n=7), yaşadıkları hamilelik dönemindeki bebek kaybı sonrası bu tür tecrübeleri olduğundan bahsettikleri gözlemlenmiştir. Daha çok kişilerarası ilişkiler ya da hayatla ilgili yeni farkındalıklarla ilgili olan bu değişimler sonradan doğan çocukla olan ilişkiyi, kişinin hayata bakış açısını olumlu yönde etkilemiştir.

- **Tema 4: Uzun Dönemde Kayıp ve Yas Tepkileri**

Bu temada, katılımcıların benzer kayıp tecrübesine sahip kişiler için verdikleri öneriler, zaman geçtikçe yaralarının sarılacağına ilişkin inançları, yasın salınımlı (oscillatroy) yapısı, profesyonel destek, yıldönümleri ve "bebek yaşasaydı" düşüncelerinden bahsedilmiştir. Katılımcılar kendi tecrübeleri üzerinde düşünerek, benzer kaybı tecrübe etmiş kişilere önerilerde bulunmuşlardır. Örneğin, eşlerin birbirine destek olmasının öneminden, kendi bireysel baş etme becerilerinin olmasından, sosyal çevrenin olumlu desteğinin öneminden bahsedilmiştir. Katılımcıların 15'i zamanın kendileri için ilaç olduğuna ya da olacağına inanmaktadır. Yasın salınımlı (oscillatory) yapısında ise, katılımcılar hayatlarının bazı dönemlerinde yaşadıkları kayba odaklandıklarını, bazen ise hayatla ilgili uğrasılar nedeniyle kayıp hakkında çok fazla düşünmediklerini belirtmiştir. Katılımcıların bahsettiği bu tecrübe aslında, alan yazınında da bahsedilen bir durumdur. Stroebe ve Schut (1999) yasın bu salınımlı yapısının normal yas süreci dahilinde ve sağlıklı bir durum olduğunu belirtmişlerdir.

Katılımcılardan 9'u kayıp sonrası profesyonel destek almanın öneminden bahsetmiştir. Kadın katılımcılardan 5'i profesyonel desteğe ihtiyaç duymalarına rağmen ekonomik, pratik (çalıştıklarından dolayı zaman bulamama, nasıl bir desteği kimden alacaklarını bilmeme vb) sebeplerden dolayı yardım almadıklarını belirtmişlerdir.

Katılımcılardan 8'i bebeğin öldüğü gün ya da bebeğin doğmasının beklendiği günün kendileri için önemli olduğunu belirtmişlerdir. Alan yazınında da bu günlerin kişilerin kaybettikleri kişiyle olan ilişki hakkında ve yaşasaydı ne olurdu gibi düşüncelerin yoğunlaştığı dönemler olduğu belirtilmiştir. Yıldönümleri "bebek yaşasaydı hayatımız nasıl olurdu?" düşüncelerinin yoğun olduğu dönemlerdir. Bebeğin cinsiyeti, bebek yaşasaydı ebeveynlerin çocukla yapacakları şeylerin neler olacağı, çocuk 1,2 vb. yaşında olsaydı neler yapabilecekleri üzerine düşündükleri yine katılımcılar tarafından paylaşılmıştır.

4. TARTIŞMA

Her ne kadar toplum tarafından kabul edilmemiş, unutulmuş görmezden gelinmiş bir yas durumu olsa da hamilelik döneminde bebek kaybeden kadın ve erkeklerin de yas tepkileri vardır.

Çocuğun Türk aile yapısındaki önemini anlatan pek çok çalışma mevcuttur. Bu duruma paralel olarak, bebeğe sahip olma motivasyonlarının sosyo-kültürel etmenleri içermesi beklendik bir durumdur. Nitekim, evlenen çiftlerin, mümkün olan en kısa sürede çocuk sahibi olmaları beklenir (Teke, 2005). Örnek (2000)'in de belirttiği gibi evde çocuk olmaması durumu kadın üzerinden konuşulmaktadır. Hamilelik dönemindeki bebek kayıpları için benzer şekilde sosyal çevrenin kadın üzerinden eleştirmesi bu duruma paralellik gösterir. Her ne kadar bebeğin cinsiyeti, katılımcıların çoğu için önemli değilse de, birkaç kişi için önem arz ettiği belirtilmiştir. Kağıtçıbası ve Ataca'nın (2005) çalışmasında belirttiği gibi, Türk toplumunda eğitim ve sosyo-ekonomik seviyenin yükselmesiyle, erkek çocuk beklentisi azalmıştır, hatta kız çocuk isteme oranının daha yüksek olduğu düşünülmektedir.

Katılımcıların tecrübe ettiği tüm kayıplar istemsiz ve beklenmedik olmasından ötürü kişilerin yaşadığı şok, inkâr, üzüntü gibi psikolojik tepkiler normaldir, bu tecrübeyi yaşamış olan katılımcılar bebekle ilgili gelecek hayallerini ve ebeveyn olma durumlarını kaybetmişlerdir. Bu durum, kısa ve uzun vadede verdikleri tepkilerini açıklayabilir. Kişilerin verdiği psikolojik tepkilerin Kübler-Ross'un teorisindeki (Kübler-Ross, & Kessler, 2014) evrelerle benzeştiği ve yine Stroebe ve Schut'un teorisindeki (1999) yasın salınım özelliğinin gözlemlendiği fark edilebilir.

Kadınların daha çok kendilerini suçlarken, erkeklerin öfkesini dışarıdaki kaynaklara yönlendirmesi, kadın ve erkeklerin yas süreçleri hakkında önemli bilgiler vermektedir. Kadınların hamilelik dönemindeki kayıplardan ötürü kendilerine yönlendirdikleri kızgınlık ya da kendini suçlama eğilimi farklı çalışmalarda da bulunmuştur (Adolfsson ve ark., 2004; Friedman ve Gath, 1989)

Özellikle kadın katılımcıların, gelecek dönemki hamilelikleri için kaygı duyması farklı çalışmalarda da saptanmıştır (ör. Cacciatore, 2010; Tseng, Chen ve Wang, 2014). Dolayısıyla, yaşadıkları kayıp sonrasında bebek sahibi olmaları, katılımcıların bu durumu daha rahat atlatmaları ve yas süreçlerinin normal sürede tamamlanması için etkili olmuştur.

Bazı kadın katılımcıların, kürtaj operasyonunun bu kayıp sonrasında akıllarında kalan en canlı anı olduğu belirtilmiştir. Hastanedeki bu süreç, yaşanan kaybı fiziksel olarak kanıtlaması ve kendi bedenlerinin kendilerini hayal kırıklığına uğratması düşüncesi (Dunn, Goldbach, Lasker ve Toedter, 1991) nedeniyle kadınları bu derecede etkilemiş olabilir.

Yaşanan kaybın bir parçanın kaybı gibi düşünülmesi ve ifade edilmesi, daha önce Türkiye'de yapılmış çalışmalarda da ifade edilmiştir (Köneş, 2018). Aslında, bu durum kişilerin bu kayıp sonrası yaşadıkları üzüntünün derinliğini de ifade eden bir kavramdır. Kaybı fiziksel terimlerle ifade edilmesi kültüre özgü bir durum olabilir. Benzer şekilde McWhirter (1983), Türkiye'de yaşayan insanların duyguları hakkında konuşmakta zorlandığı için, olumsuz yaşam olaylarından sonra somatik tepkilerinin daha fazla olduğu yorumunu yapmıştır.

Bu çalışmanın en önemli verilerinden birisi, kayıp sonrası eşten alınan/eşe verilen destekle ilgili verilerdir. Özellikle eşlerin birbirine destek olması, yaşanan tecrübenin eşler arasında paylaşılması, erkeğin kadına yönelik suçlayıcı olmayan tavrı katılımcılar tarafından olumlu algılanan eş desteğidir. Erkeklerin daha çok destek vermesi, güçlü görünmeye çalışması; kadınların ise destek gören, korumaya ve ilgi göstermeye ihtiyaç duymaları toplumsal cinsiyet rolleriyle ilgilidir. Bu roller her iki cins tarafından da o kadar benimsenmiştir ki, erkekler bir desteğe ihtiyaçları olduğunu düşünmemektedir. Kadınlarsa, bir şekilde destek verenin güçlü pozisyonunu elde edememişlerdir. Bu durum da aslında yasın cinsiyet temelli tepkileri olduğunu da gösterebilir. Nitekim, bu durum erkek ve kadınların dile dökülemeyen ihtiyaçlarına sebep olabilir. Örneğin, toplumsal cinsiyet rolleri bu kadar bariz bir şekilde kişileri etkilememiş olsaydı belki erkekler de kendi duygusal ihtiyaçlarından daha fazla bahsedebilirdi.

Kadın ve erkeklerin baş etme mekanizmaları ve sosyal ilişkilerine yönelik farklılıklar da benzer şekilde toplumsal cinsiyet ve sosyo-kültürel faktörlerin etkisiyle oluşmuş olabilir. Örneğini kadınlar yakın arkadaşlarıyla daha fazla yaşadıkları tecrübeler, duyguları üzerinden bir paylaşım gerçekleştirirken; erkekler yakın arkadaşlarıyla dahi daha çok pratik konuları paylaşmakta, yaşantılarının kendilerini nasıl etkilediğini genel olarak paylaşmamaktadır. Kadınların daha duygusal baş etmeleri, erkeklerin ise dışarda, işte zaman geçirip daha çok aktivite yaparak baş etmeye çalışmaları benzer çalışmalarda dile getirilmiştir (Avelin ve ark., 2013).

Bazı çiftlerin duygu ya da tecrübelerini paylaşma noktasında iletişimlerinin az olduğu görülmüştür. Bu durum da daha çok iletişim kurmak isteyen partnerde yalnızlık, anlaşılmadığını düşünme gibi düşünceleri yaşamalarına neden olmuş olabilir. Her ne kadar erkek ve kadınların farklı baş etme, iletişim kurma yöntemlerinin olduğu düşünülse de partnerlerin birbirleriyle olan iletişimi bu farklılığı tolere edebilir. Eğer eşler arasında açık bir iletişim sağlanırsa, farklılıkların sebebi hakkında ikisinin de fikir sahibi olması

sağlanabilir bu da birbirlerinin yas tepkilerini daha iyi anlamalarında eşlere önemli bir bilgi sağlar (Kersting ve Wagner, 2012).

Her ne kadar arada neden-sonuç ilişkisi yoksa da katılımcılar arasında hemfikir olunan bir konu da hamilelik döneminin uzamasıyla bebekle geliştirilen bağın artması dolaysıyla da kaybın daha yoğun yaşanmasına ilişkin görüşleridir. Her ne kadar anne fiziksel olarak bebeği taşıyor olsa da toplumun "annelik" ve "babalık" la ilgili yansımaları da, anne ve babanın bebekle farklı ilişkiler geliştireceği inancını pekiştirmektedir (Avelin ve ark., 2013).

Yasın sosyo-kültürel etmenlerini fark edebileceğimiz bir diğer konu ise, katılımcıların aldığı sosyal destek ve kayıp sonrası ritüeller ve törenlerdir. Katılımcıların çoğu, kayıp sonrası ziyarete gelen akraba ve arkadaşlarından bahsetmiştir, fakat bu kişilerden gelen tüm destek olumlu olarak algılanmamaktadır. Özellikle kadınlara yönelik olumsuz yorumların geniş aileden geldiği belirtilmiştir. Farklı kayıplarda daha fazla destek veren, ailenin yanında olan, başsağlığı ziyaretleri gerçekleştiren sosyal çevrenin, bu kayıpta her ne kadar "geçmiş olsun" ziyaretleri yapsa da diğer kayıplardan farklı ve görece daha az bir desteğin varlığından söz edilebilir. Kayıp yaşayan çiftler için en önemli destek daha çok yakın aile üyeleri, yakın arkadaşlardan gelen veya benzer kayıp yaşamış kişilerden gelen destektir. Katılımcılardan hiçbiri ölen bebek için bir tören düzenlememiştir ya da H çiftinde olduğu gibi, düzenlense dahi katılmamıştır. Yapılan/yapılacak törenin kendi yaslarını daha yoğun yaşamalarına sebep olacağını düşünmüşlerdir. Kayıp ve yas süreci hakkında toplumun anlamlandırma ve kayıp yaşayan kişiyi yönlendirme durumu, hamilelik dönemindeki kayıplar için gözlemlenmemiştir. Bu yüzden de katılımcılar, bu kayıp sonrası yas tutmanın normal olup olmadığını merak etmektedirler. Nitekim, çevrelerinde bilirkişi olarak gördükleri kişilere (örneğin, cami hocası, doktor), bebeğin ölümü sonrasında yapılabilecekleri hakkında sorulan sorularda net ve kesin bir bilgiye ulaşamadıklarını belirtmişlerdir.

Psikolojik danışmanlık ve rehberlik alanında, önemli konulardan birisi de çalışmanın profesyonel destekle ilgili verileridir. Katılımcılardan bazıları psikolojik desteğe ihtiyaçlarının olduğunu fakat bu desteği farklı sebeplerden alamadıklarını belirtmişlerdir. Hastanelerde doktorlar ya da diğer hastane personelinin fizyolojik ihtiyaçlarını sağlamaya yönelik yardımları genel olarak yeterli görülse de bu kişilerin kayıp ve yas sonrası yas danışmanlığı, çift danışmanlığı gibi ihtiyaçlarının desteklenmediği görülmektedir.

Aile ve Çift Danışmanları için Öneriler

1. Eşler aynı kayba farklı tepkiler verilebileceği hakkında bilgilendirilebilir.
2. Eşler arasında açık bir iletişimin kurulması, eşten yardım isteme, empatik yanıt verebilme gibi konularda çiftin desteklenmesi sağlanabilir
3. Gelecekle ilgili kaygı duymalarının normal olduğu anlatılabilir. Kaygı ve diğer duyguları düzenleme becerileri, stres yönetimi konularında çifte danışmanlık hizmeti verilebilir.
4. Geniş aile üyelerinin, çifte doğru desteği nasıl verebileceği öğretilebilir.
5. Bebek sahibi olma motivasyonları, bebeğin eşler için anlamı gibi konuların eşler arasında açıkça konuşulması teşvik edilebilir.
6. Danışmanlık hizmeti dahilinde, cinsiyet rollerinin kadın-erkek olma, anne-baba olma gibi kimlikleri üzerindeki etkileri tartışılabilir.

Aileler ve Çiftler için Öneriler

1. Sizin kaybınız da diğer kayıplar kadar önemlidir ve yas tutulabilir. Yasınızı küçümsemeyin, alanda yapılan pek çok araştırma hamilelik dönemindeki bebek kayıplarında diğer kayıplara benzer tepkiler olmasının normal olduğun belirtir.
2. Aynı kaybı tecrübe etmenize rağmen, kayba farklı tepkiler verebilirsiniz. Önemli olan birbirinizi dinlemeniz ve bu tepkileri anlamaya çalışmanızdır.

Psikolojik Danışmanlık Eğitim ve Süpervizörleri için Öneriler

1. Kayıp ve yasla ilgili, ayrıca çift ve aile terapisi eğitim ve süpervisyon gruplarında hamilelik dönemlerinde yaşanan kayıpla ilgili modüller yoktur. Eğitim içeriklerine kayıp yaşamış bu grubun danışmanlık hizmetleri de dahil edilebilir.
2. Hamilelik döneminde bebek kaybı yaşamış çiftlerle çalışan danışmanlar için verilecek eğitim ve süpervizyon gruplarında, bu kayba özgü durumların konuşulması önemlidir. Örneğin, çift açısından bebeğin taşıdığı anlam, destek mekanizmaları, hamileliğin kaçıncı ayında bu kaybın yaşandığı, kayıptan sonra gerçekleştirilen ritüeller törenler ve bunun kişiler üzerinde bıraktığı etkileri, gelecekle ilgili kaygıları gibi konular hakkında danışmanlar bilgilendirilebilir.

Psikolojik Danışmanlık ve Rehberlik Programları için Öneriler

1. Aile ve çift danışmanlığı ile, kayıp ve yas danışmanlığı ile ilgili seçmeli derslere hamilelik döneminde bebek kaybı yaşamış çiftlerle ilgili bilgi ve beceri kazandıracak konuların eklenmesi önerilmektedir.

2. Programlarda verilen derslerde danışanların toplumsal cinsiyet rollerinin ve sosyo-kültürel etmenlerin tecrübelerini nasıl etkilediğini ve kültüre duyarlı danışmanlık hizmeti verme noktasında danışmanlık öğrencilerinin desteklenmesi gerekmektedir.

Politika Belirleyiciler için Öneriler

1. Genel popülasyonun ulaşabileceği sağlık hizmetleri içerisine, hamilelik döneminde bebek kaybetmiş kişilere yönelik bilgi verebilecek hizmetler yerleştirilebilir. Örneğin, aile sağlığı ya da toplum sağlığı merkezlerinde, psikolojik hizmet veren birimlerin olması bu kişilerin kolay erişebileceği hizmetlerden olabilir. En azından, halkı bilinçlendirmek adına bu konuyla ilgili hazırlanmış afiş ve el broşürleriyle, normal yasın ne olduğu, anormal yas tepkileri verildiği durumlarda kimlerden nasıl yardım istenebileceği konularında bilgi verilebilir.
2. Çalışmadaki katılımcıların da belirttiği gibi, kaybın öğrenilmesi ve sonrasındaki süreçte hastane personeli, kayıp yaşamış kişilerle ilk iletişimi kuran uzmanlardır. Bu kişilerin kaybı çiftlere nasıl açıkladığı, empatik bir iletişimin varlığı, çiftlerin kayıp sonrası fiziksel ve psikolojik olarak sağlıklarını nasıl koruyabilecekleri konusunda ilk bilgiyi veren hastane personeline hizmet içi eğitimlerde, kayıp yaşamış bu ebeveynlere nasıl destek olabilecekleri konusunda bilgi verilebilir.
3. Katılımcıların da belirttiği gibi benzer kayıp tecrübesi olan kişilerle konuşmak, bu kişilerin kendi tecrübelerini daha normal karşılamasını sağlamaktadır. Hastaneler böyle kayıp yaşamış kişiler için grup danışmanlığı hizmeti verecek bir hizmet geliştirebilir.

İleride Yapılacak Çalışmalar için Öneriler

1. Çalışmanın nitel olması neden-sonuç ilişkisi vermediği gibi, uzamsal bilgi de vermemektedir. Bu sebeple, ileride yapılacak nicel çalışmaların, yas sürecini etkileyen etmenleri daha ayrıntılı anlayabilmesi açısından, uzamsal bir yöntem kullanılabilir.
2. Bu çalışmada önemi açıklanan sosyal destek, hamileliğin kaçıncı ayında bebek kaybı olduğu, kayıptan sonra gerçekleştirilen/gerçekleştirilmeyen ritüel ve törenlerin etkisi, toplumsal cinsiyet rolleri gibi kavramlar ve bu kavramlar arasındaki ilişkiler nicel çalışmalarla çalışılabilir.
3. Kişilerin yardım isteme davranışının çalışılması bu kişiler için hazırlanacak önleme ve müdahale programları için ön bilgi oluşturabilir.

Appendix H: Tez İzin Formu/Thesis Submission Form

ENSTİTÜ / INSTITUTE

Fen Bilimleri Enstitüsü / Graduate School of Natural and Applied Sciences ☐

Sosyal Bilimler Enstitüsü / Graduate School of Social Sciences ■

Uygulamalı Matematik Enstitüsü / Graduate School of Applied Mathematics ☐

Enformatik Enstitüsü / Graduate School of Informatics ☐

Deniz Bilimleri Enstitüsü / Graduate School of Marine Sciences ☐

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TEZİN ADI / TITLE OF THE THESIS (**İngilizce** / English) : Grief and Bereavement Experiences of Couples with Prenatal Loss Experience: Examining Psycho-Social Intricacies in a Qualitative Phenomenological Study

TEZİN TÜRÜ/ DEGREE**: Yüksek Lisans** / Master ☐ **Doktora** / PhD ■

1. **Tezin tamamı dünya çapında erişime açılacaktır. /** Release the entire work immediately for access worldwide. ■

2. **Tez iki yıl süreyle erişime kapalı olacaktır.** / Secure the entire work for patent and/or proprietary purposes for a period of **two year. *** ☐

3. **Tez altı ay süreyle erişime kapalı olacaktır.** / Secure the entire work for period of **six months**. ***** ☐

***** *Enstitü Yönetim Kurulu Kararının basılı kopyası tezle birlikte kütüphaneye teslim edilecektir.*
A copy of the Decision of the Institute Administrative Committee will be delivered to the library together with the printed thesis.

Yazarın imzası / Signature ..... **Tarih** / Date .....