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ORIGINAL ARTICLE

Emotions and Experiences of Pregnant Women with a History of Pregnancy Loss: A Qualitative Study Based on Watson's Theory of Human Caring

Gebelik Kaybı Öyküsü Olan Gebelerin Yaşadıkları Duygu ve Deneyimler: Watson İnsan Bakım Kuramına Dayalı Niteliksel Bir Çalışma

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Abstract

Objective: This study aimed to determine the feelings and experiences of pregnant women with a history of pregnancy loss.

Method: A semi-structured interview form based on Watson's caritas process was used to collect data from 13 pregnant women with a history of pregnancy loss between April and June 2020. Thematic analysis was performed according to Watson's caritas processes and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research guidelines.

Results: Pregnant women were found to expect respect, empathy, understanding, and smiling faces from healthcare professionals. In pregnancy after loss, the participants stated that they expected healthcare workers to be more sensitive to them and needed to talk to healthcare workers, share their feelings with them, and obtain more information.

Conclusion: The use of interview methods based on Watson's theory of human caring can help guide health professionals and increase the quality of care.

Keywords: Pregnancy, pregnancy loss, nursing, qualitative study, Watson's theory of human caring

Öz

Amaç: Bu çalışmanın amacı gebelik kaybı öyküsü olan gebelerin duygu ve deneyimlerini belirlemektir.

Yöntem: Çalışmanın verileri Watson'ın iyileştirme süreçlerine dayalı yarı yapılandırılmış görüşme formu aracılığı ile Nisan-Haziran 2020 tarihleri arasında elde edilmiştir. Çalışmanın örneklemini gebelik kaybı öyküsü olan 13 gebe kadın oluşturmuştur.Watson'ın iyileştirme süreçlerine göre tematik analiz yapılmış; çalışmanın raporlanmasında "Consolidated Criteria for Reporting Qualitative Research" yönergeleri rehber olarak kullanılmıştır.

Bulgular: Gebelerin, sağlık çalışanlarının kendilerine güler yüzlü, anlayışlı ve nazik davranmalarını istedikleri saptanmıştır. Kayıp sonrası gebelikte kadınlar, sağlık çalışanlarının kendilerine daha duyarlı olmasını beklediklerini, sağlık çalışanlarıyla konuşmaya, duygularını paylaşmaya ve daha fazla bilgi edinmeye gereksinim duyduklarını belirtmişlerdir.

Sonuç: Watson'ın insan bakım kuramına temellendirilen görüşme yöntemlerinin kullanılması sağlık profesyonelleri için yol gösterici olup; bakımın niteliğini artırır.

Anahtar Kelimeler: Gebelik, gebelik kaybı, hemşirelik, nitel araştırma, Watson insan bakım kuramı

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Introduction

The loss of a pregnancy due to miscarriage, stillbirth, or termination due to fetal abnormalities is referred to as pregnancy loss (1). Despite great advances in the fields of medicine and obstetrics, pregnancy loss is still frequent and affects millions of families (2,3).

Decisions regarding another pregnancy are important for women who have experienced pregnancy loss. Some families want to have another child, whereas others are afraid of experiencing further loss (4, 5). Pregnancy after loss of a is stressful, and pregnancy is perceived as a danger that continues throughout pregnancy. Therefore, pregnancy after loss can be described as a stressful period (6). Maternal stress experienced during pregnancy has negative effects on the mother and newborn baby (6-14).

More than half of women who have experienced loss intend to conceive again in a short time, with over 60% successfully achieving pregnancy within one year following the loss (15,16). Because of their loss experience, they have a greater likelihood of experiencing deep anxiety and depression (17,18), and they have a higher fear of childbirth and perception of traumatic birth (19). Therefore, planning nursing interventions for this group is important for them to pass their current pregnancy safely and to establish a healthy bond between mother and baby.

As caregivers, nurses must understand the experiences, feelings, and worries of women who are pregnant after a loss. This insight will allow them to provide more therapeutic and sensitive care (20). Although descriptive studies have been conducted with women who have experienced pregnancy loss in Turkey, these are limited. In addition, no qualitative studies have been conducted in Turkey with pregnant women with a history of pregnancy loss. This qualitative study intends to reveal the feelings and thoughts of women. It is believed that as a result of this study, health professionals will be able to understand the feelings and thoughts of pregnant women with a history of loss, which will allow them to plan their care based on these feelings and needs.

According to Watson, nursing is a person-to-person caregiving process. In this process, individuals' capacity to cure themselves can increase with the individual-nurse relationship, and a high level of awareness may develop (21). Therefore, to strengthen the coping ability of pregnant women who have a history of perinatal loss and make it easier for them to express their feelings, Watson's theory of human caring can be used. This is because Watson's care behaviors are expressed in terms of listening carefully, establishing eye contact, calming the patient, taking responsibility for the patient, honesty, touching, sensitivity, being respectful, giving verbal assurances, being physically and mentally present, being emotionally open and accessible, addressing the patient by name, being individual-centered, giving information, and taking account of cultural differences (22,23) (Table 1).

In Watson's nursing care, love is the most important source of recovery in the person-to-person caregiving process. It is believed that conducting interviews based on love in this process will help women easily express themselves. The aim of this study was to determine the feelings and experiences of pregnant women with a history of pregnancy loss.

Main Points

- After a pregnancy loss, being pregnant again is more stressful for women.
- They expected health care professionals to give more attention and to be more sensitive towards them with this experience.
- The women do not forget how health care professionals behaved them in their loss experience.
- When the subject is loss, person to person caregiving process is more important and to use the Watson Theory of Human Care help caregivers to shape their care.

Material and Method

Design and Sample

This is a descriptive and qualitative study. The study was conducted in an outpatient clinic in İzmir, Turkey. The research team consisted of three nursing academicians who identified as female, one medical academician who identified as male, and one doctor who identified as female. One nursing academic works as a professor in the gynecology and obstetrics department. One nursing academic works as an associate professor in the gynecology and obstetrics department. One of the nursing academicians is an assistant professor at the psychiatric nursing department. A medical academician works as a professor at the university gynecology and obstetrics department and also monitors pregnant women in outpatient clinics. The other doctor is a specialist in the gynecology and obstetrics department at the hospital. All researchers are experienced in working with women who have experienced pregnancy loss and are pregnant after loss. The three nursing academicians are also experienced in working with Watson's human care model and qualitative study.

The sample was selected purposively. The sample size was not preferred. Recruitment continued until data saturation was reached. The study was conducted with 13 pregnant women between April and June 2020. Pregnant women aged ≥18 years with a gestational age between 12-36 weeks, a history of at least one pregnancy loss, a healthy fetus, no communication difficulties, spontaneous conception, no complaints such as chronic disease/gestational diabetes/eclampsia/pre-eclampsia/threat of preterm labor and premature rupture of membranes, and who gave their informed consent to participate were enrolled into the study.

Data Collection

The data collection form consisted of semi-structured questions planned by the researchers according to Watson's caritas process by examining the literature (20,21,24,25). The data collection form comprised semi-structured, open-ended questions. The form included the following sections:

Section 1, socio-demographic, and obstetric information; and Section 2, the woman's feelings and thoughts about her current pregnancy (Table 2). It was planned that women who did not mention their previous pregnancy loss in this section would not be referred to Section 3, and the interview would end. The aim here was to prevent the possibility of forcing the mother-to-be to face her previous loss experiences again. However, all of the women who were interviewed talked spontaneously about their pregnancy loss, and therefore all the interviews were completed with Section 3: their feelings, thoughts and experiences of pregnancy loss, sources of support, coping methods, the effect on the current pregnancy, and what a pregnant woman with a history of pregnancy loss expected of the health care workers. The interview questions were not pilot tested. No interviews were repeated.

Interviews were conducted face-to-face with pregnant women who agreed to participate in the study in a quiet room at an outpatient clinic. There was no relationship between the participants and researchers. Before the interview, the interviewer introduced herself and the purpose of the interview to the women. The first and third authors conducted interviews. Each interview lasted approximately 30 minutes. The interviewer took notes about the women's body language throughout the interviews. The interviews were recorded using a sound recording device.

Statistical Analysis

Data analysis was performed by two researchers (PT, KY) who were independent of each other. The deductive method was used for data analysis. The interviews were coded according to the concepts in the women's statements, and later thematic analysis was performed according to Watson's caritas processes by the same two researchers (PT, KY). Once the interviews were conducted, the two authors discussed them according to the caritas factors. At a separate meeting, codes were reviewed by all authors, and consensus was achieved regarding the content. The transcripts were not returned to the participants. The study was reported using the Consolidated Criteria for Reporting Qualitative Research (26).

Ethical considerations

Ethical approval was obtained from the Ethics Committee of the Dicle University Medical Faculty Ethics Committee for Non-interventional Studies (no:2020/113, date: 05.03.2020). Verbal and written informed consent was obtained from the women before the interviews. They were informed about the study objectives before the interview. Participants were assured that they could stop the interview at any time and could skip any questions they did not want to answer.

Table 1.
Curative Factors and the Caritas Process in Watson's Philosophy

Curative Factors (CF)	**Caritas Process**
1. Formation of a humanistic- altruistic system of values	Practice of loving-kindness and equanimity in the context of caring-consciousness
2. Instillation of faith and hope	Being authentically present and enabling and sustaining the deep belief system and subjective life world of the self and the one-being cared-for
3. The cultivation of sensitivity to one's self and to others	Cultivation of one's own spiritual practices and transpersonal self, going beyond ego self; being sensitive to self and others.
4. Development of a helping-trusting relationship	Developing and sustaining a helping-trusting, authentic caring relationship.
5. Promotion and acceptance of the expression of positive and negative feelings	Being present to and supportive of the expression of positive and negative feelings as a connection with a deeper spirit of self and the one-being-cared-for
6. Systematic use of a scientific problem-solving method for decision making	Creative use of self and all ways of knowing as part of the caring process and engagement in the artistic practice of caring-healing practices
7. Promotion of interpersonal teaching-learning	Engaging in genuine teaching- learning experience that attends to the unity of being and meaning and attempts to stay within another's frame of reference
8. Provision of supportive, protective, and corrective mental, physical, sociocultural, and spiritual environment	Creating a healing environment at all levels (physical, as well as nonphysical) whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assistance in achieving human needs	Assisting with basic needs, with an intentional caring consciousness; administering human care essentials, which potentiate alignment of mind–body spirit, wholeness, and unity of being in all aspects of care; attending to both embodied spirit and evolving emergence.
10. Allowing existential phenomenological forces	Opening and attending to spiritual-mysterious and existential dimensions of one's own life-death; soul care for the self and the one-being-cared-for

Results

The socio-demographic and pregnancy-related characteristics of the women are presented in Table 3. The results are given according to the caritas factors.

Formation of a humanistic altruistic system of values (CF 1): The pregnant women stated that they wanted health professionals to behave warmly, respectfully, empathically, and helpfully toward them.

"I'd like them to behave in a sincere, good-humored way, nothing else; what else can I expect?" I mean, when they are performing their duties, I would like them to be good-humored. If they're more good-humored, I'll presumably be more open to them. If they behave distantly, I'll act more cautiously with them, but if they act warmly, I'll feel safe..." (P1)

"I want them to be a bit gentler and polite. I really didn't know that they would act so roughly... This kind of behavior upsets me because we're going through a difficult process anyway." (P9)

Instillation of faith and hope (CF 2): Some pregnant women said that when they experienced loss, they needed health professionals to talk to them and give them hope. It was observed that in these pregnancies, they maintained hope by bringing their belief systems into action. It was seen that feeling the baby's movements was an important source of hope for women with a history of loss.

"I wish they'd talked to me when I lost my baby; they could have said this is your first pregnancy, you're still young, don't be upset, it just means that there was a problem with the baby and that's why the pregnancy came to an end... If so, perhaps I would have felt better, I could have prepared myself, but they didn't speak at all... they just said 'It's heartbeat has stopped'..." (P3)

"I still feel like something could happen to the baby at any moment... like when I don't feel the baby move for a long time, I get very worried that something has happened. Is it still alive? Then when I feel a tiny movement, I can't say how much it makes me happy... just a little movement is enough, my baby says with its movements that it's still here." (P8)

Cultivation of sensitivity to oneself and others (CF 3): The pregnant women said that they wanted health professionals to pay more attention to them and to be more sensitive.

Table 2.
Interview Schedule

		Questions
Section 1	1	How old are you?
	2	What is your educational status?
	3	How many years have you been married?
	4	How many pregnancies have you experienced?
	5	How did your pregnancies turn out?
	6	What is your current week's pregnancy?
	7	Did you want to get pregnant?
Section 2	1	Can you tell me about your current pregnancy experience?
	2	What week did you find out you were pregnant?
	3	What was your first reaction?
	4	What did you feel?
	5	What did you think?
	6	Can you tell me about your relationship with your baby?
	7	Women who did not mention their previous pregnancy loss in the second section will not be referred to Section 3.
Section 3	1	What would you like to know about your previous pregnancy loss?
	2	Who has the most support in this process?
	3	What did you do during this process to comfort yourself?
	4	Do you think your previous loss experience affected your pregnancy?
	5	What do you think about experiencing loss again?
	6	What do you do to cope with these feelings and thoughts?
	7	Do you have expectations from healthcare personnel during this process?

"Seeing healthcare workers' interest and love is very important. They were sour-faced; when I asked a question they didn't answer, they only reacted when I asked again." (P5)

"I was going to the hospital; I expected the doctor to take more interest when I lost my baby, but he didn't... Taking an interest could have kept my morale up. I was crying, but the doctor was standing like a robot. What I was going through was very bad anyway, and the doctor behaving like that and not taking an interest made it even worse..." (P7)

Table 3.
Socio-demographic and Pregnancy-related Characteristics

Code no	Age	Education	Duration of marriage	No pregnancies	No surviving children	No pregnancy losses	The type of loss	Week of the current pregnancy	Wanted pregnancy?
P1	36	High school	9 years	3	1	1	24th week, premature birth	30	Yes
P2	30	University student	7 years	3	None	2	8th week, miscarriage; 24th week, premature birth	32	Yes
P3	27	University	5 years	3	1	1	15th week, heartbeat stopped	18	Yes
P4	33	High school	11 years	5	1	3	11th week, 8th week, 12th week, miscarriage	26	Yes
P5	31	Primary school	16 years	3	1	1	12th week, heartbeat stopped	24	Yes
P6	35	Middle school	10 years	4	2	1	8th week pregnant	24	No
P7	33	High school	13 years	4	2	1	13th week, heartbeat stopped	24	Yes
P8	29	High school	7 years	2	None	1	12th week, heartbeat stopped	29	Yes
P9	30	High school	8 years	2	None	1	6th week after miscarriage	12	Yes
P10	24	Middle school	4 years	4	2	1	8th week after miscarriage	26th week	No
P11	41	Middle school	22 years	6	3	2	1 miscarriage (8th week); 1 stillbirth (28th week)	28th week	No
P12	31	Middle school	9 years	5	2	2	20th week, premature birth; 8th week, miscarriage	20th week	Yes
P13	33	Illiterate	9 years	4	2	1	20th week, premature birth.	24th week	Yes

Development of a helping and trusting (human caring) relationship (CF 4): Some pregnant women said that they did not receive enough help and support when they had their loss. One stated that if only a health professional had been with her, it would have given her confidence. Another said that, in particular, trust in the doctor had calmed her down a lot.

"I want them to meet me with a smile. I need attention too... But when I go to the hospital, they don't care about people. They don't take an interest." (P6)

"I mean, we didn't talk to them like we talk to you, but I feel that they are by my side, they're with me, and that's enough for me. Even if they don't sit face to face with me and talk, if they're with me and motivating me, that's enough for me." (P1)

"When I was in the hospital, my doctor visited me during the day. We talked about how everything was going to be, and even when I was at home, I kept on getting psychological support. He always called me, he gave information." (P2)

Promotion and acceptance of the expression of positive and negative feelings (CF 5): The pregnant women expressed their feelings of loss by crying. They stated that having their feelings listened to by health professionals during their current pregnancy motivated them.

"When I lost my baby, I cried, I shouted, I screamed, but my husband didn't, or I didn't see him do it, I don't know, or maybe he didn't want to affect me, I don't know either. I didn't talk to my husband about this, maybe we didn't want to upset each other, so we didn't talk." (P1)

"When I have a problem, nurses listen to my feelings, they speak very nicely, and they motivate me very well." That's enough, I think." (P8)

Systematic use of the scientific problem-solving method of decision-making (CF 6): The pregnant women stated that they tried to overcome their losses with mutual support from their husbands. They also gained strength at the time of their loss from their living children. Some women stated that they tried to cope by taking courses or spending time with friends. They stated that to cope with worry about experiencing loss with their current pregnancy, they followed their baby's movements and went to the hospital more often.

"We talked a lot, and we're still talking. The two of us, my husband and I, have supported each other. When one of us cried, the other was quiet." (P2)

"I was with my son; I was not always at home. I took my son to school; maybe he kept my spirits up; after the loss I didn't close up, I thought of my child...(P1)"

"I went on courses to calm myself. Courses on computer, management, I went to sport, things like that... and I tried to see my friends a lot." (P3)

Promotion of interpersonal teaching and learning (CF 7): The women stated that after the loss, they needed more information about their pregnancy from health professionals. They wanted to be informed on the baby's development and the things they had to do during pregnancy.

"To be honest, these are my expectations: when I go there, they should give me fully detailed information. Are they going to give me medicine, are they going to do something like a blood test or a urine test?" I want them to explain better, to give information, not just do their job..." (P5)

"In my first pregnancy I was naive, I didn't take care, but with this one, I take more care: what I eat, drink, my sleep... everything for my baby. If the doctor talks about the baby's height and weight, its health, what I have to do in which weeks of pregnancy, how much I have to walk or what I have to do... In fact, we know these things, but it's better to hear from a health professional." (P5)

Promoting a supportive environment (CF 8): One of the pregnant women stated that she was happy with the creation of an environment to see the baby, which she had lost; another stated that she did not feel good because she was not shown the baby.

"It's good that I saw it. They told me a lot not to look and not to go in... because it was in an incubator, but I went in so that later I wouldn't regret not having done it. I went in four or five times. It would have been worse if I hadn't gone in; I would have regretted it. I'm glad I went in and saw." (Cries.) (P1)

"After I lost the baby, I did not see it. The doctor did not want me to see him. They took me outside. After that day, I started smoking." (P2)

Assisting the gratification of human needs (CF 9): The pregnant women stated that they received support from health workers in meeting their basic needs. However, they stated that other health workers were insensitive to their needs.

"When I had a pain, the nurse immediately came and saw it and followed it up regularly." (P4)

"When I lost my baby, the doctors had nothing to say. You know, they just send you off to ultrasound." (P12)

Discussion

Discussion was conducted according to the curative factors in the Watson model.

Formation of a Humanistic and Altruistic System of Values (CF 1): Values such as humaneness and altruism mean approaching oneself with love and compassion. The concepts of love, kindness, interest, forgiveness, empathy,

and ethics are also included. According to the theory of human caring, health professionals should behave toward themselves and others with love, compassion, and courtesy (24,27,28).

In this study, the pregnant women stated that they wanted health workers to behave in a good-humored manner, understanding, and courteously toward them. They felt safe in this way. They wanted healthcare workers to be more considerate to pregnant women.

In one qualitative study, it was stated that it was necessary to behave differently in pregnant women with a history of loss during their subsequent pregnancies. The pregnant women stated that the most valuable thing given to them was emotional care (25). In another study, it was stated that thoughtful and empathic care should be given to pregnancies after loss (29). It was stated in one study that health care professionals should provide tailored interventions to support these women (30).

Instilling faith and hope (CF 2): This process aims to improve positive health behaviors in patients. This includes the concepts of hope and respect for individual beliefs (31).

The pregnant women stated that they expected health workers to give them hope when they experienced loss.

Côté-Arsenault and Donato (32) stated that it was important for women to talk to health professionals about their hopes and fears concerning their pregnancies to normalize their feelings and develop positive feelings regarding their pregnancy. Health workers should encourage women to overcome their past negative experiences and develop belief and hope concerning pregnancy and childbirth (32). In another study, it was shown that women found solace and acceptance in their losses by embracing their faith and hope. Thus, it made them calmer in their new pregnancy and contributed to strengthening their bond with their unborn babies (33).

Cultivation of sensitivity to oneself and others (CF 3): According to Watson, health professionals should be sensitive to patients (34). In the study, the women stated that health professionals did not take enough interest in them, and they had difficulty even getting answers to their questions at hospitals. Similarly, a qualitative study stated that it was not easy for pregnant women to ask questions to doctors and that some doctors were seen as frightening (25). In another study, women who experienced loss stated that midwives and nurses did not act sensitively toward them (35).

Development of a helping and trusting relationship (CF 4): According to Watson, interpersonal care is very important for health professionals to develop a care relationship that is full of love, helpful, and instills trust. Such a relationship between individuals can only be achieved when there is rapport, empathy, and warm communication (36).

In this study, the pregnant women particularly stated that they needed interest and humor. Some women stated that they generally did not see interest from health workers, while others stressed that feeling that health workers were with them was very important in motivating them. Some of the women stated that their trusting relationship with doctors calmed them. Similarly, pregnant women in one study emphasized the importance of relationships with physicians, particularly the importance of relationships with physicians who understood their previous pregnancy loss and the worries associated with it (25). In another study, women stated that health workers did not take them seriously (29). It is believed that this is important in a helpful, trusting relationship.

Promotion and acceptance of the expression of positive and negative feelings (CF 5): This process involves listening sympathetically to the pregnant women's histories and expressing their positive and negative feelings about their loss and current pregnancy. The women stated that they generally cried at the time of their loss. They stated that having nurses listen to them and express their feelings motivated them.

In one study, many women stated that the health workers did not really listen to them, they did not spend enough time with them, and they did not involve them in their decisions (29). Understanding the feelings, experiences, and worries of women who have become pregnant after loss can enable more therapeutic and sensitive care to be given to these women (20). Sharing these feelings will enable women's emotions to normalize, so that they will develop positive feelings about their current pregnancies.

Systematic use of the scientific problem-solving method of decision-making (CF 6): This process encompasses the concepts of problem solving, creativity, paths of knowledge, the art of care and recovery, and the nursing process. According to Watson, health professionals should use scientific problem-solving skills to address individuals' physical, emotional, and spiritual needs (22).

The women mostly spoke to their husbands to cope with their feelings at the time of loss. Some of the women stated that they spent more time with their friends and participated in more social activities.

In one study, women stated that they wanted to talk about their loss, but they did not believe that their husbands, mothers, or mothers-in-law would completely understand them, and their friends behaved as if there had been no loss. Thus, the women stated that they needed to share their feelings both about the loss they had experienced and about pregnancy after the loss (25). On the other hand, it was stated in another study that women were able to share their feelings with those close to them (mother-in-law) and that this significantly calmed them (36,37). In addition, one study stated that couples who were able to discuss their feelings with one another appeared more cohesive than

those who experienced communication challenges in the aftermath of loss (15).

In our study, we observed that women went to the doctor more frequently in their current pregnancy, specifically to cope with loss anxiety, and that they monitored the movements of their babies. The results of studies showing that women go to the doctor more frequently and have ultrasound examination more frequently in pregnancies after a loss support our findings (12,29).

Promotion of interpersonal teaching and learning (CF 7): The concepts behind this process are effective teaching and knowledge. According to this process, individuals are given information by selecting teaching methods suitable to that individual's needs, readiness, and learning styles (38). In our study, the women stated that in the pregnancy after their loss, they need more information. They said that they would feel better if health professionals gave them information about the baby and what they should and should not do.

In the literature, it has been stated that supporting and informing women during the post-loss process is a factor that positively affects subsequent pregnancies (39) and that providing information to women is an important intervention in reducing their anxiety and calming them (40-42).

Promoting a supportive environment (CF 8): In accordance with this factor, individuals are provided with mental, physical, sociocultural, and spiritual stimulation in a calm and peaceful environment (38). In our study, the pregnant women made statements concerning the creation of an environment where they could see the baby they had lost. The sight of a lost baby calms the woman. They talked about the discomfort of women who do not see their babies. Studies have shown that seeing the baby helps families recover (43), that mothers who spend more time with their babies experience less anxiety than those who spend less time with them (44), and that the risk of depression of mothers who cannot spend as much time as they want with their babies is seven times higher (45). In another study, it was found that mothers who saw and held their babies had higher levels of depression and anxiety (46). A study conducted in Turkey found that parents who saw and touched the baby after its death and who had a photograph of the baby were better able to grieve (47). It has been reported that, generally, contact with a baby makes it better for parents in the future (48). It is believed that providing this environment is important for coping with a loss.

Assisting the gratification of human needs (CF 9): According to this factor, individuals' physical, emotional, and spiritual needs must be identified and met (38). Some of the pregnant women stated that they had no problems with meeting their basic needs, while others stated that they had problems.

The women stated that although they had experienced no difficulties with their physical needs such as pain, there were deficiencies in meeting their emotional needs. There are study results showing that women are not satisfied with the health services that they receive because of ineffective pain management and inadequate communication (49,50). Women stressed that both medical and emotional care are important at the time of loss and afterwards (22,51).

Study Limitations

This study was limited to the opinions of pregnant mothers at the study institution.

Conclusion

It has been stated that pregnant women with a history of loss want health workers to behave with good humor and understanding toward them, and in this way, they feel safe. They stated that sharing their feelings regarding their loss and feelings toward their current pregnancy and setting up a trust-based relationship with them calmed them. It is important for pregnant women to meet their physical and emotional needs.

Health professionals should approach pregnant women with a history of pregnancy loss in an empathetic and understanding manner that inspires trust and is helpful. A suitable environment should be created for women to share their positive or negative feelings, and women should be encouraged and given hope. The use of the Watson human care model is expected to be useful in this process.

Ethics

Ethics Committee Approval: Ethical approval was obtained from the Ethics Committee of the Dicle University Medical Faculty Ethics Committee for Non-interventional Studies (no:2020/113, date: 05.03.2020).

Informed Consent: Verbal and written informed consent was obtained from the women before the interviews.

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Footnotes

Authorship Contributions: Concept – P.T., K.Y.; Design – P.T., K.Y., Y.D.O., S.G., A.B; Data Collection and/or Processing – Y.D.O.; Analysis and/or Interpretation – P.T., K.Y., Y.D.O., S.G., A.B; Literature Review – P.T., K.Y., Y.D.O.; Writing – P.T., K.Y., Y.D.O., S.G., A.B.

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