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Quality Maternal Health Care from the Voices of Childbearing Women: Factors that Optimize and Disturb Wellbeing

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Abstract: Maternal health care providers play a significant role in shaping women's childbearing experiences. While there is increasing recognition of the importance of understanding psychosocial processes for childbearing women, there is a lack of research from the perspectives of women themselves. For this study, women were asked about incidents that optimized and disturbed their perinatal experience, and about what they had originally hoped for in these experiences. The results emphasize personal and relational dimensions of women's experiences with care providers over medical dimensions; correspondingly, the childbearing women's personal sense of empowerment and/or disempowerment was salient, while experiences of pain were scarcely mentioned.

Keywords: Psychosocial factors in birth; childbearing women's experiences; Enhanced Critical Incident Technique (ECIT); influence of care providers

Globally, there is a prominent turn towards recognizing the importance of positive experiences during pregnancy, labor, and postpartum, signaling a significant shift in research prioritization and health care. Despite decades of worldwide economic investment in improving the health and wellbeing of families and newborns, surprisingly, social and psychological processes have rarely been the focus of research and provider care. Poor quality care not only results in mortality; it contributes to clinical and

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psychological morbidity, with lasting effects on the mother's and infant's physical and psychosocial health and wellbeing (Renfrew et al., 2014). Investment in newborn health should be devoted to optimum care that is tailored to the individual, is person-centered, advances equity, and incorporates the view of women (Kennedy et al., 2018). Including women's experiences and perspectives of childbearing would greatly benefit and enhance the provision of quality maternal and newborn care. From an ecological perspective, a woman's experience of pregnancy, birth, and postpartum is influenced by multiple, complex, personal, and systemic factors, which vary based on context, culture, and changes over time (Bronfenbrenner & Morris, 2006). Therefore, in line with this model, the present research will consider individual, family (micro), community (meso), and cultural (macro) systems factors, which represent diverse parts of the systems in which women interact.

Women normally encounter a range of health professionals during the childbearing period, and report that their relationship with care providers is a particularly salient influence on the experience of birth (Redshaw & Van den Akker, 2008). The Quality Maternal and Newborn Care framework (QMNC) describes the type of care that should be accessible to all women and newborns (Renfrew et al., 2014). Of particular interest are the philosophy and values upon which the framework rests, founded and focused on prevention and strengthening women's capabilities. Respect, communication, community knowledge, and understanding are key values pertaining to the framework, specifically tailored to women's circumstances and needs. Markers of care providers' attunement to their patients include listening carefully, clear explanations, demonstrating respect, and spending quality time with patients. In fact, when care providers are attuned to women's emotional and psychological needs, women perceive their quality of care as higher (Wheatley, Kelley, Peacock, & Delgado, 2008).

However, research has indicated that maternal care providers have reported feeling ill-equipped to support women's emotional needs (McConachie & Whitford, 2009; Brown, Mills, McCalmont, & Lees, 2009). Moreover, research has shown that care providers may not provide quality support, especially in relation to difficult birth experiences, contributing to an experience where the mother feels powerless and confused (Waldenström, Hildingsson, Rubertsson, & Rådestad, 2004; Wheatley, Kelley, Peacock, & Delgado, 2008). Maternal and newborn care, particularly midwifery practice, has a pivotal role to play in shifting its focus to subjective experiences of birth and quality relationships, asking interdisciplinary questions, and focusing on women's lived experiences and what is important to them.

The present research focuses specifically on *Research Priority B* from the QMNC framework: "identifying and describing aspects of care that either optimize or disturb the biological and physiological processes for

healthy childbearing women and newborns" (Kennedy et al., 2018, p. 227). More specifically, within this research priority is the explicit acknowledgment of the reciprocal links between *psychosocial wellbeing* and biological/physiological processes in the childbearing continuum, with a call to investigate what practices, attitudes, and behaviors optimize or disturb these processes in care settings (Kennedy et al., 2018, p. 228). Childbearing women's subjective experiences are thus needed to inform care practices that support optimal social and psychological outcomes for women. In response to *Research priority A.2.* (Kennedy et al., 2018, p. 225), the present research involves childbearing women directly, and specifically focuses on women's experiences of maternal health care providers. The Enhanced Critical Incident Technique (ECIT; Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield, Borgen, Maglio, & Amundson, 2009), an adaptation of the Critical Incident Technique (CIT; Flanagan, 1954), was chosen for the present research because it is designed to specifically capture helping and hindering aspects of a phenomenon—in this case women's well-being during the childbearing continuum—from the perspective of the lived experiences of the participants.

Methods

In this section, we describe the participants, procedure, and the Enhanced Critical Incident Technique (ECIT) methodology utilized in the present study. The Research Ethics Board of the University affiliated with the research approved the study before it took place.

Participants

Table 1 summarizes the demographic characteristics of the sample.

Table 1 *Sample Characteristics*

Sample Characteristics	**n**	**Mean (Range)**
Mean age (years)	13	30.2 (26-36)
	n	**%**
Employment status		
Leave from employment	7	53.9
Returned to work	6	46.1
First pregnancy		
Yes	9	69.2
No	4	30.8

Vaginal birth		
Yes	9	69.2
No	4	30.8
Healthcare support		
Midwife	7	53.9
Obstetrician	5	38.5
General Practice Physician	1	7.6
Twin pregnancy		
Yes	1	7.7
No	12	92.3
In-Vitro Fertilization		
Yes	1	7.7
No	12	92.3

Procedure

Women between four and thirteen weeks postpartum were invited to participate through informational material located in waiting rooms of maternity care providers' offices. This window of time was chosen because it represents the typical time at which a woman's care transitions from her midwife or obstetrician to her primary care physician. Inclusion criteria comprised women between 4-13 weeks postpartum, with minimum English proficiency, a desire and/or willingness to be part of the research, and a level of comfort with describing their pregnancy, birth, and postnatal experiences. The first in-person interviews lasted between one and two hours, and the second interviews, used to cross-check the results with the participants, were conducted by phone or email.

Enhanced Critical Incident Technique (ECIT)

The ECIT protocol involves a semi-structured, qualitative interview about the experience of interest. Participants were asked to describe what helped them most in pregnancy and what hindered or got in the way of them doing well in pregnancy. Next, they were asked to describe what events or incidents were most helpful to them during their labor and delivery experience, and those which were hindering. Finally, they were asked to reflect on their postpartum experience thus far, including helping and hindering factors. For each phase of the childbearing continuum, they were also asked to describe "wish list" items, which represent retrospectively what they think would have been helpful. This semi-structured interview protocol focused on the subjective perspectives and insights of the research participants.

Data Analysis

Inductive data analysis identified each event or aspect of the experience (each called a "critical incident" or CI) the participants described as helping, hindering, or something they wished for. According to the ECIT technique, CIs extracted are those supported by examples (Butterfield et al., 2009). Two researchers collaboratively formed categories from individual items using inductive reasoning, patience, and the ability to see similarities and differences among the hundreds of CIs provided by participants. Each CI was placed into a category, either one which had already been created from previous interviews, or a new category that was identified. The researchers made decisions about the exclusivity of the categories, deciding in some cases to separate larger categories and to merge related smaller categories. This process was conducted one interview at a time until no new categories emerged. A minimum participation rate of 25% was required for category retention (Borgen & Amundson, 1984). Once final categories were established, major themes were identified to effectively summarize and report the results. Incidents which were particularly relevant to women's experiences with their care providers and healthcare delivery were chosen and are further detailed in the Results section.

Rigor and Validation

ECIT requires nine credibility checks as outlined by Butterfield and colleagues (2005, 2009) which were followed in this study to ensure validity and rigor (see Table 2).

Table 2 *Credibility Checks*

Credibility Check	Description
Audiotaping and Transcribing	The interviews were *audiotaped* and transcribed in order to ensure that researchers work directly and comprehensively from the words of participants, rather than from inferences or incomplete notes.
Interviewer Fidelity	*Interviewer fidelity* was ensured by using a structured interview protocol, and from researchers reviewing each other's interviews periodically.
Independent Extraction	Butterfield et al. (2005) have recommended selecting 25% of the transcripts to give to an independent individual, following which the researcher would normally discuss possible discrepancies and calculate a concordance rate.

	For this study, the authors enhanced the third credibility check of *independent extraction* by collaboratively extracting Critical Incident (CI) and Wish List (WL), and placing them in categories by consensus with 100% of the transcripts.
Exhaustiveness	*Exhaustiveness,* the fourth credibility check, indicates the point at which no new categories are being identified. This criterion was reached after 13 interviews, after which no other interviews were necessary.
Participation Rates	*Participation rate* (discussed in the text) not only provides a minimum requirement for retaining a category, but also serves to establish relative strengths of each category.
Placing into Categories by a Judge	In this credibility check, 25% of the CIs are assigned to an independent judge for category placement with a recommended match rate of 80% with the Principal Investigator. This credibility check was modified similarly to the check of independent extraction in that the researchers placed the incidents into categories collaboratively. The researchers achieved 100% agreement through discussion at the time of category formation and coding.
Cross-Checking by Participants	After the participant's results were analyzed and incidents were elicited and placed into their respective emerging categories, participants were contacted to do a second interview (by phone, e-mail, or in person). They were provided with a copy of their incidents along with the categories these incidents were placed in to confirm whether they had been placed appropriately. This honors participants' voices as the final authorities in representing their lived experience.
Expert Opinion Review	The categories were submitted to two outside experts for an *expert opinion review*. The experts were asked: (1) Do you find the categories to be useful? (2) Are you surprised by any of the categories? And; (3) Do you think there is anything missing based on your experience? The categories in this study were submitted to both a registered midwife, and to a nurse practitioner

	who is also qualified as a licensed lactation consultant and is currently working in maternal and newborn care. Both experts confirmed that the categories were congruent with their expertise, and current research in the field.
Theoretical Agreement	*Theoretical agreement* involves reporting assumptions underlying the study and comparing emergent categories with relevant literature.

Note: These nine credibility checks were performed to enhance the rigor of the analysis, according to the guidelines of the Enhanced Critical Incident Technique (ECIT; Butterfield et al., 2005; Butterfield et al., 2009), with specific project applications and/or modifications clearly noted under each description.

Results

A total of 933 CIs emerged from interviews with 13 participants. Of these, 486 (52.1%) were found to be helping, 375 (40.2%) were found to be hindering, and 72 (7.7%) were classified as wish list items. The CIs represented phases of the childbearing continuum fairly evenly with 341 (36.5%) pertaining to pregnancy, 275 (29.5%) associated with labor and delivery, and 317 (34.0%) corresponding with the postpartum period.

Themes and Categories

A total of seven themes emerged from the data analysis pertaining to 24 categories. Table 3 provides a summary of the seven themes that emerged, as well as examples pertaining to each category within a theme. Table 4 provides a summary of categories ranked in descending order in terms of number of CIs.

Table 3 *Summary of key themes and examples of critical incidents for each category*

Theme	Categories	Example of critical incident
Personal Factors	Attitudes and Expectations	"One of my close friends is a maternity nurse, so she was able to give a lot of insight into what to expect" (helping)
	Personal Wellbeing	Trouble adjusting to new body: "I had some struggle with my body image through my pregnancy, just like the changes in my body, and sometimes feeling... like out of control" (hindering)
	Agency and Empowerment	Feeling empowered by choices and awareness: "So it was empowering for me too that I took the stance… I said… I really don't want this to happen and I don't want this" (helping)
	Spirituality and Meaning	Seeking spiritual and emotional support: "So I say to my husband come here…you need to pray for me. Like pray for me now" (helping)
	Staying Active	"Not being able to be active on my terms, so not being able to do prenatal yoga or dance, that most of my activity was hauling him around" (hindering)
	Financial Issues	"Work was difficult at that point because it was slow, that was a financial stressor." (hindering)
Interpersonal Relationships and Support	Family Support and Involvement	Having sister to help around the house: "took care of the kids, and really handled some household stuff… went to the grocery store" (helping)
	Partner Relationship and Partner as Co-Parent	Husband's excitement about getting pregnant: "It felt very unsettling, but [husband] was super excited, and so that helped a lot because he couldn't believe it and he thought it was just great" (helping)

	Community Support and Connection	"We had a lot of support from our community, our friends and our family, and even prayer" (helping)
Healthcare Resources and Information	**Caregiver Support**	Lactation consultant advocacy: "She also affirmed that it was definitely my right to go in there and hold my baby whenever I wanted, so that was, sort of made me feel more empowered to fight for skin to skin time, and fight for the opportunity to nurse him... that sort of made me feel like I was going to be more comfortable putting my foot down with them" (helping)
	Healthcare Support	"I love that program that they do, they came to my house three separate times, and it was like, always like at the perfect time, I was always like losing my mind, 'Oh my god I wasn't doing something right, or this isn't going right,' and they would show up and that was really, like I really enjoyed having that service" (helping)
	Preparation and Information	"Feeling prepared for postpartum period from books and then reading ahead too about what was to come was helpful, because I felt like I was more knowledgeable and if you know what's coming it's easier to deal with" (helping)
Labor and Birth Environment and Experience	**Labor and Postpartum Environment**	Discomfort in hospital environment: "I just didn't want to be in the hospital. It was uncomfortable… and I didn't really want the baby to be around the hospital environment" (hindering)
	Labor and Delivery Experience	"It was a long, it ended up being 45 hours, it was a long labor" (hindering)
	Non-Medical Pain Management	Laboring at home in the birth pool with compact discs: "I came home and things got going along faster... I was in the pool right away, and had the cd's on, it was

		helping, it wasn't pain free, but it was so much more relaxed, I think I spent the majority of it with my eyes closed" (helping)
Parenting and Baby Characteristics	Baby's Characteristics	"I think he was a colicky baby, whenever he had a bowel movement, or a burp or a fart, he experienced it really intensely, and he would just cry and cry… as a newborn, he would just cry all the time, and we were bouncing, swinging, rocking, everything" (hindering)
	Connection with Baby	"It hindered my experience of him in the pregnancy because I wasn't overly connected in the very beginning. I remember, like, physically I knew I was pregnant, but there wasn't that connection" (hindering)
	Parenting	Parenting demands: "Having two children who are very different than each other, and having to figure out how to balance that… I think the hardest time is when they're both clearly very needy, when I'm putting him down for a nap and snuggling him, and she's screaming" (hindering)
	Breastfeeding	"They taught me how to pump, they taught me about formula, I got the support with breastfeeding" (helping)
Community and Macrosystem	Workplace Policies and Experiences	Working too much during pregnancy: "I would work sometimes up to 70 hours per week, and then I didn't have daycare… just being very tired and not having time to rest really" (hindering)
	Cultural Attitudes	Feeling judged by others' misperceptions: "They're just going to think of us as just that Christian family that has all these kids, and so being concerned about how other people viewed us, and having another kid" (hindering)
Personal Health and Medical Factors	Medical Concerns	Having so many medical appointments: "I have a prolapsed uterus, so that requires a gynecologist to look at you, and for your family doctor to look at you, and your physical therapist to look at you" (hindering)
	Medications and Interventions	Pain medication (gas) helped rest: "I was so exhausted it just helped me rest" (helping)

Table 4 *Summary of Categories ranked in descending order of number of critical incidents*

Category Name	Helping (HE), Hindering (HI), Wish List (WL)	Pregnancy (PR), Birth (B), Postpartum (PO)	Participation Rate	Total Incidents
Caregiver Support	**HE, HI, WL**	**PR, B, PO**	**100% (n = 13)**	**140**
Attitudes and Expectations	HE, HI, WL	PR, B, PO	100% (n = 13)	102
Personal Well-being	HE, HI, WL	PR, B, PO	100% (n = 13)	89
Agency and Empowerment	**HE, HI, WL**	**PR, B, PO**	**100% (n = 13)**	**75**
Family Support and Involvement	HE, HI, WL	PR, B, PO	100% (n = 13)	68
Partner Relationship and Partner as Co-Parent	HE, HI, WL	PR, B, PO	100% (n = 13)	59
Community Support and Connection	HE, HI, WL	B, PO	100% (n = 13)	51
Pregnancy, Birth, and Postpartum Environment	HE, HI, WL	PR, B, PO	100% (n = 13)	48
Workplace Policies and Experiences	HE, HI, WL	PR, B, PO	77% (n = 10)	53
Spirituality and Meaning	HE, HI	PR, B, PO	46% (n = 6)	29
Preparation and Information	**HE, WL**	**PR, B, PO**	**77% (n = 10)**	**26**
Healthcare Support	**HE, HI, WL**	**PR, PO**	**77% (n = 10)**	**25**
Labor and Delivery Experience	**HE, HI, WL**	**B**	**69% (n = 9)**	**25**
Connection with Baby	HE, HI, WL	PO	69% (n = 9)	19

Parenting	HE, HI	PR, B, PO	31% (n = 4)	19
Breastfeeding	HE, HI, WL	PO	77% (n = 10)	17
Medical Concerns	HI	PR, B, PO	62% (n = 8)	17
Non-Medical Pain Management	HE	B	46% (n = 6)	12
Medications and Interventions	HE, HI	PR, B, PO	62% (n = 8)	11
Staying Active	HE	PR, PO	54% (n = 7)	10
Baby's Characteristics	HE, HI, WL	PR, PO	54% (n = 7)	10
Cultural Attitudes	**HI, WL**	**PR, B, PO**	**46% (n = 6)**	**11**
Financial Issues	HI, WL	PR, PO	31% (n = 4)	9

Note: This table summarizes all of the categories found, ranked from highest to least number of critical incidents, and indicates whether they represented helping (HE), hindering (HI), or wish list (WL) items, and whether they occurred in pregnancy (PR), birth (B), or postpartum (PO), the participation rate represented in the category, and the total number of incidents. The categories examined in this manuscript are presented in bold text.

Categories

Categories selected for this manuscript represent individual factors and microsystem factors that are especially relevant to the scope of influence of care providers.[1] The two themes identified as pertinent for discussion in the manuscript were *healthcare support and information* and *labor and birth environment and experience*, with the following six categories identified for further discussion: (1) caregiver support; (2) healthcare support; (3) preparation and information; (4) labor and postpartum environment; (5) labor and delivery experience; and (6) non-medical pain management.

Healthcare Support and Information

Caregiver support. The professionals represented in this category include a range of care professionals such as obstetricians, midwives, family doctors, and nurses. Within the caregiver category, all 13 (100%) women contributed incidents, totaling 140 and representing helping, hindering, and wish list items.

Helping incidents included events such as the caregiver's reassurance, personable bedside manner, and respect for the woman's birth plan. One participant described her experience with a nurse who supported her birth plan: "She didn't try to talk me into getting an epidural which was nice. She was on board with the plan of trying to get through the contractions naturally, which was something I was worried about." Another participant described hour-long appointments with her midwife, saying, "It was really clear she wasn't just checking boxes, but was really invested in giving high quality care to my whole person." The same participant described her caregiver's presence during her birth as, "She was a really low-profile presence, but strong. Sort of just a guardian there to watch and witness and step in as needed, but not to take control of the circumstances."

Hindering incidents pertained to bedside manner, communication, expertise, the relationship with the care provider, nature of appointments, and disrupted continuity of care. One participant highlighted the value she placed on having hospital caregivers communicate with her as it pertained to the care of her infant:

> She started doing the tests…without talking to me beforehand, and I found out after the fact that he had been given a blood test and an x-ray. And it's not like I would have said 'no,' but I still would have felt

[1] All of the results that emerged in the analysis are important for understanding childbearing women's experiences. Themes and categories less directly relevant to the influence of care providers have been selected for discussion in separate manuscripts.

better if they had informed me before that happened and gave me the specific opportunity to make informed consent.

This captures the personal significance of the participant's identity as a mother in understanding and being personally involved in medical procedures, while respecting providers' medical expertise. Similarly, when asked to describe what they would have wished for, participants described wishing to have been taken more seriously by hospital staff when in labor, having more continuity of caregivers, and having a more personally involved care provider.

The incidents in this category highlighted the importance to women of receiving care that is at the same time highly skilled and demonstrates personal warmth. They described incidents where it was evident that their caregivers showed expertise with a tone of personal caring and encouragement. Not surprisingly, the participants valued continuity of care with providers with whom they had relationships, and experienced disruptions in care as difficult.

Healthcare support. The category of healthcare support captures women's experiences of the systems within which the care providers operate. A total of 10 participants contributed to this category (77%), with a total of 25 incidents. This category of incidents refers to (in)accessibility to care, waiting lists for care providers, and receiving additional healthcare support. The most prominent theme among the hindering incidents in this category is the challenge of accessing care. An example of this was one participant's three-month-long waitlist for a uterine repair. Other hindering incidents included having care with providers cut short due to scope of care and experiencing discontinuities with care providers and gaps in services. Not surprisingly, helpful incidents included seamless transitions between care providers, receiving donor milk when having difficulty breastfeeding, and accessing necessary specialty care such as physiotherapy for pelvic floor issues.

The wish list items women cited also spoke to the importance in their experience of accessing comprehensive care, including breastfeeding information and affordable lactation consultation, home healthcare visits, and having options in selecting a primary maternity care provider. A common wish list theme in this category was to have better support in place to prepare for birth and the postpartum period, and to cope during recovery. Together, the incidents in this category underscore the importance for childbearing women of having information and referral pathways in place for comprehensive and multidisciplinary healthcare and support.

Preparation and information. Just over half of the participants (54%; n=7) mentioned incidents related to information about the maternal and newborn experience. Hindering incidents included receiving information that was conflicting or lacking, with women citing anxiety about unexpected medical events. For example, one participant described extreme emotional distress upon discovering on her own a uterine prolapse, which she was previously unaware of as being a possible risk. In contrast, being informed helped women better prepare for birth and postpartum and made them more secure in their experiences. Care providers have a responsibility to inform women of potential risks without scaring them, to be consistent with the information, and to equip women with knowledge to care for themselves and their babies in the best way possible. In the event that providers don't know information, or are suggesting educational resources to women, it is important for the providers to ensure that the information given is accurate.

Labor and Birth Environment and Experience

Labor and birth environment. All 13 (100%) women contributed incidents, totaling 50, pertaining to the physical space of labor and birth. These represented helping, hindering, and wish list items. Describing a helping aspect of the physical space, a woman who chose to have a home birth stated: "I can't emphasize enough the impact of having it in my home with my support team, with my midwife." In contrast, another participant described how *not* having a comfortable labor environment was hindering:

> I had to wait in the waiting room for I think about 3 or 4 contractions… that was really awful… I sort of thought they were going to try and get me in a room right away, and they were just, 'Oh the doctor will be right with you.' So, I'm in the waiting room [at my doctor's office] and can't sit comfortably at that point. I have to be on all fours, so I'm on the couch…like moaning, and there are other people in the waiting room.

Within this category, several participants referred to having physical restrictions in labor as hindering, needing to drive during labor, and being turned away at the hospital due to not having sufficiently dilated. Examples in this category provide support for the relationship between perceived wellbeing in labor and birth and the physical environment.

Labor and delivery experience. Nine participants contributed incidents about their labor and delivery experience (69%), with 25 incidents in total. Helping incidents included women feeling satisfied in

being able to have the kind of birth they planned for, particularly a spontaneous natural vaginal birth, and to be able to participate actively in their labor. The hindering incidents included feeling unprepared for the intensity of birth, and labor not progressing. Although pain in childbirth is sometimes culturally accepted as the *curse of womanhood*, it is noteworthy, and perhaps surprising, that none of the women in this study spontaneously cited pain per se as a hindering incident. They did, however, discuss other components of labor and delivery as helpful or hindering. These included incidents pertaining to the length of labor, type of delivery, vaginal tearing, and physical obstacles to labor progressing. Hearing women's descriptions of their labor and delivery experience is important for providers to be able to better prepare women for birth, and to support them during labor.

Non-medical pain management. The category of non-medical pain management captures ways that women were supported to manage pain without medication. Just under half of the participants (n=6; 46%) described helpful incidents in this category. No hindering or wish list incidents were provided. Examples for this category include hydrotherapy, movement, hypnobirthing, sterile water injections, and understanding metaphors, like waves of pressure, to understand the pattern of labor contractions. For example, one woman said, "It [the metaphor] really accurately describes how a contraction feels. It just starts, then builds to a peak, then tapers off, and as the pain is building, you need to know that it's going to taper off." Another described, "My whole way of coping throughout my labor was movement. I would, you know, sway or walk." Participants in this study described a desire to choose how to cope with the intensity of labor, including a variety of approaches that did not include medical intervention.

Discussion

The purpose of this study was to hear, in women's own words, what contributed most saliently to their childbearing experience; specifically, what factors optimized and disturbed their sense of wellbeing in the childbearing continuum. From childbearing women's perspectives, it was clear that medical experiences were not as salient as being seen and heard in relationship to their care providers. Women's experiences were significantly shaped by the quality of healthcare support and information they received, which in turn influenced their personal attitudes and expectations. Although the participants in this study spoke candidly about their labor and birth environment and experience, pain was surprisingly *not* mentioned as a disturbing factor, yet experiences of empowerment and disempowerment were prominent. Situated in an ecological perspective, there are multiple and complex factors within time, context, and culture

that influence a childbearing women's experience (Bronfenbrenner & Morris, 2006). The data considered specifically for this manuscript highlights individual, micro-, and meso-level factors, but is contextualized within a cultural macro-system which, in turn, influences values and care practices with childbearing women.

Practices in maternal and newborn care directly impact women's experiences (Redshaw & Van den Akker, 2008); conversely, the subjective experiences of mothers provide valuable insights for informing maternal and newborn care practices that support childbearing women's psychosocial wellbeing. Best care practice recommendations that emerge from the results of this study are summarized in Table 5 and pertain to prenatal care, labor and delivery care, and postpartum care.

Table 5 *Best Care Practice Recommendations for Childbearing Women*

Phase	Recommendation
Prenatal Care	Encourage holistic wellbeing through rest, nutrition, community belonging, nurturing partner relationships, and whole-person care. *Encourage involvement of support people in prenatal care and preparation.* *Screen for mental and emotional health concerns and make appropriate referrals to allied health care providers.* Empower women to participate in birth planning, including making active choices about labor and birth environment, non-medical labor support people, and pain management approaches. *Actively invite women to consider birth preferences through structured consultation or take-home questionnaire.* Maintain continuity of care where possible and ensure smooth transitions between care where necessary. *Support women in being acquainted with all potential "on call" care providers.*
Labor and Delivery Care	Communicate clearly about procedures, interventions, and their rationales. Support and respect women's preferences about their birth environment and labor companions. Minimize restrictions that are not medically imperative during labor.

	Maintain human connection with laboring women with respect for the importance of birth as a life event.
Post-partum Care	Facilitate feeding and lactation support. *Provide resources, referrals and information to support feeding.*
	Provide woman-centered, flexible postpartum care, honoring the unique situation of postpartum women. *Conduct home-visits and phone check-ins when possible.*
	Maintain continuity of care with familiar providers for as long as possible and make efforts to ease the necessary transitions to other providers.

Note: Examples of recommendations are italicized

The women's own voices in this study echo what has been stated in recent literature, that investment in high quality care needs to be technically skilled and person-centered (Kennedy et al., 2018). Medical advancement cannot be to the detriment of personalized care and attention to the social and psychological processes of childbearing women. The childbearing women who participated in this study affirm the priorities being championed in the lancet series (Kennedy et al., 2018) for research and healthcare delivery. The QMHC framework (Renfrew et al., 2014) explicitly values strengthening women's capabilities and delivering care with respect and communication; this resonates powerfully with the participants' emphasis on the importance of personal empowerment in the context of attentive and person-centered care.

While the current research provides meaningful insight into the experiences that childbearing women identify as optimizing or disturbing to their wellbeing, the following limitations of the study have been identified. It was the endeavor of the researchers to explore in depth the experiences of women, in their own words, what they identified as being salient for them, without limiting their reflections to biomedical or pathological elements of childbearing. While 933 critical incidents were identified through the research process, it may be viewed as a limitation that there were only 13 participants included in this study. Further, the sample of participants represented a cohort of women who was relatively well educated, and homogenous in ethnicity and socioeconomic status. Nevertheless, the results are consistent with the body of literature which identifies how various factors within the ecological system impact women's experiences of birth as a biopsychosocial experience. The findings also reveal meaningful information that could be considered for future

research, including investigating experiences of wellbeing for a more diverse or larger sample of women. The findings are also helpful for supporting and informing policy and procedures within hospitals and maternity care clinics as they relate to patient-care provider relationships, providing further evidence that women's relationships with their care providers, and the context within which they receive care, has a meaningful impact on their experience of the childbearing period.

Conclusion

Pregnancy, birth, and motherhood represent significant life events–even a rite of passage–for women. Maternity care providers play an active role in the childbearing period and influence not only medical but also psychosocial outcomes. Participants in this study emphasized the significance of their care providers' influence on their wellbeing, citing optimizing and disturbing factors, as well as what they had wished for. Childbearing women interviewed for this study emphasized the importance of being seen and respected as persons and mothers in receiving medical care. This is facilitated by a trusting relationship with a skilled provider, in which women can feel they have a voice in their birth experience.

References

Borgen, W.A., & Amundson, N.E. (1984). *The experience of unemployment*. Scarborough, ON: Nelson.

Bronfenbrenner, U., & Morris, P.A. (2006). The Bioecological Model of Human Development. In R.M. Lerner & W. Damon (Eds.), *Handbook of Child Psychology: Theoretical Models of Human Development* (pp. 793-828). Hoboken, NJ, US: John Wiley & Sons Inc.

Brown, M., Mills, N., McCalmont, C., & Lees, S. (2009). Perinatal Mental Health Services. *Primary Health Care, 19*(8), 36-39.

Butterfield, L., Borgen, W., Amundson, N., & Maglio, A. (2005). Fifty years of the critical incident technique: 1954-2004 and beyond. *Qualitative Research*, *5*(4), 475-497.

Butterfield, L., Borgen, W., Maglio, A., & Amundson, N. (2009). Using the Enhanced Critical Incident Technique in counselling psychology research. *Canadian Journal of Counselling/ Revue Canadienne de counseling, 43*(4), 265-282.

Flanagan, J.C. (1954). The Critical Incident Technique. *Psychological Bulletin, 51*, 327-358.

Kennedy, H.P., Cheyney, M., Dahlen, H.G., Downe, S., Foureur, M.J., Homer, C.S., & Soltani, H. (2018). Asking different questions: A call to action for research to improve the quality of care for every woman, every child. *Birth*, *45*(3), 222-231.

McConachie, S., & Whitford, H. (2009). Mental health nurses' attitudes towards severe perinatal mental illness. *Journal of Advanced Nursing, 65(4)*, 867-875.

Redshaw, M., & Van den Akker, O. (2008). Understanding factors which can influence the experience of pregnancy. *Journal of Reproductive and Infant Psychology*, *26*(2), 71-73. doi:10.1080/02646830802016036.

Renfrew, M.J., McFadden, A., Bastos, M.H., Campbell, J., Channon, A.A., Cheung, N.F., ... & McCormick, F. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*, *384*(9948), 1129-1145.

Waldenström, U., Hildingsson, I., Rubertsson, C., & Rådestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, *31*(1), 17-27.

Wheatley, R., Kelley, M., Peacock, N., & Delgado, J. (2008). Women's narratives on quality in prenatal care: A multicultural perspective. *Qualitative Health Research, 18* (11), 1586-1598. doi:1177/1049732308324986.