Existential Fulfillment in Maternal Health: Affirmation of Four Fundamental Motivations in Childbearing Women's Experiences

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ABSTRACT

Women's experiences of pregnancy, birth, and postpartum adjustment are often characterized by descriptions of disempowerment and trauma. There has been little qualitative research to understand the contributing factors to maternal fulfillment and wellbeing during pregnancy, birth, and the postpartum period. The purpose of this research was to understand, from the voices of mothers directly, what contributed to healthy, positive, and fulfilling child-bearing experiences. In semi-structured interviews, women reported what they found was helpful, hindering, or what they would have wished for in their pregnancy, birth, and postpartum experiences. Out of 933 incidents reported, participants' responses formed 24 distinct categories across seven themes. These results were analyzed secondarily using the framework of Existential Analysis, specifically applying the structural model of the four fundamental motivations for existential fulfillment. Implications and recommendations for psychotherapists and counsellors working with women during pregnancy and the postpartum period are discussed.

Keywords: Maternal wellbeing; maternal fulfillment; child-bearing women's experiences; Existential Analysis

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Existential Fulfillment in Psychosocial Maternal Health: Affirmation of the Four Fundamental Motivations in Childbearing Women's Experiences

A majority of women become mothers at some point in their lives. Promoting choices in reproductive rights has been a significant focus of advocacy for women; however, empowerment for women in the context of motherhood has been relatively neglected (Gaskin, 2011). The childbearing period has the potential to be an existentially significant time in a woman's life. The unique and universal event of giving birth can be experienced as fulfilling and transformative, and pivotal in shaping a woman's identity (Dahlen, Barclay, and Homer, 2010). Poor well-being during pregnancy, childbirth, and postpartum periods also has significant consequences for mothers, infants, and their families and communities (Bornstein, 2014; Chuang, Liao, Hsieh, Jeng, Su, & Chen, 2011; Hart & McMahon, 2006; Topiwala, Hothi, & Ebmeier, 2012; Sabuncuoglu & Basgul, 2016).

The past century has seen significant shifts in maternity care practices and attitudes, most notably influenced by the medicalization of birth and counter-reactions to "de-medicalize" birth. Kitzinger (2006) argues that birth experiences offer women an opportunity for expressing personal agency, and for connecting to a sense of community. This is facilitated when women are treated holistically and personally rather than merely as medical events with the aim to manage pathology. Existing research on childbearing women is largely from quantitative methodologies and focuses on health outcomes and medical interventions. However, research focused on "repairing damage within a disease model of functioning… neglects the fulfilled individual and the thriving community" (Seligman & Csikszentmihalyi, 2000, p. 5). Consequently, the possibility of understanding the childbearing experience as an existential opportunity, is often missed. (Dahlen et al, 2010; Declercq & Chalmers, 2008; Kwee & McBride, 2015). The present research aims to present the childbearing experience as an opportunity for existential fulfillment, by listening to the lived experiences of women with a qualitative method.

A literature review addressing women's perinatal needs and interventions illuminates significant mental health needs of women during pregnancy, birth, and postnatal, and emphasizes the tendency for childbearing women to experience trauma and disempowerment (McBride & Kwee, 2016). The existing research about women's psychosocial health during pregnancy, birth, and the postpartum period demonstrates the interconnected influence of cultural values, maternity care practices, community support, family and interpersonal relationships and personal factors on childbearing women's well-being (McBride & Kwee, 2016; Kwee, McBride, & Rossen, 2020a). More specifically, women's perception of quality healthcare during the childbearing years appears to significantly influence their existential experience of pregnancy and birth (Kwee, McBride, & Rossen, 2020b; Chalmers, Dzakpasu, Heaman, & Kaczorowski, 2008). These factors in turn influence not only a mother's psychological thriving, but also her partner relationship and parenting relationship with her baby.

The framework of Existential Analysis developed by Alfried Längle (2003, 2005), offers a way for us to conceptualize the childbearing years not as medical events, but as opportunities for existential *being* and *becoming* as persons. The changes, challenges, losses, stressors, and joys together provide childbearing women with an opportunity to deepen her journey of being human, to sense herself as a person and to affirm and re-affirm life. Fulfillment in the framework of Existential Analysis includes a four-fold "yes" to four fundamental existential motivations. These four distinct affirmations include the following:

I can be here

I feel connected to life

I may be who I am

I am held in a larger context

Understanding birth and motherhood within the conceptual framework of Existential Analysis illuminates the childbearing experience as an opportunity for a woman to deepen her affirmation of and active participation in her own life. This approach to understanding maternal wellbeing contrasts sharply with the extant literature on maternal health that focuses largely on reductionistic biomedical aspects of pregnancy and birth.

CONTEXT AND PURPOSE OF THE PRESENT RESEARCH

The present research was conducted with the aim to examine the interrelated events and complex factors of women's lived experiences during pregnancy, birth, and postpartum. We generally refer broadly to these experiences as belonging to a "childbearing" period rather than a "perinatal" period, which is often defined by a specific timeframe starting during pregnancy and ending after birth. Our choice to use the language of the "childbearing period" is due to its greater flexibility in encompassing the subjectively relevant physical and existential aspects of these experiences. Two separate articles have been published that report on different components of the data collected in the research sample. One focused on the influence of caregivers and healthcare experiences on maternal wellbeing (Kwee, McBride, & Rossen 2020b) and the other focused on personal, relational, and community influences on maternal wellbeing (Kwee, McBride, & Rossen 2020a). The overarching aim for both aspects of the project has been to listen to and learn from the lived experiences of mothers in order to understand them as persons rather than as medical events. In this article, our aim is specifically to conceptualize the lived experiences of mothers within a framework of existential fulfillment. Following this, recommendations for existential psychotherapeutic accompaniment of childbearing women are considered.

METHODS

In this section, we describe the procedure, participants, 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.

Procedure

Postpartum women, between four and twelve weeks postpartum, were invited to participate through informational material located in waiting rooms of maternity care providers' offices. This timeframe was chosen because, in maternity care practices in Canada, where the research took place, it represents the typical frame during which a woman's care transitions from

her midwife or obstetrician to her primary care physician. Inclusion criteria for participating mothers included the following:

- Between 4-13 weeks postpartum,
- Minimum English proficiency for participating in interviews,
- Desire and willingness to be part of both phases of the research, including an initial interview and a follow-up interview,
- Comfort and willingness in describing pregnancy, birth, and postnatal experiences.

Interested participants were initially contacted by phone to confirm their suitability for the study and to arrange an interview. Participants were invited to choose the location of their choice for the interview. Compensation for childcare for the participant's older children was offered, if needed. All of the participants chose to have the interviews conducted at their homes. The first in-person interview lasted between one to two hours, and the second interviews (to cross check the results with the participants) were conducted by phone or e-mail.

Participants

The participants in this study were 13 heterosexual women in long-term, committed relationships. The age of participants ranged from 26 to 36 years old, with a mean age of 30. At the time of the interview, just over half of the participants were taking leave from employment while 46% (*n*=6) had returned to work. About two thirds (69%; *n*=9) of the participants were first time parents while the other third had older children. Sixty nine percent (*n*=9) of the participants had vaginal births and 31% (*n*=4) had caesarean sections. The women's births were attended by a range of maternity care providers including midwives (54%; *n*=7), obstetricians (38%; *n*=5), and a general practice physician (8%; *n*=1). One twin pregnancy was represented in the sample, and two of the participants had used in vitro fertilization (IVF) to get pregnant. See Table 1 for a description of the sample characteristics.

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

Enhanced Critical Incident Technique

The Enhanced Critical Incident Technique (ECIT), an adaptation of the Critical Incident Technique (CIT; Flanagan 1954) was chosen for this research because it is designed to specifically capture helping and hindering aspects of a phenomenon – in this case women's well-being during pregnancy, birth, and postpartum – from the perspective of the lived experiences of the participants. In addition, the ECIT has been expanded to capture "wish list" (WL) items, or what participants wished they would have known or would have had for the experience being studied. 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. Nine additional credibility checks (see Table 1) are included to ensure validity and rigour (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield, Borgen, Maglio, & Amundson, 2009).

Data Analysis

The authors of this manuscript comprised the research team which conducted the analysis for this research. Inductive data analysis identified each event or aspect of the experience (each called a "critical incident") the participants described. Interviews were audiotaped and transcribed to determine critical incidents, which were categorized into helping and hindering factors, and wish list factors. According to the ECIT technique, critical incidents and wish list items extracted are those supported by examples (Butterfield et al., 2009). Two researchers independently formed categories from individual items using inductive reasoning, patience, and the ability to see similarities and differences among the CIs provided by participants. Each CI was placed into a category, either a category which had already been created from previous interviews or by identifying a new category. The researchers made decisions about the exclusivity of the categories, deciding which larger categories needed be separated or if smaller related categories needed to be merged. 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, several broader themes were identified to effectively summarize and report the results.

Rigour 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 rigour. To fulfil the first credibility check, all of the interviews were audio-taped and transcribed. Second, interview fidelity was maintained by reviewing interview protocols and the principal investigator providing supervision of initial interviews and subsequent interview recordings. Third, independent extraction of the CI and WL items took place on all interviews, beyond the recommended 25% of interviews by Butterfield and colleagues (2005, 2009). Fourth, to ensure exhaustiveness was reached, a log of each interview was tracked as its CI and WL items were placed into the emerging categories until new categories did not emerge. Fifth, the minimum participation rate (percentage of participants that endorsed a category) determines the strength of a category. A minimum participation rate of 25% is the standard established by Borgen and Amundson (1984). Sixth, the ECIT technique suggests an 80% match rate on categories by independent researchers (Andersson & Nilsson, 1964). The present study enhanced rigour by having two researchers conduct data analysis and interpretation together ensuring 100% agreement across all categories. Coding discrepancies were addressed throughout the analysis and interpretation process between the two coders. Seventh, cross-checking by participants via a second interview, by phone, afforded participants the opportunity to confirm or review categories. The eighth credibility check drew on opinions of experts in the field regarding the categories formed. Two experts were considered as part of the research team and they provided their expertise in relation to the data analysis process and provided additional insights about the categories/themes decided upon. Finally, the ninth credibility check was to attain theoretical agreement for the emergent categories and themes, along with the assumptions of the study, in relation to the existing literature. There was consistency between the literature and the assumptions and categories/themes.

RESULTS

A total of 933 CIs emerged from interviews with 13 participants. Of the 933 incidents, 486 (52.1%) were found to be helping, 375 (40.2%) were found to be hindering, and 72 (7.7%) were wish list items. The 933 incidents could also be categorized by examining when they occurred: 341 (36.5%) were reported during pregnancy; 275 (29.5%) occurred during labour and delivery; and 317 (34.0%) corresponded to the postpartum period. In the initial analysis, a total of seven themes emerged from the data analysis pertaining to 24 categories. The seven broad themes included, (a) personal factors; (b) interpersonal relationships and support; (c) healthcare resources and information; (d) labour and birth environment and experience; (e) parenting and baby characteristics; (f) community and macrosystem factors; and (g) personal health and medical factors. See Kwee, McBride and Rossen (2020a) and Kwee, McBride, and Rossen (2020b) for a summary of the seven themes that emerged and examples of the categories within each theme. For the present analysis, which was conducted secondarily, the data was reviewed using the structural framework of the four existential "Fundamental Motivations" (FM, Längle, 2003, 2005). The following results provide examples of participants' fourfold 'yes' to life as existential fulfillment during the childbearing years, according to the fundamental existential motivations presented in Existential Analysis (EA). These results also address participants' descriptions of threats to existential fulfillment, when they did not experience the pre-requisites to say 'yes' to any of the four existential FMs. Each FM is addressed below in turn.

FM 1: Can I be?

The first FM for fulfilled existence is connected to one's ability-to-be in the world through having sufficient space, protection, and support. Addressing the theme of the first FM, research participants described examples of being challenged to come to terms with accepting health risks and conditions, fears and anxieties about their own or their baby's health, and tension and anxiety about what they could not easily accept. Several described a process of coming to accept experiences that arose, such as uncomfortable emotions, and to endure what they could not control, such as physical pain including intense labour. They offered glimpses into aspects of their childbearing journeys that felt "impossible," and both the protective and unsupportive conditions of their labour and delivery environments.

Participants spoke of being supported and protected and held by their care providers, partners, communities, and healthcare contexts. One mother described the supportive and protective experience of birthing in her own home. She said,

It was helpful just being comfortable and not having to figure out the timing of, *when do we get in the car and go? Is it too early, are we waiting too long?* It doesn't matter, I'll just go crawl into bed.

Others described the anxiety they experienced from not having enough space, protection, and support. For example, one participant described feeling unprotected and "out of control" as a result of a lack of communication and information about the decisions that were being made by medical professionals. She said,

It just felt very out of control. I'm sure it wasn't. I'm sure the doctor, he did have a paediatrician, who would have been in charge of the game plan, so I know there was a game plan. It just wasn't communicated to me and so because of that, I felt very out of control.

Indeed, participants described situations in which they could affirm "I can be here" with certain supportive people, in certain situations, and at certain moments of their childbearing journeys. They also described situations in which and people with whom they intuitively and instinctively felt, "I cannot be here." In affirmation of the first FM, and their ability-to-be, they referenced experiences of being accepted from the outside, and coming to accept their situations and themselves, and to trust their bodies and caregivers, from the inside. See Table 2 for examples of some research categories and participant quotes representing FM 1.

Table 2: Fundamental Motivation 1 Examples

Fundamental Existential Motivation 1	Examples and Descriptions of Relevant Research Categories	Examples from Participants' Experiences
FM 1 Theme: Being-In-The-World	Financial Concerns This category addressed economic considerations	"Work was difficult at that point because it was slow, that was a financial stressor" (hindering)
Central Question: Can I be?	Agency and Empowerment Participants' engagement or disengagement in decision-making, asserting needs, and self-advocacy.	"It helped that I got to be very hands on and involved. I caught my own baby and supported my own perineum… having that tactile connection with the source of my pain made it more endurable." (helping)
	Personal Wellbeing Aspects of the participants' personal wellness.	"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)
	Preparation and Information Knowledge and preparation about what to expect.	"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) "I was feeling confident about going into it. They did show a couple of videos in prenatal class…One really freaked me out and I thought *oh maybe that's not helpful to see what's going to go on*, but at the time it was helpful because I knew, *this is normal, this is what happens*." (helping)

FM 2: Do I like to live?

The second FM for a fulfilled existence pertains to one's connection to life through emotions and relationships in the context of time. An inevitable outcome of a full-term pregnancy is that the baby must be birthed in one way or another. Beyond this inevitable fact, mothers also experience their pregnancies, births, and postpartum adjustment, through the inward possibility of fully participating in the life that moves in and through them. As subjective persons, childbearing women detect feelings of liking and not liking, and of having time to

experience life and to experience relationships. The intimate experience of childbearing offers a mother a particularly unique opportunity to connect her to vitality and emotionality through warmth, closeness, and connection to what is good and valuable. Of course, this connection with life also brings childbearing mothers in touch with suffering, grief, and pain. These feelings all emerge through the active exchange of the person and their world. Participants described the vitality they experienced through feeling close to life through relationships with their partners and babies, their care providers and other friendships, as well as through their own awareness of their emotions and sense of detecting what is valuable and precious in their lives.

One participant described the warmth of being cared for by her midwife who came personally close to the participant, rather than treating her just as a medical process. This participant said,

I had hour-long appointments with [my midwife] and with the amount of time checking in with me in a really holistic manner about how things were going made a big difference. It was really clear she wasn't just checking boxes, but was really invested in giving high quality care to my whole person.

Other participants described aspects of their felt connection (or lack thereof) with their infants, partners, family members, friends, and their experience of their own feelings and emotions, which often came to the surface in the context of warm and caring relationships with others.

Relevant to FM 2, participants described situations in which they could affirm "I like to be" with a sense of profound emotion and aliveness. They described their dedication of time and energy to the precious value of connecting to and caring for their infant. They experienced joy and astonishment at the miracle of life, and of being able to take the time to slow down their pace of life to attend to what was most precious and valuable. In other situations, they described feeling pressured, disconnected and blocked from their experience of life. See Table 3 for more examples of research categories and participant quotes that touched on FM 2 themes.

Table 3: Fundamental Motivation 2 Examples

Fundamental Existential Motivation 2	Examples and Descriptions of Relevant Research Categories	Examples from Participants' Experiences
FM 2 Theme: Turning Towards Life Central Question: Do I like to live?	Connection with Baby References to the participants' relationship with their infant.	"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)
	Partner Relationship References to the participants' relationship to their partner.	"It felt unsettling, but [my 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 and Family Support Descriptions of family and community care and support at any point during the childbearing experience.	"crying with people, and people giving me hugs and the physical stuff…being comforted by people" (helping) "I'm very close with my mom, so we spent, we spend, a lot of time together, being pregnant makes you feel a little bit like you're a crazy person, because your emotions are not really what you're used to…" (helping)
[Turning Towards] Fear Experiencing and processing anxiety related to wellbeing or infant's wellbeing.	"I guess there is that fear of like, 'is she going to be normal and healthy' and kind of coming to terms with…being happy no matter what, kind of doing that process." (helping)

FM 3: May I be myself?

The third existential FM concerns the person, who is expressed in her uniqueness and authenticity. This theme relates to one's experience of being allowed to be herself in her irreplaceable uniqueness. A medical approach to maternal health care lacks consideration of how each childbearing mother navigates the pregnancy, birth, and postpartum period through her sense of inner authority and dignity, and in her unique identity. This aspect of existence was described in women's experiences of being seen, attended to, appreciated, and treated justly in their childbearing journeys. Some women described how their unique preferences were honoured and how their boundaries were respected. Participants whose boundaries were respected often also spoke of having a clear inner sense that they had a right to be themselves, especially in how they experienced their births, and made early parenting decisions with their infants. For several participants, this experience seemed to be a continuation of being given time and personally attentive care (described in previous section about FM 2) in their prenatal checkups. Arising from this, they also experienced a sense of being encountered and received as unique persons, who were really seen, attended to, appreciated, and treated with a sense of justice.

Others described how they felt their personal boundaries to be overstepped by care providers who treated them like pure bodies, and not as unique people and mothers. For example, one participant reflected on this dynamic of struggling confidence to stand up for what she felt was right for herself in relation to the care she was receiving. This came from her feeling that her boundaries had been stepped over in decision-making. She said, "There was a part of me that wondered if I would stand up for anything during the process…I thought, here I've let two things slide, am I going to stand up for anything?"

The childbearing experience presents a unique opportunity in a woman's existence to come to know and express what is truly one's *own*, saying affirmatively "I may be myself." Being born of one's mother is a universal fact of existence. However, birth – for both mother and infant

– represents a uniquely personal existential threshold towards becoming more oneself in the world. Inherent in the nature of our dialogical existence is the humbling fact that we become our truest selves not apart from, but in the context of relationships of encounter with others. In the childbearing journey, this is especially apparent in how the participants in this study spoke of the impact of the way they were treated by their care providers during this intensely personal threshold of existence. When they received attention, appreciation, and justice from the outside, they were more easily able to affirm who they truly were, with a growing sense of identity, freedom, and inner appreciation in their maternal identity and as unique persons. They expressed this through their personal involvement in their pregnancies, births, and early parenting experiences. This came from having a sense that the boundaries around themselves as persons were honoured, and they could truly express who they were with a sense that it was good and right for them to be themselves. Conversely, mothers who felt that they were categorized into medical events and nomothetic "rules" struggled more with sensing what was their own, losing personal authority and orientation in their childbearing experiences. See Table 4 for examples of relevant research categories and participant quotes that are especially relevant to FM 3.

Table 4: Fundamental Motivation 3 Examples

Fundamental Existential Motivation 3	Examples and Descriptions of Relevant Research Categories	Examples from Participants' Experiences
FM 3 Theme: Being Oneself Central Question: May I be myself?	Cultural Attitudes Macro-system attitudes that were experienced personally by participants.	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)
	Caregiver Support Examples of bedside manner, including references to respect, advocacy, 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)
	Agency and Empowerment Participants' engagement or disengagement in decision-making, asserting needs, and self-advocacy.	"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)

	Impacts or changes in relationships (Boundaries) Challenges in relationships with others emerging from living what is one's own.	"I have a friend who has been trying to get pregnant … actually, I have several friends who tried, trying to decide, *should we adopt? ...* so having to tell a really good friend, *I'm pregnant,* when the week before, she was sharing, you know… sharing with her that I was pregnant was hard, that was hard." (hindering)

FM 4: What is this for?

The fourth FM relates to the call to live meaningfully, within a broader context, and for a future that transcends the limits of one's individual life. In *matrescence*, a term that describes the transformative identity development of becoming a mother, participants who could say yes to the fourth FM of meaning described a sense that they were part of something greater than themselves. This included an awareness of being part of the age-old community of women whose embodied wisdom had brought babies into this world for as long as human history. This also included a sense of the meaningful and hopeful possibilities in the future of nurturing a new life into the world. These women affirmed their inner sense of being active participants in the ongoing cycle of creation, in which they were uniquely connected to and intensely needed by their infants.

In EA, meaning is understood as the most valuable possibility in a given situation. Finding meaning requires detecting what *should* be. This is connected to one's abilities, and affirming, *I can.* It is also closely connected to one's experience of detecting values, and affirmation of, *I like.* It also corresponds naturally to one's authenticity and affirmation that *it fits to me as a person.* The meaning of a situation is thus always an interplay of the unique characteristics of a person in their situation. Our sense is that the sample characteristics of the research participants who contributed to this study afforded them relative ease in responding to the call of their situations. Their pregnancies had mostly been planned and welcomed, they were all in long-term partnerships, and all experienced financial stability. Most described easily how they experienced being needed, engaged, and creative. Few described feeling empty or unfruitful. However, it is easily apparent through this contrast that women who find themselves unable to support themselves, disconnected from stable relationships, and unsure of who they are, may not even consider their childbearing experience on the horizon of meaning.

In the finiteness of one's existence, one must actively choose what is most valuable. For women who choose to become mothers, there are a limited number of years when this is a viable choice, and the decision to become a mother is one choice that is likely in tension with other social, personal, and vocational values. For example, the choice to become a mother may compete with opportunities for career advancement, more so than it typically does for men who become fathers. For the women in this study who had chosen actively to become mothers, it seemed that this was their affirmation that, at this point in their lives, they embraced the childbearing experience and motherhood as the most valuable possibility. Notably, the participants in this study who represented a relatively well-educated sample of mothers, were all between the ages of 26 and 36. This represents a common and relatively narrow timeframe

within a woman's lifespan. The early end of this age range is representative of the fact that a woman's sense of readiness to start a family depends not only on her biological maturity but on the time required for completing advanced education, entering long-term partnerships, and achieving sufficient financial stability. The later end of this age range represents the fact that there is a limited biological window of optimal fertility.

For participants in this research who could affirm being part of something meaningful, they had an inner sense that they were presently called to give their capacity, time, and person to take care of themselves and their babies during the childbearing period. They didn't feel trapped by this, but instead described a sense of freedom in being able to say 'yes' to an exciting future-oriented value of nurturing a child. One participant described it as follows:

I'm surrendering my body to being a mom for the next year or two years, and letting it just be what it needs to be, do what it needs to do, and not trying to control how you look or what you feel about your body.

She saw herself and her body as part of something that was life-giving and future-oriented. Rather than ruminating and worrying about changes and challenges in her body, she affirmed that it was dedicated to something of transcendent value in being a mother.

Women, in their childbearing years, have the opportunity to ask what they need to do to bring meaning to their one-and-only lives, in the broader context of their life-world situations. This allows them to affirm being held by and contributing to a larger context and to a future. For examples of research categories and participant quotes that are particularly relevant to FM 4, see Table 5.

Table 5: Fundamental Motivation 4 Examples

Fundamental Existential Motivation 4	Examples and Descriptions of Relevant Research Categories	Examples from Participants' Experiences
FM 4 Theme: Meaning, Context, and Future	Community Support Experiences with personal friends or faith communities.	"I started a mom's group… I felt, even though it was hard to get there, filled and renewed every time I went." (helping)
Central Question: What (good) is this for?	Body Image Experience and perception of body changes due to childbearing factors	"[An author] talked about the softening of our bodies and the stretching that happens and the sacrifice, and it's like 'yea' like it's sacrifice on so many different levels and it's like physical, it's the late night feedings, it's the 2am nursing, it's like it's a whole different level of sacrifice being a mother…but that can be powerful when you realize how amazing that is, and how beautiful it is that you have the opportunity to do that." (helping)

Cultural Attitudes Macro-system attitudes that were experienced directly by participants.	Feeling pregnancy is trivialized because it's the third. "Sometimes our babies get downplayed because it's like 'oh they're just having another' instead of people joining in and being joyful." (hindering)
Non-Medical Pain Management Non-pharmaceutical approaches to coping with pain including water, hypnosis, and spiritual practices.	Listening to spiritual music during labour. "We turned on [spiritual] music, that was super helpful… it is a positive message, and kind of takes you out of the moment and into the bigger picture like, 'God is in control, this is part of life, every woman in the world has been through this, every one of us came into the world like this." (helping)

DISCUSSION

The purpose of this research was to directly learn from women's lived experiences about what shaped their well-being during pregnancy, birth, and post-partum. The perspectives of the childbearing women in this study affirm that their medical experiences are not as salient to them as their personal experiences of being seen, heard, and treated with respect and dignity in relationship to their care providers. It is also noteworthy that they did not mention physical pain itself as a hindering factor but rather focused on their attitudes and expectations, relationships with supportive others, experiences of empowerment and disempowerment, and sense of purpose and meaning. Multiple ecological factors (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006) within the person, their relationships, the context, culture, and across time, influence a childbearing's women's experience.

EA provides a humanistic framework for conceptualizing the childbearing years as opportunities for being and becoming as persons. Indeed, pregnancy, birth, and motherhood are opportunities for women to deepen their four-fold affirmation of life, including *being in the world, turning towards life, being oneself,* and *finding meaning.* This person-centred approach to understanding maternal wellbeing highlights the person of the mother. This focus contrasts with the predominant bio-medical framework of maternity care and outcomes.

A woman's body expands and changes shape through the physical demands of pregnancy, birth, breastfeeding, The extraordinary potentials of a childbearing woman's body are more than just a metaphor of her existential experience; the embodied wonder of carrying, birthing, and nurturing new life speaks for itself. Moreover, it is in one's very body that a mother expresses herself and her agency, fully, visibly, and personally. A woman's embodied childbearing experience offers an existential opportunity for emergence and expansion in active, fulfilling participation with one's embodied and connected life-world (Kwee, 2019). It is in her body, not in spite of it, that a woman claims her rights and freedoms as a person in navigating the cultural and healthcare demands and expectations during her childbearing experience. Taking up one's full embodied presence in this experience can be a stance of resistance that rejects the

reductionistic medicalization of pregnant and birthing bodies as separate from the persons in these bodies. An embodiment stance provides an affirmation and participation in the physicality of being (FM 1). It offers an open stance of receptivity and participation in the flow of life (FM 2). It can be a decisive expression of one's own person and identity (FM 3). And, taking up one's embodied experience in childbearing is an opportunity to participate in the existential call of becoming and of contributing fruitfully to values beyond one's individual life (FM 4).

EXISTENTIAL ACCOMPANIMENT OF CHILDBEARING WOMEN

This enlargement of being during the childbearing experience comes in challenges and through joys, as mothers affirm the conditions to say *yes* to the opportunity to fully take up their lives with their own presence and participation. Existential accompaniment of childbearing women through counselling or psychotherapy offers an opportunity to support women in full participation in the life experiences of pregnancy, birth, and postpartum adjustment. Below, we offer examples of prompts that can be explored counselling or psychotherapeutic support appropriate for pregnancy, birth preparation, and postpartum accompaniment, focused on each of the themes of the four FMs. Due to the deeply embodied nature of being for childbearing women, we especially focus our discussion on embodiment insights in existential accompaniment.

Being in the World: FM 1

The existential pre-requisites for being able to affirm being in the first FM are space, protection, and support. These pre-requisites are met through inner and outer conditions. The personal activities of saying yes to being in the world are acceptance and endurance. Living with a sense of inner unsafety, fear, and anxiety is the result of not being able to affirm this FM. Unsurprisingly, fear predicts reduced overall well-being (Biehle & Mickelson, 2011). The results of the current study align with previous research that suggests that accurate information can reduce fear and increase a sense of inner power and preparedness. In the explicit domain of embodiment for FM 1, psychotherapeutic work aimed at strengthening a trusting relationship of a woman with her body is an important focus. The body is the physical structure of human existence, which gives one's first experience of space, support and protection as the physical existential ground in the world. We offer several prompts for exploration of this fundamental motivation of fulfilled existence in the childbearing experience:

- How is the situation related to pregnancy, birth, or caring for an infant, for me?
- Can I accept my body, as it is? Can I accept my baby as they are?
- What are the things that are difficult for me to accept about my body, my emotions, or my situation? Where do I feel tense or constricted?
- Do previous experiences in my body (such as sexual boundary violations, or traumatic birth experiences) inhibit me from developing a trusting relationship within my body? How can I cultivate a deeper sense of safety now, in my body, and in my situation?
- What feels "impossible" about my situation?

- Where do I experience the most space outwardly? How do I increase my sense of space, inwardly (for example breath work and meditation)?
- Where and from whom do I experience acceptance from the outside? Who gives me protection and support?
- What would I need to be able to accept or endure what is challenging to me right now?

Turning Towards Life: FM 2

The second FM, which affirms life, values, and emotionality is facilitated by the prerequisites of time, closeness, and relationship. The primary personal activity of saying yes to life is *turning towards,* which also includes turning towards grief. Through having time for oneself and one's emotions and time for experiencing closeness and relationships with others, a mother is able to turn towards her own life, and to notice, subjectively, how it is for her to be alive. The second highest volume of incidents coded in this study were in the categories of social connection and support. This exemplified the importance of a mother's relationship with her partner, family, caregivers, and community members, in providing tender comfort and care, which in turn allows mothers to turn towards their infants and to take the time to develop a close and vital relationship mother-child bond. This aligns with previous research that has found that the presence and involvement of a partner, including non-professional support, at birth has been seen to promote more positive interactions between a mother and baby following the birth (Kainz, Eliasson, von Post, 2010). Many women in this research cited helping, hindering, and wish list factors related to emotional attunement and support specifically from their partners. Similarly, other researchers have found that a mother's secure attachment with her partner has contributed to emotion regulation during the demanding threshold experience of period of becoming a parent (Behringer, Spangler, & Reiner, 2011). The embodiment perspective of FM 2 is that our bodies are lived bodies. They are not just a protective physical structure, but also filled with life and the experience of being alive, similar to Sartre's (1934) description of lived body or body-subject. Our bodies are relational bodies, emotional bodies, and sensual bodies. Existential accompaniment can facilitate a childbearing woman's experience of turning towards her life in and through her body. Below are some suggested prompts for this exploration:

- How is it for me to be in my body? Do I like to be in my body? Do I like my embodied existence?
- Do I feel alive and have a sense that life flows through me? Is it easy for me to feel tears? Is it easy for me to experience laughter? What emotions do my body carry? How does my body "speak" these emotions?
- Do I feel connected to life in my body, to what is good, to what is painful?
- How do I feel connected to my baby and my partner, and the relationships that I most value? Do I have time to turn towards these relationships? Where is there time in my life for turning towards? Do I have time for what I most value?
- Do I receive care and closeness from my loved ones?
- If I take the time for it, what does my sensual, emotional, vital, lived-body call my attention to turn towards?
- Do I experience my childbearing journey as good?

- What losses in my life are asking for me to turn towards? Have I lost something of value that I feel pain about? Am I taking the time to feel the pain of these losses and to reconnect to life (tears) flowing through me?

Being Oneself: FM 3

The third FM highlights that embodiment is not just another lived experience but rather a core experience of who I am as a person: *I am my body*. In one's body, a childbearing woman experiences uniqueness and singularity. This comes from being seen, attended to, appreciated, and given justice to one's own person from others on the outside. In turn, she learns to engage with appreciation from the inside. The personal activities of FM 3 are beholding and appreciating. Through this, a woman in the childbearing years has the opportunity to develop and take a position towards herself in her precious and singular uniqueness, to speak with her own voice and from her own position and identity. In maternal health care, women are often told what to do to keep themselves and their babies healthy. *Eat more, eat less, eat better, exercise more, exercise differently, avoid stress,* etc. Strengthening the possibility of affirming the third FM involves supporting a woman in stepping back to really see oneself, to listen to her own inner voice of wisdom, and to differentiate from the other with clear sense of boundaries. In navigating the childbearing journey, this may allow a woman to make themselves visible, to communicate their positions, and to advocate for themselves in their care from a basis of inwardly sensed self-worth. Just as her body expands and changes, a childbearing woman also discovers that her capacity and expression as a person is changing and growing. Mysteriously the childbearing mother also remains fully and essentially *herself*, in her radically evolving pregnant, birthing, and breastfeeding body. Below, we offer prompts for exploration of the body-self affirmations of FM 3:

- Do I experience still being myself, even as I become a mother and take on a new part of my identity as a mother? What helps me most to connect to being me in my new experience of my body and my new role as a mother?
- For myself, may I be my body, with all of its changes? Am I still me in this body?
- Do I sense that I am truly myself in *my* body?
- Am I allowed to be my body? May I ask for what my body needs from my care providers? Does my birthing plan or approach to breastfeeding reflect who I am in my body?
- I am aware of what is my own and how to communicate the boundaries of what belongs to me and to my embodied experience? How do I respond when these boundaries are stepped over?
- Where and with whom do I experience feeling seen, appreciated, and that I can be myself?
- Where do I feel my true self needs to hide, or not really show up in my body? When do I experience dissociation from my body? What do I need to be able to remain myself in my changing body and in my identity as a mother?

Finding Meaning: FM 4

Finally, to affirm the fourth FM is to answer the call to live meaningfully, to embrace a future-oriented journey of becoming, and to experience one's embeddedness in a broader context beyond one's individual life. Saying yes to meaning is connected to one's abilities, one's likes, and one's person. To know what to really say yes to requires attunement to what *should* be, and then decisive action in living it. In the life-world situation of a woman's childbearing journey, a woman has the opportunity to experience a sense of connectedness to the matriarchs of past, and a sense of meaning and value in giving her body to nurture a child of the future. The insights of FM 4 emphasize that our bodies facilitate possibilities. They are free, creative, and active. Participants in this study affirmed that it was important for them to reflect on the value of allowing their body changes to serve the good of nurturing new life. They expressed wonder at the softening, stretching, flowing possibilities of their body to be everything their infants needed. They affirmed a strong sense of being needed in their body, and that there was a clear *most valuable possibility* for their body during the childbearing period. Some women describe a surprising sense of discovery that they felt that they were born for becoming a mother and in the childbearing journey they felt clarity and fulfillment that they were doing exactly what they were meant to do. Others struggled to find meaning in the intense and immediate needs of their childbearing experience, especially when this experience competed with other contexts for fruitful development and activity. In the postpartum period, participants also described an emotional journey of finding meaning through integrating both positive and negative aspects of their pregnancy and birth experiences. Prompts for exploring the fourth FM may include the following:

- Do I have a strong sense of what my body is for? Or for whom it is good?
- Where is my body needed most? Can I say yes to where I am needed during childbirth, in skin-to-skin contact with my infant, in the middle-of-the-night feedings?
- What should I do with my body? What is it free for? Where is it creative?
- Do I experience pregnancy and motherhood as meaningful? What inhibits my sense of meaning in this experience?
- Is my life fruitful? Do I feel "stuck" by caring for my infant, or do I feel connected to the value of contributing to them?
- Do I struggle with not being able to answer some "outside calls" because of my irreplaceability as a mother? Where am I truly needed? How can I creatively say yes to the future possibilities?
- In what activities do I feel lost or unfulfilled? Am I going against my sense of what is calling me? What is the best context for me to be active and creative, as me, at this point in my life?
- Do you have a longing to be part of something that fits to you and your situation right now? Is it important to contribute and to be part of something that is not centred around motherhood? Do you attend to what is important and valuable to you?

CONCLUSION

EA provides a person-centred framework for exploring existential fulfillment among childbearing women. The present research supports findings of previous research that affirm the existential significance of experiences of pregnancy, birth, and motherhood. These experiences can shape women's lives in many, complex ways. Although we don't hold narrative memories of the decisive existential moment of our birth into this world, naked and crying, our starting *here* in this world, from where all *there's* are there, is our fleshy naked body-self. On an embodied level, we all know this, instinctively, and we know that we carry our persons within the ever-present, ever-constraining, and ever-facilitating possibilities of our flesh and bones. Childbearing women seem to experience a unique opportunity to sense the immediate relevance of their bodies as a space for presence and access to being, feeling, expressing themselves, and for contributing to the future. The framework of EA reminds us that women are always people in their bodies and in their pregnancy, birth, and postpartum experiences. A significant focus of the extant research on maternal health care is limited to bio-medical domains or to structured measures of mental distress. In this research, when asked openly what experiences helped or hindered their wellbeing, participants shared insights that fit the holistic and person-centred lens of EA.

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