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Experiences of Perinatal Care by Im/migrant Mexican Women in California's Central Valley

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Experiences of Perinatal Care by Im/migrant Mexican Women in California's Central Valley

by

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Abstract

Background: Im/migrant Mexican women represent a significant proportion of the obstetric patient population in California and have higher incidence of adverse obstetric outcomes such as maternal postpartum hemorrhage and perinatal depression than their White counterparts. Little is known, however, about im/migrant Mexican women's experiences of perinatal care, particularly communication within the patient-provider encounter.

Objectives: (1) Describe the values, expectations, and needs im/migrant Mexican women bring to their perinatal health care encounters in the United States; (2) describe im/migrant Mexican women's perceptions of patient-provider communication within perinatal care encounters; (3) describe im/migrant Mexican women's experiences of perinatal care in the United States; and (4) construct an understanding of the processes that govern the patient-provider encounter for im/migrant Mexican women through an inductive grounded theory approach.

Design: Secondary analysis of audio-recorded interview transcripts, field notes, original photographs, and analytic memos utilizing constant comparison consistent with grounded theory.

Results: Themes of pregnancy as a special time and social isolation characterize expectations and values of pregnant im/migrant women. However, communication within the patient-provider encounter is often deflected and obscured by complex past experiences and perceptions that occupy the space between the women and her provider. Negative experiences of perinatal care include deepening isolation and experiences of depressive symptoms. In contrast, positive experiences of perinatal care are associated with themes of receiving attention and shared worry.

Conclusions: Im/migrant Mexican women experience internal and external barriers to communication with their healthcare providers that impact their experience of perinatal care.

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Introduction

Statement of the Problem

An estimated 11.7 million people living in the United States (US) are Mexican by birth (American Community Surveys [ACS], 2014). The US Immigration and Nationality Act of 1952 defines these persons as immigrants. The term *im/migrant*, however, is used in this thesis in an effort to recognize the complex dynamics of both immigration and seasonal farm-work related migration. Currently, the majority of Mexican im/migrants in the United States come from the Southern states of Mexico, such as Michoacán, Jalisco, Guererro, and Oaxaca (Encuesta sobre Migración en la Frontera Norte [EMIF], 2014). Poverty and limited economic opportunity arising from complex issues related to natural resources, politics, trade agreements, racism, and organized crime are the primary forces driving immigration from this region (EMIF, 2014; Holmes, 2013; Gálvez, 2011). Some of the largest communities of these im/migrants reside in California's Central Valley seeking employment in the agricultural sector (ACS, 2014).

While motivations for crossing the border are complex, im/migrant Mexican women most commonly cite economic opportunity as a primary reason (Gálvez, 2011). Increased militarization of the border makes crossing more costly and dangerous. Many im/migrant women who might prefer to return to their country of birth to bear and raise children instead choose to stay in the United States with their partners and jobs (Gálvez, 2011; Hellman, 2009; Marcelli & Cornelius, 2001). In addition, many im/migrants face additional economic challenges upon entry to the United States. A recent study released by the United Way of California reports that 80% of Latino noncitizen im/migrants residing in California live below the Real Cost Measure (RCM), a

metric that adjusts the Federal poverty limit to account for the real cost of living in California (Block, Gascon, Manzo, & Parker, 2015). Marginalized by poverty and language and removed from traditional social supports, these women and families commonly utilize public health services for their perinatal care (Gálvez, 2011; Bernosky de Flores, 2010).

Within the common im/migrant regions of origin in Mexico, many women choose homebirth with traditional midwives over state-run birthing centers and hospitals, despite recent government efforts to extend formalized perinatal care services (Ibáñez-Cuevas, Heredia-Pi, Meneses-Navarro, Pelcastre-Villafuerte, & González-Block, 2015). Traditional midwifery care in the home setting is sought for its familiarity, affordability, availability, and integration of cultural health concepts into antenatal, intrapartum, and postpartum care practices (Ibáñez-Cuevas, et al., 2015). In the United States, public perinatal care is almost universally hospital-based (Medicaid, 2016). The medicalized and pathology-focused culture of the US health system likely presents a sharp contrast to the home-based midwifery care with which im/migrant Mexican women are familiar in their communities of origin (Davis-Floyd, 2004; Gálvez, 2011).

Little is known, however, about the experiences of im/migrant Mexican women upon encountering the US public health system for perinatal care, labor, and birth. Gathering the perspectives of im/migrant Mexican women on the perinatal care received may help health care providers to better understand and consequently better meet the needs of this vulnerable population.

Significance

Im/migrant Mexican women experience significantly worse obstetric outcomes when compared to White counterparts in the United States (Grobman et al., 2015). In the US, Hispanic [term utilized in the study] women, which includes im/migrant Mexican women, are more likely

to experience severe postpartum hemorrhage or peripartum infection compared to non-Hispanic White women, even when controlling for patient characteristics and hospital (Grobman et al., 2015). The root cause of these disparities is not well understood. However, it is well documented that im/migrant Mexican women experience increased health access barriers when compared to other Latinas with legal status or White counterparts (Valladares et al., 2009). While language and lack of insurance are often cited, im/migrant Latinas, including those of Mexican origin, are more likely to also list cultural barriers to accessing care (Valladares et al., 2009).

Recent evidence demonstrates that Mexican and Mexican-American women, including im/migrant Mexican women, also suffer disproportionately from mental health challenges such as depression in the perinatal period when compared to their non-Hispanic, White counterparts (Rios-Ellis et al., 2005; D'Anna-Hernandez, Aleman, & Flores, 2015). Factors related to the im/migrant experience may contribute to the individual's psychological burden (Frickberg-Middleton, 2015). For example, border crossing can be a psychologically traumatic experience for im/migrants (Frickberg-Middleton, 2015; Holmes, 2013). International human rights organizations and investigative journalists have estimated that the incidence of rape or sexual assault of im/migrant women during border crossing is anywhere between 60 to 80% (McIntyre & Bonello, 2014; Amnesty International, 2010).

The additional life stressors of economic insecurity, fear of deportation, and societal exclusion generate a significant psychological burden (Holmes, 2013; Frickberg-Middleton, 2015; McClure et al., 2015; D'Anna-Hernandez et al., 2015). This cumulative physiological and psychological strain of chronic stress, often referred to as the allostatic load, has been linked to the poorer physical and mental health among im/migrant Mexican women when compared with their White, non-Hispanic counterparts (McClure et al., 2015; D'Anna-Hernandez et al., 2015).

The impact of cumulative physiological and psychological strain (allostatic load) and life-course psychological trauma on perceptions of birth is the current focus of ongoing research (Frickberg-Middleton, 2015).

The disparities discussed above regarding obstetric and mental health outcomes for im/migrant Mexican women may point to deficits in our health delivery system. Recent evidence suggests that significant needs, such as screening and treatment for depression in pregnancy are not being met (D'Anna-Hernandez et al., 2015). Some authors posit that cultural norms, stigma around mental health disorders, and provider biases may contribute to provider-patient communication challenges that disrupt existing screening and treatment strategies (Holmes, 2013; Hsieh, Apostolopoulos, Hatzudis, & Sönmez, 2015).

This complex problem requires further study before solutions are proposed. In her book, *Decolonizing Methodologies,* Linda Tuhiwai Smith (2012) warns against making assumptions that only further perpetuate imperialist or colonialist systems of thought. This includes assumptions about the nature of the identified problem, including whether or not the identified problem is the chief complaint of the stakeholder community (Tuhiwai Smith, 2012). Instead of presuming to know, the researcher must first turn to the stakeholder community, im/migrant Mexican women, and ask, "What has been your experience of perinatal care in the United States?"

Thesis Aim and Objectives

The aim of this thesis is to describe experiences of perinatal care in the United States as perceived by im/migrant Mexican women. Eliciting the perspectives of im/migrant Mexican women who report positive and negative perinatal care experiences may facilitate a deeper understanding of what im/migrant Mexican women perceive as working well and of the deficits

in the care they receive. Following this aim, the objectives of this study are to (1) describe the values, expectations, and needs im/migrant Mexican women bring to their US perinatal care encounters; (2) describe im/migrant Mexican women's perceptions of patient-provider communication within perinatal care encounters; (3) describe im/migrant Mexican women's experiences of perinatal care in the United States; and (4) construct an understanding of the processes that govern the patient-provider encounter for im/migrant Mexican women through an inductive grounded theory approach. These objectives will guide in-depth inquiry of the perspectives of im/migrant Mexican women in order to inform areas of practice improvement and increase understanding of the views of im/migrant Mexican women by perinatal care providers who serve these communities.

Operational Definitions

In addition to urging researchers to be cognizant of their assumptions and motivations, Tuhiwai Smith (2012) discusses how the words used in scholarly writing to describe, define, and categorize research participants hold significant power; a power which often perpetuates imperialism, racism, and the continued oppression of indigenous and other vulnerable peoples. In an effort to mitigate these deleterious effects, care has been taken whenever possible in this thesis to use terms and phrases that originate from the participants themselves. When that is not possible, terminology is borrowed from im/migrant Mexican community leaders and activists. Operational definitions, as well as other technical terms utilized in this thesis, are defined below in thematic clusters:

- Im/migrant: As described briefly above, complex patterns of migration between regions of Mexico, California, and other parts of the United States pre-date the presence of nation-states and formalized borders (Williams, Frank, & Gould, 2013; Arzubiaga,

Noguerón, & Sullivan, 2009). Recent social and political movements within the Latino community have sought to reclaim this heritage in a political climate that is increasingly hostile to immigration (Williams et al., 2013).

- Mexican: The term *Mexican* here refers broadly to those individuals whose home communities reside within the internationally recognized borders of the country of Mexico. It is an external construct applied to categorize the study participants who themselves identify more closely with their individual communities and states of origin and to distinguish this study's participants from others who originate from different regions of Central and South America.
- Hispanic: Created in the 1970's by the US Census Bureau as an attempt to better capture data about communities originating from Latin and South America, the term *Hispanic* continues to be utilized nationally (Fischer, 2014; Mora, 2014). *Hispanic*, however, has come under criticism from individuals of Latin or South American descent who feel the term's reference to the Spanish-language over-emphasizes the Spanish colonialist history of Latin America, obscuring the African, Portuguese, French, and Indigenous identities of many individuals (Fischer, 2014; Mora, 2014).
- Latino(a/x): The terms *Latino*, *Latina*, and *Latinx* are increasingly present in the literature and popular media (Mora, 2014). Arising from within Latin American communities, it is the self-descriptive term of choice for many individuals who originate from Central or South America, regardless of language or ethnicity (Mora, 2014).
- Woman: The terms *woman* and *women* are used here to refer to this study's participants. While this term can encompass a broad spectrum of sexualities and gender identities, in

this study it is used to indicate the heterosexual, cisgendered persons who participated in study interviews.

- Perinatal care: *Perinatal care* is used to designate inpatient and outpatient encounters with health care personnel, including, but not limited to, nurses, midwives, and physicians, related to pregnancy and childbearing. This includes preconception, antepartum, intrapartum, and postpartum care.
- *Partera*: The term *partera* is the Spanish-language word for "midwife." In the Southern states of Mexico, *parteras* are most commonly traditional midwives who received their training through apprenticeship rather than formal education, practice in home settings, and are typically vibrant and central figures in their communities (Ibáñez-Cuevas et al., 2015).
- Psychological birth trauma: Psychological trauma carries a precise definition within the Diagnostic and Statistical Manual of Mental Disorder (DSM) V, and many authors have done additional work to define this phenomena within the context of birth (APA, 2013; Beck, 2004; Harris & Ayers, 2012; Simpson & Catling, 2016). However, while each the im/migrant Mexican women who participated in this research self-describe their birth or perinatal care as "traumatic," none of them were ever formally diagnosed with birth-related psychological trauma or received treatment for the sequelae (Frickberg-Middleton, 2015). Accordingly, in this thesis the term *psychological birth trauma* is used broadly to indicate perceived experiences of psychological and emotional trauma related to obstetric care. While some clinical fidelity may be lost, the looser application of this term reflects the participants' experiences, in keeping with the thesis aim and objectives.

Conceptual Framework

Im/migrant Mexican mothers suffer disproportionately from mental health burdens such as depression and experience worse obstetric outcomes such as postpartum hemorrhage and peripartum infections compared to their White, non-Hispanic counterparts (D'Anna-Hernandez, Aleman, & Flores, 2015; Grobman et al., 2015). These disparities may be related to health access barriers including language differences, lack of insurance, racism, and poverty (Valladares et al., 2009). Living within this context and navigating these barriers can be psychologically stressful and increase a woman's vulnerability to psychological birth trauma (Anderson & McCarley, 2013). Quality provider interactions have been found to have positive impact on traumatic birth perception (Simpson & Catling, 2016).

For the purpose of this thesis, I sought a conceptual framework for understanding how personal and environmental factors converge to influence communication within the patient-provider interaction. Upon review, however, a single framework that appropriately captured all of these the nuances was not found. Therefore, I build upon existing communication theory by incorporating the concepts of intersectionality and reproductive justice theories. This process is outlined below.

First, I examined existing theories of communication in patient-provider encounters. Communication, both verbal and non-verbal, forms the foundation of the patient-provider interaction, and positive or negative perceptions of patient-provider communication affect patient perceptions of perinatal care in studies of white American and European populations (Simpson & Catling, 2016).

Next I examined frameworks and theories that seek to account for the personal and environmental factors that influence patient-provider communication including self-efficacy,

intersectionality, and reproductive justice. Self-efficacy theory has emerged in recent years as a potential framework for understanding how variations within the individual's sense of confidence account for variation in labor and birth experience (Beck, 2004; Avery, Saftner, Larson, & Weinfurter, 2014; Schwartz et al., 2015; Beck, 2011; Carlsson, Ziegert, & Nissen, 2015). While aspects of the self-efficacy framework are useful, it fails to capture the important influence of unseen social forces that shape patient-provider interactions. As a result, I examined intersectionality and reproductive justice theories for their capacity to more fully describe the forces that influence patient-provider interactions.

Patient-Provider Interactions & Communication

Feldman-Stewart, Brundage, & Tishelman (2005) describe communication as a process of conveying and receiving messages. This is an iterative process informed and influenced by the participants' attitudes, beliefs, needs, values, skills, and emotions (Figure 1). Building upon prior conceptions of patient-provider communication, Feldman-Stewart et al. (2005) include space for participant goals, the attributes that each participant bring to the interaction, and the power of silence to convey messages. While this framework focuses on one-on-one patient-provider interactions, the influence of external factors influencing the patient and provider is noted within the figure (Feldman-Stewart et al., 2005).

Within this framework, all communication exists to serve the purpose of meeting goals (Feldman-Stewart et al., 2005). This includes active and passive conveyance of messages as well as verbal and non-verbal mechanisms of communication. Successful communication is that which achieves the goals of each participant. The authors note that conflicts often arise when patients and providers have different goals or the goals of either party are not clearly identified, perpetuating miscommunication (Feldman-Stewart et al., 2005).

Self-Efficacy

Albert Bandura (1977) describes self-efficacy as an internally mediated belief that one can affect a result in his or her life and environment. Self-efficacy is built by mastering challenges, further developing self-confidence. Bandura (1977) further explains that an individual's degree of self-efficacy has significant impact on life choices including conflict management or avoidance. A high sense of self-efficacy generates an internally-mediated self-confidence that promotes engagement with new tasks despite the risk of failure (Bandura, 1977). In contrast, low self-efficacy often results in reluctance to attempt new skills due to the risk of failure (Bandura, 1977). In this way, further mastery is difficult to achieve and low self-efficacy is self-perpetuating in a negative feedback loop (Bandura, 1977).

More recently, authors have built upon Bandura's work to apply this framework to childbearing, specifically related to the concepts of confidence and fear (Lowe, 2000; Roosevelt & Low, 2016). High maternal confidence and positive self-efficacy are associated with lower reported fear of childbirth, decreased anxiety and depression, and better birth outcomes (Carlsson et al., 2015). Low maternal confidence and low self-efficacy are associated with a higher likelihood of perceived psychological birth trauma (Carlsson et al., 2015). The concepts of maternal confidence and self-efficacy help to understand the complex relationship between fear of childbirth, maternal coping, and experiences of trauma during childbirth.

Intersectionality & Reproductive Justice

Surrounding each individual are systems and structures that have direct and indirect impacts on personal wellbeing. The rigid and static nature of these systems often fails to capture the nuance of a person's lived existence. In her writing, Kimberle Crenshaw (1991) put forward the framework of intersectionality to describe how individual lives occur within multiple,

overlapping planes. Living within the intersections of multiple identities often means living on the margins (Crenshaw, 1991). Crenshaw (1991) describes how being Black and being a woman disenfranchised her from both the Black and feminist movements as in neither place was the fullness of her being adequately expressed. In this way, those that find themselves living in the intersections of different groups often feel, and in many ways are, invisible (Crenshaw, 1991).

Within the context of women's health, the framework of reproductive justice builds upon intersectionality. According to Loretta Ross (2006), reproductive justice affirms that, in contrast to self-efficacy theory, a woman's ability to make decisions regarding her reproductive health is not the product of her own internal capabilities but rather directly linked to conditions in her community that extend beyond individual choice and access. Ross (2006) argues that structures like institutionalized racism and poverty may play a much larger role in the health decisions women make than previously appreciated.

In addition, Crenshaw & Ross (1991, 2006) add that for those who occupy intersections, there is no mechanism for leaving those identities and the experiences related to them behind; instead they accompany the person wherever she or he goes, including into the patient-provider care encounter (Crenshaw, 1991; Ross, 2006). Undoubtedly, to be an im/migrant Mexican woman means living at the intersection of a myriad of identities. This marginal place in society significantly limits avenues for expression of voice and agency.

Comparison & Discussion

The framework of patient-provider communication developed by Feldman-Stewart et al. (2005) provides a useful starting place to understand the forces at work within the healthcare encounter for im/migrant Mexican pregnant women. In addition, self-efficacy theory – and its relationship to psychological birth trauma – contributes a helpful perspective on successful

communication. Self-efficacy emphasizes the impact of life-course on the present-moment experience. It is important to consider what each woman brings to the experience of her pregnancy and birth in order to better understand her own individual context.

Researchers must be careful, however, to not reduce a complex process to an individual level, ignoring the larger structures and systems that impact self-efficacy. By over-emphasizing the role of the individual, all the responsibility for coping – positive or negative – is placed on the woman herself. In reality, however, external structures such as cultural privilege maximize opportunities for positive coping and high self-efficacy for some, while for others immigration pressures, racism, and poverty systematically eliminate or reduce agency, eroding self-confidence. In addition, caution should be taken to not over-emphasize the pathology of low-self efficacy and negative coping while masking resiliency and other assets.

The frameworks of intersectionality and reproductive justice shift the focus from the individual to broader social conditions. Understanding im/migrant Mexican mother's experiences of perinatal care cannot be accomplished without acknowledging the power dynamics inherent in structures such as race, class, gender, immigration status, and clinical hierarchy. In addition, these frameworks provide richer opportunities to more fully explore the impact of the health provider and the health system on the woman's care experience.

Therefore, the conceptual framework for this study combines attributes of Feldman-Stewart et al.'s (2005) communication theory while placing the entire interaction within the context of intersectionality and reproductive justice (Figure 2). Feldman-Stewart et al. (2005) describe external influences, but leave them outside the circle of messages conveyed and received between patient and provider. This seems to imply the patient-provider encounter as a pristine space, unaffected by external realities. While this is perhaps the ideal patient-provider

encounter, intersectionality theory would point us away from such an over-simplification. Instead, the client's intersecting identities and experiences accompany her into the patient-provider encounter.

In this new framework, I propose that successful communication is that which achieves the goals of the participants, per Feldman-Stewart et al.'s (2005) original definition. Motivated by the theories of intersectionality and reproductive justice, I expand the original work to include how each participant brings perspectives and past experiences into the encounter that are informed by their own intersecting identities (Figure 2). I now have a construct where successful communication is contingent upon the ability of the participants to individually and together transect the perspectives and past experiences they each bring to the encounter. Here individual goals are identified, messages are accurately conveyed and received, goals are met, communication is successful, and care is effective.

Review of Literature

A systematic search of the literature was conducted of the PubMed and CINAHL databases in an effort to contextualize the work of this thesis. Search terms included "perinatal," "pregnancy," "antepartum," "prenatal," "birth," "intrapartum," "postpartum," "reproductive health," "healthcare," "experiences," "perceptions," "immigrant," "migrant," "indigenous," "Mexican," "Latina," and "Hispanic" in various combinations. Despite rigorous searching, only two publications were found to specifically address the topic of im/migrant Mexican women's experiences with perinatal care (Frickberg-Middleton, 2015; Deeb-Sossa, Olavarrieta, Juarez-Ramirez, Garcia, and Villalobos, 2013).

In addition, the reference lists of Frickberg-Middleton's (2015) dissertation and other related published sources were reviewed in an effort to identify related studies. Through these extended measures, an additional publication was found that described im/migrant Mexican women's experiences of care for their chronic health conditions (Chandler, Malone, Thompson, and Rehm, 2012). These three publications are discussed in detail here to provide the context and background for this research.

Im/migrant Mexican Women's Experiences of Perinatal & Reproductive Health Care

Frickberg-Middleton (Appendix A.1). The most immediately relevant work on this subject is the doctoral dissertation study conducted by Ellen Frickberg-Middleton (2015). Utilizing grounded theory, Frickberg-Middleton conducted a series of three, hour-long semi-structured interviews per participant with seven Mexican im/migrant women residing in California's Central Valley who self-described as having experienced perinatal trauma. Interviews were facilitated by a certified translator and occurred at the time and location of the participant's choosing (Frickberg-Middleton, 2015). Interviews most often took place in the

participant's home in the presence of other family members, although other settings including the library or the interviewers' car were also utilized when the participant desired additional privacy (Frickberg-Middleton, 2015).

Frickberg-Middleton's (2015) work explores the complex relationship between life-course trauma and adversity on the individual's perception of the birth experience. Frickberg-Middleton (2015) found that the discussion of perinatal trauma opened a door to a much larger conversation about life trauma generating broad themes of a "fragile existence" and "self-mandated silence" (p. 70, 77). Additional themes were specific to perinatal care experiences: lack of control, care versus caring, provider mistrust, and high-tech/low-touch care (Frickberg-Middleton, 2015). Frickberg-Middleton (2015) also found that the fragility of their lived existence makes im/migrant Mexican women particularly vulnerable to negative or psychologically traumatic birth experiences.

Frickberg-Middleton's research represents the first study of im/migrant Mexican women's experiences of perinatal care and the relationship of their perceived care experiences to their life-course trauma. Her findings therefore represent a significant contribution to our knowledge of the experiences of Mexican im/migrant women who access perinatal care services. However, there are some key limitations. As Frickberg-Middleton herself notes, this work was conducted in a cross-cultural, cross-language manner. Validity was promoted by utilizing a certified interpreter and key informant to provide a cultural "cross-check," but it is possible that important nuances and cultural contexts were missed. Other key limitations are the method and characteristics of the sample. While consistent with the researcher's original intention of evaluating the impact of life-course adversity on perceptions of birth trauma, selecting only for

women who experienced traumatic births yields a narrow scope and perhaps overly pathological results.

As a secondary analysis of the Frickberg-Middleton primary interviews, this thesis seeks to build upon the findings of Frickberg-Middleton (2015) and deepen our understanding of the care encounters themselves. Frickberg-Middleton (2015) takes a broad view of the perinatal care experiences and their relationship with the participant's life course experiences. This purpose of the present study was to look more narrowly and deeply at the patient-provider encounters to better understand im/migrant Mexican women's experiences of perinatal care.

Deeb-Sossa et al. (Appendix A.2). The second relevant study identified in the literature search examined healthcare experiences and utilization by im/migrant Mexican women in California (Deeb-Sossa et al., 2013). Researchers conducted a series of interviews with both eight im/migrant Mexican women who used health services in Yolo County as well as seven community providers both in the same region as well as in the common originating state of Oaxaca. While the focus of this study was on opinions and utilization of family planning and sexual health services, the specificity of the population increases its relevance to this research. Accordingly, the findings provide valuable insight into the experiences of im/migrant Mexican women upon accessing care.

Deeb-Sossa et al. (2013) identified several barriers to sexual and reproductive health care: undocumented status, language, and partner reproductive coercion. Undocumented status was the most significant barrier to care (Deeb-Sossa et al., 2013). Fear of deportation prevented participants from seeking information about support services and resulted in an increased sense of vulnerability that impacted willingness to be seen out of the house or wait for an extended period of time in the clinic waiting room (Deeb-Sossa et al., 2013). This is consistent with the

findings of Frickberg-Middleton (2015) who reported many participants who eschewed public meeting locations for the perceived safety and privacy of their own homes.

The findings by Deeb-Sossa et al. (2013) diverge and concur with those of Frickberg-Middleton (2015) in additional ways. Deeb-Sossa et al. (2013) cite language as a key barrier to receiving care; Frickberg-Middleton (2015) found that this was not a common barrier identified by the women participating in her study. In the sample interviewed by Frickberg-Middleton (2015), participants felt that there was always either a Spanish-speaking provider or that their partner was able to translate. This may be related to the differences in resources between inpatient and outpatient services or variations between different regions of California or different health systems. In addition, Deeb-Sossa et al. (2013) found that gender dynamics within the im/migrant Mexican couple and interpersonal violence negatively impacted reproductive health care seeking behaviors. Similar to Frickberg-Middleton (2015), many participants reported past or present experiences of intimate partner violence or reproductive coercion.

By including im/migrant Mexican women, key informants from the community, and women in Oaxaca, hoping to immigrate to the US, Deeb-Sossa et al. (2013) aimed to provide a wide variety of perspectives in their research. Each group of persons, however, was interviewed with different thematic guides, however, and so it is difficult to fully synthesize and integrate the data from the different groups of participants. In addition, details of care experiences were not solicited as much as general feelings, broad impressions, and perspectives on barriers to accessing care (Deeb-Sossa et al., 2013). Finally, the authors primarily focused on access to sexual and reproductive health services (Deeb-Sossa et al., 2013). Deeper understanding of how the patient-provider encounter impacts perceptions of perinatal care for im/migrant Mexican mothers is needed.

Im/migrant Mexican Women's Experiences of Health Care

Chandler et al. (Appendix A.3). As literature specific to im/migrant Mexican women's perceptions of perinatal care was lacking, search terms were expanded to include im/migrant Mexican women's perceptions and experiences of health care broadly. Chandler et al., (2012) investigated the experiences of undocumented im/migrant Mexican women with chronic illnesses as they sought care from a safety net clinic in California's Central coast. The women interviewed by Chandler et al. (2012) were commonly employed through agricultural work. The objective of Chandler et al. (2012) was to explore the health-care seeking experiences of twenty-six undocumented im/migrant Mexican women. Thematic analyses utilizing an interpretive phenomenological approach revealed a paradigm theme of recognition (Chandler et al., 2012). In particular, Chandler et al. (2012) find that im/migrant Mexican women report feeling repeatedly ignored by healthcare providers. According to Chandler et al. (2012), this feeling of being overlooked generates emotional and psychological pain and contributes to a perception of lacking essential human value. Many participants ascribed their perceived unimportance as directly related to their undocumented status and a sense of being invisible (Chandler et al., 2012).

Chandler et al. (2012) also describe a breakdown in communication between provider and patient. In this study, as in Frickberg-Middleton's, the barriers to communication lay not with the language specifically, but in cultural differences (Chandler et al., 2012, p. E33). Variations in facial expressions and physical cues used to communicate something like pain contributed to missed diagnoses and inappropriate care (Chandler et al., 2012). These experiences of being ignored, unheard, or misunderstood generate distrust in individual providers and the healthcare system broadly (Chandler et al., 2012).

Participants had mixed feelings about the health system. Some had positive experiences. Positive health care experiences were characterized by moments of mutual recognition, feeling seen, or having a complaint be heard and addressed. This broadens Frickberg-Middleton's (2015) supposition of trust as a mediating factor for trauma in labor and birth. In the cases reported by Chandler et al. (2012), the women who reported positive experiences had no prior relationship with the providers involved. However, these single instances of being shown concern, having a complaint legitimized, or being defended against perceived discrimination or contempt from others ameliorated the impact of other negative experiences.

The findings of the Chandler study are relevant to the present analysis because the samples were drawn from a similar population, im/migrant Mexican women residing in California, and examined perceptions of healthcare encounters, abeit chronic illness related rather than pregnancy and birth related. The limitations of Chandler et al.'s (2012) study are similar to those of the other two studies reviewed. Similar to the research of Frickberg-Middleton (2015) and unlike that of Deeb-Sossa et al. (2013), data collection was cross-cultural and cross-lingual, exposing the research to potential errors in translation and missed cultural cues, although this was moderated by the use of a bilingual-bicultural translator. Despite these limitations, the study findings help to shed light onto the lived experience of im/migrant Mexican women.

In contrast to Frickberg-Middleton (2015), Chandler et al. (2012) focused on descriptions of the individual patient-provider care encounter and included descriptions of positive experiences in contrast to those that are negative. In this way, the objectives of Chandler et al. (2012) are relevant to those of this study. However the needs and expectations of individuals with chronic health concerns may be very different than those pursuing care for pregnancy and birth and these differences are likely to impact perceptions of the patient-provider encounter.

Summary of the Review of the Literature

The most striking conclusion one can draw from this review of the literature is how few data are available regarding im/migrant Mexican women's experiences of perinatal care in the Untied States. With only three qualitative studies, two on perinatal care and one on chronic care health encounters, it is difficult to draw conclusions regarding im/migrant Mexican women's experience of perinatal care in the United States. However, several common themes were identified. Namely, im/migrant Mexican women experience challenges in accessing perinatal or other health care. While not all im/migrant Mexican women name language as a barrier to communication or healthcare access, differences in cultural understanding are widely experienced. Additionally, the research demonstrates that the many of the experiences im/migrant Mexican women have within the US health system – like fear of deportation – may not be communicated to or perceived by the healthcare provider, yet impact their perceptions of the patient-provider interaction nonetheless.

The two immediately relevant studies (Frickberg-Middleton, 2015; Deeb-Sossa et al., 2013) take broad views of perinatal and reproductive health care experiences as situated within the broader context of participants' lives. In contrast, Chandler et al. (2012) looked more closely at patient-provider interactions, yet the participants in that study were pursuing care for chronic diseases. It is likely that the needs, expectations, and experiences of childbearing im/migrant Mexican women are different than those pursuing care for chronic disease. Further investigation is needed to better understand im/migrant Mexican women's experiences of perinatal care, particularly the dynamics surrounding the patient-provider encounter.

Methods

Study Design & Setting

This thesis utilized qualitative design and methods. The selection of qualitative methods was driven by the thesis aim and objectives, the extremely limited preliminary studies, and the constraints of secondary analysis. The data for this thesis was collected as a part of Frickberg-Middleton's doctoral research, which used qualitative methods and a grounded theory approach with a small sample (Frickberg-Middleton, 2015).

This constraint, however, does not conflict but rather enhances the aim and objectives of this thesis. Qualitative research is founded upon a holistic and inductive approach to gathering individuals' perceptions and perspectives through in-depth, detailed descriptions (Grove, Burns, & Gray, 2013). Qualitative researchers utilize methods such as interviews, case studies, or focus groups to gather data in the hopes of fully describing the *why* and *how* of a particular phenomenon (Grove et al., 2013). Within nursing research, this is a particularly useful approach for research aimed at increasing understanding about problems, patient needs, or specific phenomena (Grove et al., 2013). As little is known about the perspectives and needs of im/migrant Mexican women who receive pregnancy, birth, and postpartum care while living in the United States, qualitative methods support the aim and objectives of this thesis.

Common qualitative approaches include, but are not limited to, phenomenology, ethnography, and grounded theory (Grove et al., 2013). Each approach arises from a philosophical base that informs the methodology (Grove et al., 2013). Phenomenological research arises from a phenomenological philosophy, which sees the person as inseparable from their environment and prioritizes deep and detailed understanding of the individual lived experience over broad generalizability (Grove et al., 2013). Ethnographic research is based on

the philosophies of naturalism and ethics and seeks to describe cultures from the perspectives of insiders (Grove et al., 2013). Finally, grounded theory research is founded upon the philosophy of symbolic interaction, which posits that an individual's reality is shaped by perceptions of interactions with others and expressed symbolically through media such as language and attire (Blumer, 1986; Grove et al., 2013; Polit & Beck, 2010).

To achieve the aim and objectives of this thesis, grounded theory was selected from the various qualitative methods. While similar to phenomenological research in many ways, grounded theory differs in that the emphasis on theory development motivates a greater level of abstraction beyond the lived experience of the participant with a view to describe interactions between the participant and other individuals (Grove et al., 2013). The primary aim of this thesis was to describe experiences of perinatal care in the United States as perceived by im/migrant Mexican women within patient-provider encounters and how they may shape perceptions of care.

In practice, grounded theory research is an iterative process in which data collection and analysis occur in tandem (Charmaz, 2012). Constructionist grounded theory recognizes that the interactions between the participant and the researcher result in a co-creation of the data, and that rigor is maintained through constant comparison and further theoretical sampling, allowing themes and theory to emerge from the data while maintaining fidelity to the foundational philosophical concepts (Corbin & Strauss, 2008; Charmaz, 2012).

As this is a secondary analysis of the qualitative interview data collected by Frickberg-Middleton during her doctoral research, the interaction between the researcher and the participant shifts to become an interaction between the researcher and the previously collected data sources. The iterative process of concurrent data collection and analysis in grounded theory

promotes rigor by keeping the researcher actively engaged with the data (Charmaz, 2012). In this secondary analysis, moving through the interview transcripts chronologically mimics the process of concurrent data collection and maintains the integrity of the grounded theory process (Andrews, Higgins, Waring Andrews, & Lalor, 2012).

Sample

Recruitment occurred at a local clinic where the principal investigator of the primary study worked as a nurse practitioner. Inclusion criteria included self-identification of having experienced perinatal trauma, age greater than 18 years, currently healthy, Mexican origin, less than 5 years residency in the United States, ability to speak either English or Spanish, and 6 months or greater postpartum. Exclusion criteria included current receipt of psychological counseling or care, age less than 18 years, country of origin other than Mexico, inability to speak English or Spanish, residency in the United States greater than 5 years, or declination to participate.

Human subjects approval was obtained from the Committee on Human Research (CHR) of the University of California, San Francisco (UCSF). In order to maintain immigration protections, informed consent was conducted verbally upon enrollment to the study and at the beginning of each interview. Participants were informed that they could withdraw from the study at any time. While no one formally elected to withdraw, migratory work patterns and a mandated delay between enrollment and interview resulted in five participants being lost to follow up. In addition, due to the sensitive nature of the experiences discussed, an emotional distress protocol was established that allowed participants to end the interview at any time or take breaks as needed. During the course of interviews, several periods of emotional distress emerged, however none of the participants elected to take a break or end the interview early.

Data Collection

Data for this secondary analysis were provided in the form of English-language transcripts from the audio-recorded interviews, field notes of Dr. Frickberg-Middleton and her certified translator, photographs taken by Dr. Frickberg-Middleton of the participants' homes and environs, and memos of Dr. Frickberg-Middleton's analytic work. The original Spanish-language audio recordings were not used in this analysis.

Data Analysis

The methods of grounded theory are structured yet flexible (Grove et al., 2013; Charmaz, 2012). Analysis is usually accomplished by first deconstructing interview transcript data through line-by-line coding, then reconstructing the data through axial coding to identify emerging themes (Charmaz, 2012). This is an iterative process of constant-comparison that promotes rigor by maintaining the active engagement of the researcher (Charmaz, 2012). As themes emerge, their relationship is described, developing codes and categories, which are then validated with participants through constant-comparison and theoretical sampling (Corbin & Strauss, 2008; Charmaz, 2012).

For this thesis, an effort was made to maintain a sense of chronology and concurrent data collection and analysis that would be similar to the process of collecting and analyzing primary interview data. Each participant's interview transcripts were read and line-by-line coded before engaging with the next participant's interview transcripts. Field notes of Dr. Middleton-Frickberg and her certified translator, photographs taken by Dr. Frickberg-Middleton of the participants' homes and environs, and Dr. Frickberg-Middleton's analytic memos were also reviewed in the course of line-by-line coding to provide additional context. I conducted additional memo-writing and journaling to observe my own reactions and interactions with the

participants as they were represented in the data. When all interview transcripts had been read and deconstructed through line-by-line coding, I proceeded to axial coding. Further memo-writing at this stage helped to identify emerging themes.

As the data had already been collected, theoretical sampling and member-checking was not conventionally possible. However, by analyzing each participant's interview transcript one at a time, and using the new insights to reflect on that already reviewed, emerging themes were confirmed within the analytic process and saturation achieved. After initial codes had been created, anthropological materials were reviewed for deeper understanding of the cultural and health belief structures of the Sothern regions of Mexico. Finally, ongoing conversations with the original investigator added additional depth to the text of the English-language transcripts.

As core categories were solidified, the emergent framework was re-applied to the data to evaluate for self-consistency. In addition, special care was paid to keep emerging themes grounded in the participants' own words. At every new level of abstraction, returning to the data and grounding themes within direct participant quotes helped to ensure against an erasure of the important voices of the women themselves.

In qualitative research, rigor and trustworthiness are characterized by the openness of the researcher, adherence to the philosophical tenets of the selected research method, congruence between the method selected and the processes employed, and minimization of researcher bias through self-understanding (Grove et al., 2013). In this thesis, rigor was enhanced by application of constant-comparison through simulated chronology, open coding, and an iterative process that remained grounded in the data at every new level of abstraction.

Results

Sample Characteristics

The sample consisted of eight women residing in and around Fresno, California. Ages ranged from nineteen to forty-seven years. Six were married to their current partner, one was partnered, and one was single. Of the seven who were partnered, five had their partner living with them at home, while two were separated from their partners who were residing in Mexico at the time of the interview either by deportation or choice.

All participants had children. The number of children ranged from one to five, and the ages of the children ranged from one year to twenty-one years. Four of the women worked outside the home at the time of the interviews, while the other four worked within the home only. All the women who participated had worked outside of the home at some point since im/migrating to the US. Agriculture was the most common type of employment with seven out of eight participants listing current or past employment in fieldwork or packinghouses.

The Mexican states represented by the sample included Guadalajara, Michoacán, Oaxaca, and Guerrero. All eight participants spoke Spanish. In addition, two participants identified with an indigenous group and also reported speaking Nahuatl and Mixteco Alta, respectively. Length of time in the US ranged from four to seventeen years. Most participants noted having moved back and forth across the border several times within that time.

Overview of Themes

The results of the data analysis reveal six main themes. The first theme was shared values of ***pregnancy as a special time***. This is connected to the second theme, wherein expectations of celebration and support surrounding pregnancy and birth only serve to highlight an experience of deep ***social isolation***. Next, shifting to the experience of patient-provider communication within

the perinatal care encounter, the third theme is that of ***keeping it all in***, maintaining silence that is generated and perpetuated by perceived otherness, stoicism, distrust of the healthcare provider, and fear of deportation. Fourth, the theme of ***distorted and deflected c*ommunication** often characterized the patient-provider interactions. The fifth theme emerged from descriptions of **negative experiences of perinatal care,** revealing *unmet needs* and *deepening isolation*. Finally, **positive experiences of perinatal care** highlight the themes of *receiving attention and shared worry*. These themes and their related sub-themes are discussed in further detail here with verbatim exemplar quotes presented under pseudonyms.

Theme 1 - "Food in my bed:" Pregnancy as a special time.

Participants describe pregnancy and birth as a special time. They discussed how pregnant women in their home communities in Mexico are exempted from harder or more physical tasks, expected to eat well, to rest, and to participate in self-care activities. Many participants described modifying their own work or household duties upon learning of their pregnancies. Diana (pseudonym used) describes her feelings about becoming pregnant:

> …In my town, my mom – when a baby is born – my grandma [a community *partera* (midwife)] takes good care of them, and she doesn't let them get up, and they bring food to the bed. They wash your hands with warm water. They change you, comb your hair, everything.

Study participants reported feeling happy, excited, and/or proud of their pregnancies. They often linked their joy of pregnancy to the positive expectation of motherhood. Their pregnancies represented real and tangible children whose care was already their responsibility. As Diana described, "I love her [the baby], and I want her to be healthy and very strong."

In Mexico, the special time marked by pregnancy extends through labor and birth to the postpartum period as well. Women who have recently given birth are treated with special attention and care. Many described with fondness the practices in their home communities in Mexico where, as the participant above described, other women in the family provide unique, attentive care. Food is brought to the postpartum mother, her hands are washed with warm water, and her hair is combed. These tender, intimate tasks evoke an image of a pregnant and postpartum woman who is treasured, nurtured, and protected.

Theme 2 - "Nobody but myself:" Social isolation.

Im/migrant Mexican women describe themselves as isolated, cut off from the immediate and extended family and community networks that provide critical support during the time of pregnancy and immediately after birth. After describing the special care and attention she would have received from her mother and grandmother in Mexico, Diana continues, "But here, who is going to help me? Nobody but myself." Often the joy of pregnancy only underscores the distance from family, particularly mothers and grandmothers. Study participants universally described the emotional difficulties of living so far from their mothers. Several mentioned considering crossing back into Mexico to be with their mothers for their pregnancies and births, but found themselves hindered by the challenges of re-entering the US and the threat of then facing separation from their partner and other children.

Study participants described a degree of isolation that extended beyond distance from family, but included isolation from friends and social networks that often led to overwhelming feelings of loneliness. Some women acknowledged having a partner who provides emotional and psychological support, but experiences of intimate partner violence were also commonly shared. A few participants described creating a "new family" within a faith community. Despite new

community connections or a supportive partner, every study participant described themselves as feeling alone – physically, emotionally, or both – at some point during their pregnancy, labor, or birth experience.

Im/migrant Mexican women come to the perinatal care encounter with a deep personal and cultural value of pregnancy and a desire for healthy children. Their experiences of perinatal care in their home communities create an expectation of attentive, nurturing care. However, their experiences in the United States are that of social isolation. This sense of isolation both generates and perpetuates emotional needs for support.

Theme 3 – "Keeping it in:" Needs not communicated.

Study participants commonly described the dynamic of "keeping it in," choosing not to share emotional or psychological pain or even physical needs with those around them or their health provider. As another participant, Alma described: "I just leave everything I have with me…I keep it inside." Further analysis of this phenomenon revealed how this self-imposed silence arises and is maintained by numerous forces both internal and external: perceived other-ness, stoicism and self-sufficiency, distrust, and fear of authorities and deportation.

Perceived Other-ness. Participants described an acute awareness that this new place was not their homeland. One participant, Ana, explains this feeling:

> Everything is so different, and you come and you don't know anybody, and then you are "Oh my gosh, where am I at?!" And then you start thinking, and then because I came I have to get used to it and start my life here, and then I didn't want to do battle again…I felt like a stranger.

Disorientation, feelings of being lost, and of not belonging appeared to create a sense of perceived other-ness among some of the participants. Im/migrant Mexican women who

participated in this study describe feeling as though they do not belong. They are resigned to accommodating and adjusting themselves and their expectations to their new environment rather than feeling empowered to ask for what they might need.

Stoicism and self-sufficiency. The im/migrant Mexican women who participated in this study described a culture-bound stoicism that creates another barrier to communicating needs, particularly emotional ones. Alma describes this phenomenon: "We the Latinos we have the issue – we don't ask you how you are doing or how you are feeling. If you are having problems, that is your life, that is your business. Deal with it." Alma highlights that for Latina women, the outward appearance of silence and stoicism masks an internal environment that may be quite different. This process is both individually and culturally maintained as a sort of unspoken understanding: problems are not to be shared but handled independently. In addition, asking about potential problems risks breaking this cultural code.

Not all participants view this cultural value as problematic. Some describe this same phenomenon with pride, not as a problem, but as a mark of self-sufficiency. As Ana explained:

> I think it's how your parents educate you, and your mother how she was. I'm talking about the ones from Mexico because the ones who live here don't want to do anything, and they complain about everything…here the education is very different. It's like in the case with me: I can move the sofa. I can do everything. I can do it myself. I don't need my husband…I feel like I don't need help from anybody, and I learned it from my mom, because she was that way. She had to be that way.

For Ana, her ability to handle problems on her own is a mark of her capacity, tied to the model she inherited from her mother. Her independence and self-reliance are intrinsically tied to her identity.

Distrust of Health System/Provider. Another theme that contributes to the silence of im/migrant Mexican women is a sense of distrust in the provider or health system. For some, this stems from past experiences, as Ana describes: "In the hospital they don't do anything, but finally we went to the hospital, and they didn't do anything…they told me to go see my regular doctor, told me to get plenty of rest and gave me the paper work." For others, distrust is generated in the clash between cultural values of stoicism and privacy and the nature of Western healthcare, as Alma explains:

> [Latinas] think when you [the healthcare provider] are trying to help us, we take it the wrong way – like they are interested in us, why do they want to help us? For example, I didn't know [my provider] very well, and then she came and tell me about all the help she can do and look. I said, why does she care about me? It was weird. But because I know her well now, I accept that.

In addition, participants described how knowing or not knowing their provider influenced their sense of trust in the provider. Having sense of trust positively influenced willingness to share personal information and to receive any help that was offered. This relationship between trust, distrust, and patient communication of needs is illustrated by this Alma's comment:

> I tell you and I have told you problems that I have had, but if it was another person, I probably wouldn't tell because I don't think they really care about me…meaning you give the trust.

Past personal experiences and cultural perceptions influence an im/migrant Mexican woman's level of trust in her provider. This level of trust or distrust joins the other themes discussed here to filter what needs the woman will share with her provider. When distrust is present, the silence deepens.

Fear of authorities/deportation. For im/migrant Mexican women, the final theme identified that contributes to "keeping it in" is the fear of deportation. While the primary researcher did not explicitly inquire about immigration status, many participants shared about their experiences crossing the US-Mexico border illegally. Experiences with their own deportation or the deportation of a loved one contributed to a desire to stay "under the radar." This fear of causing a disturbance and the potential consequences often manifested itself when participants were invited to comment on negative aspects of their care experiences or health care providers. Diana's response illustrates this: "No, I won't criticize them…because I don't want to have problems here, because I am not from here so maybe they can tell me to go away."

When reflecting on patient-provider communication within the perinatal period, im/migrant Mexican women describe the experience of "keeping it all in." The subthemes of perceived otherness, stoicism and self-sufficiency, distrust of the healthcare provider and/or healthcare system, and a fear of authorities and deportation represent internal and external processes that both generate and maintain this silence. These experiences and perceptions are present in the perinatal encounter and seem to occupy the space between the woman and her provider. When layered together, they can create an almost impermeable barrier, maintaining a shroud of silence around the im/migrant Mexican woman.

Theme 4 - "They told me:" distorted and deflected communication.

Despite the barriers to the im/migrant Mexican woman's communication with her provider, the women who participated in this study were able to recall encounters when they shared a need or concern with their providers. Motivated by their value for a healthy pregnancy and birth, these women overcame their circle of silence to communicate with their provider.

Despite these efforts, the end result demonstrates these efforts distorted and at times even deflected away by additional layers that occupy the space between the woman and her provider.

One participant, Bianca, experienced a neonatal death with her first pregnancy in Mexico. She had an urgent cesarean birth for gastroschisis, a complex congenital anomaly, and her son died within a few days of life at a different hospital. Because of her own recovery, she had been unable to visit her son before he died. This experience impacts her current pregnancy in the United States. Bianca describes an encounter with the US health care system:

> When I got pregnant, I was really very scared that this [neonatal death] would happen again to me, and when I went to the hospital and they asked me if I wanted to have a normal delivery, because in Mexico I had a c-section. And then they told me because I had the cesarean that it would be a 70% probability that she [the baby] could die. And I got like – you know – I started crying, and they said, "Okay, we will go with a cesarean." And that's how I had the c-section.

This woman approached her encounter with a deep terror of losing her child again. While we cannot know what exactly the provider said in the process of counseling her for labor after cesarean (LAC) versus a repeat cesarean delivery, it is clear that her perception of the encounter is weighted with misinformation and miscommunication. Her underlying fear is not addressed and is only exacerbated by the information the provider offers when counseling around the risks of LAC. Once again, this fear – communicated in her tears and emotional distress – is not apparently addressed. Instead, the decision for a repeat cesarean delivery is made for her, leaving the greater questions – spoken and unspoken – unanswered. Instead of a closed loop of communication, this woman's need for reassurance, expressed in her physical expression of emotional distress, is not met. Instead, it is lost in the space between herself and the provider,

deflected and distorted by the layers of experience and identity that filter her attempts at communication.

Another participant, Diana, recounted a similar experience. Diana had escaped a physically abusive home and emotionally abusive partner and had been navigating her pregnancy alone. In her home community, her grandmother was a traditional midwife. The participant recalled fondly watching how her grandmother soothed aches, pains, and other ailments with massage and the use of a *rebozo*, a woven scarf used in pregnancy and birth to help position babies for birth. When close to term, she learns that her baby is breech and a cesarean delivery is recommended. She describes her care encounter:

> They were giving me appointments every Tuesday and Friday. Each time I went to the appointment they told me the baby won't turn. They told me it has to be a c-section because the baby won't turn. And the doctors talked to me, and at the last appointment they told me if I want the baby normal [vaginally] maybe they could help me by putting the baby into position. I asked them if this was dangerous, and they told me yes, but if you want to have a normal delivery, we can help you a little bit. I told them that if it is dangerous, it is better to have a c-section because I don't want anything to hurt my baby. Then they gave me an appointment [for when my baby will be born].

For Diana, a "normal" or vaginal birth is her expectation. The circumstances of her pregnancy, however, create a situation in which her expectation of a vaginal birth is placed in conflict with the value of a healthy baby. When offered an external cephalic version (ECV), a procedure to reposition the fetus while in utero, she communicates her concerns for her baby's safety. Again, we do not have access to the record of what the provider said, but regardless, her perception of the encounter involves a succinct conversation in which a relatively low-risk

procedure is represented as an imminent threat to the well-being of her unborn child. Her expectations to have a healthy pregnancy and to achieve a vaginal delivery are shared with the provider, but again lost in the space between, breaking the communication loop.

Theme 5 – "Feeling Bad:" Negative Experiences of Perinatal Care

When lines of communication between the woman and her provider are broken and the forces that occupy the space between the two people subsume her needs and expectations, the consequences are significant. It is possible that unmet emotional needs contribute to deepening isolation and can manifest in depression.

Unmet need. Many of the women who participated in this study reported experiences self-described as psychologically traumatic. Perinatal loss and emergency cesarean delivery were the most common. In these circumstances, the im/migrant Mexican women we interviewed described an increased burden of emotional need. Sara, who experienced a perinatal loss, shared her experience:

> I was hoping the doctor would tell me that there was something to help me…she told me to go to the house and be on complete rest and drink a lot of water because I needed it…I really needed somebody to listen to me… I feel inside me that I want somebody to ask what I went through.

In the face of tragedy, this woman expresses her hope in the physician's capacity to help – to help prevent the impending stillbirth, to help her maintain a healthy pregnancy. More than physical needs, however, this woman deeply desired to be heard and to be given a forum for expressing her fears and her feelings.

Deepening isolation. For many participants, the experiences of broken communication with their health provider contributed to a deepening sense of isolation. Already removed from

their immediate families and communities of origin, these women had attempted to create new connections with their health care team as they worked to build a new family and a new life. Sara's story continues to illustrate this:

> Nobody asked me about it [perinatal loss]. When it happened – nobody…When I came to the clinic they thought I was still pregnant, and I said I lost my baby. So they said, "Oh, sorry. We didn't know." When they didn't know, I felt bad because this is the place that they were taking care of me. I feel the clinic should have had the record of what was happening…This is the place where I came so you could check my baby and listen to the heart. We are like living together at this point.

The betrayal of being unknown and unseen leaves a searing mark in Sara's memory and defines her perinatal care experience. She describes the relationship between a woman and her obstetric care team in intimate terms. She perceives that her depth of connection and commitment to the clinic team is not shared, deepening her sense of isolation.

Experiences of depressive symptoms. Of the eight women who participated in our interviews, six of them report experiences of depressive symptoms following their birth experience. Three of the six women who reported symptoms to providers were offered resources of some kind. The most common resource was a phone number, a hotline for perinatal loss. Only one woman out of the six reported receiving a diagnosis and treatment for her depression.

Theme 6 - "Feeling Well:" Positive Experiences of Perinatal Care

Not all perinatal experiences described by the study participants were framed negatively. In fact, within almost every woman's account, there were both positive and negative encounters described. Descriptions of positive encounters – those where the woman felt good, cared for, or safe – yielded two key themes: receiving attention and shared worry.

Receiving Attention. Im/migrant Mexican women bring an expectation of attentive, nurturing care to their perinatal encounters. As Ana describes, "It is very special here because they give you a lot of attention. They take your blood pressure. They ask you how you are feeling, and they see you often." Monitoring of health, assessment of emotional well-being, and frequency of appointments are cited as evidence of attentive, nurturing care.

In the inpatient setting, women described additional indicators of attentive care. In Sara's words: "At the hospital, they treated me very well. They were paying attention to me. They asked what I need – water – or if I was with pain. They really treated me very well." Here, consideration of basic human needs such as pain and thirst communicated care, dignity, and respect to the woman.

Shared Worry. The im/migrant Mexican women who participated in this study also stressed that attentive, nurturing care not only addresses the physicality of pregnancy and human needs but also the emotional and relational aspects as well. When asked how to best care for women, Sara stated:

> The best thing is to talk to them [women] and hug them. I was in a lot of pain. I didn't have my mother here. It is nice when somebody comes and hugs you. I felt very grateful for the nurse who hugged me that day when everything happened. I felt like someone was worried about me me….I think you feel well when someone is worried about you and they feel the pain that you are having.

Sara describes a simple moment between the bedside nurse and her patient – a hug. Yet in her view, this embrace communicated care and concern in a way that prior conversations with her providers had not. The nurse was present to her emotional pain and responded in a way that communicated empathy and genuine care.

Being asked. It is important to note, as well, that in the accounts of attention and worry, the women describe a dynamic of being asked. Instead of having to initiate communication verbally, these women were approached by the care provider and asked specific, tangible questions – are you in pain? can I get you some water? would you like a hug? Relieved of the burden of having to overcome their own barriers to communicating needs, these women were grateful to receive these basic human kindnesses.

In summary, analysis of the data reveals multiple themes. The im/migrant Mexican women who participated in this thesis research shared values around pregnancy as a special time, yet expectations for celebration and support only serve to highlight their deep social isolation. Patient-provider communication within the perinatal care encounter is characterized by keeping it all in, maintaining silence that is generated and perpetuated by perceived otherness, stoicism, distrust of the healthcare provider, and fear of deportation. As a result, communication is often distorted and deflected. Experiences of perinatal care include unmet needs and deepening isolation. Those that describe positive experiences of perinatal care highlight the themes of attention and worry.

In order for the values, expectations, and needs of the im/migrant Mexican mother to be met, communication must occur. Ideally, the woman communicates her expectations and needs, these are heard and understood by the provider, and care is tailored to meet those needs. Communication transects the layers of past experiences and identities that occupy the space between the woman and her provider. The communication cycle is a closed loop (Figure 2).

Analysis of participants' experiences within perinatal care settings, however, reveals a different image (Figure 3). In these encounters, layers of past experiences, personal and cultural values, and intersecting identities occupy the space between the woman and her provider. These

act like filters, stacked upon each other to at times create an impermeable barrier, preventing needs from being shared. In other cases, when needs are shared by a woman with her provider, this communication does not pass through these filters unscathed, instead distorted and deflected. Provider communication similarly passes through the same space resulting in a double distortion.

Participants attribute their negative experiences of perinatal care to distorted and deflected communication. In particular, the unmet need, deepening isolation, and profound sense of disappointment and betrayal that many participants describe is highlighted by the women themselves as traumatic. In contrast, participants' descriptions of positive experiences represent a more fully closed communication loop. In these cases, needs are communicated verbally or non-verbally and care is received.

Next we will discuss and interpret these findings in the context of the current literature. In addition, we will present the evolving theory of patient-provider communication within the perinatal encounter and how analysis of these themes through an inductive grounded theory process yields a new contribution to our understanding, building upon communication, intersectionality, and reproductive justice frameworks. Finally, we will present limitations and strengths of this thesis as well as possible implications for practice and future research.

Discussion

Compelled by the prevalence of the im/migrant Mexican population in perinatal care settings in California, the disparities in mental health and obstetric outcomes experienced by im/migrant Mexican women, and the relative lack of literature describing their perceptions of the US health system, I set out in this thesis to describe the experiences of perinatal care of im/migrant Mexican women residing in California's Central Valley. To achieve this aim, I identified four specific objectives: (1) describe the values, expectations, and needs im/migrant Mexican women bring to their US perinatal care encounters; (2) describe im/migrant Mexican women's perceptions of patient-provider communication within perinatal care encounters; (3) describe im/migrant Mexican women's experiences of perinatal care in the United States; and (4) construct an understanding of the processes that govern the patient-provider encounter for im/migrant Mexican women through an inductive grounded theory approach.

The grounded theory analyses revealed that the im/migrant Mexican women hold some shared values and expectations regarding pregnancy and perinatal care. Communication of these values was often distorted and deflected by internally and externally motivated silence, generated and perpetuated by perceived otherness, stoicism, distrust of the healthcare provider, and fear of deportation. Negative perinatal care experiences were characterized by unmet needs, deepening isolation, and descriptions of symptoms of depression. In contrast, positive experiences of perinatal care were characterized by the themes of attention and worry. My analysis resulted in a further modification of the communication theory of Feldman-Stewart et al. (2005) to include intersectionality, and reproductive justice theories (see Figure 3). My findings from this thesis add further evidence of im/migrant women's perceived social isolation and deflected and distorted communion with perinatal care providers. My analysis revealed several new themes,

including women's perceptions of receiving attention and shared worry. These findings and my further modification of Feldman-Stewart's Communication Framework based on these findings represent a unique contribution of new knowledge in this field.

In this section, I will present the results of this thesis in the context of the broader literature, evaluating for similarities and identifying key differences that demonstrate a unique finding of this research. I will use the aim and objectives of this thesis as an organizing structure through the lens of our emerging theory. Finally, I will identify limitations to this thesis as well as make recommendations for future research.

Objective 1: Values, Expectations, and Needs Im/migrant Mexican Women Bring to the Perinatal Care Encounter

It is well documented that patients and providers approach the care encounter with their own individual values, expectations, and needs. Partnering with patients to identify these motivations and bridging the gap between the patient's and the provider's individual agendas is the foundation of the patient-centered care movement (Brennan, et al., 2014). In 2001, the Institute of Medicine (IOM), called for an increase in "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 3).

Pregnancy as a special time. The preferences, needs, and values that im/migrant Mexican women bring to their perinatal care experiences are less established in the literature. The finding that the im/migrant Mexican women who participated in this study place a high value on childbearing and maintaining a healthy pregnancy is supported by the research of Alyshia Gálvez among im/migrant Mexican women in New York City (2011). She found that Mexican women residing in the US often linked their childbearing to the concept of *superación*,

i.e. the idea of literally surpassing oneself or bettering oneself (Gálvez, 2011). Similarly, Bernosky de Flores (2010) found that a healthy pregnancy is an important value among im/migrant Mexican women and that a healthy pregnancy is supported by a variety of physical, emotional, and social traditions. Similar to my findings, Bernosky de Flores (2010) describes the central role of a social network to support a healthy pregnancy, particularly the presence of family and friends that gave good advice.

The values on childbearing and maintaining a healthy pregnancy are not necessarily unique to the population of im/migant Mexican women. A shared value of childbearing and healthy pregnancy seems to transcend cultures (Callister, 1995; Kitzenger, 1989). However, variations exist between cultures both in associated beliefs and in the expression of those beliefs (Callister, 1995). Research conducted in rural states of Mexico, where the home communities of the study participants are located, indicate a belief in the normalcy of pregnancy and birth, a health belief model that views physical, spiritual, and emotional well-being as interconnected, and emphasizes the community and key figures like the woman's mother and the *partera* (midwife) as central to maintaining the pregnant woman's health and thusly the health of the baby (Ibáñez-Cuevas, et al., 2015).

Isolation. While some beliefs and their expression may be culturally specific, there are also dynamics that seem to be unique to the im/migrant experience. Benza and Liamputtong (2014) reviewed the values and health beliefs of im/migrant women primarily of African and Southeast Asian origin. Like the participants of this thesis, experiences of pregnancy were marked by isolation and distance from their extended families and the associated traditions (Benza and Liamputtong, 2014). The findings of this thesis in regard to isolation are consistent with other literature on Latina im/migrants (Hurtado-de-Mendoza, Gonzales, Serrano, &

Kaltman, 2014; Silva-Martínez, 2016). Mexican im/migrant women report significant experiences of isolation, both from family and friends (Hurtado-de-Mendoza, et al., 2014). This limits their access to informal networks of support and, as a result, they may carry more needs into their encounters with formal support networks such as the healthcare system (Silva-Martínez, 2016).

Objective 2: Patient-Provider Communication within the Perinatal Care Encounter

The central findings of my analysis revolve around im/migrant Mexican women's experiences of perinatal care encounters. In particular, I evaluated the path of communication from the woman to her provider and back through a series of filters that arise from individual past experiences, culture-bound perspectives, and systems issues. Based on the descriptions of the participants, these filters coalesced at times to generate impermeable barriers that at times prevented effective communication from occurring and resulted in unmet needs.

Keeping it in: needs not shared. Much of the recent literature on Latina's experiences with healthcare describes the perception of barriers to communication with providers. This body of literature largely focuses on disclosure of intimate partner violence or chronic disease management (Silva-Martínez, 2016; Chandler, et al., 2012). While in many ways these circumstances vary from that of perinatal care encounters, they still provide helpful insight into the forces that shape patient-provider communication within this population.

When viewed from the interior of the woman's experience, impeded communication is often described as "keeping it in" (Silva- Martínez, 2016). When viewed externally to the woman, the outcome is silence (Silva- Martínez, 2016). This silence is a complex coping mechanism, both internally and externally motivated. Middleton-Frickberg (2015) describes this phenomenon as "self-mandated silence" (p. 77). In this anaysis, I found that, when in the context

of the patient encounter, this silence was constructed and maintained by a confluence of factors including perceived otherness, stoicism and self-sufficiency, distrust of health care providers, and a fear of authorities and deportation.

Perceived Other-ness. A perception as oneself as "other" is consistent with the existing literature. Hurtado-de-Mendoza et al. (2014) found that a lack of familiarity with systems, limited access to information due to limited or non-existent informal support networks, and perceived difficulties making connections with new friends in their destination communities acted as barriers to establishing social networks amongst im/migrant Latina women. In addition, Chandler et al. (2012) describe how an acute sense of non-belonging, exacerbated by a lack of insurance, language differences, and lack of education, diminishes ones sense of ownership, agency, and rights to the benefits of society. However, in my analysis, although a general sense of "stranger-ness" was communicated, the specific factors of lack of insurance and lack of education were not mentioned.

Stoicism and Self-Sufficiency. Some participants cited culture-bound stoicism or a perception of self-sufficiency as a barrier to communicating their needs with others or their providers. The literature on stoicism within Latino culture focuses on the expression of physical pain, but parallels can be seen to the expression of emotional or psychological pain that this thesis's participants described. Duggleby (2003) describes stoicism as a cultural value on enduring pain without complaint and that the ability to endure pain is a reflection of one's strength. Stoicism is more commonly described in Latino men, but the same principles are seen in this study's participants' reactions to emotional pain.

It could be possible to shift the conversation about this communication pattern away from stoicism, a trait that often has negative connotation, toward the concept of resilience, which has

been gaining more prominence in recent literature. Within the responses from study participants, this nuance was evident: what one participant described as a "problem" another shared with pride. Silence was not always a negative reaction to the external world but at times a reflection of internal capacity, strength, and self-sufficiency. My analysis is consistent with the findings of Gálvez (2011) who describes in her book how im/migrant Mexican women learn how to be "strong, resilient, and resourceful" from their mothers (p. 152).

Distrust in the health system/provider. Unfortunately, the theme of distrust in the health system or health care provider is common among the literature. This distrust most commonly stems from past personal experiences both in the US and Mexico (Chandler, et al., 2012; Deeb-Sossa, et al., 2013; Silva- Martínez, 2016; Ibáñez-Cuevas, et al., 2015). These experiences include instances of racial and ethnic discrimination, conflicts with provider values, and situations in which care was requested but not received (Chandler, et al., 2012). In addition, distrust can be generated by rumors that spread through the community (Chandler, et al., 2012; Deeb-Sossa, et al., 2013). Provider distrust also seems common within im/migrant communities broadly when cultural and language differences generate tensions within the health encounter (Benza & Liamputtong, 2014).

For the participants in this thesis who had little exposure to the US health system prior to their pregnancies and births, provider distrust arose primarily from a perceived lack of relationship. It may be that the perceived lack of relationship emerged from cultural and lingual differences. However the theme stressed by the study participants was the lack of being "known." This finding is consistent with the research of Baxley and Ibitayo (2015) who found that a feeling of trust in the provider increased when im/migrant Mexican women perceived their providers as "friendly, caring, and personable" and providing personalized care (p. 392). The

im/migrant Mexican women who participated in this thesis valued and desired relationship-based care in their perinatal care encounters.

Fear of authorities/deportation. Although the primary researcher did not ask study participants about im/migration status directly, many volunteered their experiences of crossing the US-Mexico border "*without papers,*" without legal authorization. For study participants, the tenuous nature of their legal status created an additional barrier to disclosure. However, in the literature, legal status is not universally reported as a barrier to patient-provider communication (Platanova, Warren-Findlow, Saunders, Hutchinson, & Coffman, 2016; Chandler et al., 2012). This may result from the inherent self-mandated silence surrounding im/migrant Mexican women and the fact that legal status is so rarely discussed for ethical reasons. However, the results of this thesis as well as the work of Frickberg-Middleton (2015) indicate that when health providers fail to discuss legal status due to ethical concerns, providers may also neglect to acknowledge a main factor impacting health.

The studies that do discuss legal status present findings very similar to those of this thesis. In recent years, several studies have specifically focused on im/migrant Mexican women who reside in the US *"without papers"*. They found that legal status influences decisions on everything from calling the police to report instances of intimate partner violence to how long to be out of the house in any given day (Silva- Martínez, 2016; Deeb-Sossa, et al., 2013). Similar to my findings, these women described by Silva-Martinez (2016) felt particularly vulnerable and chose to live a life "in the shadows" in order to avoid raising suspicion or notice (p. 535).

"They told me:" Communication distorted and deflected. The patient care encounters recorded and summarized in this thesis represent a unique contribution to the literature. A thorough review of the literature did not yield a prior qualitative study exploring the perinatal

care experiences of im/migrant Mexican mothers in the area surrounding Fresno, CA. Similar studies have explored the care experiences of im/migrant Mexican women diagnosed with a chronic disease or in seeking reproductive health care (Chandler, et al., 2012; Deeb-Sossa et al., 2013). My findings with regard to experiences of distorted or deflected communication within the patient-provider encounter are consistent with these studies.

In contrast, my findings differ from these other studies in the nature of the values and expectations that pregnant im/migrant Mexican women appear to bring to their perinatal care encounters. In contrast to those who suffer from chronic disease, the study participants presented to care from an assumption of health, normalcy, and wellness. It is when these values are challenged by the threat of a perinatal loss or an obstetric complication that the woman's emotional and physical needs increase. Without robust informal networks of support, the woman necessarily places more need upon her provider to "fill the gap." The layers of experiences and identities occupying the space between the woman and her provider, however, dam up this flood of need. Messages are distorted and deflected, and opportunities to communicate care are many times lost.

Language. It is important to note that a key difference between this thesis and the recent literature is the role of language in generating a barrier to communication and care. Many of the similar studies referenced here list language as a principle barrier to care for im/migrant Mexican women and other Latinas (Silva- Martínez, 2016; Deeb-Sossa, et al., 2013; Hurtado-de-Mendoza, et al., 2014; Baxley & Ibitayo, 2015; Chandler, et al., 2012). When queried, this thesis's participants did not feel that language was a barrier for them. Several mentioned having a provider who spoke Spanish or having a partner available to translate and therefore feeling comfortable in their communication. In the area surrounding Fresno, there are many Spanish-

speaking providers and healthcare staff. This difference may be a reflection of the demographics of the region in which the research was performed. However, other research has indicated the potential loss of content that occurs in cross-lingual, cross-cultural communication, and further research is warranted (United Nations Population Fund [UNFPA], 2008; Gurnah, Khoshnood, Bradley, & Yuan, 2011).

Objective 3: Im/migrant Mexican Women's Experiences of Perinatal Care

The third objective of this thesis was to describe the experiences of im/migrant Mexican women's perinatal care encounters. In particular, I sought to reflect upon descriptions of both negative and positive perinatal encounters as described by the participants in order to better understand the processes within the encounters that contribute to a negative or positive experience. Participants' descriptions of negative encounters revealed experiences of broken communication that generated feelings of deepening isolation and unmet mental health needs. Descriptions of positive experiences revealed that, particularly in the context of difficult circumstances such as a perinatal loss or obstetric emergency, receiving attention and shared worry are linked to feelings of having received care.

"Feeling Bad:" Negative experiences of perinatal care. Distortions and deflections in communication between the woman and her provider resulted in negative experiences that define the woman's perinatal care experience. Unmet emotional needs triggered a cycle of deepening isolation and experiences of depressive symptoms. This process seemed to contribute to a perception of psychological birth trauma.

***Deepening isolation*.** When communication between the woman and her provider failed to appropriately meet the woman's needs, the primary result was a deepening sense of isolation. Im/migrant Mexican women, who already described a pervasive loneliness as discussed above,

felt as though they had been left to find meaning and cope with their challenging birth experience alone. While there is limited literature on the experiences of im/migrant Mexican or Latina women during labor and birth, this process of unmet emotional needs and deepening isolation mirrors that described in literature related to care experiences of im/migrant Mexican women with chronic conditions (Chandler, et al., 2012). Similar to my findings, women there described how having needs unrecognized by providers made them feel invisible and invaluable (Chandler, et al., 2012).

***Experiences of Depressive Symptoms*.** Latina women are more likely to experience mental health challenges than their non-Latina counterparts and less likely to receive appropriate support (Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008). The rates of mental health disorders are even higher for those Latinas that are non-citizens and rates of access to mental health services lower (Rios-Ellis et al., 2005). Shattell et al. (2008) linked the high prevalence of mental health disorders among Latina im/migrants to separation from family, financial worries, loneliness, and concerns about legal status. My results also describe how separation from family, social isolation, and concerns about legal status contribute to poorer mental health among the im/migrant Mexican women participants.

It is difficult to truly ascertain the incidence of postpartum depression among im/migrant Mexican women because so few access care (Callister, Beckstrand, & Corbett, 2011). However, previous studies have estimated a range from 14.7 to 54% (McGarry, Kim, Sheng, Egger, & Baksh, 2009; Lucero, Beckstrand, Callister, & Sanchez-Birhead, 2012). Seventy-five percent of this thesis's participants described experiences of postpartum depression. Similar to the findings of Callister et. al (2011), this thesis's participants cited the role of cultural beliefs in relation to mental health stigma. In particular, participants described how cultural expectations around the

ideal strength of the mother and the shame associated with mental illness, drove them to seek help internally or from informal sources of support such as family. In my analysis, perceived isolation from extended family networks and friends, however, left im/migrant Mexican women without these informal support networks. This is consistent with the findings of other authors (Callister et. al, 2011; McGarry et al., 2009).

Psychological birth trauma. While psychological birth trauma is not the primary focus of this paper, it was an important context through which to evaluate the experiences of the study participants. The original sampling sought out women who self-reported an experience of a traumatic birth. Accordingly, each of the study participants framed her experience as psychologically traumatic.

The phenomenon of psychological birth trauma has been the subject of investigation for some time. Researchers have sought to understand the root causes of psychological birth trauma as well as to describe the impacts of a psychologically traumatic birth on the mother-infant dyad and future pregnancies. Emerging factors that influence the perception of the birth experience include fear for self or infant, perception of personal performance, locus of control, type of delivery, ability to achieve priority expectations of birth, adaptability when birth expectations are not met, cultural expectations, and the quality of provider interactions (Sorenson & Tschetter, 2010).

Very little is known regarding the process of psychological birth trauma within im/migrant Mexican or Latina populations. Of the causative factors identified in the literature, my findings indicated that fear for self or infant, locus of control, type of delivery, cultural expectations, and the quality of provider interactions were identified by im/migrant Mexican women as contributing to their psychological trauma during pregnancy and birth. Middleton-

Frickberg (2015) posits that adverse life course experiences such as violence, family separation, poverty, and fear of deportation create a fragile existence that may predispose im/migrant Mexican women to a traumatic perception of birth. My analysis concurs that social isolation and lack of informal support networks limited traditional pathways of coping, deepening isolation and increasing the risk for postpartum mental health disorders such as depression.

"Feeling Good:" Positive experiences of perinatal care

A few participants described care encounters when a provider met their needs whether physical or emotional. Within these high quality provider interactions, participants perceived their needs as being met when they received care described as receiving attention and/or sharing worry. While previous literature on im/migrant Mexican women's expectations of care developed themes of trust and relationship, the themes of receiving attention and shared worry represent a new contribution to the literature (Bergman & Connaughton, 2013; Baxley & Ibitayo, 2015).

Receiving Attention. My analysis for this thesis found that im/migrant Mexican women desired and appreciated attentive care that addressed basic physical needs. This was perhaps related to past experiences of attentive, personable care from their mothers and community *parteras* (midwives), marking pregnancy as a special time. In short, the care-giver was cared for. Perhaps the separation from their home communities generated a greater reliance on the provider or health system to provide these basic human kindnesses.

Shared Worry. For the im/migrant Mexican women represented in this thesis, care communicated by the provider's concern for emotional needs was described as "worry." While worry may have a negative connotation within certain contexts, study participants described feeling good when they perceived that someone was worried about them. Similarly, they

described a consequence of isolation as not having anyone to worry about them. In this way, the concept of worry may have been a proxy for the close, familial relationships that these women often lacked.

Worry may also signify an inherent visibility and importance that creates a sense of value. In this way, the positive construct of worry relates to the findings of Chandler et al. (2012). Chandler et al. (2012) found that im/migrant Mexican women living with chronic diseases reported a desire to be seen, recognized, and valued by their providers. Perhaps the affirmation of essential human value through the demonstration of basic human kindnesses was able to communicate care despite the perceived barriers that otherwise would filter and distort patient-provider communication.

Objective 4: Emerging Communication Theory

The final objective of this thesis was to construct an understanding of the processes that govern the patient-provider encounter for im/migrant Mexican women through an inductive grounded theory approach.

Communication within the patient-provider context has been the subject of much study and discussion. Successful communication is seen as integral to positive health outcomes and patient satisfaction (Ha, Anat, & Longnecker, 2010). Research has focused on attributes of the patient, such as readiness to change or learn new health information, or aspects of the provider, such as communication style, in an effort to identify the factors that impact patient-provider communication (Ha et al., 2010; Farzadnia & Giles, 2015). Patient-provider communication can also be impacted by linguistic differences and cultural congruence (Ha et al., 2010).

Initial modifications of the Feldman-Stewart et al. (2005) Communication Theory presented in my selection of a conceptual framework (Figure 2) were evaluated in the context of

my analysis and further modifications made to reflect my results (Figure 3). This is consistent with the constructivist grounded theory tradition as described by Charmaz (2012). The communication theory posited by Feldman-Stewart et al. (2005) describes an encounter where the patient and provider carry their own internal motivations yet enter a mutually pristine environment capable of unobstructed communication. However, in my analysis, participants described how communication within the patient-provider encounter was often characterized by unseen forces. Past experiences and perceptions shaped by internal and external processes were present within the patient-provider encounter and impacted clarity of communication. Accordingly, my thesis presents an emerging communication theory that expands on the work by Feldman-Stewart et al. (2005) to include how these internal and external factors occupy the space between the patient and the provider (Figures 2 & 3).

This modification of Feldman-Stewart et al.'s (2005) theory of communication was driven by analysis of the participants' experiences, grounded in the frameworks of intersectionality and reproductive justice, and represents a unique contribution to communication theory. Additional research is needed to further test and evaluate this emergent theory. In particular, the data for this thesis did not include provider interviews, and a deeper understanding of the provider's perspective is critical to a fully developed theory of patient-provider communication.

Limitations & Strengths

The findings from my thesis should be viewed in light of its limitations and strengths. First, the sample consisted of women who self-identified as having experienced a psychologically traumatic birth. The lack of participants with a positive perception of their

prenatal care and birth may have generated an overly negative representation of im/migrant Mexican women's experiences of perinatal care services.

Further limitations may exist with regard to the research methods. Analyses were conducted secondarily, after all interviews were concluded. The inability to be present for the interviews may have resulted in loss of information since body language, cadence, and tone of voice were not available to this researcher. In addition, the interview transcripts were analyzed in their English translation version as the lack of Spanish-language fluency of the researcher prevented the use of the Spanish-language transcripts. While a certified, bilingual interpreter had been used during the interviews and to validate the English language transcripts, it is possible that mistranslations occurred impacting the data and subsequent analysis. Secondary analysis did not allow for true theoretical sampling, which is commonly utilized to validate emerging themes within the practice of grounded theory (Charmaz, 2012). However, an iterative process of constant-comparison allowed for saturation to be identified and rigor to be maintained.

Finally, a key limitation of this study was the inability to elucidate the provider's perspectives. Understanding the perceptions of the im/migrant Mexican women who participated in this study is an important first step in describing the problem from those who have experienced it. Experiences, perceptions, and cultural context of the provider or the environment likely contribute additional factors that act as further filters within the patient-provider encounter. In order to adequately understand the full dynamics at play in the patient-provider encounter additional data from provider and staff interviews as well as observed encounters could prove fruitful.

Implications for Practice

The findings of my thesis have several implications for clinical practice. First, although the participants did not describe language as a significant barrier to care, all did cite instances of miscommunication that included and exceeded the verbal exchange of words. Providers should be aware that communication is more than language and increase their understanding of the cultural nuances of non-verbal communication that exist within the im/migrant Mexican community.

A central finding of my analysis was that the participants struggled to cope with emotional and psychological burdens due to a profound sense of isolation. Building trust and relationship through consistent, kind care may help to improve patient-provider communication and care. Additionally, efforts to increase a client's social networks through the use of group-based care could have a positive effect that persists beyond the patient-provider encounter. Centering Pregnancy ™ and similar group-based prenatal care programs have been demonstrated to improve pregnancy outcomes for im/migrant Mexican women through social engagement (Trudnak, Arboleda, Kirby, & Perris, 2013).

In addition, my analysis underscored the importance of basic human kindness in patient-provider interactions, particularly those that have the potential to be distressing such as during a perinatal loss or obstetric emergency. For im/migrant Mexican women, care may be better communicated by less talking and more doing, particularly in the inpatient context when fundamental needs such as appropriate treatment of pain and comfort of the environment are often more pressing. A failure to meet basic human needs in a timely and caring way could enforce a societally-promoted perception of being value-less, further deepening that woman's psychological pain.

Implications for Further Research

Due to the unique confluence of circumstances and demonstrated health disparities faced by im/migrant Mexican women seeking perinatal care, further research on this topic is needed. In order to deepen the understanding of the experiences of im/migrant Mexican women, similar studies should be conducted in other locations and settings around the country that also include more diverse perinatal care experiences and outcomes. Understanding the perspectives of im/migrant Mexican women who self-identify as having had positive birth experiences may help to better understand the roots of psychological birth trauma within this community.

With regard to communication, further research is needed to assess the modifications to the Communication Theory proposed by Feldman-Stewart et al. (2005) and further developed in my thesis. This research should include exploration of the provider perspectives and any perceptions and past experiences that the provider brings to the encounter. Evaluation of the impacts of the physical space and structure of the clinic could also yield valuable information in further defining the factors that impact patient-provider communication.

Finally, the findings of my thesis related to receiving attention and shared worry represent a unique contribution to the literature. Further research is needed to evaluate these concepts across different care settings and different populations.

My analysis may also provide motivation for additional research related to public policy. Highlighted in this study's findings is the additional impact of punitive immigration policies. Fear of identification and deportation may exacerbate social isolation, undermining established methods of coping with emotional and physical needs through informal support networks for im/migrant Mexican women. The women in this study clearly linked their criminalized status as an im/migrant *"without papers"* with a hesitancy to seek care or communicate openly with

healthcare providers. Additional barriers to health insurance and access related to their legal status in the US further impact communication within patient-provider interactions. Future policy should address these impacts by better reflecting the lived reality of these women and their families, their inherent value as members of the human family, and their essential rights to open and accessible care.

Conclusion

Im/migrant Mexican women represent a significant portion of the population in California, and particularly so in California's Central Valley. Data suggest, however, that they suffer disproportionately from mental health disorders including antepartum and postpartum depression. Utilizing a framework of patient-provider communication that incorporates the theories of intersectionality and reproductive justice, grounded theory methods were employed to describe the perinatal care experiences of im/migrant Mexican women residing in that region.

Secondary analysis of qualitative data revealed that the im/migrant Mexican women who participated in this research carry a high individual and cultural value on pregnancy and the experience of profound social isolation with them into the patient-provider interaction. Communication of needs and expectations with the provider is often distorted and deflected by an internally and externally motivated silence that is generated and perpetuated by perceived otherness, stoicism, distrust of the provider, and fear of deportation. The result is often unmet need and deepening isolation. Simple acts of human kindness by the provider, however, can penetrate the layers of expectation and experience that occupy the space between the woman and the provider. These actions affirm the inherent dignity of the woman, communicating attention and worry.

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Appendix A.1 Frickberg-Middleton

Citation	Design & Methodology	Aims	Sample & Setting	Analysis	Findings
Frickberg-Middleton, (2015), Dissertations & Theses at University of California	*Study design* Qualitative research through grounded theory *Data sources* Series of three, one-hours semi-structured interviews Photography Memo-writing	*Purpose* To evaluate the impact of life-course adversity on perceptions of birth trauma among recent Mexican immigrant mothers in California's Central Valley	*How many participants were there?* 7 *What were the sample demographics?* *What was the sampling approach?* Recruitment happened at the low-income/free clinic where the primary researcher works as a nurse practitioner. Enrollment and data collection occurred simultaneously until saturation of the core categories was achieved. *Inclusion criteria* Age greater than 18yrs, time in US <5yrs, self-report of a traumatic birth experience *Exclusion criteria* Current psychiatric or other health condition, declination of participation *How was the setting selected?* The recruitment setting was determined by the primary investigator's place of work. Interview setting (time and place) was determined by the participant.	*How were data analyzed?* Grounded theory process beginning with line-by-line coding proceeding to axial coding to identify emerging themes. Theoretical sampling was utilized iteratively until saturation of core categories was achieved.	*What were the major themes and findings?* "Fragile existence" characterized by self-protective silence Trust in provider as possible moderating factor of maladaptation following traumatic birth experience

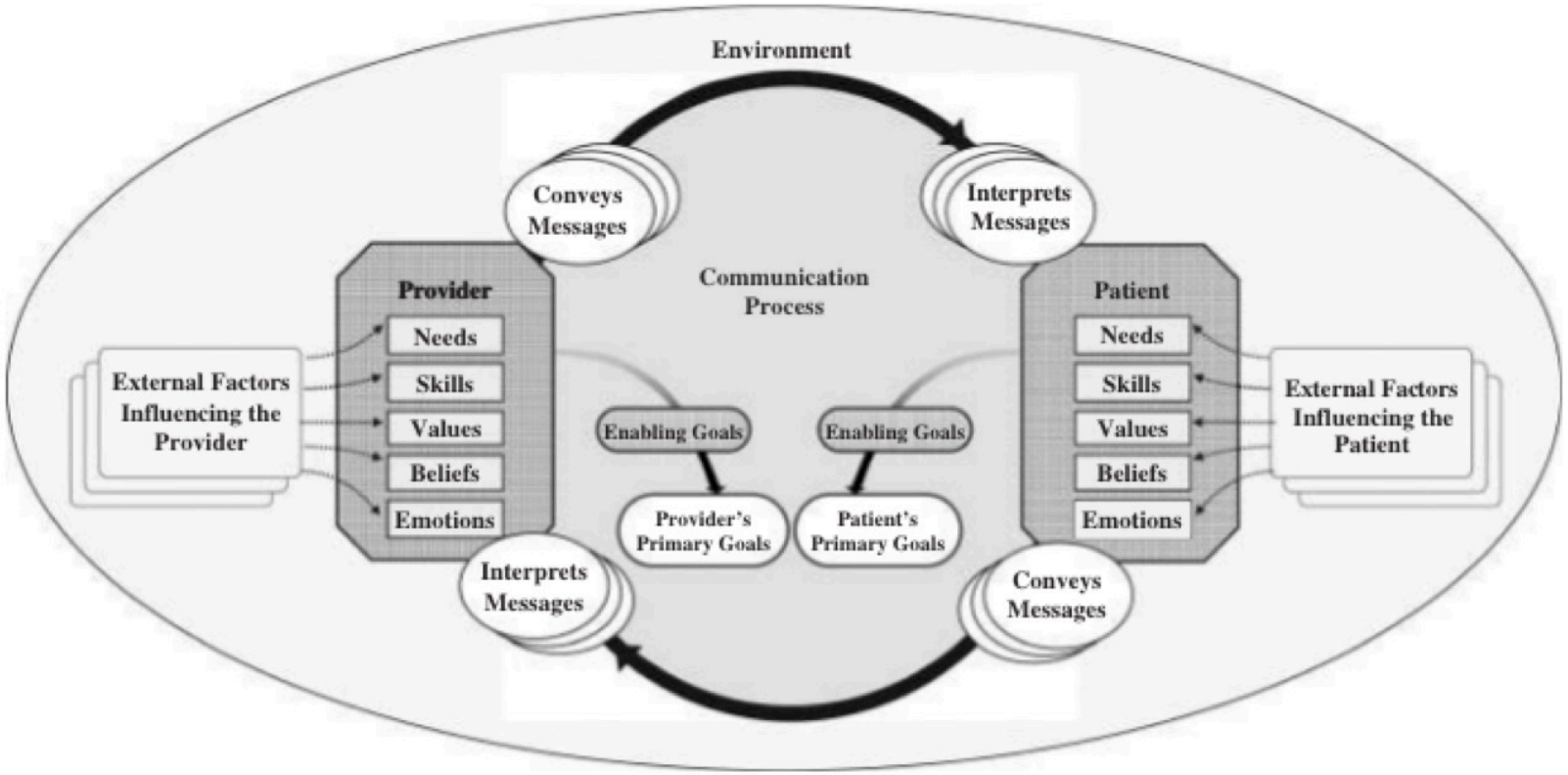
Appendix A.2 Deeb-Sossa et al.

Citation	Design & Methodology	Aims	Sample & Setting	Analysis	Findings
Deeb-Sossa, (2013), *Cadernos de Saude Publica*, 29(5), 981-991.	*Study design* Qualitative-Interpretive within a life-story model *Data sources* Interviews with participants and key informants Non-participant observations in collaborating clinical sites *Data collection strategies* Thematic guides & semi-structured interview guides An analysis guide was used to code non-participant observations	*Purpose* To document the experiences of undocumented Mexican immigrant women in Yolo County, California, related to use of reproductive and sexual health services	*How many participants were there?* 8 participants 7 key informants in US/Mexico *What were the sample demographics?* Mexican women, ages 20-45 years Living in the US for 8-22 years *What was the sampling approach?* Recruitment occurred in partnering county health clinics servicing the target population & selective sampling based on time spent in US *Inclusion/exclusion criteria* Not specified. *How was the setting selected?* The primary author's affiliation with UC Davis provided proximity. Additionally, the concentration of undocumented Mexican immigrants in California prompted a local focus.	*How were data analyzed?* Audio recording were transcribed and analysis was conducted manually following the model of discourse analysis put forward by Wetherell & Potter. Data matrices were then created for thematic categories and each type of informant.	*What were the major themes and findings?* Findings included several barriers to sexual health care – namely, undocumented status, language, and partner reproductive coercion. In addition, the authors found that immigrant Mexican women often lead a dual existence, utilizing both Western and traditional health services to meet their reproductive and sexual health needs.

Appendix A.3 Chandler

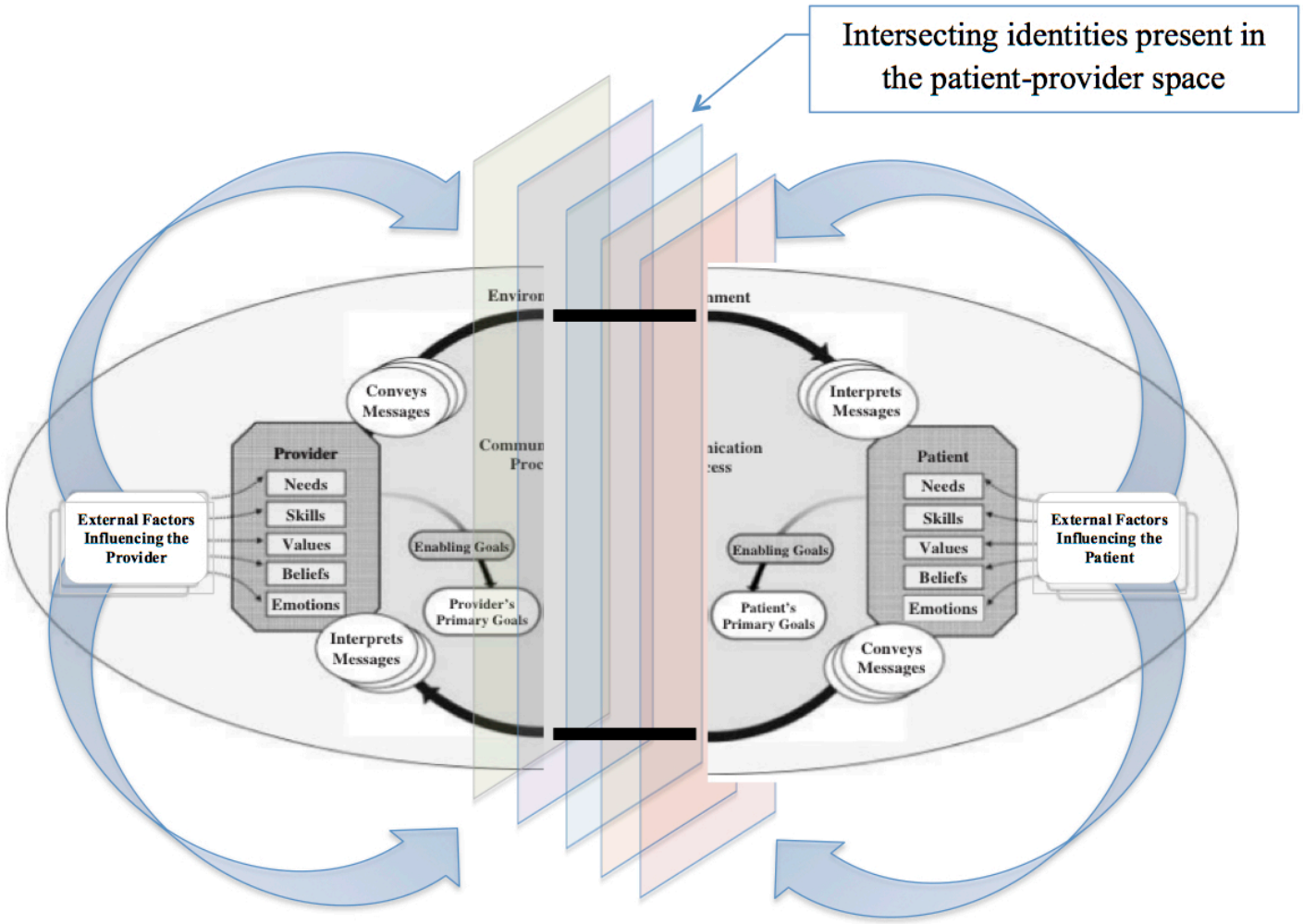
Citation	Design & Methodology	Aims	Sample & Setting	Analysis	Findings
Chandler, (2012), *Advances in Nursing Science*, 35(2), E24-E36.	*Study design* Interpretive phenomenological *Data sources* Interviews with participants and observations of clinic proceedings *Data collection strategies* Open-ended, semi-structured interviews Participant observation Field notes and memo-writing	*Purpose* To explore the health-care seeking experiences of undocumented Mexican immigrant women with chronic illness	*How many participants were there?* 26 participants 3 key informants *What were the sample demographics?* Mexican women, ages <28-70 Time in US <5->20yrs *What was the sampling approach?* Purposive sampling was used with recruitment through word of mouth and snowballing methods through the clinic site *Inclusion criteria* Lacking legal documentation Diagnosis of chronic illness Lacking full-scope health insurance Of Mexican origin Female At least 18 years old. *How was the setting selected?* The primary author had worked previously in the clinic selected	*How were data analyzed?* Analysis was conducted in conjunction with data collection utilizing *Atlas ti* software. An interpretive phenomenological approach was used to first identify themes, extract exemplars, and select paradigm cases.	*What were the major themes and findings?* Key themes centered around the concept of recognition and include: lack of recognition as invisibility, unrecognized solicitation, relief from pain as recognition Participants experienced significant power hierarchies when seeking care that left them feeling unrecognized in their suffering and unvalued.

Figure 1. Feldman-Stewart, Brundage, & Tishelman's Conceptual Framework of Patient-Provider Communication



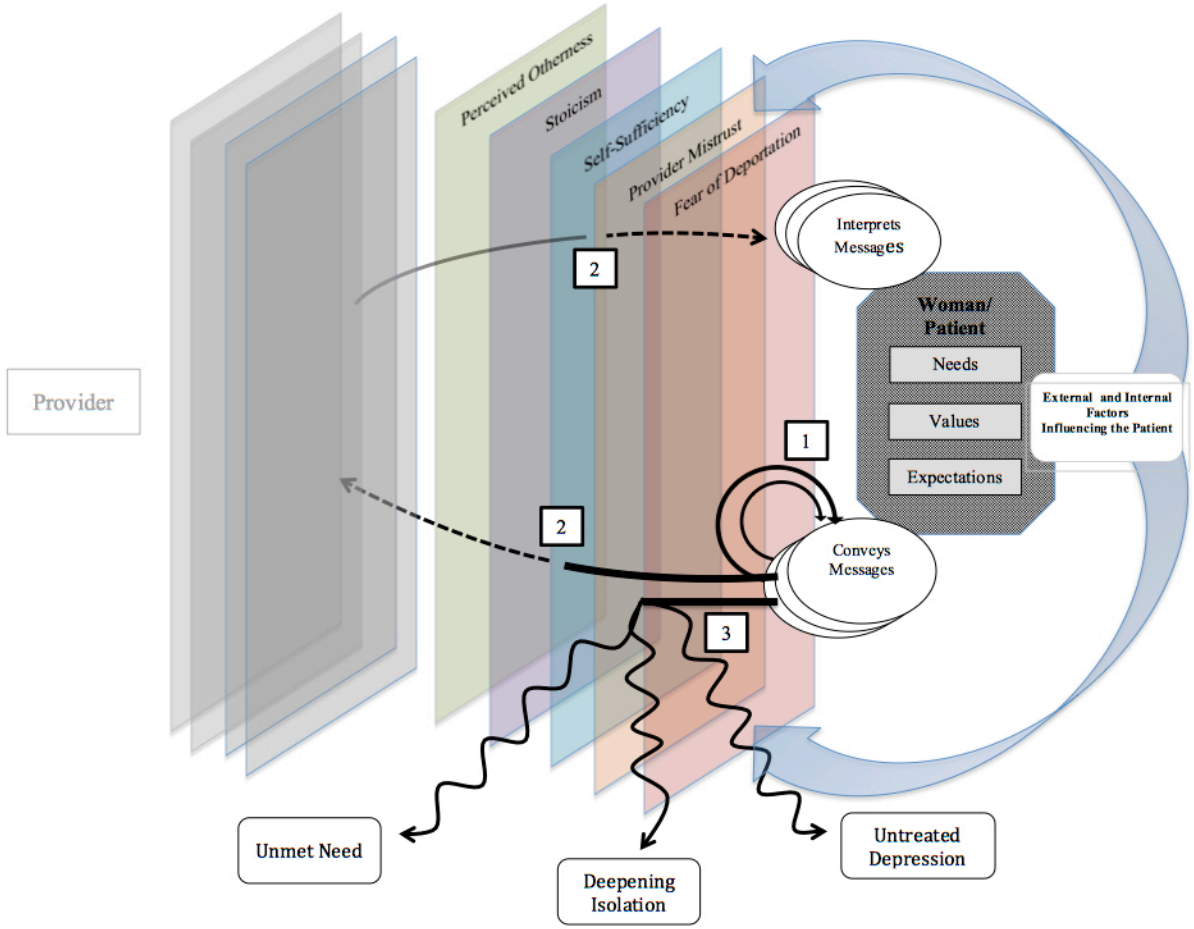
Feldman-Stewart, D., Brundage, M.D., & Tishelman, C. (2005) A conceptual framework for patient-professional communication: An application to the cancer context. *Psycho-Oncology, 14,* 801-809.

Figure 2. Conceptual Framework: Successful Patient-Provider Communication in the Context of Intersectionality



Adaptation of figure presented by Feldman-Stewart, et al. (2005).

Figure 3. Results: Communication Distorted and Deflected



1) Messages not conveyed; 2) Communication distorted as it passes through filters of past experiences and perceptions, messages lost; 3) Communication deflected by filters of past experiences and perceptions, further messages lost.
Note: The provider and the past experiences and perceptions that the provider brings into the shared patient-provider space are indicated in this figure but are presented in grey as the scope of this research is unable to speak to the provider experience.

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