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An Exploratory Study about the Emotions Experienced by Users of a Health Care Service

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Abstract

This study focused on the ambivalent emotions (positive and negative) experienced by obstetric services users. Identifying such emotions can help setting priorities and improving services quality, increasing patient satisfaction. It was implemented a qualitative and exploratory research, by means of personal interviews with semi-structured approach. The data was analyzed and interpreted using content analysis, direct observation and its triangulation. As main results, we highlight the understanding of ambivalent emotions incidence, especially fear and joy/happiness and identification of directions for maximizing positive emotions and minimizing negative emotions, reflecting on the perceived services quality and customer satisfaction.

Key Words: Emotions; Ambivalent Emotions; Consumer Behavior; Service Quality; Health Care Services.

Introduction

In view of the consolidation of the service sector in the world economy, studies that amplify the understanding of the relation between the users and the service providers are pressing. The customer, by interacting with the service provider, in this moment represented by its frontline employees, reacts, mental and physically, evaluating service quality (Hochschild, 1983; Darden & Babin, 1994). It is stressed, in health area, that hospitals must adopt new policies, strategies and technics to chance its processes, increment service quality and support other organizational changes that are needed for a better performance (Caccia-Bava, Guimaraes, & Guimaraes, 2009; Klinger, Pravemann, & Becker, 2015).

Specifically, each user of services connected to maternity will have experiences that are going to vary depending on the place for the baby's birth, kind of care performed in prenatal, during labor and postnatal. To guarantee that the obstetric service be effective it is necessary that the professionals be responsive in relation to the characteristics and needs of the mothers. The pregnant is not considered a sick woman and the emotions she lives have a powerful effect on her expectations and perceptions and her ability to think rationally (Tinson, 2000).

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Identifying what is relevant for them is useful to find out the strong aspects and the vulnerabilities of the work unit and to help the strategies inherent to services. This way, the service can be promoted internally, having a feedback for teams, motivating them to the continuous improvement of service quality. Determining the sources, the expectations, perception levels, and the degree of satisfaction or dissatisfaction of these pregnant may help diagnose in which aspects the performance is adequate and in which of them it should be improved. This information help manage the operational risks; minimize the complaining and the emerging of factors that generate dissatisfaction (Proctor & Wright, 1998; Oliver, 2010; Zeithaml, Bitner, & Gremler, 2011).

In the study, the analyses focus was directed to ambivalent emotions intrinsic to labor, because, during the pregnancy, the woman goes through a series of physical transformations, emotional and psychosocial. The pregnancy is configured as a phase in which the organism modifies to take a new life for a period of, generally, forty weeks. Many symptoms emerge during these nine months. On average, the woman gains, in this period, from nine to twelve kilos, what, logically echoes on her look about the world, about her effectiveness and her behavior (Bergström, Rudman, Waldenström, & Kieler, 2013).

Most women experience a combination of helplessness, anxiety and a pleasant expectation feeling. The energy that is taken off their daily lives is used to solve these emotional conflicts. The pregnancy period is a time that the woman should learn a lot about herself and the new role that is about to be played in the future, the mother one (Brazelton, 1998; Parker, 2003). The anguish in the labor time is sharp, because the woman experiences a loss feeling, emptying and fear of the unknown, the baby and its needs. With birth, the idealized image of the baby falls apart the same way it becomes an "independent" being, getting all the affection and attention, that before were given to the pregnant. This moment is when the mother will give a new meaning to maternity. And such experience can be positive or negative.

Hence is the importance of managers of health services in recognizing the emotions of women in labor and give a good attendance, transmitting them more security and satisfaction with labor (Avortri, Beke, & Abekah-Nkrumah, 2011; Martin & Fleming, 2011), with the delivered services and with the service provider itself, what is directly related to business performance (Yoo & Park, 2007; Stahl, Drew, & Kimball Klinger, 2014; Pravemann & Becker, 2015).

The emotions felt, therefore, affect the cognitive perception, being considered as filters that intervene in daily experiences and that are inherent to service usage (Grönroos, 2000; Lin & Mattila, 2010; Winterich & Haws, 2011; Biron &Van Veldohoven, 2012). Thus, this research aimed at identifying elements that can support the answer to the following question, which translates the research problem: what are the emotions, positive or negative, therefore, ambivalent emotions experienced by obstetrics service users in labor time?

As a result, the research general objective was defined, that was of understanding the incidence of positive and negative emotions at the same time (ambivalent emotions), experienced by obstetrics service users in labor time. Besides the general objective, the following specific objectives were established: identify the main emotions, positive and negative, experienced and that build the maternity experience in labor time; and verify the emotional ambivalence (incidence of positive and negative emotions at the same time) experienced during labor from the perception of the women in labor, in the sense of enabling evidences for possible directions to qualify the delivered services in the study context.

For so, the study was set at the Obstetric Center of a public hospital, which has all the attendances performed by SUS – Sistema Único de Saude (Public Health Care System). The hospital, located in the countryside of the State of Rio Grande do Sul, Brazil, was founded in 1998 and is attached to a university, and is certificated by MEC – Ministério da Educação e Cultura (Culture and Education Ministry) and by the Ministério da Saúde (Health Ministry) as a teaching hospital. This hospital takes patients from 49 region cities, is located in a six-floor building, with about 12.5 thousand meters squared, with facilities for clinic treatment, surgery, diagnose, and support services. There are 236 beds, 49 in ICU – Intensive Care Unit, 33 for pediatrics and other 155 beds in several areas of clinic and surgical hospitalizations.

It is important to note that the focus of the Obstetric Center is the attendance of pregnant women in all phases of pregnancy: prenatal care, labor and postpartum. Every year, about 1.500 births are performed, some caesarean births (42%), or natural births (58%), which illustrated the importance of delivered services for the region's population.

2. Literature Review

2.1 Definition and Types of Emotions

Emotions do not emerge in isolation, since culture, social interactions and the way life is organized, strongly influence emotions (Fields & Kleinmann, 2006; Otnes, Lowrey, & Shrum, 1997). That is why emotions can emerge from body experiences or the unconscious, emerging from an interpretative process inherent to a relational or specific social situation experienced (Whiteman, Müller, & Johnson, 2009). Emotions, therefore, can be understood as a kind of affective psychological reply, non-cognitive, that is related to feelings. And they are experienced in different levels of corporal alert or excitement, as, for example, nervousness, and transpiration and, even, with the increased heart rate (Peter & Olson, 2004; Salzman & Fusi, 2010). In other words, they include excitement states and several ways of affection, which can be given singular interpretations (Oliver, 2010). They are like a readiness mental state, which emerges from the cognitive evaluations from an event or the person's own thoughts (Lazarus, 1991; Bagozzi, Gopinath, & Nyer, 1999; Griskevicius, Shiota, & Nowlis, 2010).

Emotions configure a set of reactions that can be publicly observed. This means that the emotional condition of a service user can generate behavioral clues. The emotion is the combination of a mental evaluative process, in which answers frequently directed to the body and brain emerge, producing additional mental alterations. Therefore, emotions are complex reaction standards and present a fundamentally formulaic nature that include primary emotions, or universal, which are inborn; secondary emotions, or social, and background emotions, that are part of human bio regulators mechanisms aiming at survival (Watson & Spence, 2007; Martin, O'Neil, Hubbard, & Palmer, 2008). Authors like Mehrabian and Russell (1974), that originated the PAD scale – Pleasure-Arousal-Dominance, Izard (1977), with the DESII scale – Differential Emotions Scale II, Plutchik (1980), Batra and Holbrook (1990), Liljander and Strandvik (1997) and Richins (1997), with the CES scale – Consumption Emotion Descriptors proposed typologies and instruments to measure human emotions. However, up to now, such instruments are studied and questioned about their degree of validity, being the typology/scale developed by Izard (1977) still the most used one (Richins, 1997).

That is why in the present research the typology proposed by Izard (1977) was adopted, as the basis for categorization of the emotions to be identified and their following ambivalences. This author suggests ten types of emotions, being two positive ones (+), a neuter one (=) and seven negative emotions (-), which are: **interest** (+): considered a fundamental and relevant emotion in regular and healthy people; **joy/happiness** (+): phenomenologically characterized with the trust feeling, contentment and, frequently, warmth. Psychologically happiness can increment the tolerance level in relation to frustration; **surprise** (=): it plays an important role, because it represents the state of transition and as opposition for other emotions. As functional utility, it liberates the nervous system to act or react to eminent actions; **sadness** (-): it has several functions, such as showing when something is wrong and motivating the person to reduce or eliminate the discomfort cause; **anger** (-): it is the result of frustration or restrictions, that is, in these cases, the feeling of self-preservation becomes imminent; **fear** (-): it affects people in different circumstances, in some way.

Depending on its intensity, the fear is felt as preoccupation or as lack of security; **shame** (-) it has a social role and can be activated in any situation in which the focus is directed to inadequate or inappropriate attitudes of individuals or group of people; **guilt** (-): it is related to the discrimination between what is right and what is wrong. Normally it is connected to something that is conscious and is not moral; **repulsion/heartbreak** (-): it is frequently associated to angry and situations that can cause an aversion feeling and that are connected to bad smells or tastes. In this case, it seeks to eliminate the origin or the stimulus that caused such aversion; and **contempt** (-): it surges with an evolutionary perspective and can emerge as a way to prepare the person to a dangerous situation. It happens in situations in which the person needs to feel stronger or better than other people.

2.2 The Influence of Emotions on Quality and Customer's Satisfaction Perceptions

Emotional replays particularly influence high contact services evaluations (Johnson & Zinkhan, 1991; Jayanti, 1996; Fox, 2001; Silvestro, 2005), as is the case of health services area.

In these services, the staff physical, psychological and emotional proximity with customers make them, normally, able to realize and predict customers' quality expectations (Mattila & Enz, 2002; Lin & Mattila, 2010). One prerequisite to generate a high quality level is to have employees that understand the needs and desires, the preferences, habits, expectations and perceptions of customers. To individualize the care, the frontline employees need to be able to adapt the service in real time to customers profile and behavior (Bitner, Brown, & Meuter, 2000; Naidu, 2009; Narang, 2010; Owusu-Frimpong, Nwankwo, & Dason, 2010). The extra attention given by the professionals helps creating positive emotions on service users and social and affective bounds between the parties. Otherwise, the negative emotions emerge easily in situations with fails in the minimum quality standard expected (Price, Arnould, & Deibler, 1995; Lin & Liang, 2011; Biron & Van Veldohoven, 2012).

In this sense, Baker, Choi and Henshaw (2005) stress three essential features for women satisfaction in maternity related services: the choice, the continuity and the control over what may happen during labor. The last one is pointed out as central aspect in a childbirth process and an essential vector for the patients' satisfaction level (Green, Coupland, & Kitzinger, 1990; Waldenström, 1999; Waldenström, Brown, McLachlan, Forster, & Brennecke, 2000; Bergström et al., 2013). Besides, the control sensation is pointed out by Dencker, Taft, Bergqvist, Lilja, and Berg (2010) as a determinant factor related to positive emotions, mainly in the young first-time mothers.

Researches results indicate that health service quality perceptions are strongly related to professionals' competence, to their high level of knowledge, trust posited by customers, professionalism, empathy, courtesy and tangible aspects, that are crucial in evaluating service quality and that directly reverberate in the patients' satisfaction (Halliday & Hogarth-Scott, 2000; Badri, Attia, & Ustadi, 2009; Vinagre & Neves, 2008; 2010). Such relations, in turn, are also influenced by emotions experienced in these moments (Jayanti, 1996; Liljander & Strandvik, 1997; Watson & Spence, 2007; Martin, O'Neil, Hubbard, & Palmer, 2008; Lin & Liang, 2011).

3. Research Method

The study can be characterized as a qualitative with exploratory character research (Alvesson & Kärreman, 2011; Hennink, Hutter & Bailey, 2011; Scott & Garner, 2013), which was performed by means of personal interviews, with a semi structured approach, by the application of a basic question guide (King & Horrocks, 2010; Gubrium, Holstein, Marvasti, & McKinney, 2012), elaborated from literature (Tucker III, 2002; Larsson & Wilde-Larsson, 2009; 2010; Drennan et al., 2011). After approval of the research project by the Institution Ethic Committee, for content validation, the basic question guide was submitted to two experts appreciation (teachers and researchers), ending the data collection instrument to be used in the interviews conduction, according to recommendations found in the literature (Kvale & Brinkmann, 2009; Remler & Van Ryzin, 2011; Malhotra, Birks, & Wills, 2012).

In view of the researchers' judgment, the pre stablished number of interviewees that would be a part of the research was fifty patients (pregnant), believing that this set of participants would generate a reasonable amount of data for further analyses and interpretation. From this definition, the interviews were conducted in the hospital in a unique section, on agreed dates, at the postpartum, with the formal authorization of patients, which signed an Individual Informed Consent Term, and with no losses for their recovery. All interviews were recorded and transcribed to facilitate the posterior process of data analyses and interpretation (Kvale & Brinkmann, 2009; Gubrium et al., 2012).

In addition to the interviews conduction, the direct observation was applied (Hennink, Hutter, & Bailey, 2011; Remler & Van Ryzin, 2011), in the sense of understanding the formation of the working groups and relationship among the teams and the professionals, as well as the presence of family, visit hours and the ambient in the waiting room of the Obstetric Center. Besides, the observation helped understanding the relationship of the professionals with the pregnant and other patients with just born babies and the realization of periodic meetings among the working teams. A documental research was also proceeded (Hennink, Hutter, & Bailey, 2011; Malhotra, Birks, & Wills, 2012), accessing reports about the function of the delivered services, which were available by the Obstetric Center responsible person.

For data processing, analyses and interpretation, the content analyses method was applied (Schreier, 2012; Krippendorff, 2013), separating data and the information obtained in analyses categories (Gibbs, 2008; Bernard & Ryan, 2010; Scott & Garner, 2013). The analyses categories consisted of, basically, data related to each participant profile and the emotions experienced (positive, neuter, negative and the identified ambivalences), which were categorized from the proposed typology by Izard, with the DESII scale (Izard, 1977).

Aiming at increasing the result validity, the identified emotions categorization went through the judge method (experts), with the participation of three experts (Malhotra, Birks & Wills, 2012; Scott & Garner, 2013), implemented by means of a personal interview with the obstetrician that had greater time of working (experience) in the Hospital Obstetric Center, who has been in the institution for ten years.

4. Results and Discussion

4.1 Interviewee Profile

In all, fifty patients were interviewed. Board 1 features the interviewed women, stressing the aspects that define each profile.

Board 1 – Interviewees profile

Interviewees	Age and Marital Status	Creed (Religion)	Previous Births	Prenatal	Current Birth
I1	21, married	Evangelic	2 Caesareans	yes	Caesarean
I2	36, married	Jehovah's witness	2 Caesareans	yes	Caesarean
I3	31, single	Evangelic	1 Natural	yes	Natural
I4	30, single	Evangelic	Primipara	yes	Natural
I5	34, married	Catholic	2 Natural	yes	Natural
I6	19, single	Lutheran	Primipara	yes	Caesarean
I7	31, single	Catholic	1 Natural	no	Natural
I8	27, married	Evangelic	2 Natural	yes	Natural
I9	35, married	Catholic	3 Caesareans	yes	Caesarean
I10	22, stable union	Evangelic	Primipara	yes	Caesarean
I11	25, stable union	No creed	Primipara	yes	Natural
I12	34, stable union	Umbanda	4 Caesareans	yes	Caesarean
I13	26, married	No creed	1 Caesarean	yes	Caesarean
I14	42, married	Catholic	2 Caesareans	yes	Caesarean
I15	23, stable union	Catholic	3 Caesareans	yes	Caesarean
I16	18, stable union	Catholic	Primipara	yes	Natural
I17	19, stable union	Catholic	Primipara	yes	Caesarean
I18	33, stable union	Evangelic	6 Natural	yes	Natural
I19	25, single	Evangelic	2 Natural	yes	Natural
I20	40, stable union	Catholic	5 Natural	yes	Natural
I21	27, stable union	No creed	2 Natural	yes	Natural
I22	29, stable union	Evangelic	4 Natural	yes	Natural
I23	39, divorced	No creed	Primipara	yes	Caesarean
I24	14, single	Evangelic	Primipara	yes	Natural
I25	28, single	Catholic	2 Natural	yes	Natural
I26	30, married	Catholic	1 Natural	yes	Natural
I27	26, married	Catholic	1 Caesarean	yes	Caesarean
I28	30, stable union	Catholic	1 Caesarean	yes	Caesarean
I29	27, stable union	Catholic	1 Caesarean	yes	Caesarean
I30	31, married	Mormon	1 Caesarean	yes	Caesarean
I31	26, married	Evangelic	2 Caesareans	yes	Caesarean
I32	21, stable union	No creed	1 Caesarean	yes	Caesarean
I33	15, stable union	No creed	Primipara	yes	Caesarean
I34	15, single	Catholic	Primipara	yes	Natural
I35	21, stable union	No creed	Primipara	yes	Caesarean

I36	21, stable union	Catholic	Primipara	yes	Natural
I37	18, stable union	Evangelic	Primipara	yes	Natural
I38	41, stable union	Catholic	4 Natural	yes	Natural
I39	31, married	Evangelic	Primipara	yes	Natural
I40	19, stable union	Catholic	Primipara	yes	Natural
I41	33, married	Catholic	1 Natural	yes	Natural
I42	22, stable union	Buddhist	1 Natural	yes	Natural
I43	34, stable union	Evangelic	4 Natural and 1 Caesarean	yes	Natural
I44	25, stable union	Evangelic	Primipara	yes	Caesarean
I45	24, stable union	Evangelic	Primipara	yes	Caesarean
I46	33, married	Catholic	Primipara	yes	Caesarean
I47	38, stable union	Catholic	5 Natural	yes	Natural
I48	34, stable union	Catholic	1 Natural	yes	Natural
I49	34, stable union	No creed	1 Caesarean	yes	Caesarean
I50	42, married	Catholic	3 Natural	yes	Natural

Source: Data from research.

Main Emotions Experienced and Emotional Ambivalences Identified

Aiming at illustrating and strengthening the argumentation on emotional ambivalence during labor, reports from the interviews are presented. It was evidenced that **anger** and **contempt**, characterized as negative emotions, were not identified with the interviewees. Such emotions are more frequent in stillborn cases and from sexual violence labor, according to the sector professionals report. In this study, specially, there was not the incidence of such facts during data collection period.

In each report, the emotional ambivalence or concurrency was present. Positive and negative emotions emerged from the memories just lived by the mothers. The following excerpts are enlightening: Labor is the baby's birth, it is to have one more child, bring one more child to the world, take care of one more baby [...] I got nervous, a lot nervous, than happy, curious, but it is more anxiety (I1).

My son is the first that comes to my mind, it is difficult, but there is a reward [...] he is going to help me grow, maybe [...] let's see some time from now what I am going to think about it (I6). For other mothers, regardless of been young first-time mothers or multipara, negative emotions prevailed and were observed, making labor a more fearful experience than it could really be. To illustrate such situation, some interviewees' perceptions follow:

Paúra [fear in Italian], my mother had twelve children. We appreciate our mother, we have to be a mother, after I had the first one it disappeared, labor is important, it is suffered, it is not easy, but it is good (I3). Labor is very heavy, suffered. We don't remember almost any good things, but, pain, we just remember pain, that is it [...] labor is the person there, that doesn't have what… many people if could go back wouldn't have, would go back, would not have the labor. It is a strong word; it depends only of you at the time (I5).

The first thing that comes to my mind is life risk, you can go well or not [...] pain is the meaning of labor for me […] I felt alone and also afraid (I12). Fear, fear, it was very weird, a bad sensation, it felt like the air was not coming through, that the chest was about to blow, and than you don't understand what is going on inside your belly and it gives a lot of fear and than when the baby came out I didn't hear his screaming and I got afraid of not seeing the baby and they doing, I don't know what with the baby, and you get really scared, like, what is going on? There is something wrong, it is bad […] the word fear you are going to hear a lot from my mouth (I23).

There was just a concern that since the beginning I had high blood pressure and I had fear, a lot of fear, in relation to that, that something went wrong, some complication, because the doctor said that if I didn't take care of everything, not just the baby, it was me and the baby running risk. And I was afraid, because I had a friend that had to choose between her or the bay (I43). **Guilt** is another negative emotion that was expressed when medical complications, that is, labor happened in an unexpected way, because of health problems, risk of death or some incident that anticipate the baby's birth.

Usually, mother and child are separated because of the need of specific treatment, like, Neonatal UCI hospitalization. Thereby, the following excerpts illustrate such fact: So, when I got pregnant from this one, we couldn't take it to the negative side, who lost a child knows how it hearts, but it is better that comes one more than it doesn't come. We have expectations, is it a girl or a boy [...] the good part: life, and the bad: pain, that goes away and we don't remember anymore (I2).

Life, love, affection, pain [...] I think life is all, isn't it!? Even more of a child […] depending, I guess sometimes we feel a little guilty, but we know it's not our fault, because it's a destiny thing, who knows if I haven't pushed to hard, if my labor would have been natural, but as far as possible […] the doctor said no, but I don't know, at the moment, sometimes it feels like guilt, than it goes away, but what can we do, life is this way […] (I11).

The incidence of **positive emotions** was also perceived, actually, less frequently, since simultaneous occurrence with fear (ambivalence) emerged in the majority of reports. However, some patients make of labor a realization moment of the capacity of being mothers and give life to other human being. I felt very pretty, very happy. Off the pain, I felt it was normal, that it is nature following the course (I7 – crack and other chemical substances user. Low social case for the baby born. According to the Obstetric Center professionals, the baby was born underweight and in chemical abstinence situation). Pain. Just pain and then the happiness of seeing my son [...] there is no explanation. I am very happy, it was my birthday, it was such a present (I17 – labor of 14 hours).

That happiness, that emotion, even though you get a lot of pain, you are anxious there, waiting to see, after all there were nine months waiting, wright?! (I21). I felt the pain was worth it. It was worth it […] now I feel very happy, fulfilled (I41).

A baby born is the most important thing for me today [...] a surprise, how is it going to be? Is it going to look like myself? Is it going to look like the father? Is it coming healthy? It is a very strong thing that comes inside you, even my blood pressure was high during labor of so […] and you cry, you cry because it's a joy that is very good, sometimes you feel pain, ouch, it is very good (I45).

Sensation of power, because we do this, nobody else can do this. So, it's a sensation in that moment that you are the most important […] nobody else can do this for you […] in the heart there was love […] in mind doubts about how your life is going to be, your journey […] in the body the fear of not knowing if you are going to be able to get to the end, if you can bring this life with health, if you can do the service right, if you are going to be able to help. And then, there are three things: love, fear and doubt about how the future is going to be, of what you are going to do to give a better life […] you have that joy but at the same time that fear, you don't know what waits for you, the new […] (I25).

Fear and **joy/happiness** were emotions that characterized greater labors followed during the study, independent of the interviewee profile, kind of labor or the baby's birth conditions. Such emotions were most incidents and identifiable, how can be observed in the following reports:

I felt fear, I felt love for the baby, I knew, couldn't wait for her to be born, to hear the crying and see her face [...] it was the best moment of my life, that's it (I9).

Being a mom is the best thing there is, despite having one, having two [children], but the emotion is always the same, always the same [...] I just felt emotion and anxiety […] I was afraid of the anesthesia (I15).

I was afraid, I didn't know how to push, I got a little scared, my mom was holding my arm and telling me to push, the heart was beating strongly […] I was prepared to have him (I24 – long period of labor, she had the total uterus inversion, remaining in ICU for more than 24 hours).

Fear, I was afraid of natural birth, I ratter prefer a cesarean section. The labor? I think there isn't a better thing in the world, the happiness of having a little piece of you there, I think that is it… It was very quiet, I didn't feel myself, of course I was afraid, but I didn't feel anything that let me distressed, in agony, nothing […] I got anxious, we always get a little, but not like being afraid of something, very quiet (I28). Everything, good things and bad things. We get worried, but it was more about good things, to see the little face, to see whom he looks like, it is all good. The doctors were very attentive.

The doctor hearing my screaming, he said: calm down that it is about to go away, and I said: It's not […] but it was good. I felt like I imagined, because I was afraid, I cried, I made a mess (I29). It's one of the most important things, a new life is coming. It's the most beautiful feeling that must exist in our lives […] I was a bit afraid, I didn't know how it was going to be, but I was calm, everything was all right, no unforeseen happened and it was very quiet, well planned, it was all fine (I31).

I felt a little afraid, it's not good, but then everything gets, everything goes fine […] I felt happiness, fear and doubt about how it was going to be (I33). I was very distressed, very nervous; it's a sensation like, happiness of seeing my daughter was born, but very distressing (I36). Its inexplicable what goes on, everything, at the same time that you smile, you cry, you feel, right?! And it's not easy, the pains, the contractions are strong, but you can't wait to get your little baby. It's very unique (I39).

Fear, nervousness, happiness, many of emotions. I was anxious, nervous. I'm not from here, I was in a very complete strange place, and nothing was from my routine. So, even because of that I was more nervous, a little more (I46 - premature birth, baby in ICU). At the same time, it's bad and it's good. You're giving birth, it's exciting, after birth it's exciting […] In the heart no matter what, but I hope it's worth later, I just thought about that (I47).

I couldn't wait for her to be born, to see her face. It's a lot of pain, unbearable, but after all it's worth it, it was born, took out with the hand […] I was very anxious, a lot, I even thought she was going to be born, even because I got in premature labor. I thought she was going to be born well before, I was since the beginning of the month waiting to see her, I was very anxious, now she is there (I48).

Birth is life. During labor, I was just afraid about my son not being well, I just wanted him to be fine, I couldn't think about myself, I just wanted to hear him crying. From the moment I heard him crying, the pain, everything I was feeling went away (I49- she aborted twice, HIV positive, last pregnancy of high risk for mother and baby).

In summary, based on the transcribed reports, Boards 2 and 3, respectively, rescue the main emotions experienced by the mothers, as well as the emotional ambivalences identified.

Board 2 – Emotions incidence experienced during labor

Emotions Experienced	Emotions Incidence in Interviewees Perceptions
Interest (+)	Interviewees 6, 9, 13, 15, 16, 21, 24, 26, 29, 30, 32, 36, 38, 39, 41, 47, 48 and 49
Joy/Happiness (+)	Interviewees 1, 2, 7, 9, 14, 15, 17, 18, 20, 21, 22, 24, 25, 26, 27, 28, 31, 32, 33, 34, 36, 37, 39, 41, 45, 46, 47, 48 and 49
Surprise (=)	Interviewees 12, 34 and 45
Sadness (-)	Interviewees 11, 13 and 46
Anger (-)	No incidence
Fear (-)	Interviewees 3, 5, 9, 10, 12, 14, 15, 18, 20, 23, 24, 25, 27, 28, 29, 30, 31, 33, 34, 37, 38, 39, 40, 43, 46, 47, 49 and 50
Shame (-)	Interviewee 6
Guilt (-)	Interviewees 2 and 11
Repulsion / Heartbreak (-)	Interviewees 1 and 5
Contempt (-)	No incidence

Source: Elaborated by authors from the emotions typology proposed by Izard (1977).

Note: (+) positive emotions, (=) neuter emotions and (-) negative emotions.

Board 3: Emotional ambivalence incidence

Identified Emotional Ambivalences	Emotional Ambivalences Incidence
Interest (+) and Shame (-)	Interviewee 6
Interest (+), Joy/ Happiness (+) and Fear (-)	Interviewees 9, 15, 24, 39, 47 and 49
Interest (+) and Fear (-)	Interviewees 29, 30 e 38
Interest (+) and Sadness (-)	Interviewee 13
Joy/ Happiness (+) and Guilt (-)	Interviewee 2
Joy/ Happiness (+) and Fear (-)	Interviewees 14, 18, 20, 25, 27, 28, 31, 33 and 37
Joy/ Happiness (+), Surprise(=) and Fear (-)	Interviewee 34
Joy/ Happiness (+), Sadness (-) and Fear (-)	Interviewee 46
Joy/ Happiness (+) and Repulsion / Heartbreak (-)	Interviewee 1

Source: Elaborated by authors from the emotions typology proposed by Izard (1977).

Note 1: (+) positive emotions, (=) neuter emotions and (-) negative emotions.

Note 2: Even though it is not characterized as ambivalence, it was also registered, with the Interviewees 45 and 13, respectively, the incidence of Joy/Happiness (+) and Surprise (=) and Surprise (=) and Fear (-).

From the ambivalent emotions identified, there was greater incidence of the ambivalences: joy/happiness (positive emotion) and fear (negative emotion), the interest, joy/happiness (positive emotion) and fear (negative emotion) and interest (positive emotion) and fear (negative emotion). It is possible to understand, therefore, that even though for most mothers, giving birth is an expected moment, desired, there is a strong ambivalence for fear, fear for feeling pain, fear that something happens to them or the babies. That is why it is important that the professionals that deliver the service transmit security, inform the patients (service users) about the evolution of the birth, focusing more on positive emotions than on the negative ones, dispelling the ambivalences to avoid some kind of emotional suffering and even physical for mothers.

Results Validity

For results validity, by the triangulation technic, an interview with the most experienced obstetric doctor was conducted, which provided evidences for the consolidation of the data obtained in the performed interviews with the mothers. The perceptions were congruent in concern to the experienced emotions, what can be found from some interview excerpts presented on Board 4.

Board 4: Excerpts of the interview with the Obstetric Center responsible

Main Questions	Answers of the Professional Interviewed
From the mothers attended in the Obstetric Center, is the emotional ambivalence during labor evident?	I think since they check in, since their admission, yes, always.
From positive and negative emotions, which are the most observed?	I think that from the negative ones is insecurity about what is going to happen… maybe fears are reinforced by what they already heard […]
Previous experiences can influence future births?	Yes, for sure. Even because we never know if the patient went through the same service. She can come from other services and we don't know how it was conducted. Sometimes even a word badly said from someone influences the person. We try to verify what was good, if it was quick, if there wasn't a surgery, uterus incision. We try taking the positive side, try to prioritize that to demystify a little of what they bring, but it's not easy.
How are positive emotions perceived during labor?	The positive ones we perceive more, mainly, when they are not alone, when there are other patients that are in labor at the same time, they help each other, reinforcing that all the pain will go away soon, that it's the way it is [...]
The type of delivery, natural or caesarean, influences in positive or negative emotions?	Yes, we battle for natural childbirth, but the society, in general, doesn't accept it very well. It accepts it more like an obligation than as a good thing that has to happen, that is natural for the woman. In general, always when they come in thinking it's going to be natural birth, they already come in with negative things, it's a statistics from here. If we take a data collection of all of them, if we analyze it for a month, greater part that comes in and knows it's going to be natural birth, already come in with negative things [fear, doubts and insecurity].
The socioeconomic profile of the mother can influence the labor experience?	In their admission it can, but from the moment they are physiologically experiencing labor this resets […] we can compare with the patients we perform natural birth in the private, the reason is the same. The reaction for pain is the same, if they will scream it's the same thing, the will to perform a caesarean is the same […] it's the same for everyone, I guess so, this is very nice.
What can professionals do to minimize the negative impact of emotions and enhance the positive impact? What kind of prepare do professionals need to have so that the mother feel more protected or more supported?	First, it would be necessary to know that we have to talk. I try to talk the most, make myself present, present myself […] look, I am the night-duty, I'm staying for the night with you, anything you need call me. This is a breath already, sometimes patients report that nobody came to talk to them. Talking to the patient is half way.

Source: Data from research.

Emotions and the emotional ambivalences identified (see Boards 2 and 3) were also presented to this professional, which completely agreed with the results. With such procedure, it sought to validate the content analyses, verifying, from an experienced professional perspective, connected to the study environment, if the positive or negative emotions, as well as the ambivalent emotions identified, in fact, are pertaining to the emotional experience of service users and that are seen by professionals from the area, bringing greater trust in identifying and characterizing the emotions.

Final Considerations

Emotional ambivalences experienced become indications that the connection between mothers and their babies is marked by life stories, past experiences, information and knowledge level. Even more for the first child mothers, there is a perplexity with emotional contradiction: happiness, fear, guilt, everything happening with no harmony and simultaneously. Breaking the emotional universe of a pregnant woman and identifying the intrinsic psychical elements is an activity for the professionals that will take care of her. And this can greatly influence service strategies definition, in its infrastructure and the quality of the delivered attendance (Jayanti, 1996; Winterich & Haws, 2011; Bergström et al., 2013), as well as the care with the behavioral and emotional aspects intrinsic to the involved professionals (Fox, 2001; Lin; Mattila, 2010; Lin & Liang, 2011; Biron & Van Veldohoven, 2012).

The behavior of the frontline employees of the health service provider institution is crucial to evaluate the service by its user (Price, Arnould & Deibler, 1995; Mattila & Enz, 2002; Lin & Mattila, 2010).

In relation to the researched context, it was verified that, among the first time mothers, focused greater anxiety in comparison to the multiparous (women that went through the experience of more than one labor). Such finding was possible by direct observation of these women during labor time and by body language, the greater interest about routines and procedures and a kind of declared rush to end up with the pain with more vehemence than in the case of multiparous, which corroborates the evidences by Rosenberg (2004).

Maternity, although is considered as a romanticized phase by women, it is about a complex life experience and charged with ambivalences, because social issues, economic level, sexual option, the way to get pregnant and family organization contribute to the way the woman experiences maternity. However, in this study, it was not possible to infer or determine the relation between the socioeconomic profile of pregnant women and the influence over experienced emotions. There was not enough empirical evidence to prove that religion, occupation, income level, age or scholarship degree of the pregnant women could influence, leverage or vary declared or implicit emotional ambivalence of the interviewees concerning labor intrinsic emotions.

When it comes to this type of service management and the decision for more effective strategies, service quality and the client's satisfaction (patient) are the greatest achievements desired (Vinagre & Neves, 2008; 2010) and public services are not excluded from this context. Health service quality is related to the level of humanization of the services and the professionals' competence evolved in service execution and, if these factors are perceived in elevated levels by users, the degree of satisfaction with services tend to increase (Tucker III & Adams, 2001; Tucker III, 2002; Avortri, Beke, & Abekah-Nkrumah, 2011; Chahal & Kumari, 2011; Gaur et al., 2011). Besides, health service quality is represented by four dimensions, related to tangible attributes, personal attention and empathy, competence, knowledge, credibility and information veracity delivered and professionalism and courtesy, being responsible for the global evaluation of the delivered services (Badri, Attia, & Ustadi, 2009; Larsson & Wilde-Larsson, 2009; Lin & Liang, 2011).

More than in other services, as, for example, financial services or connected to tourism, quality is more complex to be defined in health because it considers people's lives and the main influences for service users analyses hovers on professionals cordiality, competence, time spent (attention) with the patient and the quantity of provided information. Patients look for support behaviors, effectiveness, care, help and attention by health service providers (Naidu, 2009; Bergström et al., 2013; Stahl, Drew & Kimball, 2014), directly impacting on their service satisfaction level (Larsson & Wilde-Larsson, 2010). From direct observation and the interview performed with the Obstetric Center obstetric doctor, it was found that some infrastructure changes, in operational processes and people management could positively influence service quality perceived level and, consequently, obstetric users satisfaction level. Some considerations about the layout and physical facilities of the Obstetric Center; patients' interaction with physiotherapists, during labor; equipment working properly; ready service, that is, a quicker attendance in doctor consults and the sorting process; wider antepartum rooms and that the pregnant could count on a family monitoring; professionals trainee, as well as psychological and social monitoring of them; a career plan, adequate remuneration and labor gymnastics, to relief tension related to service delivered nature, could resonate in a greater perceived service quality level.

Certainly, such aspects are related to satisfaction level of service users, but, also, take in consideration the involved professionals activity, requires them a largest behavioral flexibility and emotional self-control (Biron & Van Veldohoven, 2012). It is relevant to stress that experienced emotions during labor do not show a direct or complete judgment about perceived quality or service satisfaction. However, a better adequate attendance structure will strongly influence minimizing negative emotions, allowing the maximization of positive emotions (Griskevicius, Shiota, & Nowlis, 2010), making of this a non-traumatic experience. The focus is to add value to customers (Sheth & Sisodia, 2012).

As study limitation it is possible to highlight the possible bias in analyses process and data interpretation, and the categorization of the identified emotions. Besides, there are other emotions typologies, even though the typology proposed by Izard (1977) has been shown very adequate. Maybe, by the nature of the approach done with the interviewees (postpartum), a moment in which data collection should be brief, must have impaired more robust data collection, as well as the audiovisual record, if allowed, could bring in other important evidences to identify and better categorize emotions.

In relation to the development of future studies, methods such as experiments and the application of a survey research could be useful for data collection and the construction of more solid evidences in relation to the identification of the emotions in service context (health or other environments). Besides, studies that associate emotions (positive, negative and ambivalent) would be timely, constructs such as perceived quality, perceived value, customer satisfaction, the involvement with the service and the perceived risk and its possible impacts over possible repurchase of the services or over customer retention or customer loyalty.

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