

Mental Well-Being of Primigravida Receiving Progressive Muscle Relaxation as Part of Midwifery Care in the Third Trimester

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Abstract

This study explored the mental well-being of primigravida women receiving progressive muscle relaxation (PMR) as part of midwifery care in the third trimester. This study used a qualitative-dominant mixed-methods case study involving five purposively selected participants. Interviews, observations, and midwifery records provided qualitative data, supported by descriptive pre-intervention and post-intervention Mental Health Continuum–Short Form (MHC-SF) scores. Four weekly PMR sessions were delivered from 25 July to 15 August 2025, and the posttest was conducted on 22 August, seven days after the final session. Participants described emotional vulnerability before PMR and greater relaxation, improved coping, and increased readiness for childbirth afterward. All five participants had higher post-intervention scores. Mean MHC-SF scores increased from 39.4 to 65.0, with individual increases of 24–31 points. PMR delivered within midwifery care was followed by higher reported mental well-being and positive participant experiences. These findings support further investigation but do not establish effectiveness or causality because the study included five participants without a comparison group.

Keywords: *Mental well-being, Midwifery care, Primigravida, Progressive muscle relaxation, Third trimester pregnancy*

Introduction

Mental well-being during pregnancy remains a global public health concern. The World Health Organization (WHO) reports that approximately 10% of pregnant women experience a mental disorder, primarily depression; the corresponding estimate in developing countries is 15.6%. Maternal mental disorders can impair daily functioning and affect children's growth and development. These concerns support integrating mental health into maternal and child health services (World Health Organization, n.d.).

A promotive approach to maternal mental health also asks what enables women to experience a sense of well-being while navigating pregnancy. Mental well-being includes positive emotions and the capacity to function meaningfully in personal and social life. It is therefore broader than the absence of anxiety or depressive symptoms. Research on the Mental Health Continuum–Short Form (MHC-SF) supports distinguishing positive mental health from mental illness, even though these constructs are related (Keyes, 2002; Lamers et al., 2011). For an

antenatal study, this distinction determines what an outcome score can reasonably represent: a well-being measure describes positive experience and functioning, whereas a symptom scale addresses the burden of particular psychological difficulties.

This conceptual distinction is relevant to the first experience of pregnancy. A woman may seek reassurance about childbirth while also feeling hopeful about becoming a mother; concern and positive expectations need not be mutually exclusive. In the present study, emotional preparedness is approached as an experience that women describe in their own terms, rather than as a diagnostic category. Combining these accounts with a positive well-being measure allows attention to how women understand coping, bodily comfort, and confidence. It does not imply that the measure can determine whether professional mental health assessment is needed. Such assessment remains a separate component of comprehensive maternal care.

Research during pregnancy also links positive mental health with psychosocial circumstances. In a cross-sectional study of 702 pregnant women, anxiety and loneliness were associated with lower positive mental health (Monterrosa-Castro et al., 2023). That study used the Positive Mental Health Questionnaire, a different instrument from the MHC-SF. Its findings support attention to the social and emotional context of antenatal experiences, without establishing causal relationships or validating the instrument used here.

The WHO guide on integrating perinatal mental health into maternal and child health services emphasizes respectful care, opportunities to discuss difficulties without stigmatization, and responses adapted to local contexts (World Health Organization, 2022). This provides a service-level rationale for exploring supportive practices during routine antenatal contact. Midwifery consultations may offer an opportunity to discuss emotional experiences alongside physical concerns. However, the value of a supportive relationship and the specific contribution of a relaxation exercise are different questions. A study examining both together must make this context explicit rather than attribute all reported changes to the exercise alone.

Relaxation-based approaches have been examined as supportive interventions during pregnancy. A systematic review and meta-analysis covering 32 studies and 3,979 participants found benefits for maternal stress, anxiety, and depressive symptoms, although interventions and study designs varied (Abera et al., 2024). These findings provide a rationale for examining accessible relaxation practices within antenatal care, while distinguishing evidence for relaxation interventions as a group from evidence for an individual technique.

In Indonesia, mental health during pregnancy also requires attention. A study involving 100 antenatal care attendees in Balikpapan reported that 24% screened positive for common mental disorders using the Self-Reporting Questionnaire-20 (SRQ-20) (Angrella & Ariane, 2025). An analysis of the 2018 Basic Health Research involving 8,889 pregnant women reported a prevalence of 12.6% (Ariasih et al., 2024). These estimates refer to different study populations and should not be treated as interchangeable or as prevalence estimates for Makassar.

The Indonesian estimates establish the relevance of maternal mental health, but they do not directly describe positive well-being or determine the needs of each woman receiving care. Screening-positive proportions depend on the instrument, population, and circumstances of assessment. The current study therefore does not use these figures to classify its participants or to estimate a local prevalence. Instead, they motivate a complementary question about the experience of supportive care: how do women describe their emotional circumstances, their responses to a structured relaxation practice, and their perceived readiness for childbirth? Addressing that

question requires attention to their accounts as well as to the numerical direction of questionnaire scores.

Within this context, exploring women's experiences of supportive antenatal care in Makassar can help clarify how relaxation is perceived during late pregnancy. The present study focuses on primigravida women receiving midwifery care at Kassi-Kassi Community Health Center, with attention to their emotional experiences and perceived changes over the course of care.

Progressive muscle relaxation (PMR) offers a structured practice involving muscle tension and relaxation. In an Indonesian controlled study, a combination of PMR and positive affirmations was associated with reduced SRQ-20 symptom scores (Pusporini et al., 2025). Because the intervention combined two components, its results cannot establish the independent contribution of PMR. Exploring PMR within routine midwifery care can complement such quantitative evidence with accounts of women's experiences.

Intervention content and outcome selection are especially important when interpreting this literature. The relaxation approaches summarized by Abera et al. (2024) differed in technique and duration. A favorable result for a combined intervention cannot show which component accounts for a change, and reduced symptom scores cannot automatically be interpreted as improved functioning in every domain of well-being. These distinctions shape the present inquiry: PMR is examined as a component of ongoing midwifery care, and the questionnaire is used to support description rather than to establish efficacy. The study also retains attention to what participants themselves considered meaningful, including recognizing tension and responding to worry.

A further issue is the relationship between the period of care and the period recalled by the outcome instrument. A retrospective questionnaire can summarize experiences across several sessions, including time between sessions, rather than capture only the immediate response to the final exercise. Clear reporting of the intervention dates and assessment interval is consequently necessary to interpret a pretest–posttest pattern. In addition, using an instrument across languages requires a distinction between evidence for its general conceptual structure and evidence for a particular translation. These reporting considerations are part of understanding the five cases and the limits of the conclusions that can be drawn from them.

Although quantitative studies have examined relaxation during pregnancy, participants' experiences of PMR within routine midwifery care warrant further exploration. This study aimed to explore the mental well-being of primigravida women receiving PMR as part of midwifery care in the third trimester, using experiential accounts supported by descriptive MHC-SF score changes. The focus on positive mental well-being provides a promotive perspective and contextual insights for woman-centered antenatal care without testing clinical effectiveness.

Methods

This qualitative-dominant mixed-methods case study explored the experiences of five primigravida women receiving PMR within routine antenatal midwifery care at Kassi-Kassi Community Health Center in Makassar. Each woman was treated as an individual case, with qualitative accounts prioritized and questionnaire scores used descriptively, consistent with contextual case study inquiry (Creswell & Poth, 2024). Participants were recruited purposively. Eligibility criteria included a first pregnancy at 28–40 weeks of gestation, willingness to participate with written informed consent, and no obstetric or medical complications requiring specialized or

high-risk care. All five participants remained pregnant throughout the observation period, including at the posttest assessment on 22 August 2025. Baseline MHC-SF scores ranged from 35 to 44. The five cases provided a bounded account of participants' experiences; statistical representativeness and data saturation were not claimed. Participant identifiers P1–P5 were used in reporting.

PMR was integrated into Varney's seven-step midwifery management framework. First, interviews and observation assessed emotional state, perceived stress, pregnancy- and childbirth-related anxiety, coping strategies, and social support. Second, these data were interpreted iteratively to identify patterns in participants' accounts and observed behaviors. Third, actual and potential problems were identified, including emotional tension, adaptation difficulties, and anxiety approaching childbirth. Fourth, immediate support needs and indications for psychological or medical referral were assessed. Fifth, an individualized care plan incorporating PMR was developed. Sixth, the plan was implemented within routine antenatal care, with observation of emotional responses and engagement. Seventh, post-intervention interviews, reflective discussions, and observational notes were used to evaluate perceived changes in mental well-being, emotional control, coping, and daily functioning and to support triangulation.

Four PMR sessions were delivered once weekly, on 25 July and 1, 8, and 15 August 2025. Each session lasted 20–30 minutes and involved sequential tensing and relaxing of major muscle groups with controlled breathing and body awareness. The sessions occupied four consecutive weekly appointments, with 21 elapsed days between the first and final sessions.

Baseline data and the MHC-SF pretest were collected on 1 July 2025, 24 days before the first PMR session. The posttest was administered on 22 August 2025, seven days after the fourth session and 28 days after the first session. The elapsed interval between the baseline and final measurements was 52 days. These intervals distinguish the overall observation period from the period during which the four scheduled sessions were delivered.

The standard MHC-SF recall period is the past month. With that instruction, the baseline assessment on 1 July would cover approximately June 2025, while the final assessment would cover approximately late July through 22 August 2025. The latter window would encompass the intervention period and the week following the last session, rather than a full month after completion of PMR. The printed questionnaire does not specify the recall period, which limits certainty about this temporal interpretation. The 24-day interval between baseline assessment and intervention initiation also means that experiences immediately before the first session were not captured by a separate contemporaneous assessment.

Participants' mental well-being was assessed using the 14-item Indonesian-language MHC-SF questionnaire presented in Table 1 (p. 2785) of Perwitasari et al. (2024). The present study retained all 14 items, covering emotional (3 items), social (5 items), and psychological (6 items) well-being. These dimensions correspond to the positive mental health construct described by Lamers et al. (2011) and the study's focus on mental well-being among primigravida women. Perwitasari et al. (2024) supplied the Indonesian item wording used as the source for the questionnaire. Their psychometric analysis, reported in Table 2, concerned an 11-item modification after removal of items 4, 5, and 7 from the 14-item blueprint. The present study therefore used the complete item set presented in their Table 1, while treating the validation findings as evidence concerning their modified version.

The questionnaire's scoring key lists six response categories: 0 (never), 1 (once or twice), 2 (approximately once a week), 3 (twice a week), 4 (almost every day), and 5 (every day). The

printed response grid displays columns 1–5. A total range of 0–70 presupposes that all six categories were available across the 14 items; restricting responses to 1–5 would yield a range of 14–70. This difference is relevant to interpretation of the recorded totals. Scores were analysed descriptively alongside the interviews, without assigning flourishing, moderate mental health, or languishing categories from total-score thresholds (Söderqvist & Larm, 2023).

The Indonesian wording was sourced from Perwitasari et al. (2024), rather than from the studies of Setswana-speaking South Africans or Swedish adolescents. Those international studies provide background evidence about the MHC-SF across linguistic and population contexts (Opperman et al., 2025; Söderqvist & Larm, 2023). Putra (2023) provides additional Indonesian adaptation evidence in young adults. These references support discussion of the instrument's conceptual and psychometric background; they are not presented as direct validation of the particular 14-item administration in this study. No independent psychometric validation is claimed for these five participants.

Qualitative data were examined thematically, drawing on interviews, observations, and midwifery documentation. Integration occurred during interpretation by considering participants' score changes alongside their experiential themes. Quantitative analysis was limited to individual scores, paired differences, and descriptive means, without significance testing or causal inference. Credibility was supported by repeated engagement, triangulation, and member checking; dependability by documentation of the research process; and confirmability by reflexive journaling and an audit trail. Because the researcher also provided care, participants may have emphasized favorable experiences to please the researcher. Reflexive interpretation therefore requires attention to this dual role. Transferability is limited to contexts comparable to these five third-trimester primigravida cases in one antenatal care setting.

The qualitative themes are presented with participant identifiers and illustrative quotations, while the numerical results retain each participant's paired scores. This reporting distinguishes experiential interpretation from measurement: a quotation can illustrate a theme without demonstrating its frequency, and an increase in the total MHC-SF score cannot establish which specific domain changed. The interpretation therefore considers similarities between the two sources without treating them as independent confirmation. All paired observations are displayed to make the descriptive pattern visible rather than allowing the group mean alone to represent the cases.

The study received ethical approval from the Health Research Ethics Committee, Universitas Islam Negeri Makassar, under approval number S.018/KEPK/FKIK/VII/2025. Participants provided written informed consent. Participants' rights, safety, and confidentiality were protected, and participant codes P1–P5 are used in reporting.

Results

Quantitative Results: Mental Well-being Scores (MHC-SF)

All five participants had higher MHC-SF scores after the PMR-based midwifery care period (Table 1). Baseline scores ranged from 35 to 44 and post-intervention scores from 60 to 70. Mean scores increased from 39.4 to 65.0, giving a mean paired increase of 25.6 points. Individual increases ranged from 24 to 31 points. These changes describe the five cases and do not establish that PMR caused the increase.

Table 1. MHC-SF Scores Before and After the Intervention

Participant	MHC-SF score Before intervention	MHC-SF score After intervention
P1	38	62
P2	41	65
P3	35	60
P4	44	68
P5	39	70

Qualitative Results: Emergent Themes

Thematic analysis of interview data, observations, and midwifery documentation yielded four interrelated themes describing participants' experiences of mental well-being before and after receiving PMR as part of midwifery care.

Theme 1: Emotional Vulnerability During Late Pregnancy

Before the intervention, participants described heightened emotional sensitivity during the third trimester. Feelings of anxiety, worry about childbirth, fear of pain, and uncertainty about the maternal role were commonly reported. Physical discomfort, such as sleep disturbances and fatigue, further contributed to emotional strain. "I often felt anxious at night thinking about labor and whether I could handle it." (P2)

P2's account places the worry in a concrete setting: nighttime thoughts about labor and the question of whether she would be able to manage it. The concern is prospective, centering on an experience that had not yet occurred. The quotation illustrates uncertainty about personal coping as well as anticipation of childbirth. Within this theme, emotional vulnerability therefore refers to the experience of feeling unsettled by future demands, rather than to an established psychiatric diagnosis. The reported sleep difficulties and fatigue provide context for these concerns, but their relationship to anxiety cannot be separated or quantified from the available accounts.

Within this theme, uncertainty about childbirth provided the context for interpreting later accounts of calmness and confidence. P2's nighttime worry illustrates how anticipation of labor could enter everyday experience before delivery. The theme captures the meaning of emotional vulnerability in the participants' accounts, without assigning a psychiatric diagnosis or assuming that all women expressed identical concerns. This distinction is particularly relevant in a small case study, where an individual quotation contributes detail that a summary score cannot convey.

Theme 2: Increased Body Awareness and Relaxation

Following PMR sessions, participants reported greater awareness of bodily tension and relaxation. PMR helped them recognize physical signs of stress and provided a structured way to release tension through controlled muscle relaxation and breathing. "I realized how tense my body was, and after the exercises, I felt lighter and calmer." (P4)

P4's description links recognition of tension with a perceived contrast after the exercises. Her statement begins with becoming aware of how tense her body felt and ends with feeling lighter and calmer. Analytically, the contrast identifies body awareness as part of the reported experience, rather than treating relaxation as an unexplained change in a score. The account suggests that physical sensation provided a recognizable point of reference for describing emotional comfort. It

remains a subjective description; no physiological measurement accompanies the quotation to establish the extent or mechanism of muscle relaxation.

The theme concerns noticing bodily tension and experiencing its release during a structured practice. P4's language connects a physical sensation with a feeling of calmness, suggesting that the contrast itself was meaningful to her. Body awareness provides a concrete description of the session experience, while the following coping theme concerns a reported response to anxiety. These related themes address different aspects of the participants' accounts. The duration of the perceived relaxation between appointments cannot be established from the quotation.

Theme 3: Improved Emotional Regulation and Coping

Participants described improved emotional control and coping abilities after practicing PMR. Feelings of anxiety and restlessness were perceived as more manageable, and participants reported feeling calmer when facing pregnancy-related concerns. "When I start to feel anxious, I use the relaxation techniques, and it helps me calm down." (P1)

P1's account describes a response to the onset of anxiety: noticing the feeling, using a relaxation technique, and perceiving that she could become calmer. This sequence gives the coping theme a practical meaning. The change described is not the elimination of all concern about pregnancy but having a response available when concern occurs. It can therefore be interpreted as a perceived increase in manageability. The quotation expresses the participant's own attribution of helpfulness, which is valuable experiential evidence while remaining distinct from a controlled demonstration of therapeutic effect.

The account suggests an active role for the participant in responding to emotional discomfort. Her emphasis on using the technique when anxiety began indicates that the perceived value of PMR extended to having a response available. In relation to the preceding theme, body awareness concerns recognizing tension, whereas coping concerns acting on an uncomfortable feeling. This interpretation remains grounded in the participant's description: the quotation does not specify the frequency of independent practice, the duration of relief, or situations in which the technique was unhelpful.

Theme 4: Enhanced Sense of Well-being and Readiness for Childbirth

By the end of the intervention, participants expressed a stronger sense of mental well-being and preparedness for childbirth. PMR was perceived as a supportive and empowering component of midwifery care that enhanced confidence and emotional readiness. "I feel more confident and prepared to face labor now." (P5)

P5's statement emphasizes her anticipated ability to face labor. The meaning of readiness in this account is emotional confidence about an approaching event, rather than demonstrated competence during delivery. The narrative marks a shift in how childbirth was viewed at the end of the care period. It does not provide evidence about labor pain, delivery mode, obstetric outcomes, or postpartum adjustment. Readiness is therefore reported as a participant-defined experience within antenatal care, with the boundary between expectation and subsequent outcome kept explicit.

Across the four themes, the accounts move from uncertainty toward recognition of bodily tension, the perceived availability of a coping response, and greater confidence. This ordering is an interpretive way to present related experiences; it is not evidence that every woman progressed through four fixed stages. The quotations illustrate different participants' perspectives and cannot reconstruct a complete longitudinal trajectory for each case. The thematic account is consequently

most informative about the meanings attached to supportive care, while the paired questionnaire values describe the overall direction of reported well-being.

Integration of Quantitative and Qualitative Results

The direction of MHC-SF score changes was consistent with participants' accounts of greater relaxation, improved coping, and readiness for childbirth. The narratives contextualized the numerical changes, but both sources involved the same participants and care relationship. Their convergence supports a coherent description of the cases rather than independent confirmation of an intervention effect.

At the individual level, P1's score increased from 38 to 62 alongside her illustrative account of using relaxation when anxiety arose; P4's scores were 44 and 68, and her quotation emphasized noticing and releasing bodily tension. P5's scores increased from 39 to 70, while her account emphasized confidence about labor. P2's baseline quotation illustrated worry, and her scores increased from 41 to 65. P3 also had a higher final score, from 35 to 60, but no individual quotation from P3 is presented here. This comparison shows the limits of the integration: the numerical pattern includes all five cases, whereas the illustrative extracts provide selected experiential detail and do not establish complete case-by-case thematic coverage.

Discussion

This study explored the mental well-being of five primigravida women who received PMR within third-trimester midwifery care. Higher MHC-SF scores after the care period accompanied accounts of greater relaxation, improved coping, and readiness for childbirth. The numerical and experiential findings describe a favorable pattern within these cases. However, because PMR formed part of an ongoing care relationship, the contribution of the exercises cannot be separated from reassurance, repeated contact, or other changes occurring during pregnancy.

The findings are consistent in direction with the review by Abera et al. (2024), which reported benefits of relaxation interventions for maternal psychological symptoms. That review considered several relaxation approaches, so it does not establish that every technique has equivalent effects. The present study adds contextual accounts of how participants experienced PMR during antenatal care, but its descriptive score changes cannot be compared directly with pooled intervention effects from controlled studies.

Pusporini et al. (2025) examined PMR combined with positive affirmations in a controlled study of 40 pregnant women and reported reduced SRQ-20 symptom scores. Their intervention combined components and used a different outcome instrument. In contrast, the MHC-SF concerns positive well-being. These differences matter: a reduction in symptoms is not identical to an increase in well-being, and neither finding establishes that PMR alone explains the changes observed here.

The meta-review by Silverwood et al. (2023) considered non-pharmacological management of perinatal anxiety in primary care and identified a heterogeneous evidence base. This supports interpreting relaxation as one possible component of supportive care rather than assuming a uniform response across women or settings. Future comparisons should define the intervention, care received by the comparison group, and outcome timing clearly so that findings can inform antenatal practice more reliably.

The four themes add an experiential perspective to this evidence. The contrast between P2's anticipatory worry and P5's reported confidence identifies a clinically relevant subject for

conversation, but it is a contrast between illustrative accounts from different women, not a direct estimate of change in a single person. P4's account describes the felt distinction between tension and relaxation, while P1 describes a coping response. These accounts help specify what participants found meaningful about the care period. They should guide questions for subsequent research rather than be combined into a presumed universal pathway from physical relaxation to psychological recovery.

The care context is central to this interpretation. Repeated appointments may include attention, opportunities to voice concerns, and reassurance, alongside the exercises themselves. The study cannot estimate the relative contribution of these elements. Woman-centered care can reasonably attend to a participant's preference for relaxation while recognizing that an apparently simple intervention is delivered through a relationship. WHO's integration guidance supports locally appropriate, respectful mental health support within maternal services (World Health Organization, 2022). The present findings are compatible with that orientation, but they do not evaluate a service model or establish that the same approach will be acceptable to women with different needs.

Participants' descriptions of recognizing bodily tension and using relaxation when anxiety arose suggest that the practice was experienced as an accessible coping resource. Their accounts also connect physical sensations with emotional preparedness. These are interpretations of reported experiences, not evidence of an established physiological mechanism. The themes do not show that every participant experienced each change to the same extent, and the available quotations should not be used to infer theme frequencies or represent women outside this setting.

The score pattern also requires careful interpretation. The mean increase of 25.6 points summarizes the five paired observations, while one participant reached the standard maximum total of 70. A maximum score leaves no room for further increase on that scale and warrants attention to possible ceiling effects. Without item-level responses, the categorical status of all participants cannot be verified. Moreover, numerical change alone does not establish clinical importance, sustained improvement, or the absence of a mental disorder. These distinctions are essential when positive well-being measures accompany qualitative accounts.

The assessment schedule further qualifies the score comparison. The posttest on 22 August occurred seven days after the final session. Under the standard past-month instruction, its recall window would include all four scheduled appointments, and higher final scores would describe a period containing both PMR and ongoing antenatal care. They would not demonstrate persistence for a month after completion. However, the printed form does not state the recall period; this temporal interpretation depends on confirmation of the instructions actually given. Baseline measurement also preceded the first appointment by 24 days, during which other changes could have occurred. A measurement immediately before the first session would have provided a more temporally aligned reference point.

Instrument version and administration require consideration when interpreting these findings. The present study used the 14-item Indonesian blueprint published by Perwitasari et al. (2024), including the three social well-being items omitted from their 11-item validation analysis. Their psychometric results consequently concern a different item set. Evidence from an Indonesian adaptation in young adults (Putra, 2023) and international studies provides additional context but does not establish validity in these five primigravida cases. The study form's response columns and scoring key differ, and an explicit recall instruction is absent from the printed form. These features constrain comparability with standard MHC-SF administration and interpretation of score

ranges and recall windows. Questionnaire findings are therefore treated as descriptive support for the qualitative accounts, without claims of psychometric validity or clinical effectiveness.

Total scores also compress potentially different experiences into one number. Two women can have similar totals while reporting different distributions of emotional, social, and psychological well-being. The available totals do not show whether improvements were concentrated in one domain, and the qualitative themes cannot supply missing item-level information. For example, confidence about childbirth is not equivalent to a demonstrated change across all psychological well-being items. Future work should retain item responses, verify scoring, and report domain-specific results where justified by the chosen version and study design. Such detail would help assess whether the measured pattern corresponds to the aspects of experience highlighted in interviews.

Published psychometric studies provide a rationale for considering an overall well-being score, while also showing why interpretation depends on the population and instrument version. Monteiro et al. (2021) found support for a general positive mental health factor among Portuguese postpartum women. Yeo and Suárez (2022) likewise reported that a general factor accounted for most MHC-SF variance in samples from Singapore and Australia. These findings help contextualize the use of totals but do not establish the validity or responsiveness of the Indonesian questionnaire administered in this study. In Denmark, Santini et al. (2020) combined psychometric analysis with cognitive interviews and identified difficulties interpreting some items, particularly those concerning social well-being. Future Indonesian antenatal studies could similarly examine how women understand the wording and response options alongside quantitative validation.

For midwifery practice, the accounts identify aspects that could be explored in further work: women's understanding of muscle tension, their willingness to practice, and how relaxation fits into routine care. A larger study could document session attendance, participant preferences, contextual stressors, and follow-up experiences alongside outcome scores. Comparison with routine care would help determine whether PMR adds benefit beyond the supportive relationship itself.

A subsequent study should also describe intervention delivery sufficiently for readers to judge what was offered and received. The TIDieR reporting framework identifies the importance of detailing materials, procedures, providers, delivery arrangements, dose, and fidelity (Hoffmann et al., 2014). For PMR in antenatal care, this could include the instruction sequence, any pregnancy-related adaptations, attendance at each appointment, and whether additional practice was recommended and recorded. These are priorities for prospective documentation, not procedures assumed to have taken place in this study. Documenting discomfort and reasons for missed or discontinued sessions would also help distinguish a favorable account from a broader evaluation of feasibility.

For the qualitative component, fuller reporting of interview circumstances and analysis would allow readers to assess how the themes were developed. COREQ emphasizes the research team and reflexivity, study design, and analysis and reporting, including the use of supporting quotations (Tong et al., 2007). Future interviews should permit discussion of disappointing, neutral, or inconvenient experiences as well as perceived benefits. An interviewer who is not the care provider may help participants express criticism. Transparent documentation of original interview language and quotation translation is also necessary to preserve meaning when findings are presented in English. These improvements would strengthen the evidential basis of the experiential interpretation.

This study has several limitations. It included five purposively selected participants at one site, which restricts transferability. Without a comparison group, changes cannot be separated from natural adaptation, concurrent care, repeated measurement, or regression to the mean. The researcher also provided care, creating potential social desirability and interpretive bias despite the reported reflexive procedures. No long-term follow-up was reported, so persistence of the changes remains unknown. Limited contextual detail and reliance on self-reported outcomes further constrain interpretation. The findings should therefore be treated as exploratory accounts and descriptive changes, not evidence of effectiveness.

Conclusion

Among these five third-trimester primigravida women, PMR delivered within midwifery care was followed by higher MHC-SF scores and reports of greater relaxation, improved coping, and readiness for childbirth. The findings provide preliminary, context-specific insights into women's experiences of supportive antenatal care. They do not establish that PMR caused these changes or is clinically effective. Larger studies with comparison groups and longer follow-up are needed to assess its contribution and the persistence of reported changes.

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