**Women's Psychological Support Needs in Primiparous Childbirth Experience Across Delivery Modes**

Yasmine L. Konheim-Kalkstein,1 Talya Miron-Shatz,2 Fiona Kiernan,3 Naama Srebnik,4 Hen Y. Sela4

1Simon Center for Professional Military Ethic & Dept of Behavioral Sciences and Leadership, United States Military Academy, West Point, NY, U.S.A.
2Center for the Study of Medical Decision Making, Faculty of Business Administration, Ono Academic College, Kiryat Ono, Israel
3Northwell Health Physicians Partners Medicine Specialties, Great Neck, NY, U.S.A.
4Department of Obstetrics and Gynecology, Shaare Zedek Medical Center in Jerusalem, Hebrew University School of Medicine, Jerusalem, Israel

**Correspondence**

Yasmine Konheim-Kalkstein, Nininger Hall, United States Military Academy, West Point, NY. Email: yasmine.kalkstein@westpoint.edu

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**Abstract**

**Objective:** Supportive interactions with healthcare providers in childbirth correlate positively with postpartum emotional well-being. We aimed to determine what support individuals who had unplanned cesarean deliveries (UPCD), vaginal deliveries (VD), and planned cesarean deliveries (PCD) cherish and lack the most.
**Methods:** Based on a framework developed from a pilot of 227 primiparous UPCD women describing their moments of feeling most and least supported during delivery, we surveyed a sample of primiparous women (206 UPCD, 61 PCD, and 161 VD) using multiple-choice questions, regarding support given by healthcare providers.
**Results:** Women, regardless of delivery mode, characterized their most supported moments similarly: adequate provision of information, decisional inclusion, and emotional support. Lack of support was experienced more by UPCD women. Those moments were mostly characterized by being excluded from decision making about their care and lacking emotional support. **Conclusion:** Individuals in all childbirth delivery modes appreciate useful information, decisional inclusion, and emotional support given by a healthcare provider. Individuals with UPCDs are especially likely to feel their emotional support needs were not met. By taking time to inform women, include them in medical care decisions, and support them emotionally (and in UPCD, to empathize with changes in plans), we can prevent women from enduring negative birth experiences.

*Keywords:*childbirth, patient-centered care, shared decision-making, peripartum period, cesarean delivery, vaginal delivery, emotional support

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Many women experience negative feelings around giving birth,1 particularly when it does not go according to expectations.2 A woman may experience a loss of control, decreasing birth satisfaction.3 An unplanned cesarean delivery is especially likely to leave a woman with lower birth satisfaction.4

Low birth satisfaction has physical and mental health implications; it can diminish family well-being5 and influence future health-related decision-making.6,7 Negative subjective birth experiences are the highest risk factor for birth-related PTSD, followed by having an operative birth.8

In this study we differentiate between planned cesarean delivery (PCD) and unplanned cesarean delivery (UPCD). In UPCDs, a woman expects to have a vaginal delivery (VD), and after she begins laboring, ends up with a cesarean delivery. Cesarean deliveries (CD) are highly prevalent; data (2010–2018) from 154 countries reports a 21.1% CD rate9, a rising statistic10. Reports of UPCD rate varies; 10-15% were reported globally over the last two decades11,12. In 2021, the USA low-risk CD rate (nulliparous, term, singleton, cephalic) was 26.3%13; given that the criteria of low-risk CD includes no indications for PCD, it can be assumed that this is largely reflective of the UPCD rate in nulliparous women.

Cesarean deliveries, especially UPCD, are associated with higher risk of postpartum depression12 and PTSD.8,14 Women who had a UPCD were more likely to feel disappointed, to feel they had failed, and to report more negative birth experiences, compared with women who had a VD.4,15

Both the psychosocial and medical nature of the delivery influence women’s response to the event. In one meta-analysis, the strongest correlate for PTSD was experiencing postpartum depression, followed by “negative interactions with medical staff”.16 A meta-analysis found that trauma can result from a lack of relationship with the healthcare provider, poor communication, or feeling dismissed or out of control.17 Similarly, mothers are more likely to have a traumatic birth experience if health care providers are perceived to lack care and compassion.18,19 Lack of emotional support is associated with more regrets in women with UPCDs.20 Psychosocial support can mitigate negative emotions surrounding childbirth. Birth satisfaction is predicted by emotional support and being included in the decision-making.21

Given that perceived quality of care and supportive interactions repeatedly emerged as a strong predictor of disappointment, depression, and trauma, our study objective was to understand what supportive and non-supportive care during delivery looks like, from women’s perspectives. We hypothesized that UPCD women would more often perceive a lack of support, and that moments where support was lacking would more often involve emotional support.

**Materials and methods**

This was a survey-based study that used community Facebook groups for American mothers with data collected in January 2020.

***Survey development***

A convenience sample of women was recruited through American community Facebook groups for mothers, as well as the ICAN (International Cesarean Awareness Network) Facebook group. A recruitment post indicated an opportunity to participate in a research project about women’s first and only birth experience, that resulted in a UPCD and live birth 4 years ago or less. Inclusion criteria were women 18 and older who planned on having a VD up until labor started but ended up having a UPCD. Qualified women were directed to a Google survey, which ended with an option to enter an email for a US $100 gift card raffle. Data collection ran from February 2018 to March 2018. As part of a larger survey (the quantitative data from this survey was published in Miron-Shatz & Konheim-Kalkstein, 202021), participants answered the following open-ended questions, that were not previously analyzed:

1. Describe when you felt most supported during a challenging moment in your birth experience (if you cannot think of one, write N/A).
2. Describe when you felt least supported during a challenging in your birth experience (if you cannot think of one, write N/A).

The 227 participants ranged in age from 18 to 46 years (*M* = 32.18 years, *SD* = 4.72).

Three coders agreed on a coding scheme identifying the type of support given or desired, using a framework capturing emotional, decisional, practical, and informational support,20 who gave the support, and when. Based on the responses for moments of most support, the coders added subthemes of 1) emotional support: verbal (e.g., “I am here for you”), physical (e.g. “held my hand”), and by giving time to process (e.g., “she gave me time to get used to the idea”); (2) medical support, and (3) advocating for mother. For moments of support lacking, we added “general support”.

Using content analysis, participants’ responses were analyzed separately by two coders (a cognitive psychologist and a nursing student). Disagreement was resolved with a third coder (a psychologist specializing in medical decision making) through a discussion, ensuring rigor.22 A coding scheme resulted (see Table 1 and 2) that was used to develop the multiple-choice survey for this study.

Our pilot indicated that, for UPCD, the most salient support was emotional, informational, or decisional inclusion. When support was missing, women mostly lacked decisional inclusion and emotional support (sometimes even feeling actively dismissed/unsupported). The results showed that 63% of the most supportive moments and 94% of the least supportive moments explicitly named a healthcare provider. Therefore, we focused our multiple-choice survey on healthcare providers.

For this study, three multiple-choice surveys (for each birth modality) were developed. In addition to age and educational attainment, participants answered the following multiple-choice question (see Tables 3, 4, and 5 for responses):

Think of the moment where your healthcare provider MOST provided you with support. In that moment, what was the support? (check all that apply)

Think of the moment where your healthcare provider LEAST provided you with support. In that moment, what was the support that was missing (check all that apply)

During what moments of labor and delivery did you not get enough emotional support?

***Participants***

Separate recruitment posts indicated opportunities to participate in a study about women’s first and only birth experience (37 weeks gestation and above) that occurred up to two years earlier and resulted in a UPCD, VD, or PCD. Other inclusion criteria were women 18 and older who were fluent in English. For UPCD, the woman had to have planned on a VD up until they arrived at hospital. At the end of the Qualtrics survey, they could enter an email in a raffle for a US $50 gift card.

***Ethics***

The institutional review board (IRB) of the Ono Academic College approved the pilot study, on which we developed the survey for this study, in 2018 (#201930ono). No identifying information was collected. Informed consent was implied if subjects continued after reading an introductory paragraph about the study and how the data would be used. In 2020, the same IRB approved this research (#201930onoEx2020). No identifying information was collected, and informed consent was likewise implied.

**Results**

There were no significant age differences between VD (*M* = 32.8, *SD* = 5.5) and UPCD (*M* = 32.1, *SD* = 4.8) samples. However, the PCD women were significantly older by 3-4 years (*M* = 36, *SD* = 6.0). Educational levels did not differ between the groups; in all groups, at least 79% of women had at least a 4-year college degree (VD = 83.8%; UPCD = 79%; PCD = 80.3%) (see Table 3 for demographic data).

***Most supported moment***

Women characterized their most supported moment by endorsing characteristics of that moment from various options (Table 4). Nearly 15% of UPCD women were unable to consider a “most supported moment” and endorsed “not applicable” as their response); as did 11.8% of VD and 6.5% of PD women (the proportions were significantly different; χ2(2) = 151.17, *P* < 0.001). Across all participant groups, the most supported moment primarily involved informational (VD = 52.1%, PCD = 50.0% and UPCD = 41.0%). Both VD and PCD women endorsed emotional support as the next most common characteristic (34.7% and 34.8%, respectively), whereas UPCD women endorsed decisional inclusion as the next most common (35.5%). For 34.1% of VD women and 30.4% of PCD women their most supported moment involved feeling included in a decision, whereas 25.7% of UPCD women characterized their most supported moment as one where emotional support was provided.

***Least supported moment***

Only 20.8% of the UPCD women endorsed “not applicable” when asked what their least supported moment was, compared with 41.7% of the VD women and 46.8% of the PCD women (Table 5; χ2(2) = 21.18, *P* < 0.001). Across all groups, the least supported moment primarily involved a lack of emotional support (UPCD = 35%, VD = 23.4%, PCD = 24.5%), followed by being excluded from decisions, for UPCD women (27.9%), but not for VD or PCD (χ2(2) = 11.49, *P* = 0.003). Women with UPCD (19.1%) and VD (15.2%) were more likely to characterize the moment as lacking informational support (χ2(2) = 6.10, *P* = 0.047; compared to PCD = 4.3%), and to characterize a lack of time to process (26.2%), compared with VD (11.6%) and PCD women (8.7%; χ2(2) = 15.62, *P* < 0.001).

When asked specifically about lacking emotional support (see Table 6), 85% (n=155) of UPCD women were able to identify such a moment, compared with 43% (n=73) of VD women and 57% (n=26) of PCD women (χ2(2) = 62.60, *P* < 0.001). For VD women, emotional support was mostly lacking “when laboring” (59%). For UPCD women, it was “when something wasn’t going according to the plan” (47%), “when you realized you were having a cesarean” (47%), “during the cesarean” (45%), and “after the cesarean” (49%).

In summary, the most common characterization across supportive moments tended to be informational, followed by either emotional or decisional, depending on birth modality. When examining least supportive moments, emotional support was most likely to be lacking, followed by decisional inclusion for UPCD and VD. When only analyzing women who could identify a moment (removing N/A responses), there were no significant differences in distribution of answers across all the categories between moments of most support (χ2(8) = 5.46, *P* = 0.70) and least support (χ2(8) = 7.48, *P* = 0.49), highlighting that women’s support needs align across delivery modes.

**Discussion**

The WHO recognized a “positive childbirth experience” as a significant goal for childbearing women.23,24 Yet, for some women, childbirth becomes a negative and disempowering experience.25 Understanding women’s support needs advances this goal. Our results show that women’s needs converge across modes of delivery and are centered around three themes: emotional support, information, and decisional inclusion (a need that was understandably more crucial for UPCD women). While psychological support is appreciated across birth modalities, our results indicate that women with UPCD are less likely to receive the support they needed.

Our findings that emotional support is important to childbearing women are consistent with recent studies. A systematic review showed that women emphasize safety and psychosocial well-being equally in their birth experience.26 Furthermore, the doctor’s demeanor and relationship are pivotal to the patient’s healing.27 Supportive care can help reduce women’s fear of childbirth and promote positive labor outcomes.28,29

Conversely, lack of support is correlated with higher rates of postpartum PTSD.17,19 Negative birth experiences can lead to postpartum depression and PTSD30 and influence the baby’s social-emotional development.31

Decision making during childbirth, regardless of the delivery mode, is challenging: it requires negotiating the risks of mother and baby, interpreting uncertain diagnostic information, and balancing a patient’s desire for control with the authority of the healthcare provider.20 Time pressure, staff shortages, and medical bureaucracy can further obstruct patient-centered communication.32 However, previous work20 suggests that quick interventions that do not obstruct the medical procedure can provide women with support.

The salience of a lack of emotional support across delivery modes suggests providers might benefit from guidance in how to address women’s emotional needs during birth and delivery. Providers should be particularly attentive to UPCD as the information is communicated that a UPCD is necessary, and after the UPCD, where nearly half of our sample indicated lacking emotional support. This recommendation may help ameliorate the birth experience that is more likely to be negative for UPCD15,33 and that is associated with increased rates of postpartum depression34 and trauma.8

Obstetricians have professional guidelines regarding complex medical situations and ethical dilemmas, enabling proper care for patients. However, guidelines for psychological support, that our study identified as crucial for laboring women, are lacking. A search through the American College of Obstetricians and Gynecologists (ACOG) clinical management guidelines list of titles from January 2014 to July 2024 suggests that no document regarding psychological support during childbirth exists. To the best of our knowledge only one document recognizes traumatic birth experiences,35 recommending strategies to prevent re-traumatization for trauma survivors. That notwithstanding, the guidelines lack tools or recommendations for providing support during birth, to prevent trauma in the first place.

Recent ACOG committee opinions on limiting interventions during labor and delivery46 recommend that women in the latent phase of labor should have the opportunity to engage in shared decision making to create a plan for self-caring activities and coping techniques, and that continuous 1-to-1 emotional support by support personnel such as a doula is associated with improved outcomes for women in labor.

Our results, and previous findings, indicate that using non-medical support can increase birth satisfaction and decrease delivering women’s sense of being unsupported. Our research suggests that supportive words of a healthcare provider can transform the experience into a more satisfying one. Words can convey emotional support (e.g. “I know this isn’t going like you imagined and that is probably frustrating…”), can help a patient feel included (e.g., “while we’d really like to follow your birth plan, we recommend X because of your health – do you agree?”), or provide information (e.g., “We are going to do to the safest thing for you and the baby, and let me briefly explain the steps involved.”). Future research can examine how these types of communication can impact experience, and if providing training on psychological support influences birth satisfaction and even postdelivery mental health outcomes.

Our study has several limitations. We describe women’s delivery experiences from their subjective perspective up to 2 years later, and cannot validate them against an objective measure or compare them to healthcare professionals’ reports. Still, the responses reflect women’s lingering recollections of their birth and delivery that, regardless of accuracy, are what the women are left with when considering their birth. Lastly, our sample came from American Facebook groups. While we collected information on age and education level, we cannot infer how representative the sample is of our population of women from the United States or elsewhere. Further studies should consider how demographics interact with support needs and explore how universal these needs are.

In summary, women’s non-medical needs in delivery converge across delivery mode. Women mainly need emotional support, decisional inclusion, and information. Learning about these needs, and how to cater to them, even in the pressing context of delivery, can and should be included in medical guidelines. A short checklist can guide clinicians’ interactions with the women, be streamlined into the care, and help increase birth satisfaction while reducing negative emotions.

**Author contributions**

Study design, data analysis, and writing: Yasmine Konheim-Kalkstein and Talya Miron-Shatz. Data analysis and writing: Fiona Kiernan. Interpretation of data and writing: Naama Srebnik. Study design and writing: Hen Y. Sela.

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**Conflict of interest**

The authors have no conflicts of interest.

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**Renumbering of References (after matching in-text citations)**

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**Table 1**. Pilot study: nature of supporting behaviors

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| **Type of support** | **Example** |
| Emotional – wordsn = 3725% | “When my OB shared ‘we need to get her out’ it felt like it was empowering even though there was little to be done. It made me feel like ‘okay- here we go’.” |
| Decisional inclusionn = 2718% | “When the doctor told me it was my choice as to how to proceed (ie, continue labor or go ahead with c section)” |
| Informational supportn = 2618% | “I was in labor for more than 30 hours. I was not only exhausted but anxious at that point. At almost 40 hours of labor my husband, the doula and the doctors kindly explained to me that we have done all that they could to help with dilation (I never went pass 2cm) and that the baby had poop inside and was already too long without amniotic liquid. Everyone knew I didn't want a C-section so they took the time to answer any questions I had and walked me through the process kindly and slowly.”“My OB drove in on during the middle of the night after 30 hours of labor for my emergency c-section. Before the surgery, he held my hands and asked if I was okay and explained what was happening and how I might feel as different things happened in the surgery. He made me feel very heard and considered and valued by taking those moments for just he and I to connect before the surgery.” |
| Medical supportn = 1510% | “My daughter’s heart rate abruptly slowed and an entire team of nurses came in to monitor her, adjust me, and administer meds ASAP. It was scary but I knew that everyone was to help- and fast.” |
| Practical supportn = 139% | “When I was in blinding pain and my doula caught me when I nearly fell over.” |
| Emotional – physical touchn = 107% | “When the doctor told me we would have to do a c-section because my baby was breech (at 32 weeks 5 days), the doctor was holding one hand and the midwife was holding my other hand. I really appreciated that.” |
| Emotional – time to processn = 96% | “When the Dr told me my daughter was too large to drop into my pelvis and I would not be able to deliver vaginally. She was very clear, but still gave me time to talk it over with my husband and get used to the idea.” |
| Advocating for mothern = 96% | “After my c section, my nurses were very proactive and advocated for me to nurse as soon as possible after delivery. They kicked out my excited family and promoted my wishes without me having to ask.”“Nurses went against doctor to cut an aggressive pitocin dosage” |

**Note:** A given event can be categorized in more than 1 way. n = 153 women identified a most supportive moment. Of them, n = 146 described the nature of the moment. They constitute the number from which we calculated percentages.

**Table 2**. Pilot study: nature of unsupportive behaviors

|  |  |
| --- | --- |
| **Type of support lacking** | **Example** |
| Not included in decisionn = 4930% | “When the doctor took my family out in the hallway and apparently had a 20 min conversation with them..... WITHOUT ME! and essentially made everyone go against my wishes making me feel like I was making uneducated decisions. It’s hard to emotionally labor when you feel everyone is against you.” |
| Lack of emotional supportn = 4326% | “A head nurse came in and told me I wasn’t pushing hard enough after I had been pushing for 3 and a half hours. She was rude and made me feel like a failure. Meanwhile my child’s head was stuck.” |
| Lack of general supportn = 3622% | “I was induced; my doula cancelled on me 6 hours before my scheduled induction. The next night when I was in hard active labor after my water broke and called her back up doula, she said she was on her way. After an hour she still wasn’t there my husband called to see what was the hold up and she told him that one of her clients went into labor so we weren’t her priority and we were on our own. Hearing that was probably the moment I felt least supported.” |
| Problem with medical supportn = 2716% | “Not being able to get pain medication right away, to ease the pain so that I could rest up.” |
| Lack of informational supportn = 2314% | “When no one would tell me why I couldn’t see my baby.” |
| Lack of practical supportn = 85% | “I had to hoist my butt in the air, and nobody covered my bottom for ten of the longest seconds on Earth”" |

**Note:** A given event can be categorized in more than 1 way; n = 165 women identified a moment where they felt least supported. Lack of general support was a category that indicated someone was unavailable (or it was not specified what was missing).

**Table 3**. Demographic sample data

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Delivery mode | Age | Less than high school education | Some college | Four year college degree | Some graduate work/Masters degree | Doctoral degree |
|   | M(*SD*), range | n(%) | n(%) | n(%) | n(%) | n(%) |
| Vaginal delivery (VD) | 32.8 (*5.5*), 20-50 | 2(12.34%) | 25(15.43%) | 53(32.71%) | 67(41.35%) | 15(9.26%) |
| Unplanned cesarean (UPCD) |  32.1 (*4.8*), 21-47 |  1(0.50%) |  43(21.39%) |  66(32.83%) |  64(31.84%) |  27(13.43%) |
| Planned cesaeran (PCD) | 36.0 (*6.0*), 20-53 |  1(1.63%) |  11(18.03%) |  18(29.50%) |  21(34.42%) |  10(16.39%) |
|   |   |   |   |   |   |   |

**Note:** There is no significant difference in educational attainment between the three groups (χ2((8) = 7.36, *P* = 0.50). VD and UPCD groups were not significantly different in terms of age, but planned cesarean was significantly older than the other two groups [*F(2, 425)* = 13.04, *P* < 0.001].

**Table 4**. Characterizations of moments of most support

|  |  |  |  |
| --- | --- | --- | --- |
| Think of the moment your healthcare provider most provided you with support. In that moment, what was the support? (check all that apply) | Vaginal delivery | Unplanned cesarean delivery | Planned cesarean delivery |
|  | % | n = 167 | % | n = 183 | % | n = 46 |
| Including you in a decision or giving you options | 34.1 | 57 | 35.5 | 65 | 30.4 | 14 |
| Explaining something / giving you information | 52.1 | 87 | 41.0 | 75 | 50 | 23 |
| Empathizing/emotionally supporting you | 34.7 | 58 | 25.7 | 47 | 34.8 | 16 |
| Something medical | 18.6 | 31 | 15.8 | 29 | 26.1 | 12 |
| Giving you time to process | 18.6 | 31 | 21.9 | 40 | 23.9 | 11 |
| Not applicable | 11.4 | 19 | 14.8 | 27 | 6.5 | 3 |

**Table 5.** Characterizations of moments of least support

|  |  |  |  |
| --- | --- | --- | --- |
| Think of the moment where your healthcare provider LEAST provided you with support. In that moment, what was the support that was missing (check all that apply) | Vaginal delivery | Unplanned cesarean delivery | Planned cesarean delivery |
|  | % | n = 164 | % | n = 183 | % | n = 46 |
| Including you in a decision or giving you options | 16.5 | 27 | 27.9 | 51 | 8.7 | 4 |
| Explaining something / giving you information | 15.2 | 25 | 19.1 | 35 | 4.3 | 2 |
| Empathizing/emotionally supporting you | 24.4 | 40 | 35.0 | 64 | 23.9 | 11 |
| Something medical | 10.4 | 17 | 12.0 | 22 | 8.7 | 4 |
| Giving you time to process | 11.6 | 19 | 26.2 | 48 | 8.7 | 4 |
| Not applicable | 41.5 | 68 | 20.8 | 38 | 45.7 | 21 |

**Table 6.** Perceptions of when emotional support was lacking during the birth experience

|  |  |  |  |
| --- | --- | --- | --- |
| During what moments of labor and delivery did you not get enough emotional support? | Vaginal delivery(44.5% identified) | Unplanned cesarean delivery(85% identified) | Planned cesarean delivery(56.5% identified) |
|  | % | n = 73 | % | n = 155 | % | n = 26 |
| Laboring through contractions | 59.9 | 37  | 32.9  | 51 | 21.4 | 6 |
| Pushing | 27.7 | 18 | 11 | 17 | N/A | N/A |
| When something wasn’t going according to plan | 27.7 | 18 | 46.5 | 72 | 25 | 7 |
| When you realized you were having a cesarean | N/A | N/A | 46.5 | 72 | N/A | N/A |
| During the cesarean | N/A | N/A | 44.5 | 69 | 21.4 | 6 |
| After the cesarean | N/A | N/A | 49 | 76 | 25 | 7 |