**Talya, Some notes before on publication**

**Title Page:** The title page should adhere to [APA Style](https://apastyle.apa.org/style-grammar-guidelines) and include an APA-style Author Note. The manuscript’s title should be no more than 12 words long, and it should not state an assertion or conclusion.

**Abstract:** Empirical reports must include a structured abstract with < 250 words and these headings:

* **Objective:** Brief statement of the purpose or aims of the study.
* **Methods:** Essential information about the study design, procedures, and measures.
* **Results:** Primary findings; include sample size and primary statistical results, if possible.
* **Conclusions:** Main conclusions based on the primary findings.

Papers such as narrative reviews or invited commentaries for which a structured abstract would be inappropriate should include an unstructured manuscript with a maximum of 250 words.

**Keywords:** List up to five keywords below the abstract. Use National Library of Medicine medical subject heading ( [MeSH](https://www.ncbi.nlm.nih.gov/mesh%22%20%5Ct%20%22_blank) ) vocabulary or [APA psychological index terms](https://www.apa.org/pubs/databases/training/thesaurus) .

**Body of the Manuscript:** Empirical reports should include:

* a clear statement of the research question, hypothesis, specific aims, or purpose of the study;
* essential information about the methods even if a separate methods or protocol paper is cited;
* descriptive statistics to characterize the sample, the sample size, and the measures;
* a CONSORT-style participant flow diagram, if appropriate;
* disclosure of the study’s limitations; and
* conclusions that are consistent with the findings.

The methods section of reports of research involving human participants must provide information about institutional review board or ethics board approval, including the name(s) of the institution(s) that approved the study, or an explanation of why the study was exempt from approval and oversight. Informed consent and assent procedures should also be briefly described.

Reports should explain the significance or novel contribution of original research without overstating the study’s translational, clinical, or public health significance.

If the purpose of the work is to attempt to replicate or extend previous studies, this should be disclosed, and minor innovations or superficially novel features should not be overstated.
The statistical methods should adhere to the [APA Task Force on Statistical Inference](https://www.apa.org/science/leadership/bsa/statistical) guidelines. Statistical results, tables, and figures should adhere to [APA Style](https://apastyle.apa.org/style-grammar-guidelines) guidelines.

**5 OCT 2022**

**COVER LETTER:**

Date

Dear Dr. Freedland,

We submit to you a manuscript - ‘Women's Psychological Support Needs in Primiparous Childbirth Experience Across Delivery Modes’. It details two studies around patient-centered care as it relates to birth, and highlights women’s emotional, instructional, and decisional needs through it.

Women’s birth satisfaction is important in and of itself, and also determines their wellbeing post-partum. However, current medical guidelines do not include any reference to these needs or offer any solutions.

We focused on women’s first childbirth experience in three modalities: deliveries that end in an unplanned cesarean delivery (UPCD, Study 1), as well as vaginal birth (VD) and planned cesarean delivery (PCD, Study 2). Our paper highlights that women’s needs converge to three main topics: information, decisional inclusion, and emotional support. Women who have UPCDs are less likely to perceive their support needs as being met. They also need specific emotional support and acknowledgment around the fact that their plans and hopes for vaginal delivery have been thwarted.

The convergence of women’s support needs across delivery modes, and their previously shown association with wellbeing, suggests that medical guidelines should encompass psychological guidelines as well. Since needs converge, such guidelines can be implemented without requiring extensive additional training, or taking away too much time from medical treatment during delivery.

We have based Study 1 on unpublished data from a previous study. Study 2 follows up on this with an online survey to nearly 400 women, in three modes of delivery.

The unique contribution of this paper lies in the extensive inquiry of support needs, elicited both in open-ended manner and in survey form, by asking women when they felt most and least supported . The ensuing results offer illuminating insights into patients’ psychological needs in general, including in emergency situations.

We followed the author instructions for *Health Psychology* to the best of our ability, and all authors have read and approved this paper. It has not been published elsewhere, is not currently under review elsewhere, and does not contain data that are under review or published elsewhere.

We thank you for your consideration,

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

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**Abstract**

**Objective:** Supportive interactions with healthcare providers in childbirth correlate positively with postpartum emotional wellbeing, and vice versa for non-supportive ones. We aimed to determine what support women in unplanned cesarean deliveries (UPCD), vaginal deliveries (VD), and planned cesarean deliveries (PCD) cherish and lack the most.

**Methods:** In Study 1, 227 primiparous UPCD women described their moments of feeling most and least supported during delivery. In Study 2, a second sample of primiparous women (206 UPCD, 61 PCD, and 161 VD) responded to predetermined questions regarding support, based on Study 1.

**Results:** In Study 1, the most-supportive moments involved emotional support, decisional inclusion, and providing information. The least-supportive moments involved lack of decisional inclusion and lack of emotional support. In Study 2, women, regardless of delivery mode, characterized their most supported moments similarly: adequate provision of information, decisional inclusion, and emotional support. Lack of support was felt more by UPCD women, and those moments were more likely to be characterized as being excluded from decision making about their care and lacking emotional support.

**Conclusions:** Women in all childbirth delivery modes appreciate useful information, decisional inclusion, and emotional support. Women with UPCDs are less likely to feel their emotional support needs are 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, psychology, peripartum period, cesarean delivery

**What Women Want in Birth: Support Needs Converge Regardless of Delivery Mode**

Birth is typically thought of as a joyous time for mothers, and yet, post-birth reflections on the experience are often far from satisfying (Khalife‐Ghaderi et al., 2021). While birth usually ends with the positive outcome of a baby being born, many women experience negative feelings after birth (Aragon et al., 2013), particularly when their birth does not go according to expectations (Mei et al., 2016). When expectations are not met, a woman may experience a loss of control, which reduces birth satisfaction (Jafari et al., 2017). However, the negative emotions are often overlooked by society and the medical system if the woman ends up with a healthy baby (DeGroot & Vik, 2017).

Low birth satisfaction has implications that extend beyond women reminiscing about their birth and can influence subsequent family well-being (Sawyer et al, 2013). For example, breastfeeding and maternal-infant bonding are negatively impacted by low birth satisfaction (Staneva, 2013), and post-traumatic stress from childbirth may influence the baby’s social-emotional development (Garthus-Niegel et al., 2016, Huffhines et al., 2022). At the extreme, a traumatic birth experience can lead to post-traumatic stress disorder (PTSD). Negative subjective birth experiences were the highest risk factor for PTSD, followed by having an operative birth (Ayers et al., 2016). Furthermore, a dissatisfying birth experience can have lingering effects and influence future health-related decision-making, such as opting for an out-of-hospital delivery (Reed & Sharman, 2017; Heyne et al., 2022).

A meta-analysis suggests that 4% of women in community samples may experience postpartum PTSD, and up to 19% of women from high-risk groups experience it(Dikmen et al,. 2017; Yildiz et al., 2017). Alarmingly, in a study of over 200 healthcare professionals in the UK, they identified birth trauma in 34.4% of mothers and 25.0% of partners. (Delicate, Ayers, & McMullen, 2022).

Birth modalities vary, sometimes according to women’s wills and sometimes based on medical considerations, which may diverge from what a woman has planned. In this study we differentiate between planned cesarean delivery (PCD) which involves no maternal or fetal compromise and may be performed at a time that suits the woman and maternity services, and unplanned cesarean delivery (UPCD). A UPCD is, by definition, a case where a woman expects to have a vaginal delivery (VD), and ends up with a different, more intrusive and medicalized procedure altogether.

Cesarean deliveries are highly prevalent: Latest available data (2010–2018) from 154 countries covering 94.5% of world live births shows that 21.1% of women gave birth by CD worldwide. The World Health Organization estimates that CD sections rates are on the rise, and that there is significant difference in rates worldwide, some of which is driven by medical capabilities, but some by demand. For example, in the US 31.6% of deliveries are CD, as are 43% in Latin America, compared with 5% in Sub Sahara. A study that examined delivery rooms in the US in 2002-2008 has found that while the overall CD rate in the US at that time was 31.2%, this was divided between 18.1% of PCD, and 13.1% of UPCD (Zhang et al, 2018). This roughly corresponds with an estimate that 40-60% of CDs are unplanned and occur during labor (Robson, 2001).

Cesarean deliveries, especially emergency ones (UPCDs), increase the risk of postpartum depression (Xu et al., 2017) and PTSD (Ayers et al., 2016; Carter et al., 2022). Women who had a UPCD were more likely to feel disappointed, to feel they had failed, to report more negative birth experiences in comparison with women who had spontaneous VD (Kjerulff, & Brubaker, 2018; Coates et al., 2020).

The psycho-social nature of the delivery, not just its medical circumstances, also influences the women’s response to the event. In a community sample, the strongest correlate for PTSD was experiencing postpartum depression, followed by negative interactions with medical staff; in fact, ‘negative interactions with medical staff’ was a stronger predictor of postpartum PTSD than history of a psychological disorder (Grekin, & O'Hara, 2014). 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 (Elmir et al., 2010). Furthermore, mothers are more likely to have a traumatic birth experience if health care providers are perceived as lacking in care and compassion (Beck, 2004; Moloney and Gair, 2015). Similarly, perceiving a loss of control increases the risk of experiencing a traumatic birth (Furuta, et al., 2016; Jafari et al., 2017).

Previous work has shown that negative emotions surrounding childbirth can be countered by relatively simple means, most of which do not relate to the medical nature of the event. Emotional support, for example, has been shown to decrease the likelihood of having a traumatic birth experience. Birth satisfaction can be predicted by emotional support and being included in the decision-making, (Miron-Shatz & Konheim-Kalkstein, 2020), and lack of emotional support is associated with more regrets in women with UPCDs (Konheim-Kalkstein, & Miron-Shatz, 2019). Interestingly, while women who recount their delivery report, on average, ten challenges per birth, many of these are resolved by informational inclusion, decisional inclusion (mostly by health care providers), practical support, and emotional support (mostly by partners) (Konheim-Kalkstein, Miron-Shatz, & Israel, 2018).

Thus, the literature shows that the psychological experience of birth predicts psychological postpartum health, and that the medical literature is effectively moot on this experience, offering little guidance to physicians who aim to be supportive. This is especially alarming with regards to UPCDs, which leaves those who undergo it most prone to maternal mental health issues. Given that perception of quality of care and supportive interactions have shown up consistently in the literature as a strong predictor of disappointment, depression, and trauma, the present research aimed to understand what supportive and non-supportive care during delivery looks like, from the eyes of women, and in their own words.

In Study 1, we reached out to women who had a UPCD as their first and only birth experience. We asked them to identify moments when they felt most and least supported through free response. This was coded according to a framework set in Konheim-Kalkstein, Miron-Shatz, and Israel (2018). In Study 2, we aimed to broaden the scope of the investigation and to test the generalizability of the findings, by reaching out to samples of women who for their first and only birth had an UPCD, a vaginal birth (VD), or a planned cesarean. They responded to a survey developed based on the data from the open-ended inquiry in Study 1.

**Method**

**Study 1:**

UPCD can be a challenging experience for women. To better understand the socio-emotional perceptions of their birth experience, 227 women who had an UPCD were surveyed about the moments they felt most and least supported.

***Ethics***

In 2018, institutional review board (IRB) approval from Ono Academic College was secured for this research. 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.

***Participants***

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 an unplanned cesarean birth. Inclusion criteria were women 18 and older who were planning on having a vaginal birth up until the day labor started but ended up having an unplanned cesarean delivery and live birth. The experience had to have happened four years ago or less and was their first and only birth experience since. Women who qualified clicked on a link to a Google survey and those who qualified were invited to continue. At the end of the survey, they could enter an email in a raffle for a US $100 Amazon Gift Card.

Data collection began in February 2018 and ended in March 2018. Two hundred twenty-seven women met our inclusion criteria. Women ranged in age from 18-46 years, with a mean of 32.18 (SD = 4.72). Women could indicate where they learned of the survey. Most of them answered “Facebook” but some specified which Facebook group, revealing that the sample included women from local mothers’ groups in the following states: Florida, Minnesota, New York, Massachusetts, Colorado, Maryland, New Jersey, and Virginia. About 8 percent of respondents indicated that they had learned about the survey from the ICAN group.

***Materials***

In the context of a larger survey, 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 moment in your birth experience (if you cannot think of one, write N/A).

***Coding:***

To code the answers to the two questions, three coders agreed on a coding scheme together, which included identifying the type of support given or desired, using the framework developed by Konheim-Kalkstein and Miron-Shatz (2018), in addition to identifying who gave the support, and when the support was provided. The two coders coded separately and then came together to discuss discrepancies, with the third acting as a referee.

**Results**

Of the 227 women, 153 (67%) identified a moment they felt most supported and 161 (71%) identified a moment they felt least supported. These moments were coded for who did (or did not) provide the support and when the support was (or was not) provided (**Table 1**).

 Most often (60.1% of the time), moments of most support described support given by a healthcare provider. The support was most often during labor or before surgery (58% of the time), particularly when the decision to perform a cesarean section was being made (19% of women indicated this was a moment of most support). When another person was implicated in the least supportive moment being described, it was most often a healthcare provider (91.7% of the time). The least supportive moments most often occurred around labor or before surgery (e.g. “I didn’t want to be laying down on the bed and it felt like I had to choose between that or laboring longer on my own”), particularly when the decision to cesarean section was being made (e.g.,“When doctor told me I needed a c-section, left room and no one would tell me what was going on”).

The most supportive moments (n = 153) were classified as to the type of support provided (**Table 2**). Of them, 146 described the nature of the moment. The most identified element was “emotional support” (31.4% of instances). Emotional support could be given in terms of words, physical support, and time to process unexpected changes. The next most common groupings of supportive moments were decisional inclusion and informational support.

Most women (71.9%, n = 165) identified a moment where they felt least supported (**Table 3**). The most commonly mentioned least supportive moments were not being included in decisions (30% of instances). Sometimes the women felt a lack of respect for their preferences. For example: “*I wish the first nurse hadn’t bruised and stuck my hand with the IV needle. I wish she wrote my birthing plan on something other than a napkin.”* Feeling dismissed often led women to feeling a lack of control. For example, “*I wish they would have listened to my wishes. I didn’t feel like I was in control at all.”*

Women commonly referred to instances where they felt the healthcare providers did not empathize or emotionally support them (26.4% of instances). The examples below illustrate this: *“I was shocked and upset to be admitted to a hospital/induced. When they sent me from the sonogram upstairs to be admitted, I was crying. The nurse there looked at me like I was crazy and couldn’t understand why I was upset.”* And: *“The hospital staff was making jokes to one another preparing me for the c-section. Inside jokes while I was worried about my baby. It felt awful”*

***Key Findings:***

Data from Study 1 highlight that, for women, the salient moments are those that are emotionally supportive or unsupportive, as well as moments where women feel included in or excluded from decision-making. Moments of support are often those where information is provided.

**Study 2:**

In Study 2, we sought to expand our findings by determining whether the perceptions of women’s experience of healthcare provider support are generalizable across types of birth. We used Study 1’s coding scheme to develop our multiple-choice questions for Study 2. We gathered data from three new samples of women with UPCD, women with a VD and women with a PCD.

***Ethics***

In 2020, institutional review board (IRB) approval from Ono Academic College was secured for this research. 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.

***Participants***

 A convenience sample was recruited through community Facebook groups for mothers around the United States (e.g., Moms of Orange County, New Moms in Los Angeles, and NYC Moms). Each sample was recruited with separate posts targeting women who have had an unplanned cesarean, vaginal, or planned cesarean. Women who qualified were invited to click on a link which opened a Qualtrics Survey. The survey began with inclusion and exclusion criteria for this study. The woman must be a fluent English speaker of at least 18 years, have had the birth experience that aligned with the survey they were taking (VD, UPCD, PCD), the birth experience was their first and only one so far and happened two years ago or less, had to have given birth at greater than 37-weeks’ gestation, and if she was being recruited for the UPCD group, she had to have expected a VD up until she arrived at the hospital for labor and delivery. Women who qualified were invited to continue to the survey and were offered the opportunity to enter their name in a raffle for a US $50 Amazon Gift Card.

Data was collected in the Fall of 2020. There were no significant differences in age between the VD women (*M* = 32.8, *SD* = 5.5) and UPCD women (*M* = 32.1, SD = 4.8), however the PCD women were significantly older by 3-4 years (M = 36, SD = 6.0). There was no significant difference in educational levels between the groups; in all groups, at least 79% of women had at least a four-year college degree (VD = 83.8%; UPCD = 79%; PCD = 80.3%).

***Materials***

In addition to basic demographic data, women responded to multiple-choice questions asking them to characterize the moments their healthcare provider provided them with the most support and least support. They were also asked to identify when during their birth experience they did not receive enough support.

**Results**

As in Study 1, women were asked to characterize their most supported moment. In Study 2, they did this by endorsing characteristics of that moment from various options (**Table 4**). Nearly 15% of UPCD women endorsed “not applicable” as their response, suggesting they may not have been able to consider a “most supported moment”; 11.8% of VD and 6.5% of PD listed “not applicable” (the proportions were significantly different; χ2(2) = 151.17, p < .00001). Across all three participant groups, informational support was the most common characteristic of that supported moment (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 endorsed decisional inclusion as the next most common (35.5%). 34.1% of VD women and 30.4% of PCD women characterized their most supported moment as one where they felt included in a decision. 25.7% of UPCD women characterized their most supported moment as one where emotional support was provided. None of these proportions are significantly different, suggesting that regardless of delivery mode, similar characteristics of supportive moments are appreciated.

When asked what their least supported moment was, 41.7% of the VD women and 46.8% of the PCD women endorsed “not applicable”, as opposed to only 20.8% in the UPCD group (**Table 5;** χ2(2) = 21.18, p < .0001). Of those who identified a least supported moment, the most common characterization across all groups was a lack of emotional support (PCD = 24.5%, VD = 23.4% respectively, UPCD = 35%). The second most common characterization of lack of support was when these women with UPCD perceived being excluded from decisions (27.9%), and this was significantly different than the other delivery modes. (XXXXXX) Women with UPCD and VD were more likely to characterize their moment as lacking informational support (XXXXX), and UPCD women were more likely to characterize a lack of time to process, as compared to women with VD and PCD. (XXXXX)

Women were further asked when during their experience whether emotional support was lacking (**Table 6**). Whereas only 43% (n = 73) of VD women, and 57% (n = 26) of PCD women identified a moment, 85% (n = 155) of UCPD women identified such a moment, perhaps highlighting a greater need for unmet emotional support (XXXXXXXX). For VD women, the top response of a moment where emotional support was lacking was “when laboring” (59% of the women who answered the question chose this). For UPCD women, the top responses were “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%).

The statistically significant differences we found between women in UPCD vs. PCD and VD in characterization of most supportive moments are mainly attributed to the proportion of women who responded ‘not-applicable’ in each birth modality. This suggests that women in UPCD have significantly more moments where they feel unsupported. However, when we removed the N/A responses, the profiles of women’s support needs appear to converge when examining what women appreciated, regardless of delivery mode. From the perspective of healthcare provider training, this convergence allows for streamlined protocols that address women’s non-medical needs during birth and delivery.

***Key Findings:***

In Study 2, we sought to expand our findings by determining whether the perceptions of women’s experience of healthcare provider support are generalizable across types of birth (UPCD, PCD, and VD). We used Study 1’s coding scheme to develop our multiple-choice questions for Study 2. From both studies, the data illustrate the influence healthcare providers have on women’s experiences through delivery, and the potential they have for improving women’s experiences.

**Discussion**

Childbirth is an event that, for too many women, can be a negative and disempowering experience (Olza et al., 2018; Murphy and Strong 2018). The WHO recently recognized a ‘positive childbirth experience’ as a significant end point for childbearing women (Oladapo et al., 2018; World Health Organization 2018). However, this not fully reflected in medical practice.

In this research, we sought to understand women’s experiences during delivery, through their own words and in a multiple-choice manner. In Study 1, we asked women who had a UPCD to describe their most and least supportive moments during childbirth through their own words. In a vast majority of responses, this moment involved their healthcare provider. In Study 2, we reached out to women who had a VD, PCD, or UPCD to share their experience through a survey questionnaire about moments of support that involved their healthcare provider. Our results show that women’s needs converge across modes of delivery and are mainly centered around three themes. These were the need for *emotional support, information,* and *decisional inclusion* (a need that was understandably more crucial for UPCD women).

Furthermore, women who had UPCD were more likely to recall a moment they were not supported and less likely to recall a moment they felt supported, suggesting a more negative birth experience. This is consistent with research showing that women who have a UPCD are more likely to have a negative birth experience (Kjerulff, & Brubaker, 2018; Grisbrook et al., 2022) which may result in increased rates of postpartum depression (Xu et al., 2017) and trauma (Ayers et al., 2016). In our study, lack of emotional support and lack of decisional inclusion were the top characteristics of their least supportive moments. When asked to identify a moment when emotional support was lacking during birth, women who had a UPCD were nearly twice as likely to identify a moment, compared to women with a VD.

Overall, our results indicate that the nature of the psychological support appreciated is similar across birth modalities, however, women with UPCD are less likely to receive the level of support they need for their challenging birth experience. Providers can be particularly attentive to them when something is not going according to plan (which is synonymous with having an unplanned CD), during the UPCD, and most of all, after the UPCD, where nearly half of our sample indicated they did not get enough emotional support.

Our findings that emotional support is important to childbearing women is consistent with recent studies. A systematic review showed that women emphasize safety and psychosocial wellbeing equally in their birth experience (Downe et al., 2018). Similarly, a population survey in Norway found that Norwegian women seek care that focuses on socio-cultural and psychological aspects of childbirth, alongside physical and clinical factors (Vedeler et al., 2022). This aligns with findings of the pivotal place the doctor’s demeanor and relationship with the patient has in healing (Miron-Shatz, 2021).

In line with what we expected, women identified moments where they experienced emotional support by partners, and decisional inclusion on the part of HCPs, as the most supportive. This has implications beyond the birth. Supportive care can help reduce a women’s fear of childbirth and support positive labor outcomes (Jameei-Moghaddam et al., 2021; Baxter, 2022).

Conversely, lack of support is correlated with higher rates of postpartum PTSD (Grekin, & O'Hara, 2014; Moloney & Gair, 2015). Indeed, negative birth experiences can have far reaching effects, including postpartum depression and PTSD (Dekel et al., 2020) and an impact on the baby’s social-emotional development (Chan et al., 2021).

Decision-making during childbirth, regardless of the delivery mode, is challenging in that 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 (Konheim-Kalkstein et al., 2018). Further variables such as time pressure, staff shortages, and medical bureaucracy can obstruct patient-centered communication (Huschke,. 2021). In emergencies such as an UPCD, decisional and informational inclusion can be particularly difficult for the healthcare team, and fully informing the patient may not be possible. Informing the patient and reaching a shared decision in these situations is further complicated by prognostic uncertainty and the limitations of medical knowledge. How then to reconcile time pressure and occasionally imminent danger to mother and newborn, with women’s pressing non-medical needs?

Professional guidelines regarding complex medical situations and ethical dilemmas exist in obstetrics and enable the obstetric team to provide care for these patients; however, it seems that the toolbox is lacking a guideline of how to provide the psychological support that our study identified as crucial, to laboring women, while taking into account time and medical constraints. Searching through the American College of Obstetricians and Gynecologists (ACOG) clinical management guidelines for Obstetrician-Gynecologist list of titles from August 2020 it appears that no document regarding psychological support of women during childbirth exists(American College of Obstetricians and Gynecologists, 2020). Performing the same search through the website of the Royal College of Obstetricians and Gynaecologists (United Kingdom) reveals several guidelines that address psychological support. However, one is in regard to the management of women with late intrauterine fetal death and stillbirth and the other is regarding the management of women with nausea and vomiting of pregnancy and Hyperemesis Gravidarum while none are related to the management of women in labor (Royal College of Obstetricians and Gynaecologists, 2021; Royal College of Obstetricians and Gynaecologists, 2010). Similarly, searching the term ‘psychological support’ in one the major textbooks in obstetrics (Gabbe et al., 2016) did not yield any matching, so that essentially there appeared to be no mention of psychological support during birth.5

The lack of guidelines on medical team psychological support for women in labor is even more evident in recent ACOG committee opinions regarding approaches to limit interventions during labor and delivery (ACOG Committee Opinion No. 766, 2019). In this document, on the one hand, it is recommended that women who are in the latent phase of labor should have the opportunity to engage in shared decision making to create plan for self-caring activities and coping techniques, and that continuous one-to-one emotional support provided by support personnel such as a doula is associated with improved outcomes for women in labor. Yet, on the other hand, concrete tools for doing so are lacking, possibly because of their focus on the non-medical aspects of delivery.

This paper can help address this gap, and highlight the need in doing so, through relatively large samples, and a choice of two robust research methods. Furthermore, our results indicate that such tools and guiding principles can be simple enough to use across delivery modes, and, in accordance with previous findings, can both increase birth satisfaction, and decrease the sense of being unsupported during birth, which is associated with PTSD and other adverse effects. Therefore, suggestions for going forward include training for medical professionals on how to support women emotionally and pragmatically.

Our study has several limitations, some of which we alluded to in the text. First, while in Study 1 we asked women to recount their experiences in their own words, in Study 2 we restricted them to responses based upon Study 1. This limitation has allowed us to review three fairly large samples of women, with considerable uniformity, while relating to women’s support needs as were expressed in Study 1 and in previous work. Second, there is a time gap between the events, and women’s reports: A four-year gap in Study 1, and a two-year gap in Study 2. However, the literature indicates that women’s recollections of their birth and delivery experiences remain accurate years after the event (Yawn et al., 1998). Lastly, we describe women’s delivery experiences solely from their own perspective, so we cannot validate them against an objective measure, or compare them to healthcare professionals’ reports. These two final limitations notwithstanding, the responses reflect women’s lingering recollections of their birth and delivery, and though these may be somewhat inaccurate, as suggested by the memory-experience gap, they are still what the women are left with when considering their birth.

**Conclusion**

Women’s non-medical needs in delivery converge across delivery mode and can be summarized as the need for 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 and be streamlined into the care.

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**Tables:**

***Table 1.*** Moments of most and least support: Who supported the woman and when was the support given. **(pg. 11)**

|  |  |  |
| --- | --- | --- |
| **Who** (in descending order of ‘most’ supportive) | **Most Supportive Moments (n = 153)** | **Least Supportive Moments (n = 161)** |
| *(n of events that mentioned a “who” = 163), 5 of them mentioned more than one “who”* | *(n of events that mentioned a “who” = 121)* *3 of them mentioned more than one “who”*  |
| Doctor 27% | Unspecified HP38% |
| Nurse 21% | Doctor34% |
| Unspecified 19% | Nurse18% |
| Unspecified HP 10% | Midwife4% |
| Spouse 9% | Spouse 3% |
| Doula 6% | Doula 2% |
| Midwife 5% | Family2% |
| Family 2% |  |
| **When** (in chronological order) | *(n of events that mentioned a “when” = 160)* | *(n of events that mentioned a “when” = 159)* |
| Before birth (on way to hospital)2% | Before birth (on way to hospital)0.6%  |
| While laboring 32% | While laboring 17% |
| While pushing6% | While pushing 4% |
| Unspecified before surgery18% | Unspecified before surgery 20% |
| The moment “ we are going to have a c-section” is revealed 20% | The moment “ we are going to have a c-section” is revealed 19% |
| During surgery8% | During surgery 10% |
| After birth 4% | After birth 14% |
| Unspecified 19% | Unspecified16% |

**Note:** All data is presented in %. Percentages were calculated from the overall number of responses per question.

***Table 2*.** Most Supportive Moments: Nature of supporting behaviors **(pg. 11)**

|  |  |
| --- | --- |
| 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 (i.e. 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 support n = 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 support n = 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 one 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 3*.** Least Supportive Moments: Nature of unsupportive behaviors. **(pg. 12)**

|  |  |
| --- | --- |
| 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 support n = 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 support n = 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 support n = 2716% | *“Not being able to get pain medication right away, to ease the pain so that I could rest up.”* |
| Lack of informational support n = 2314% | *“When no one would tell me why I couldn’t see my baby.”* |
| Lack of practical support n = 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 one 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 wasn’t specified what was missing).

***Table 4*.** Characterizations of Moments of Most Support (**pg. 13)**

|  |  |  |  |
| --- | --- | --- | --- |
| Think of the moment your healthcare provider most provided you with support. In that moment, what was the support? (select 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 (**pg. 14)**

|  |  |  |  |
| --- | --- | --- | --- |
| Think of the moment your healthcare provider least provided you with support. In that moment, what was the support? (select 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 receive enough emotional support? (select all that apply) | 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 |