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BIRTH ISSUES IN PERINATAL CARE WILEY

Basic psychological needs: A framework for understanding childbirth satisfaction

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Abstract

Women often report being dissatisfied with their childbirth experience, which in turn predicts negative outcomes for themselves and their children. Currently, there is no consensus as to what constitutes a satisfying or positive birth experience. We posit that a useful framework for addressing this question already exists in the form of Basic Psychological Needs Theory, a subtheory of Self-Determination Theory (Deci & Ryan, *Can. Psychol.*, *49*, 2008, 182). Specifically, we argue that the degree to which maternity care practitioners support or frustrate women's needs for *relatedness*, *competence*, and *autonomy* predicts their childbirth satisfaction. Using this framework provides a potentially powerful lens to better understand and improve the well-being of new mothers and their infants.

KEYWORDS

childbirth satisfaction, basic psychological needs, postpartum depression

1 | INTRODUCTION

Birth is a transformational life event, and as such, optimizing women's[1] experiences of childbirth is widely recognized as a priority.[1,2] Despite this fact, an alarming number of birthing people report dissatisfaction stemming from their childbirth experience. This, in turn, predicts negative outcomes for both mother and child.[3,4] However, there is no consensus regarding the precise dimensions that engender positive birth experiences.[5-7] In this paper, we argue that Basic Psychological Needs Theory, an existing framework, provides an optimal way to organize the vast literature on this topic. Across domains, evidence shows that when individuals are supported in three basic psychological needs, their well-being improves.[8] Thus, we argue that employing the lens of Basic Psychological Needs can improve our understanding, predictions, and interventions in the domain of childbirth satisfaction.

A substantial proportion of women worldwide report dissatisfaction, or even trauma, associated with their birth experience.[9-16] Between 5% and 17% report childbirth as a negative experience overall,[17-19] and up to 24% report at least one symptom of PTSD related to giving birth.[20-23] Globally, there are systematic shortcomings in meeting the needs of women during childbirth.

Women's dissatisfaction with childbirth is not merely a momentary unpleasantness.[24] Rather, it predicts a host of negative outcomes for mother and child. Dissatisfaction with childbirth predicts poorer breastfeeding,[25] higher maternal anxiety and stress,[26] poorer attachment between mother and infant,[27] and has a strong link to postpartum depression.[28-35]

What is it that truly characterizes a satisfying birth experience? In their meta-analysis, Bell and Andersson[3] point out that there is no "gold standard" measurement for birth satisfaction; indeed, more than 36 measures

[1] We acknowledge that the terms "women" and "mothers" do not represent all people who can become pregnant and give birth. However, the vast majority of people experiencing childbirth identify as women and we are resistant to reducing the category of women to a body part or function, such as "people with uteruses" or "birthing people." For these reasons, we opt to use the terms "women" and "mothers" in this paper.

exist in published studies.[36] Several authors have attempted to summarize which aspects of the experience are most important. Waldenstrom[37] named involvement in the decisions (perceived control) and support from the care practitioner as critical, while Hodnett[38] described personal expectations, the amount of support from caregivers, and involvement in decision-making as powerful predictors. Karlström et al.[39] summarized birth satisfaction as coming from internal factors (confidence and preparedness; feeling in control) and external factors (supportive relationships with caregivers, being seen and heard, and caregiver providing adequate information/guidance). Recently, Leinweber et al.,[6] using a literature review and feedback from birth experts, defined a positive childbirth this way: "A woman's experience of interactions and events directly related to childbirth that made her feel supported, in control, safe, and respected; a positive childbirth can make women feel joy, confident, and/or accomplished and may have short and/or long-term positive impacts on a woman's psychosocial well-being" (p. 364).

Despite the lack of theoretical coherence, certain recurrent themes emerge across these characterizations: birth satisfaction is engendered by: (1) supportive caregivers, who elicit trust; (2) confidence, self-efficacy, and provision of adequate information; and (3) control and inclusion in the decision-making process[10,39,40-45].[2,7,37] Other factors that appear repeatedly in the literature as influencing birth satisfaction include fear;[46] pain[38]; expectation–experience mismatch;[47,48] and birth setting, mode, and obstetric interventions.[49,50]

We argue that an apt framework for organizing these disparate characterizations of birth satisfaction already exists in the form of Basic Psychological Needs Theory (BPNT).[51,52] Under the broader umbrella of Self-Determination Theory, BPNT contends that humans have an innate drive to develop and flourish, but that to do so they must be supported in their basic psychological needs by the social context. These psychological needs are relatedness, competence, and autonomy.[8,51] *Relatedness* refers to feeling warmth and connection with others. Isolation and rejection frustrate the need for relatedness. *Competence* refers to feeling effective and capable. The need for competence is frustrated by an inability to influence one's environment, or when one feels like a failure. *Autonomy* refers to feeling agency and volition. Autonomy is frustrated when one is pushed to do something contrary to one's will. Unlike other attempts to characterize a satisfying birth experience, this characterization is consistent with a broader theory: Relatedness, competence and autonomy are important in childbirth because they are important in *all* contexts—they are fundamental human needs.

Consistent with this theory, the satisfaction of these psychological needs predicts well-being across many domains, including relationships, work, parenting, teaching, coaching, and health care[53-56]; for a review, see Ref.[8] For instance, when teachers support students' basic psychological needs, students earn a higher GPA and show more engagement in school.[57,58] Across healthcare domains, support for autonomy is associated with better mental health and higher levels of health-promoting behaviors.[59,60] In the perinatal period, lower satisfaction of psychological needs (e.g., from the partner) predicts postpartum depressive symptoms, as well as lower positive affect and vitality.[61-63] Thus, we predict that a birth environment that supports the basic psychological needs would engender not only greater satisfaction with the birth, but improved well-being in the postpartum period as well. This may manifest as lower depression, greater vitality, higher parental self-efficacy, better quality parenting, as well as in other ways.

Surprisingly, no research has focused on meeting basic psychological needs during the actual transition to motherhood—that is, during childbirth. We argue that this time of intense physiological and psychological changes may represent a critical period in mothers' identity and well-being. Furthermore, we argue that care practitioners (rather than partner or family) are distinctive in their power to support—or frustrate—birthing people's basic psychological needs.

To examine the literature in this domain from the perspective of Basic Psychological Needs Theory, we performed a literature search using "birth/childbirth" and "satisfaction/ dissatisfaction" as key terms. We then expanded the search to include all of the factors identified above: caregiver support; self-efficacy; pain; expectancies; mode of delivery: cesarean versus vaginal birth; interventions; and autonomy/control. The field is vast. Just searching 2013–2023, the phrase "childbirth satisfaction" appears in the title of over 1500 papers on Google Scholar. The few dozen referenced here are representative and recent selections, and they represent a variety of countries and cultures, for example,[64] (Turkey)[40]; (the UK)[65]; (Iceland)[66]; (Pakistan)[67]; (the United States)[68]; (the Netherlands)[69]; (Hungary)[34]; (Australia)[45]; (Norway).

Below, we demonstrate how women's dissatisfaction with childbirth can largely be captured as frustration of the three basic psychological needs. Both quantitative and qualitative studies support the aptness of this framework. Each section below addresses a single basic need, summarizing the literature and illustrating the point with quotes from study participants describing their childbirth experiences. These quotes were selected from three interview studies in three different countries: Iceland,[65] Norway,[45] and the UK.[40]

2 | BASIC PSYCHOLOGICAL NEED: RELATEDNESS

> At a certain stage [in the birth experience] you start to want, you start to yearn for this caring, you start to yearn for... somehow you are exhausted and you have been doing this for so long and then you just want someone to be kind to you and you know...help you. You just realise that you can't do this alone...
>
> (Halldorsdottir, & Karlsdottir[65]), p. 53.

> She was great, she looked straight into my eyes and came to me [and] touched me warmly, in a personal way ...like she was saying 'I am with you' ...you know, an empowering touch which makes you stronger because you can sense that someone is with you in this...
>
> (Halldorsdottir, & Karlsdottir[65]), p. 54.

A lack of *relatedness* with caregivers underlies many accounts of dissatisfying birth experiences.[70] Women report feeling bullied, ignored, invisible, and dehumanized during labor and the immediate postpartum period.[40,45,71] Craving support and connection during childbirth may have evolved from selective pressures that caused human ancestors to seek out support and assistance during birth and early parenting; from an evolutionary perspective, feeling alone or ostracized, and in fact being alone or ostracized, during this vulnerable period, could pose a grave risk for both mother and child.[72-74] Nonetheless, contemporary obstetric care does not typically prioritize a trusting relationship between the patient and caregiver. In fact, it is common for women to deliver attended by physicians they have never met or do not know well,[75,76] and to be left unattended for long stretches of time in hospital settings.[77]

On the positive side, a supportive caregiver is often one of the strongest predictors of birth satisfaction.[19,39,78] When women give birth attended by people they trust and care for, they feel less pain and have fewer interventions; they also report improved bonding and more successful infant feeding.[78-80] Caregiver quality even influences how the birth is remembered; specifically, challenging experiences of childbirth are remembered more positively when there was a supportive relationship with the caregiver.[81] In fact, any kind of one-on-one continuous support, even from a stranger, predicts fewer interventions and greater birth satisfaction than being without such support.[82]

Mothers' relatedness with their own infants is also disrupted by many common birth practices. Relatedness between the mother and infant, embodied in bonding and breastfeeding, is a typical outcome of a healthy birth. In physiologic birth, infants are usually placed immediately skin-to-skin with the mother, which triggers an influx of oxytocin, the bonding hormone, in both mother and baby.[83] However, common interventions can impede these processes. For instance, women who receive epidural anesthesia experience a reduced influx of oxytocin,[22,83,84] blunting the increase in socialization that nonmedicated mothers experience after birth,[85,86] which can impede successful bonding and breastfeeding.[87-89] In short, the feeling of relatedness—or that sense of belonging and importance to another—appears to play an important role in how satisfied women are with their births.

3 | BASIC PSYCHOLOGICAL NEED: COMPETENCE

> They don't have respect for the female body and its ability to give birth
>
> (Vedeler et al.,[45] p. 652).

> I think they ought to have let me have a walk around or tried me in different positions and they didn't offer that...
>
> Interviewer: And you didn't ask?
>
> No, I didn't ask 'cos I thought that's the way that every mother has a baby sort of lying on your back and sort of just having it... But I didn't know ...I didn't know you could change positions or anything
>
> (Baker et al.,[40] p. 325).

Many women report that their feelings of *competence* were thwarted during childbirth and in the immediate postpartum period, and that this negatively influenced their birth satisfaction.[45,90] When birth is routinely treated as a medical emergency rather than a natural event, women receive the message that their bodies are not competent to deliver without interventions.[91-94] Some standard medical terms applied to labor imply failure on the part of the mother, including "incompetent cervix," and "failure to progress".[92] This image of birth as an emergency and mothers' bodies as incompetent may come from care practitioners as well as the broader culture (depictions in movies and TV, etc.). The influence of this shift can be seen in the language used by birthing mothers: "I wasn't *allowed* to eat or drink," or, as above, "I didn't know I *could* change positions."

Interventions are now ubiquitous in childbirth; normal, physiologic labor is no longer the norm.[95-98] The panoply of common interventions includes induction

of labor, administration of synthetic oxytocin (Pitocin), continuous fetal monitoring, epidural, episiotomy, forceps delivery, and cesarean delivery.[99] The majority of women now experience some combination of these.[96,98] As stated by the WHO:[100] "Most health care providers no longer know what 'non-medicalized' birth is. The entire modern obstetric and neonatological literature is essentially based on observations of 'medicalized' birth." Indeed, it is common for obstetricians to emerge from their residency training having *never* witnessed a birth without interventions.[101]

Particularly frustrating is the "cascade of interventions," where one intervention leads to more.[102] For instance, the so-called "failure to progress" in labor—the cause of many unplanned cesareans—is made more likely by the administration of epidurals and restriction of movement[103,104] and is measured against a time line repeatedly shown to be invalid.[105,106] In addition, some intrapartum interventions are shown to impede bonding and breastfeeding.[87,88] Thus, the (usually unmentioned) risks of one intervention can cascade into many other "failures" to birth or feed the baby as intended.

There are cases in which interventions are recommended and even life-saving, but these are uncommon.[105] In fact, for pregnancies at low risk for medical complications, birth that is allowed to progress physiologically is *at least as* safe as highly medicalized births.[107,108] Even the governing body of obstetricians and gynecologist in the United States agrees that standard obstetric care uses interventions more than medically necessary.[109-111]

Overall, women are more satisfied with childbirth when it proceeds physiologically; as the number of interventions goes up, satisfaction goes down.[112-114] Forceful exhortation of interventions, without adequate provision of information, tends to make women feel ineffective and powerless.[92,115] In contrast, when care practitioners emphasize the competence of women's bodies, women feel empowered[116] and their belief in their ability to birth well predicts a variety of positive outcomes, including later parenting self-efficacy.[117]

At the same time, women may experience pressure from society or from caregivers to birth "naturally," which can also lead to feelings of failure or incompetence if medical interventions are used. Women tend to be satisfied with interventions they themselves request.[118,119] This implies that the number or type of interventions women experience may not be a good predictor of satisfaction; rather, women's sense of competence and autonomy in choosing or declining interventions is paramount. Pain is proposed as an important factor in women's childbirth satisfaction.[38] The role of pain in satisfaction, however, may have more to do with women's sense of competence in coping with the pain than with the pain itself. Women who go into labor with a higher sense of self-efficacy report decreased feelings of pain and improved birth satisfaction.[116] Women who experience pain in a competence-supporting environment feel an enormous sense of empowerment when it is over.[42,45,120,121] One woman, describing the intense pain of childbirth, said, "When you do that as a woman, you know you can do anything" ([121] p. 7). Thus, the perception of pain as traumatic may be more closely aligned with unmet needs for support than an independent predictor of satisfaction. Feeling competent during labor, despite pain, may be empowering for women—even beyond the specific context of delivery.

4 | BASIC PSYCHOLOGICAL NEED: AUTONOMY

> ...Total lack of control. I mean nobody listens to you
>
> (Baker et al.,[40] p. 323).

> They were pushing me to break my waters and I didn't want to have them broken. I just thought well, leave me alone, I'm fine... and in the end I felt that I'd been bullied
>
> (Baker et al.,[40] p. 324).

One of the most common findings regarding childbirth experience is that satisfaction is related to the degree to which birthing women feel control, or *autonomy*.[23,34,38,44,122-127] Women's autonomy is thwarted by not being recognized as an individual—by being treated as "some piece of furniture" (Baker et al. p. 331) or a "vessel" (Beck,[128] p. 32). Autonomy is also thwarted when women are denied dignity, privacy, and respect. One woman described being in the all-fours position in a hospital gown, when numerous students were ushered in without her permission. She used her hand to try to hold her gown over her naked bottom, and a nurse forcibly removed her hands from her gown. "So, I felt raped," she said, "and my dignity was taken from me" (Beck,[128] p. 32).

The need for autonomy is also frustrated when women are not adequately involved in decision-making about their own care, which is a distressingly common theme in birth stories.[34,41,67,68,69,97,124,127,129] In multiple countries, women's birth stories often include being ignored or over-ruled by hospital staff.[40,45,130] One woman described how she had to "argue" to receive an examination while she was in labor, while another wanted to be left alone but was pressured into having her water broken.[40] In one videotaped and well-publicized case, Kimberly Turbin was forcibly given an episiotomy despite yelling, "Don't

cut me!!".[92] Informed consent for medical procedures is a human right (American Medical Association; AMA.org). One might argue that this should be at least as true during the momentous experience of childbirth relative to other medical procedures[92] (WHO, 2018).

5 | BASIC PSYCHOLOGICAL NEEDS IN CHILDBIRTH ARE INTERRELATED

> I didn't really know why I'd have to have that [suction delivery]. But er, with the first one I didn't know what to expect anyway so you just sort of go along with it. But you know, you don't feel like you really have much say because you don't really know what's happening
>
> (Baker et al.,[40] p. 324).

> The best thing for me was being treated like I was an integral part of my own care. The nurses and doctors talked to me as if I knew what was going on and that my opinion mattered. They really listened to me and were very helpful to me in achieving what I wanted to during and after the birth of my baby
>
> (DeClercq et al.,[131] p. 33).

The quotes above illustrate how the three psychological needs are interrelated in maternity care. The first mother reports not knowing what to expect (lack of competence-support), leading her to not participate in the decision to have intervention (lack of autonomy-support). The second quote highlights how important the connection with care practitioners (relatedness-support) is in providing competence and autonomy support. Women are most satisfied with their births if they have care practitioners who care about their well-being as individuals, and who furnish them with information and support. With this support, mothers can make autonomous decisions and emerge from the experience feeling competent, no matter what challenges were faced in the process.

In order to improve the well-being of birthing mothers, it is important to support their needs for relatedness, autonomy, and competence in the birthing process. We argue that this framework is a powerful lens for synthesizing the vast literature on women's childbirth experiences, and for improving our ability to predict outcomes. If this framework indeed captures the core dimensions where birthing women need the most support, this suggests a series of research questions and possible areas for intervention.

One prediction arising from this argument is that support for women's basic psychological needs will predict childbirth satisfaction better than other potential factors. For example, number and type of interventions likely matters less to women than their involvement in the decisions to use them. The proposed factor of mismatch between expectancy and experience may mostly reflect a lack of autonomy, as in Preis et al.[48]. Likewise, women's perception of pain may be less directly related to their satisfaction than their perceived competence and support in dealing with the pain. Future research comparing these different predictors in the same sample could help refine this model.

This framework suggests that support for basic psychological needs would predict well-being for the mother into the postpartum period. Supporting basic needs across many contexts predicts more vitality, less depression, more self-efficacy, and more beneficial health behaviors.[8,60] Thus, we predict that people whose needs are supported during childbirth will exhibit lower postpartum depression, more parental self-efficacy, better well-being, and more positive relationship with their infants.

Given the claim that autonomy, competence, and relatedness are *universal* human needs, this framework can be used across numerous populations of birthing people. Support for these needs should predict well-being within and across different types of healthcare systems, care practitioners, and cultural norms. Affirming the dignity, competence, and worth of every individual receiving perinatal health care may provide one route to improving the experiences of historically disempowered groups, including racially minoritized individuals, immigrants, and non-cisgendered birthing people.[132-134]

Adopting a Basic Psychological Needs framework may benefit not just the patient but the practitioner as well; care practitioners also benefit from contexts that meet their own needs for relatedness, competence, and autonomy.[135] Developing a warm, consistent relationship with patients supports the relatedness needs of both parties, improves care practitioners' job satisfaction, and reduces burnout.[136] Providing care that results in optimal outcomes and a positive evaluation from patients satisfies the caregivers' need to feel competent and effective. There is also reason to predict a "trickle-down" effect, in that care practitioners who are provided more autonomy will in turn support autonomy in their patients (see Reeve et al.[137] for similar findings with teachers and students). La Guardia[138] discusses the benefits of this model for care practitioners and provides suggestions for how practitioners can advocate for their own needs to be met within larger systems of healthcare delivery.

Based on the proposed benefits of supporting basic psychological needs in maternity care, our provisional

suggestions to practitioners are to emphasize three aspects of maternity care that are already commonly used. One, to the extent possible, patients should be provided an option for continuous care with one or a small number of care practitioners. When an individual develops a relationship with one care practitioner over the course of pregnancy, delivery, and postpartum care, her sense of trust and satisfaction improves greatly.[139] Two, prenatal education, emphasizing the body's competence in unmedicated delivery, as well as describing risks, benefits, and recommendations for some of the more common interventions, would go a long way toward improving birthing self-efficacy.[117] Three, the need for true informed consent cannot be overstated. Despite informed consent being hailed as a basic human right, women often report not being given a chance to consider pros and cons of a given action—which includes, by definition, the pros and cons of *not* doing that action.[93] True emergencies aside, care practitioners who advocate for patients to have time to digest relevant information and make autonomous choices, would likely reap benefits in terms of mothers' satisfaction with their care and their future well-being.

In sum, dozens of studies confirm that mothers' psychological experiences during childbirth matter for their evaluation of the birth and for their own later well-being and that of their children. However, prior work on this issue has not settled on a framework for what leads to a satisfying birth. We argue that the literature can best be understood through the lens of Basic Psychological Needs Theory,[51] and that supporting women's needs for relatedness, competence, and autonomy during childbirth may have far-reaching benefits for new mothers and their children.

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CONFLICT OF INTEREST STATEMENT

We have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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