Factors Associated with Negative Perceptions Related to Vaginal Childbirth: Women's Reports in the Immediate Postpartum Period

Fatores Associados às Percepções Negativas Relacionadas ao Parto Vaginal: Relato das Mulheres no Puerpério Imediato

Factores Asociados a las Percepciones Negativas Relacionadas con el Parto Vaginal: Relato de las Mujeres en el Puerperio Inmediato

RESUMO

Objetivo: Investigar as percepções de puérperas que vivenciaram o parto vaginal como uma experiência angustiante. **Método:** Estudo qualitativo, realizado com puérperas em até 48 horas após o parto, que indicaram sentimentos de angústia por meio da questão 7 do questionário Birth Satisfaction Scale-Revised (BSS-R). Foram conduzidas entrevistas narrativas, analisadas por meio de categorização temática. **Resultados:** Participaram da entrevista 4 mulheres sendo que a maioria delas concluíram o ensino médio (50%), 75% eram casadas e o BSS-R, resultou no escore médio de 21,75. A angústia foi associada à dor intensa das contrações, mas também ao sentimento de impotência, ausência de escuta ativa, falhas no acolhimento e sensação de abandono. **Conclusão:** O sentimento de angústia no parto, evidencia que a dor não é o único fator de sofrimento nesse momento. Falhas na escuta, acolhimento e comunicação agravam a experiência, tornando muitas vezes o parto, um momento solitário e assustador.

DESCRITORES: Parto vaginal; Angústia; Puerpério; Humanização do parto; Saúde da mulher.

ABSTRACT

Objective: To investigate the perceptions of postpartum women who experienced vaginal delivery as a distressing experience. **Method:** Qualitative study conducted with postpartum women within 48 hours after delivery who indicated feelings of distress through question 7 of the Birth Satisfaction Scale-Revised (BSS-R) questionnaire. Narrative interviews were conducted and analyzed using thematic categorization. **Results:** 4 women participated in the interview, most of whom had completed high school (50%), 75% were married, and the BSS-R resulted in an average score of 21.75. Distress was associated with intense pain from contractions, but also with feelings of helplessness, lack of active listening, failures in reception, and feelings of abandonment. **Conclusion:** The feeling of distress during childbirth shows that pain is not the only factor of suffering at this time. Failures in listening, welcoming, and communication aggravate the experience, often making childbirth a lonely and frightening moment.

DESCRIPTORS: Vaginal delivery; Distress; Postpartum period; Humanization of childbirth; Women's health.

RESUMEN

Objetivo: Investigar las percepciones de las mujeres que han dado a luz por vía vaginal y han vivido el parto como una experiencia angustiosa. Método: Estudio cualitativo, realizado con mujeres en el puerperio hasta 48 horas después del parto, que indicaron sentimientos de angustia a través de la pregunta 7 del cuestionario Birth Satisfaction Scale-Revised (BSS-R). Se realizaron entrevistas narrativas, analizadas mediante categorización temática. Resultados: Participaron en la entrevista 4 mujeres, la mayoría de las cuales habían completado la enseñanza secundaria (50 %), el 75 % estaban casadas y la BSS-R dio como resultado una puntuación media de 21,75. La angustia se asoció al dolor intenso de las contracciones, pero también al sentimiento de impotencia, la falta de escucha activa, las deficiencias en la acogida y la sensación de abandono. Conclusión: El sentimiento de angustia durante el parto pone de manifiesto que el dolor no es el único factor de sufrimiento en ese momento. Las deficiencias en la escucha, la acogida y la comunicación agravan la experiencia, convirtiendo a menudo el parto en un momento solitario y aterrador.

DESCRIPTORES: Parto vaginal; Angustia; Puerperio; Humanización del parto; Salud de la mujer.

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INTRODUCTION

Childbirth is a unique moment in a woman's life, permeated by physical, emotional, and cultural aspects. Although it is a physiological process, childbirth has been progressively medicalized, especially in some countries, and ends up distancing women from their active role. This distancing contributes to many women experiencing childbirth as an experience of suffering and distress[1].

Studies show that negative perceptions of childbirth may be related to intense pain, a sense of helplessness, a lack of support, and the way the healthcare team manages the process[2]. Although the sensation of pain is an expected element, it does not, on its own, explain the experience of suffering reported by many women. Distress, in this context, gains relevance as a complex feeling that goes beyond the physical component[3].

Furthermore, the social and cultural constructs surrounding vaginal childbirth contribute to ambivalent perceptions of this experience. Many women, even during pregnancy, hear negative accounts marked by pain, violence, and loneliness, which generate anticipatory fear and insecurity[4]. This collective imagination can directly influence reproductive choices, given that television media has a strong influence, promoting the view of cesarean delivery as hygienic, safe, and pain-free, while vaginal delivery is perceived as the opposite[5].

Women's perceptions are increasingly valued, especially given the need for improvements in maternal and child health care services. Questionnaires are considered one of the main strategies for gathering feedback on health care in general. In the Brazilian context, the importance of using the **Birth Satisfaction Scale-Revised (BSS-R)**[6] as a standardized tool to assess the childbirth experience across different dimensions—such as the support received, the pain experienced, and the sense of control—is highlighted. The translation and cultural adaptation of this instrument into Brazilian Portuguese expands the possibilities for systematic assessment of birth satisfaction, allowing for more precise identification of critical aspects of obstetric care[7]. Furthermore, qualitative studies involving direct interviews with Brazilian women are essential for understanding the cultural, social, and institutional factors that shape their experiences. This approach helps reveal inequalities, instances of violence, and the potential for improved care during childbirth, providing valuable insights for the development of public policies and more humane and equitable care practices[8].

The use of questionnaires is an important method for directly hearing what women in labor feel, helping to reduce negative situations and thereby improving care in the health service during this time of high vulnerability. The **Birth Satisfaction Scale-Revised (BSS-R)**[6] was considered one of the best-rated in a systematic review[7] and analyzes women's perceptions during labor and delivery based on the quality of care provided, the stress, and the feelings they experience[9]. It was originally developed in the United Kingdom and has since been translated and validated in several countries, making it possible to cite studies from the United States[10], Spain[11], and Brazil[6]. The consistency of results, even among versions translated in different countries, is an important global indi-

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cator for analyzing birth satisfaction[9].

The BSS-R questionnaire consists of 10 questions, ranging from (Question 1: I went through childbirth without any physical or emotional consequences; Question 4: I felt very anxious during my labor and delivery; Question 7: I found the experience of giving birth distressing; Question 10: The delivery room was clean and sanitized. Although this questionnaire is classified as quantitative—since the questions are scored and a total score is calculated—its questions can serve as triggers for a more in-depth qualitative study[8]. In this context, narratives stand out as appropriate tools for investigating the interviewee's representations of reality. Based on these representations, one can grasp the context in which the informant is situated[12]. This approach of combining quantitative and qualitative methods broadens the understanding of a given phenomenon, adding numerical data to the richness of personal narratives. This approach enables the researcher to access information that contributes to the production of scientific knowledge grounded in the reliability of the accounts and the uniqueness of the data obtained. Furthermore, it allows for deeper investigations by integrating life stories with the social and historical contexts in which they are embedded[8].

OBJECTIVE

To investigate the perceptions of postpartum women regarding their distressing vaginal childbirth experience, as well as to analyze the frequency with which this feeling arises and its associated factors.

METHOD

This is a qualitative study, linked to a larger project that translated and culturally adapted the BSS-R questionnaire into Brazilian Portuguese. We thus identified two stages for this research: the first was the cross-cultural adaptation of the BSS-R, and the second was the administration of question 7 of the questionnaire, through which, based on the responses of the postpartum women, it was possible to quantify the degree of distress experienced during their childbirth; these women were considered eligible for this study.

In these cases, after administering the BSS-R, women who reported feelings of distress were invited to narrate their experiences, allowing for a more in-depth analysis using the thematic categorization technique[8].

The study included literate postpartum women aged 19 to 50 years, within 48 hours of vaginal delivery, and admitted to the maternity ward of Santa Casa de Misericórdia de Santos.

Those with a medical diagnosis of conditions such as pre-existing heart disease, preeclampsia, kidney problems, autoimmune disorders, cancer, or severe infection, prematurity (<37 weeks), or post-term pregnancy (>42 weeks) were excluded from participating in the study. Likewise, those who presented situations that could alter the psychological response to labor, such as intrauterine fetal death, intrauterine growth restriction, early neonatal death, or congenital anomalies, were excluded.

After administering the BSS-R questionnaire to postpartum women who rated their deliveries as a time of distress (**question 7**), we asked them to narrate their delivery. Narrative interviews are unstructured tools that aim to explore specific aspects of a subject, from which life stories emerge—both those of the interviewee and those interwoven within the research context[8].

The interviews were recorded, then transcribed into a field notebook, and subsequently organized and analyzed through thematic categorization until data saturation was reached. The interviews were conducted in a private setting, ensuring confidentiality and comfort for the postpartum women. The researcher recorded the accounts in field notes and later converted them into structured narratives. To ensure methodological rigor, the technique of thematic categorization based on reiteration and theoretical relevance was used. The data analysis sought to identify common units of meaning among the accounts, grouping them into categories that expressed the central dimensions of the experience of distress during childbirth.

Content analysis through qualitative research categorization is performed based on theoretical relevance or data repetition, which is carried out by the researcher and is influenced by them. Consequently, the conclusion of the hypotheses is conceptual, yielding new knowledge and revised assumptions applied to understand others. At the end of the study, we provided the women with their narrated stories as a form of contribution[13].

The research was approved by the UNIFESP Ethics Committee, in accordance with the principles of CNS Resolution 466/12. All participants signed the Informed Consent Form, with approval number CAAEE: 96412318.8.0000.5505.

Mixed-methods research (qualitative-quantitative) involves the collection and analysis of both qualitative and quantitative data and their integration, combining the strengths of both approaches[14]. For this study, saturation sampling was used, which is a conceptual tool considered of utmost importance in qualitative studies. Questions such as "who?" in relation to "how many?" represent inseparable strategies. After all, the most significant aspect of this study was the intention or purpose of the feelings experienced and the representativeness and quality of the information obtained from them[14]. Furthermore, for the quantitative analysis of the data, simple descriptive and frequency statistical analysis was used.

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RESULTS

Among the 35 women who participated in the BSS-R validation study, 40% agreed with the feeling of distress at the time of delivery. Notable reports include "The pain was very acute and, as time went on, it only got worse" and "The pain had been with me for so long that it made me believe I would no longer have the strength to have a normal delivery."

Of the total number of postpartum women who participated in the larger study, all were literate, with an average age of 28.5 years, up to 48 hours after vaginal delivery, and were admitted to the ward of the Santa Casa de Misericórdia de Santos or the ward of the Dr. Silvério Fontes Hospital Complex in Santos. Their educational levels ranged from incomplete elementary school (11.4%) to complete elementary school (17.1%), incomplete high school (8.6%) to complete high school (57.2%), and higher education (5.7%). Regarding marital status, 20% were single, and the majority (80%) considered themselves married. Regarding parity, the majority (71.4%) were multiparous. When asked about participation in any health education activities during pregnancy and, more specifically, whether they had completed a birth plan, few women had this type of preparation for childbirth (5.7%).

Regarding the questionnaire's total score, the BSS-R score ranged from 0 to 40 points, with a mean total score of 24.5, representing moderate satisfaction regarding the moment of childbirth.

Regarding the subgroup of women who reported a distressing childbirth experience and had their experience accounts collected (N=4), 50% of them had completed high school, 25% had not completed high school, and 25% had completed higher education; regarding marital status, 75% were married and the remainder were single; when assessing multiparity, the rate was 50%. Upon completing the BSS-R questionnaire, they achieved a mean total score of 21.75, representing a difference of 2.75 points compared to the total group of women.

Three main categories emerged from the analysis of the narratives

1. "The pain that paralyzes and causes distress"

In addition to the physiological factors that cause pain, such as distension of the lower uterine segment and dilation of the cervix, the most common complaint is pain in the lower abdomen and lumbosacral region among women who have had a vaginal delivery[15]. Furthermore, the emotional context also significantly influences the perception of pain, as fear generates pain and pain increases fear[19]. The way an individual perceives and reacts to pain is influenced by emotional, social, and cultural factors, which shape their interpretation and expression of this stimulus[5].

Women associated the pain of vaginal childbirth with extremely unpleasant sensations, describing it as traumatic and difficult to endure[4]. In other studies, the pain was described as intense and acute, especially during normal childbirth, and was compared to severe cramps both during labor and at the moment of birth[15]. The sensation of pain, although common during childbirth, is multidimensional and influenced by other factors such as fear, abandonment, loneliness, and insecurity, particularly when experiencing childbirth for the first time and there is a lack of information about what will occur[16]. There is a lack of adequate information for women, which contributes to ignorance about the childbirth process and reinforces the beliefs and myths that fuel these fears[5]. Furthermore, women's low self-efficacy perpetuates the fear of being unable to endure the pain. This intensifies the pregnant woman's anxiety during labor, causing feelings of insecurity and uncertainty to arise[16].

"The contractions were so strong that anxiety overwhelmed me and I started crying." (Jadi) "The pain was so intense that I thought I wouldn't make it. It was as if my body was collapsing." (Alexsandra)

We can see from these statements that women's confidence levels tend to be lower at the time of delivery. This fact increases insecurity, anxiety, and other negative feelings. The importance of prenatal education addressing the changes and bodily signs experienced by pregnant women has been widely discussed, highlighting its effectiveness in boosting the birthing woman's confidence that "everything is progressing as it should." From this perspective, her confidence or self-efficacy increases as she realizes that her attitudes and actions can minimize physiological responses, such as pain relief. In the broader context of health education, all strategies that reduce and manage emotional stress can strengthen women's self-efficacy during childbirth[17].

2. The Lonely Wait

When a woman in labor finds herself in an environment lacking the support of a healthcare team prepared for potential complications during childbirth, she tends to develop an anxious pattern that intensifies her negative perception of childbirth. In such contexts, childbirth is often associated with suffering and physical pain, which can hinder the physiological progression of labor and negatively impact the woman's experience[18].

According to the Ministry of Health's National Guidelines for Normal Childbirth Care, it is essential that healthcare professionals assess a woman's knowledge of strategies for relieving pain and fear and provide appropriate and balanced information for the situation. This practice promotes greater confidence, auton-

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omy, and active participation by the pregnant woman in the childbirth process, reinforcing the humanization of care[19]. Given this scenario, the qualified involvement of the various health professionals who may be present at this time is essential, as it is their responsibility to provide humanized, woman-centered care. It is important to recognize the emotional and physical aspects involved in childbirth, which also contribute to reducing fear and pain. Simple measures, such as non-pharmacological pain relief strategies—including massage, particularly in the lower back; guidance on breathing exercises; encouraging warm showering; and activities using a birthing ball or birthing stool—can provide greater comfort and well-being during this time[20].

"I spent hours in the hospital in pain, waiting for someone to tell me what to do. I felt forgotten." (Ana Caroline) "I asked for a C-section because I thought I couldn't handle it. But no one really listened to me." (Ana Caroline)

3. Support That Strengthens

Women who received physical and emotional support during childbirth—from the medical team or a support person—reported more positive feelings, even in the face of pain. Law No. 11,108/2005, known as the "Companion Law," guarantees pregnant women the right to be accompanied by a person of their own choosing during all stages—such as labor, delivery, and the postpartum period—and must be enforced in all SUS healthcare facilities. This presence provides the woman with security, comfort, and a sense of welcome, reinforcing her agency and autonomy in the childbirth process. Humanized care is characterized by open listening, free from judgment and prejudice, which instills confidence in the woman and encourages her active participation during childbirth. This supportive interaction contributes to a healthier birth and strengthens the bond between mother and child[21].

Among the companions the woman in labor can choose, the baby's father plays a fundamental role during childbirth, as he provides physical and emotional support. Actions such as expressing affection, giving massages, offering desired food and drinks, capturing the moment in photos, and attending to aspects of the environment—such as music and even scents—contribute to creating a welcoming atmosphere. Thus, the presence of the companion becomes an important factor in promoting a more positive and satisfying childbirth experience[22].

In addition to the partner's presence, a welcoming environment is another essential element in empowering the woman during childbirth, as the interprofessional healthcare team provides attentive and compassionate listening, addressing the pregnant woman's complaints, doubts, and feelings, and demonstrating empathy and commitment to meeting her needs[23].

Finally, it is essential to recognize that childbirth is a unique and subjective experience, to which each woman assigns her own meanings. Therefore, the healthcare professionals present at that moment must base their actions on dialogue and respect for the birthing woman's experiences and knowledge, avoiding impositive behaviors that may cause discomfort or hinder the progress of labor. Support, knowledge, respect, and active listening are fundamental to empowering women during this significant moment.

"The ball, the shower, the massage... all of that helped me keep going. The team was there for me." (Alexsandra) "Even though I was in pain, I felt capable. The physical therapist helped a lot with my breathing." (Alexsandra)

DISCUSSION

Based on question seven of the BSS-R questionnaire, a significant number of women associated the moment of childbirth with feelings of distress. The narrative interviews revealed that this distress was not exclusively related to physical pain, but also to experiences of helplessness, fear, a sense of loss of control, the absence of a support person, and shortcomings in the care provided by the healthcare team. The participants described childbirth as a moment of high emotional vulnerability, highlighting the importance of emotional support, skilled listening, and respect for women's autonomy. These findings reinforce the need for public policies and clinical practices aimed at humanizing childbirth and promoting safe and welcoming environments.

Although vaginal childbirth is a physiological event, it can be experienced negatively when women do not feel supported[3]. Analysis of the accounts shows that distress is frequently related to a lack of active listening, neglect, impersonal conduct, and difficulty accessing continuous care. These factors accentuate women's emotional vulnerability and intensify their perception of suffering, and this fact was evident in this study, as women who reported feelings of distress during childbirth had a lower BSS-R score compared to the other women in the study.

The way childbirth is understood socially and culturally has a direct influence on women's choices. The idea that vaginal childbirth is painful, traumatic, and even dangerous is sustained by intergenerational memories, social discourse, and media reinforcement[5]. Negative experiences, such as dehumanized care, are linked to the rise in the number of cesarean sections, even without actual medical indications or the onset of labor. Studies show that many women begin their pregnancies preferring vaginal birth, but the lack of support for this choice during prenatal care, combined with negative experiences during labor, leads to a shift in

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preference toward cesarean section[24]. This demonstrates that the choice of delivery method, when made, is not solely clinical but can be influenced by emotional, cultural, and care-related factors.

In 2015, the World Health Organization (WHO) developed a document in partnership with the United Nations (UN) titled "Global Strategy for Women's, Children's, and Adolescents' Health," which aims to encourage women to thrive and reach their full potential in terms of health and life, rather than merely surviving[25]. To achieve this goal, regarding motherhood and maternal and child health, the WHO compiled recommendations addressing women's psychological and emotional needs in a document titled "WHO Recommendations: Intrapartum Care for a Positive Birth Experience." It is emphasized that there must be assurance that women eat and stay hydrated during labor, along with regular monitoring and clear communication among the interprofessional team present, among other recommendations cited in the document.

Therefore, combating this negative view of vaginal childbirth requires valuing positive experiences, disseminating evidence-based information, and strengthening woman-centered obstetric care. The negative perceptions reported in this study—such as suffering, a sense of abandonment, and unnecessary interventions—highlight gaps in care, underscoring the importance of empathetic listening and the active presence of professionals sensitive to women's individual needs.

The participants' accounts reinforce that, although pain is a defining element, it is the quality of care that determines how that pain will be interpreted. In the literature, a qualitative study with pregnant women—though the number of participants was limited—established a theoretical and practical framework for healthcare professionals aimed at broadening their psychological understanding of the different stages of pregnancy and the postpartum period, identifying experiences, expectations, fears, and anxieties[3]. In addition to this study, a qualitative study featuring the testimonies of 14 women in labor can be cited, and it was possible to identify a pattern of feelings linked to negative experiences, such as a sense of vulnerability, frustration, and devaluation at the time of delivery, since the study reported non-humanized treatments, such as the use of the Valsalva maneuver and instructions not to scream[2]. The present study corroborates this evidence, demonstrating that distress is strongly associated with how women are treated at the moment of their baby's birth.

The study offers several positive insights by reporting on the distress experienced by women during vaginal childbirth. It highlights the emotional aspects that occur during this time and which are often overlooked. One of the most relevant aspects of the research is the active listening to the postpartum women, which made it possible to transform their interviews into narratives. This approach allows access to their experiences from the women's own perspective, valuing their individual experiences and respecting each account, along with the supportive nature of each interview, contributing to making the research environment more comfortable for the study to be conducted.

The use of the BSS-R questionnaire, which was translated into Portuguese, lends methodological validity to the study, serving as a positive factor in its clinical and scientific contribution. Emotional and contextual factors associated with feelings of distress were highlighted, demonstrating that distress is not limited to physical pain but is related to a lack of support, fear, feelings of abandonment, and shortcomings in the care provided by the healthcare team. These results reinforce the importance of WHO guidelines for promoting safer, more welcoming, and woman-centered care during childbirth. Thus, the study contributes significantly to the advancement of humanized care during childbirth and to the empowerment of women.

Among the limitations encountered during this study, it is worth noting the difficulty in finding women who met the eligibility criteria, including those without a medical diagnosis of pre-existing heart disease, preeclampsia, kidney problems, autoimmune disorders, cancer, or severe infection, the babies had to be full-term (37 to 42 weeks), and the women in labor had to have no psychological distress during labor, such as having experienced an episode of intrauterine fetal death, intrauterine growth restriction, early neonatal death, or congenital anomalies. Furthermore, even when participants met the criteria, there was also difficulty locating the women in their hospital rooms to collect data for the study. These factors limited the study's ability to recruit a larger number of participants; however, it is important to emphasize that the criteria are necessary to ensure the study is conducted as consistently as possible to yield the best possible results.

CONCLUSION

Distress during childbirth, as reported by 40% of the participating postpartum women, demonstrates that pain is not the only factor—though it is the most clearly recognized—contributing to suffering at that moment. Failures in listening, support, and communication exacerbate the experience, often making childbirth a lonely and frightening moment.

Understanding these perceptions is fundamental to transforming obstetric care, ensuring that childbirth is experienced as a positive, safe, and respectful event. Valuing women's accounts contributes to the adoption of truly humanized practices.

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