BIRTH EXPERIENCES: THE ROLE OF GUILT, SHAME, AND RELATIONSHIP SATISFACTION DURING PREGNANCY

by

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Certain psychological factors affect whether the experience of giving birth is positive or negative. Guilt and shame have been linked to negative mental health outcomes in both general and perinatal populations, but neither have been studied in relation to birth experiences. The purpose of the current study was to determine whether guilt and shame were associated with birth experiences. Additionally, I sought to determine whether relationship satisfaction moderated the effects of guilt and shame on birth experiences. My thesis used existing data from a longitudinal, self-report survey design. Participants completed questionnaires during their third trimester of pregnancy that measured guilt, shame, and relationship satisfaction. They also completed a questionnaire at six-weeks postpartum measuring birth experience. I conducted linear and hierarchical linear regressions and found that shame during pregnancy was associated with birth experiences such that higher levels of shame were associated with more negative birth experiences. Guilt was not associated with birth experiences, and relationship satisfaction did not moderate the associations between shame and birth experiences nor guilt and birth experiences. These findings suggest that shame may play a bigger role in the birth experiences of perinatal people while guilt and relationship satisfaction may be less important.

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Introduction

Birth is a physically and emotionally intense experience that can be exciting and gratifying but can also be very overwhelming and scary. There are many factors that may influence how positive or negative a birthing person perceives their birth to be, which we refer to as birth experiences. Some influential factors predicting variation in birth experiences include the psychological well-being of pregnant individuals (Kaliush et al., 2024). Guilt and shame, two indicators of psychological well-being, may contribute to negative birth experiences. Importantly, relationship satisfaction has been found to act as a buffer between multiple variables that predict emotional distress, which suggests that it may be a protective factor in the associations in the current study as well (Røsand et al., 2012). My thesis sought to determine if guilt and shame were associated with birth experiences and whether relationship satisfaction acted as a protective factor in that association.

Birth Experience

The birth of a child is a major life event and transitional period that affects the physical health of the birthing person and their infant as well as the mental health of the entire family (Saxbe et al., 2018). Birthing people can have different experiences when entering labor or giving birth. Some births can be extremely negative and even traumatic while others are relatively positive. For instance, some mothers (especially first-time mothers) tend to report significant fears prior to birth as well as negative experiences during birth such as extreme pain, lack of perceived support, stress, and loss of control or powerlessness surrounding the birth (see Saxbe et al., 2018, for a meta-analysis). On the other hand, some mothers report a more positive birth experience in which they feel calm, in control of their experiences, and supported by those around them (Karlström et al., 2015).

Predictors of Birth Experience

It's important to study factors that may affect birth experiences because the quality of birth experience reported postpartum has large implications for mental health (Bell et al., 2016; McKelvin et al., 2021) and parenting outcomes (Bell et al., 2019; Seefeld et al., 2023) down the line. There are many psychological factors that impact birth experience outcomes including emotion dysregulation, psychopathology, stress, fear about childbirth, and trauma (Kaliush et al., 2024). Two psychological factors that have yet to be examined in relation to birth experiences but may be related are guilt and shame. Guilt and shame are universally experienced emotions that have been linked to mental health outcomes (Kim et al., 2011). They are distinct from each other despite often occurring at the same time (Malinokova et al., 2019). The most current accepted definitions of guilt and shame offered by Malinokova and colleagues (2019) are as follows: guilt is felt when someone has violated their own personal standard for themselves, for example blaming themselves for things that other people wouldn't. On the other hand, shame is experienced when someone feels as though they've violated societal or cultural standards and often involves wanting to disappear or sink without a trace.

There hasn't been any research directly linking guilt and shame to birth experiences but in the general population, guilt and shame have both been widely linked to depression (Kim et al., 2011). Additionally, guilt and shame are both significantly correlated with suicidal ideation; however, shame is no longer significantly related when accounting for depressive symptoms, suicide attempts, and guilt (Kealy et al., 2021). Guilt and shame are also both correlated with non-suicidal self-injury (Sheehy et al., 2019), anxiety symptoms, and PTSD (Cândea & Szentagotai-Tătar, 2018).

Guilt and shame have also been examined in association with mental health during the perinatal period, albeit in only a few studies. Shame is associated with prenatal depression, (Wilson, 2013), postpartum depression (Caldwell et al., 2021; Dunford & Granger, 2017; Barr, 2012), and acute stress in parents (Barr, 2010). Guilt has similarly been linked to negative mental health outcomes postpartum. For parents whose infants have been recently treated in the NICU, guilt, but not shame, is moderately associated with post-traumatic stress disorder, anxiety, and depression (Barr, 2012). Additionally, in the context of infant feeding outcomes, guilt and shame are both associated with a self-perception of being a bad mother (Jackson et al., 2021). Further understanding whether guilt and shame are also associated with birth experiences is imperative.

Protective Factors in the Face of Guilt and Shame

Given how important birth experiences are for parenting experiences, understanding factors that may protect birthing people from the negative impacts of guilt and shame on their birth experiences is another important next step. Many relationship theories support the concept that satisfying relationships are linked to positive mental health outcomes and can even protect against negative experiences. For instance, attachment theory (Hazan & Shaver, 1987) suggests that people seek to be close to their partner, especially when they are experiencing negative psychological states like anxiety or when they are pursuing difficult activities (Finkel et al., 2016). Attachment theory also argues that people develop a “safe haven” between themselves and their partner where a partner can act as a protective entity during times of distress (Collins & Feeney, 2000). For example, one study found that relationship satisfaction protected against the effects of ten different variables that predict women’s emotional distress: self-esteem, first-time motherhood, education, somatic disease, social support, family income, partner's emotional distress, partner's relationship satisfaction, partner's unemployment, and partner's education

(Røsand et al., 2012). Relationship satisfaction also protects against the negative association of maltreatment in childhood with depressive symptoms as an adult (Henry et al., 2015). In terms of the perinatal period, although relationship satisfaction has not yet been studied as a protective factor between negative predictors and birth experiences, it has already been found to be associated with positive birth outcomes. A birthing person feeling supported by those around them is more likely to have a positive birth experience (Kaliush et al., 2024; McKelvin et al., 2021). High relationship satisfaction is associated with more positive birth experiences as well as lower anxiety and less post-traumatic stress symptoms for new parents (Seefeld et al., 2024; Zerach & Magal, 2017). Using these past studies and attachment theory as a framework, my thesis aims to examine whether relationship satisfaction can also act as a protective factor between guilt and shame and birth experiences.

The Current Study

I used existing data from a longitudinal, self-report dataset in which participants completed questionnaires during their third trimester of pregnancy and then again six-weeks postpartum. I examined whether guilt and shame during pregnancy were associated with birth experiences postpartum. Next, I examined whether relationship satisfaction during pregnancy moderated those associations.

Hypotheses:

Guilt and Shame as Predictors

1. I hypothesized that higher guilt during pregnancy would be significantly associated with higher negative birth experiences postpartum.

2. I hypothesized that higher shame during pregnancy would be significantly associated with higher negative birth experiences postpartum.

Relationship Satisfaction as a Moderator

3. I hypothesized that relationship satisfaction would be a significant moderator of guilt with birth experiences such that the association of higher guilt during pregnancy with higher negative birth experiences would be less strong when relationship satisfaction during pregnancy was high than when relationship satisfaction during pregnancy was average or low.
4. I hypothesized that relationship satisfaction would be a significant moderator of shame with birth experiences such that the association of higher shame during pregnancy with higher negative birth experiences would be less strong when relationship satisfaction during pregnancy was high than when relationship satisfaction during pregnancy was average or low.

Methods

Participants and Procedure

Participants (N = 142) included a sample of individuals who completed the first and second time point of a longitudinal study. Participants were recruited from two locations, Salt Lake City, Utah and Eugene, Oregon. Additionally, there were three recruitment groups: those with current self-injurious thoughts or behavior, past self-injurious thoughts or behavior, or no self-injurious thoughts or behavior. Participants with no self-injurious thoughts or behavior were recruited on the basis of having higher emotion dysregulation while the other two groups had varying levels of emotion dysregulation. Each participant was compensated $85 for each time point they completed. Participants' ages ranged from 19 - 46 years (M = 30.96, SD = 5.31). Relationship satisfaction and guilt and shame were measured during the third trimester of pregnancy while birth experiences were measured at six weeks postpartum.

Measures

Birth Experience

I used the 10-item Birth Experiences Questionnaire to measure birth experiences (BEQ) (Horton et al., 2017). The questionnaire assesses stress, fear, and partner support during childbirth. The first 9 items from the birth experience measure were as follows:

1. *Would you say you found the birth: Stressful?*
2. *Overwhelming?*
3. *Painful?*
4. *Uncontrollable?*
5. *The way you planned or expected it to go?*

6. *Did you fear for your baby's life?*
7. *Did you fear for your own life?*
8. *Was your partner involved in the process?*
9. *Did you find your partner to be supportive?*

These items included response options that ranged from *Not at all (1)* to *Extremely (7)*.

Item 10, *How would you rate your birth experience overall?* included a response option that ranged from *Extremely negative (1)* to *Extremely positive (7)*.

To calculate birth experiences, I reverse scored items 5, 8, 9, and 10 and then I averaged all items together, with higher scores indicating more challenging birth experiences. I found this measure to be highly reliable in our sample (α = .81).

Guilt and Shame

I used the Guilt and Shame Experience Scale to measure guilt and shame (GSES) (Malinakova et al., 2019).

The 4 items from the guilt subscale were as follows:

1. *If I do anything wrong, I have to think about it all the time.*
2. *When I do something wrong, I feel an exaggerated feeling of guilt.*
3. *I blame myself even for things that other people do not think of.*
4. *I feel the need to explain or apologize for the reasons of my actions.*

These items included response options that ranged from *Not at all (0)* to *Significantly (3)*

The 4 items from the shame subscale were as follows:

1. *I feel guilty, even though I do not know exactly where it is coming from.*
2. *There are moments when I would rather sink without trace.*
3. *I am losing hope that I will ever be a good parent.*

4. *I experience moments when I cannot even look at myself.*

These items included response options that ranged from *Not at all (0)* to *Significantly (3)*.

To calculate guilt and shame, I summed all items from the guilt subscale together, and all items from the shame subscale together. Higher scores indicated higher guilt and higher shame. I found that the guilt subscale (α = .86) and shame subscale (α = .81) were both highly reliable in our sample.

Relationship Satisfaction

I used the 10-item Dyadic Adjustment Scale to measure relationship satisfaction (DAS) (Spanier, 1976). Only participants who were in a current romantic relationship (n = 128) were asked questions from the DAS. The item response options varied by question. The first 7 items were as follows:

1. *How often have you discussed or considered divorce, separation, or terminating your relationship?*
2. *How often do you and your mate leave the house after a fight?*
3. *In general, how often do you think that things between you and your partner are going well?*
4. *Do you confide in your mate?*
5. *Do you ever regret that you married or lived together?*
6. *How often do you and your partner quarrel?*
7. *How often do you and your mate "get on each other's nerves"?*

The first seven questions were asked on a scale that ranged from *All of the Time (0)* to *Never (5)*.

Item 8, *Do you kiss your mate?* included a response option that ranged from *Every Day (0)* to *Never (4)*.

Item 9, *Please choose your degree of happiness, all things considered, with your relationship,* included a response option that ranged from *Extremely Unhappy (0)* to *Perfectly Happy (6).*

Item 10, *Which of the following statements best describes how you feel about the future of your relationship?* included a response option that ranged from *I want desperately for my relationship to succeed, and I would go to almost any length to see that it does (0)* to *My relationship can never succeed, and there is no more that I can do to keep the relationship going (5).*

To calculate relationship satisfaction, I reverse scored items 3, 4, 8, 10 and then I summed all items together, with higher scores indicating higher relationship satisfaction. I found this measure to be highly reliable in our sample (α = .88)

Data Analysis

All analyses were run in SPSS version 29.0.2.0. First, I conducted paired means *t*-tests to determine whether average levels of guilt and shame were significantly different between the pregnancy and six-weeks postpartum time-points. Next, I examined correlations between key study variables. Neither age nor income yielded a statistically significant correlation coefficient with birth experiences, so neither were used as statistical covariates in the regression analyses. Next, to test my first and second research questions I ran linear regressions. In the first model, I entered guilt into the model as the predictor variable and birth experiences as the outcome variable. In the second model, I entered shame into the model as the predictor variable and birth experiences as the outcome variable.

Next, to test my third and fourth research questions testing moderation, I ran hierarchical linear regressions to examine whether there was a significant interaction effect between the

predictor variable and moderator variable with the outcome variable. In the first model, I entered guilt as the predictor variable, relationship satisfaction as the moderator variable, and birth experiences as the outcome variable. In the second model I entered shame as the predictor variable, relationship satisfaction as the moderator variable, and birth experiences as the outcome variable.

Results

Preliminary Analyses

Results of the paired means *t*-test revealed that there was a significant difference in guilt ($t(136) = 2.92$, $p = .004$) such that guilt decreased from the pregnancy time point to the six-weeks postpartum time point. There was no significant difference in shame ($t(136) = 1.89$, $p = .06$) between the pregnancy and six weeks postpartum time-points.

Shame during pregnancy was significantly correlated with birth experiences ($r = .23$, $p = .02$). Guilt ($r = .18$, $p = .08$) and relationship satisfaction ($r = -.12$, $p = .24$) during pregnancy were not significantly correlated with birth experiences.

Shame during pregnancy was significantly correlated with relationship satisfaction during pregnancy ($r = -.22$, $p = .01$). Guilt during pregnancy was not correlated with relationship satisfaction during pregnancy ($r = -.01$, $p = .88$). Shame and guilt during pregnancy were significantly correlated with each other ($r = .67$, $p < .001$). (See Table 1 for Pearson's correlation coefficients for main study variables and additional demographic variables).

Variable	*N*	1	2	3	4	5	6
1. Birth Experiences	100	—					
2. Shame	141	.23*	—				
3. Guilt	141	.18	.67**	—			
4. Relationship Satisfaction	140	-.12	-.22**	-.01	—		
5. Age	142	-.05	-.27**	-.23**	-.08	—	
6. Income	139	-.14	-.24**	-.16	.11	.39**	—

Table 1: Correlations for Study Variables

Note: Pearson's two-tailed correlations (* $p < 0.05$; ** $p < .01$)

Primary Analyses

I conducted a linear regression and found that shame during pregnancy was associated with birth experiences (b = .09, β = .23, p = .02) (see Figure 1); however, guilt during pregnancy was not associated with birth experiences (b = .06, β = .18, p = .08) (see Figure 2).

Lastly, I conducted a hierarchical linear regression and found that relationship satisfaction did not moderate the association between shame and birth experiences (b_{int} = 0.01, p = .28) nor guilt and birth experiences (b_{int} = -.0003, p = .95).

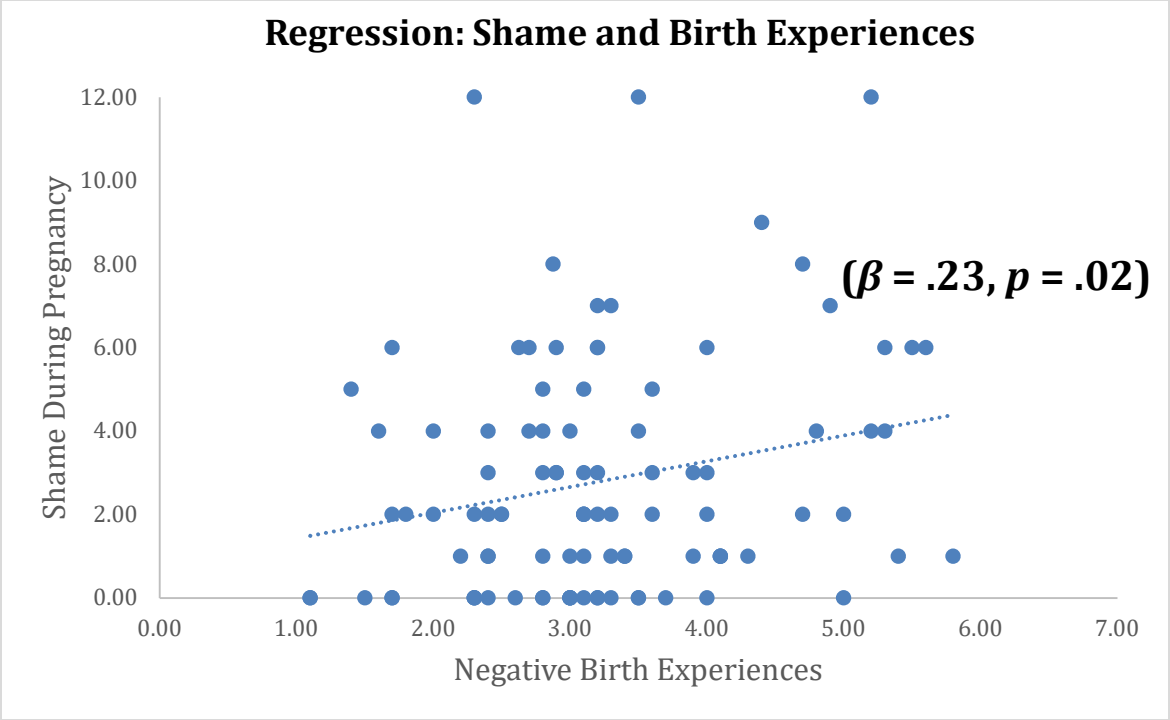

Figure 1: Regression: Shame and Birth Experiences

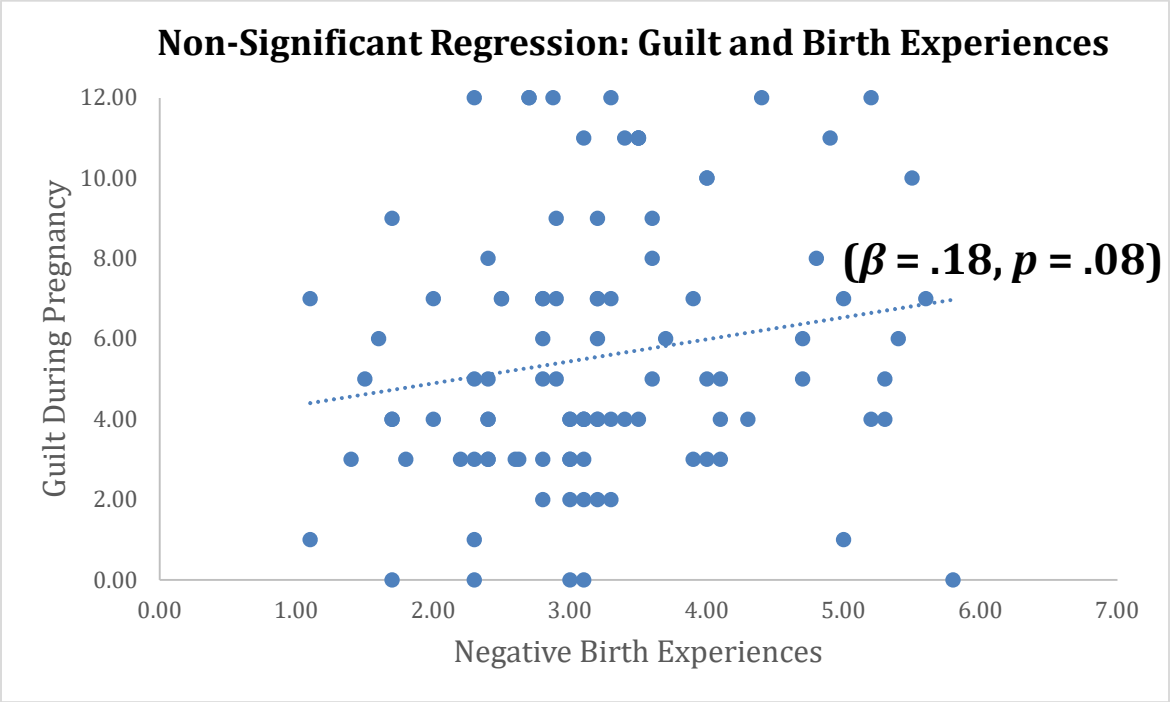

Figure 2: Non-Significant Regression: Guilt and Birth Experiences

Discussion

This study was the first to examine the role of both intrapersonal and interpersonal factors during pregnancy with birth experiences reported six-weeks postpartum. I examined guilt, shame, and relationship satisfaction with birth experiences to gain an understanding of what factors play a role in one's birth experiences. Identifying psychological factors that are associated with more negative birth experiences helps identify unknown factors that may play a role in a mother's birth experiences, which may inform the medical support that is offered for perinatal populations.

I found four noteworthy findings. As hypothesized, shame was positively associated with birth experiences such that higher shame was associated with higher negative birth experiences, but contrary to my hypothesis guilt was not associated with birth experiences. Additionally, relationship satisfaction did not moderate the association between shame and birth experiences nor guilt and birth experiences.

These results are somewhat consistent with past research that has found higher levels of shame linked with negative mental health outcomes in the general population (Cândea & Szentagotai-Tătar, 2018; Kim et al., 2011; Sheehy et al., 2019) as well as the perinatal population (Dunford & Granger, 2017; Barr, 2012; Barr, 2010; Jackson et al., 2021; Wilson, 2013). The literature linking guilt to negative mental health outcomes is mixed for both the general population and the perinatal population. This may be partially due to shame and guilt being measured in different ways in different studies. In the general population, guilt was significantly associated with depression, however the strength of that association was much smaller than that of shame (Kim et al., 2011). Similarly, the association of guilt with anxiety symptoms (Cândea & Szentagotai-Tătar, 2018), and postnatal depression (Dunford & Granger, 2017) was also much

smaller than that of shame along with being non-significant when controlling for shame. The results of the current study suggest that similar to previous studies, guilt may not be a driving factor in the determination of birth experiences during the perinatal period.

One reason that guilt may not be as important as shame for birth experiences is that in some circumstances guilt can strengthen relationships by improving coping styles in conflict-resolution (Behrendt & Ben-Ari, 2012). While it may be perceived as a negative psychological state, the experience of guilt has prosocial function, as in it is a factor that is beneficial for interpersonal relationships, and thus it may increase the level of support someone seeks from a relationship (Saintives & Lunardo, 2016). A study examining both guilt and shame and their relation to prosocial behavior found that guilt increased prosocial behavior while shame decreased prosocial behavior (Roos et al., 2014). While there is some disagreement within the literature on whether shame can be a prosocial psychological state, the current consensus is that it lacks prosocial utility and has negative effects on mental health (Kim et al., 2011). The result of the current study implies that the relationship between guilt and mental health outcomes is more complex and less clear than that of shame and mental health.

The results of the current study surrounding relationship satisfaction are inconsistent with the general finding that relationship satisfaction acts as a buffer between many negative psychological factors and emotional distress (Røsand et al., 2012). Furthermore, relationship satisfaction was not correlated with birth experiences in the current study. It may be that other interpersonal factors such as partner support during this stressful time are more influential for birth experiences. Because relationship satisfaction is a somewhat stable perception that one has of their relationship, it also may be less important than other acute factors such as medical complications when considering birth experiences. Previous studies have found that health

complications, lack of control, and not being seen or heard are linked to negative birth experiences (Henriksen et al., 2017).

Limitations and Strengths

I would like to note some of the limitations of my thesis. Participants were recruited on the basis of having current, past, or no suicidal thoughts or behaviors. The group with no suicidal thoughts or behaviors had high emotion dysregulation, which is a transdiagnostic clinical measure that has implications for psychopathology, making it challenging to generalize beyond a clinical perinatal population. Another limitation is that I did not statistically account for medical complications. Failing to consider those acute factors could have overshadowed the protective effects of relationship satisfaction given how important the health outcome of the birth is for perceptions of birth experiences. Additionally, while partner support during childbirth has been associated with more positive birth experiences, participants' overall relationship satisfaction may not be indicative of whether their partner supported them throughout the birth experience. Furthermore, because relationship satisfaction was measured during pregnancy in the current study, participants' view of their relationship when they reported it may have been different from their relationship satisfaction during the birth.

Although having a clinical sample limits the generalizability of this research to the general population of perinatal women, it is a strength of this study in that it offers valuable information about a population that is rarely studied in comparison to the general population. The current study indicates that shame during pregnancy is an important factor for birthing people who have experienced past or present suicidal thoughts or behaviors or have high emotion dysregulation. Another strength of this study is that I utilized longitudinal data. Because relationship satisfaction, guilt, and shame were measured during pregnancy, I was able to

determine that shame is a predictive factor of negative birth experiences. While I cannot make a causal claim, the findings of my study are strengthened by the methodological use of multiple time-points.

Future Directions

Future studies should attempt to replicate these results in a random sample drawn from the general population, measure birth experiences closer to the actual event of the birth, measure partner support in addition to general relationship satisfaction, and control for important factors like medical complications. In addition to controlling for medical complications, some previous studies have controlled for guilt when examining shame and shame when examining guilt in their analyses (Cândea & Szentagotai-Tătar; Sheehy et al., 2019; Dunford & Granger, 2017) which I did not do. Thus, more research needs to be done to understand the direct association of guilt and shame with birth experiences as well as when accounting for each other with perinatal outcomes.

Additionally, further research should explore the specifics of how guilt is related to birth experiences. Given that shame is associated with many negative mental health outcomes, it is possible that mental health is a mediator between guilt and birth experiences. I did not examine any potential mediating factors, and thus it is possible that guilt is associated with negative birth experiences by way of negative mental health outcomes such as depression and suicidal ideation.

Lastly, I found that shame is positively correlated with more negative birth experiences, thus, future research is warranted on interventions that have the potential to reduce shame during the perinatal period. Although the result that shame is correlated with birth experiences does not indicate that shame causes birth experiences to become more negative, it is still worth determining if decreasing shame can result in more positive birth experiences.

Conclusion

This study was the first to examine the relationships between guilt, shame, relationship satisfaction, and birth experiences. The positive association of shame during pregnancy with higher negative birth experiences is a promising finding. However, the association should be further examined in a manner that accounts for additional variables. Furthermore, the relationships between these variables should be examined in different populations given that the data from this study was gathered from a clinical sample. The results of my thesis also imply that neither guilt during pregnancy nor relationship satisfaction during pregnancy are important factors in birth experience outcomes. This may be due to guilt being a prosocial psychological state and relationship satisfaction not being indicative of partner support during the birth experience. Overall, further research is warranted on how these psychological factors might impact people during the perinatal period.

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