



REVIEW ARTICLE

Psychosocial factors affecting risk of post-partum depression among mothers and their Birth satisfaction: A systematic review

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Abstract

Negative birth experiences have been associated with an increased risk of post-partum depression (PPD). However, an exhaustive systematic literature review of existing literature examining this correlation is lacking. This systematic review investigates the association between birth satisfaction and the likelihood of post-partum depression. Additionally, it seeks to identify modifiable psychosocial factors influencing this relationship by conducting a systematic literature review of existing literature. Studies published between 2010 and 2024 were systematically reviewed, employing three electronic databases in compliance with PRISMA reporting guidelines. The inclusion criteria focused on studies conducting conceptual analysis on post-partum depression, birth satisfaction, or both. Search strategies utilized a wide range of terms, focusing on English-language publications. The systematic literature review was conducted in three phases: abstract review, title review, and full-text review. Twenty-one studies meeting the inclusion criteria were analyzed. A significant correlation was found between postnatal depression and birth dissatisfaction. Furthermore, psychosocial factors such as social support, maternal self-esteem, and healthcare facilities were identified as crucial factors influencing post-partum depression and birth satisfaction. These findings underscore the importance of tailored interventions to support maternal mental health during the post-partum period.

Keywords: Post-partum depression; Birth satisfaction; Psychosocial factors; Maternal mental health; Childbirth experience.

Introduction

Women experience significant physiological and psychological changes throughout the perinatal period, from pregnancy to the first year following childbirth (Setse et al., 2009). Due to the various influences on this critical reproductive phase, women often have different experiences during pregnancy and the post-partum period. While some women maintain their health and psychosocial well-being, others face considerable challenges. For instance, up to 25% of women report dissatisfaction with their labor and delivery experiences (Barbosa-Leiker et al., 2015). Moreover, post-partum depression (PPD) affects approximately 20% of new mothers,

potentially impairing both child development and the mother-infant bond (O'Connor et al., 2016).

The term birth satisfaction refers to a woman's overall feelings of well-being, contentment, and fulfillment after childbirth. It encompasses a variety of psychological, physiological, and emotional aspects related to the labor and delivery process. Expectations regarding childbirth differ among women, as do the levels of support they receive from family, friends, and healthcare providers (Dannenbring et al., 1997; Gibbens & Thomson, 2001). Common expectations include being treated with respect, having comfort prioritized, being listened to, receiving desired pain relief, coping effectively during labor, feeling in control, being well-prepared, avoiding major obstetric injuries, and achieving the preferred method of delivery.

A positive birth experience can enhance a woman's self-esteem, foster a successful transition to motherhood, and contribute to personal development (Nelson, 2003). Conversely, a negative birth experience may lead to adverse health outcomes, including post-partum depression, anxiety regarding future pregnancies, a preference for cesarean delivery in subsequent pregnancies, or a reluctance to become pregnant again (Nilvér, 2017; Smarandache et al., 2016). Consequently, satisfaction with childbirth is considered a vital component of obstetric care.

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Patient satisfaction is widely regarded as one of the most important elements in the evaluation and improvement of healthcare services (Rudman et al., 2007). Assessing women's satisfaction with their childbirth experience can offer valuable insights into potential areas for service improvement. It can also help identify high-risk scenarios where dissatisfaction could contribute to negative health outcomes, including post-partum depression (Jha et al., 2017).

Martin, Fleming, and Hollins identified three core areas of childbirth satisfaction, which they incorporated into an effective measurement tool-Birth Satisfaction Scale (BSS):

- The provision of services (e.g., home examination, birthing environment, support from medical professionals)
- Personal attributes (e.g., coping skills during labor, sense of control, preparedness for childbirth, relationship with the child)
- The stressors encountered during labor (e.g., anxiety, obstetric injuries, quality of medical attention, obstetric interventions, pain, prolonged labor, and the health of the baby).

Birth satisfaction is multifaceted, with women evaluating the events that occurred during labor in conjunction with these key factors (Jha et al., 2017).

Promoting positive birth experiences can help prevent post-partum psychological trauma. In their systematic review of prenatal and intrapartum interventions, Taheri et al. (2018) identified maternal support, minimal interventions during labor, and thorough birth preparedness as critical factors contributing to positive childbirth experiences. Interestingly, pain management and relaxation techniques were not included in this group. Funai et al. (2021) argue that the quality of the caregiver-patient relationship, particularly in terms of respect, communication, continuity of care, and shared decision-making, is one of the most significant factors influencing birth satisfaction. Similarly, Hildingsson et al. (2013) found that personalized, high-quality care during labor is strongly correlated with higher levels of birth satisfaction. Recognizing the importance of promoting positive childbirth experiences, the World Health Organization (WHO) has established global guidelines for post-partum care aimed at fostering positive experiences. The WHO (2018) notes that implementing practices such as allowing mothers to choose a support person not employed by the hospital is directly linked to reduced rates of post-partum depression (PPD).

Depression is a clinical condition characterized by a combination of negative emotions (e.g., sadness, worthlessness), negative thoughts about oneself (e.g., guilt, self-blame), negative beliefs regarding personal control over life outcomes (e.g., helplessness, hopelessness), and physical symptoms (e.g., fatigue, appetite loss, sleep disturbances) (The American Congress of Obstetricians and Gynecologists (ACOG), 2012).

Post-partum depression (PPD) is a medical condition diagnosed based on specific criteria outlined in the International Classification of Diseases (ICD). Primary symptoms include mood disturbances, loss of interest in daily activities, fatigue, difficulties with concentration, excessive concern for the child, feelings of sadness, frequent crying, indecision, reduced libido, appetite changes, sleep disturbances, and, in severe cases, thoughts of death or suicide (Ghaedrahmati et al., 2017).

Approximately 2–4% of women experience post-traumatic stress disorder (PTSD) following childbirth, and birth satisfaction is closely correlated with the development of this disorder. Numerous scholarly studies consistently demonstrate that negative childbirth experiences are a significant predictor of an increased likelihood of developing post-partum depression (Mariño-Narvaez, 2021; Tuohy & McVey, 2008; Unsal Atan, 2018). PTSD can also impair the mother-infant relationship (Yildiz et al., 2017). Maternal PTSD is associated with lower self-esteem, reduced infant birth weight, breastfeeding challenges, and decreased sexual desire. Symptoms of maternal PTSD are also a predictor of post-partum depression (Garthus-Niegel, 2018; Niegel et al., 2018).

Psychosocial stressors, including insufficient social support and low maternal self-esteem, are also reliable predictors of PPD, as documented in studies by Beck (1991), O'Hara (2009), and Robertson et al. (2004). The global prevalence of post-partum depression is estimated to be approximately 17%, with considerable variation across countries (Hahn-Holbrook et al., 2018). Factors such as birth dissatisfaction, stress, and lack of social support play a critical role in the onset of PPD. Additionally, other factors such as the number of previous pregnancies, mode of delivery, and an individual's mental health history may also contribute to the development of post-partum depression (Martínez-Galiano et al., 2019). The Edinburgh Postnatal Depression Scale (EPDS) is frequently used as a standardized screening tool for PPD.

In light of existing research, this comprehensive and analytical study aims to explore the connections between maternal psychological distress and Birth satisfaction and identify modifiable factors that could influence this relationship.

Methodology

Sample Search Strategy

This review was conducted in compliance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Toews, 2017). We searched three electronic databases—PubMed, CINAHL, and PsycINFO—using Medical Subject Headings (MeSH), a controlled vocabulary thesaurus from the National Library of Medicine that standardizes biomedical literature indexing. Search terms included various combinations of “post-partum or

pregnant,” “maternal well-being and healthcare,” and “birth satisfaction and post-partum depression.” Peer-reviewed journal articles published between 2010 and 2024 were eligible, provided they met the inclusion criteria. Only studies available in full text and published in English were included in the review.

To be considered for inclusion, studies had to meet the following criteria:

- Provide original research in either qualitative or quantitative form, examining the correlation between post-partum depression (PPD) and a woman’s childbirth experience.
- Published in peer-reviewed English-language journals.
- Provide original data gathered either during pregnancy or both during pregnancy and post-partum, with a focus on maternal outcomes rather than solely infant outcomes.
- Employ qualitative or quantitative methodologies to evaluate post-partum depression, birth satisfaction, or both.

The review followed a three-phase process of abstract screening, title screening, and full-text assessment to ensure methodological rigor. Studies focusing exclusively on the delivery method or other childbirth features rather than women’s subjective experiences were excluded. Additionally, a manual examination of reference lists was conducted to identify any overlooked studies.

Results

Literature Search

The PRISMA approach was utilized to identify records through a comprehensive database search. A total of 207 records were initially retrieved, supplemented by four additional records from other sources. After duplicate removal, 136 records remained. Specific limits reduced the count to 98. The titles and abstracts were screened, resulting in 63 records being reviewed, while 35 were excluded. Reference list searches added seven more records, bringing the total to 70. After 33 records were excluded due to insufficient data, 37 full-text articles were deemed eligible for further evaluation.

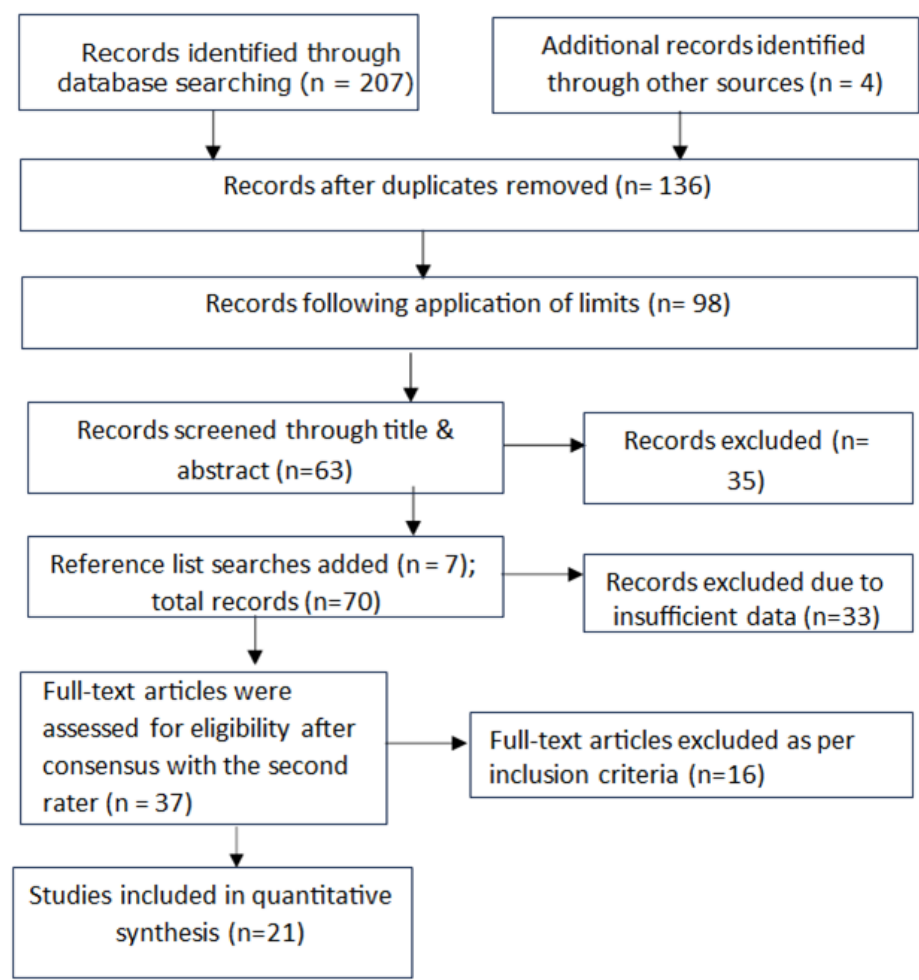


Fig 1.1: PRISMA flowchart for study Identification and selection process

Ultimately, 21 studies were included in the quantitative synthesis, with 16 articles excluded for various reasons.

The process can be visualized in the following PRISMA flowchart: Fig 1.1

Overview of the included studies

The years of publication varied from 2010 to 2024, and 21 studies were included for final review. Several screening instruments and evaluation metrics were employed in the various research. The Birth Satisfaction Scale (BSS) was the most widely used instrument to measure birth satisfaction. For post-partum depression, the most popular screening instrument was the Edinburgh Postnatal Depression Scale (EPDS).

Table 1 Presents an overview of the features and findings of the research that were part of the systematic review:

Collectively, these studies underscore the pivotal

role that birth satisfaction plays in preventing post-partum depression. The findings strongly advocate for a compassionate, respectful approach to childbirth care, as this directly contributes to improved maternal mental health and a reduced risk of PPD. By providing comprehensive care, healthcare professionals can support mothers through the post-partum period, reducing the likelihood of PPD and improving their childbirth experiences.

Discussion

Psychosocial factors affecting PPD and Birth satisfaction

The perinatal period represents a critical phase in a woman's life, marked by profound biological, psychological, and social changes. Several physiological factors contribute to post-partum depression (PPD) among mothers and

Table 1: Characteristics and results of studies included in the systematic review

Sr No.	Author	Objective	Sample	Measures	Findings
1.	Martin et al. (2011)	To state the BSS's validity, reliability, and factor structure and develop a short version of the tool.	(n=228)	BSS-R	BSS-R is a valid, reliable, robust, and trustworthy tool suitable for both domestic and international use.
2.	Yim et al. (2015)	A systematic review of research published from 2000 through 2013 on biological and psychosocial factors associated with PPD.	(n = 214) publications based on 199 investigations of 151,651 women in the first post-partum year	NA	The strongest biological risk predictors for PPD are hypothalamic-pituitary-adrenal dysregulation, inflammatory processes, and genetic vulnerabilities. Among psychosocial factors, the strongest risk predictors are severe life events, some forms of chronic strain, relationship quality, and low support from partner and mother.
3.	Fleming et al. (2016).	To confirm high birth satisfaction rates and the effectiveness of the BSS-R for women who gave birth at home or in a birth center.	(n = 2229)	BSS-RI	Satisfaction was higher for women with vaginal births compared with cesarean deliveries. BSS-R is an important tool in promoting person-centered maternal healthcare.
4.	Martin et al. (2017).	To streamline the instrument to create the BSS-RI.	NA	BSS-RI	A brief and simple- to-administer measure that assesses clinical service delivery in compliance with policy documents that underscore the importance of women in the birth experience.
5.	Jafari et al. (2017)	It aims to address factors related to women's childbirth satisfaction in physiological and routine childbirth groups.	(n = 340)	A 5-part questionnaire composed of demographic and obstetrics details Mackey's Childbirth Satisfaction Rating Scale (CSRS), satisfaction with the birth setting, Labor Agency Scale (LAS), and Visual Analogue Scale (VAS)	To conclude, several elements contribute to the happiness of childbirth, including better birth room environments, mothers' participation in labor, Birth satisfaction, and a sense of control.

6.	Silverman et al. (2017)	To examine the impact of the history of depression on PPD and pre- and Perinatal risk factors.	Nationwide cohort study	Diagnostic history	Women with a history of depression are over 20 times more likely to experience post-traumatic stress disorder (PTSD). Gestational diabetes also raises the risk of PPD.
7.	Upadhyay et al. (2017)	To estimate the prevalence of PPD in Indian mothers and associated risk factors.	(n = 427)	EPDS	Reported risk factors for PPD included economic difficulties, domestic violence, previous history of psychiatric illness, marital conflict, lack of spousal support, and birth of a girl child. It advocated for more funding for the treatment of maternal mental health issues.
8.	Li et al. (2017)	To examine the vital association between depression and social support during the perinatal stage.	(n = 240 pregnant women)	EPDS and Perceived Social Support Scale	Women's perceptions of social support and risk of PPD differed depending on the stage of the perinatal period and that social support was a Central buffer against depression at every stage.
9.	Abdollahi et al. (2018)	Longitudinal study for assessing effects of PPD on Iranian women's health.	(n=1801 pregnant women without depression at 32–42 weeks of pregnancy)	EPDS, GHQ	Found that four years after birth, women who suffered PPD were more likely to suffer from depression and other physical and mental health concerns, so appropriate and early interventions are required.
10.	Luegmair et al. (2018)	To evaluate women's satisfaction with care at the birthplace in Austria and to contribute data for cross-country comparisons within the international Babies Born Better project.	(n=539)	Babies Born Better (B3) Survey	Positive experiences were mainly experienced as individuality in care, negative experiences were related to issues of the existing infrastructure, breastfeeding counseling etc.
11.	Batt et al. (2020)	Evidence diagnostic distinction for PPD from depression concerning epidemiology, etiology, and treatment	NA	NA	PPD occurring in the early post-partum period differed from depression in symptom severity, heritability, and epigenetic data, suggesting PPD as distinct, whereas depression occurring in the later post-partum period was more similar to major depressive disorder occurring outside of the perinatal period.
12.	Martínez-Borba et al. (2020)	Longitudinal study examining biopsychosocial correlates of PPD	(n = 266, weeks 16-36 during pregnancy) (n = 101, weeks 2-4 during Post-partum)	MMF website was used to collect socio-demographic and biopsychosocial online	Biopsychosocial factors such as age, affective ambivalence, personality characteristics, social support, and depression were associated with concurrent Depression during pregnancy, but the stability of depression across time declined.
13.	Urbanová et al.'s (2021)	To examine the association between birth satisfaction and the risk of post-partum depression (PPD).	(n=584), women in 2-4 days post-partum	BSS EPDS Perceived Stress Scale (PSS)	Lower satisfaction with childbirth may increase the risk of developing PPD.
14.	Maskálová et al. (2021)	To understand the obstetric and socio-demographic aspects of Satisfaction with childbirth	(n=161) primiparous women	Childbirth Experience Questionnaire (CEQ)	Highlight the significance of providing high-quality treatment (management of labor pain relief, improving and promoting professional support Provided by midwives) and positive birthing experiences (promoting active participation of mothers during childbirth, supporting spontaneous vaginal delivery).

15.	van et al. (2021)	To identify both distinct and overlapping risk factors for anxiety and PPD.	(n= 1406) at 3 weeks and 12 months post-partum	EPDS and State-trait Anxiety Inventory (STAI-6)	Factors associated with a higher risk of depression are a history of depression, low maternal self-efficacy, and poor health of the mother. Factors associated with a higher risk of anxiety are higher educational level, history of depression, preterm birth, negative experience of delivery and first week post-partum, excessive infant crying, low maternal self-efficacy, low partner support, and poor current maternal health.
16.	Yakupova & Suarez (2021)	To examine the relationship between risk of PPD and birth experience in Russia.	(n=190) ages 19-46, two months post delivery.	Russian version of EPDS and BSS-RI	Emphasizing the experience of birth satisfaction to minimize the risk of PPD and that individualized expert support throughout labor can help mothers in their experience.
17.	Tiwari et al., (2022)	To translate the UK-BSS-R into Hindi, and psychometrically validate it on the Indian population.	(n = 312) postnatal Hindi speaking women in India	(Hindi)-BSS-R	Expands the cultural relevance of BSS with the Indian population by highlighting contextual aspects of the birth experience
18.	Cardoso and Fonseca (2023)	Examining the progression of anxiety and depressive symptoms in mothers with high risk for PPD from 3-4 months to 9-11 post-partum and understanding difficulty in emotional regulation when faced with such conditions.	(n = 156 women in the post-partum period)	Instruments accessing constructs of depressive, anxiety symptoms, emotion regulation difficulties	30% of mothers had depressive and anxious symptoms in comorbidity. Emotion regulation difficulties are significantly related to depressive and anxiety symptoms.
19.	Konieczka et al. (2024)	To evaluate and determine the factors influencing women's satisfaction with their delivery experiences.	(n=275)	Self-designed survey questionnaire	The highest levels of satisfaction were related to the best delivery facilities and favorable relations with medical professionals.
20.	Đuričeková et al. (2024)	To examine risk variables for PPD and symptoms of post-traumatic stress disorder (PTSD) in Slovak women.	(n=437 post-partum women)	EPDS, City BiTS	Subjective views of birth, birth satisfaction, past trauma in anamnesis and a lack of respect during childbirth are important risk factors for both PPD and PTSD.
21.	Dennis et al. (2024)	Narrative review, providing a summary of PPD, examining the etiology and consequences, pharmacological and psychological treatments, potential mechanisms of change, and current barriers to care.	NA	NA	To collaborative care models, task-sharing with non-specialist clinicians, and virtual care are ways to improve accessibility and address the growing burden of PPD.

also influence birth satisfaction. These include hormonal changes, stress levels, and health concerns for infants, each of which can impact a mother's mental health and overall satisfaction with her childbirth experience. During this sensitive period, many women become more vulnerable to emotional distress and depressive symptoms, particularly nulliparous women who face additional challenges, such as the transition to parenthood. The reorganization of mental self-representation, along with the usual psychological and relational adjustments associated with pregnancy, can

create unique obstacles. Women encountering difficulties in navigating this transition are more likely to experience depressive symptoms, which can persist long after childbirth (Smorti et al., 2019).

This review indicates that post-partum depression (PPD) is often influenced by factors such as low socioeconomic status (SES), inadequate social support, and early adverse experiences. Women who experience depression for the first time in the post-partum period are frequently those with histories of childhood maltreatment or poor-

quality relationships during childhood. Factors such as low education levels, financial difficulties, poor housing conditions, and lack of support from spouses or significant others have also been associated with PPD. Many mothers, especially those experiencing depression for the first time, do not receive timely psychiatric care, highlighting a significant gap in maternal mental health services. Research has shown that mothers with PPD often report negative childhood experiences. Childbirth can trigger unresolved trauma from early life, which may influence emotional regulation and interpersonal behaviors later in life (Kettunen & Hintikka, 2017).

The factors that contribute to a positive birth experience include high-quality care, supportive relationships with healthcare professionals, and effective pain management. On the contrary, inadequate pain relief, poor communication, and a lack of emotional support are commonly associated with negative birth experiences, which in turn increase the likelihood of post-partum depression.

In these studies, age has emerged as a critical factor influencing birth satisfaction. Older women report higher levels of satisfaction with their childbirth experiences compared to younger mothers. This finding suggests that older women may have more realistic and attainable expectations of childbirth. At the same time, younger mothers may experience diminished self-efficacy and personal control due to limited life experience. Consequently, younger mothers tend to report lower satisfaction with their delivery experiences.

Similarly, multiparous women—those who have given birth to more than one child—consistently report higher levels of satisfaction with childbirth compared to primiparous women, who are giving birth for the first time (Al Ahmar & Tarraf, 2014). Multiparous women may have a greater sense of control and familiarity with the birthing process, which contributes to their overall satisfaction.

Factors Cross-Sectionally Associated with Prenatal Depressive Symptoms

Several psychological factors have been identified as cross-sectional predictors of prenatal depressive symptoms. These include age, neuroticism, affective ambivalence, and negative affect, all of which have been associated with increased risk for depressive symptoms during the perinatal period. In contrast, positive affect has been shown to serve as a protective factor against concurrent depressive symptoms, reinforcing the notion that psychological resilience plays a crucial role in mitigating prenatal depression. Women who rely on avoidance strategies are more likely to attribute their negative experiences to supernatural causes. In contrast, those using approach coping strategies experienced less severe psychological, interpersonal, and physiological consequences, as well as reduced pain from the illness.

Approach coping is also linked to a greater sense of hope for positive outcomes in managing stress (Awasthi & Mishra, 2019).

Beyond these established risk factors, the present review also examined two additional variables with potentially protective effects against prenatal depression: extraversion and positive affect. While positive affect demonstrated a clear negative correlation with the severity of depressive symptoms, confirming its protective role, extraversion did not emerge as a significant factor in this review. This finding is unexpected, given previous studies that have linked extraversion to lower levels of emotional distress. One possible explanation for this discrepancy could be the particular characteristics of the sample population in this review.

The participants in this study were predominantly well-educated adults, most of whom reported being in committed relationships. Given that this group might have had access to stronger social support networks, extraversion, which is often tied to social engagement, did not play as critical a role as it might in more vulnerable populations with lower levels of structural social support. Social support, typically defined as emotional, informational, and instrumental assistance, is often a key buffer against stress and depressive symptoms during pregnancy. However, the influence of social support may vary across populations, depending on the individual's ability to access and mobilize these resources.

In this context, it is important to distinguish between structural social support (e.g., having family, friends, or community resources) and functional social support (e.g., the quality of emotional and instrumental help received). It is likely that, in well-supported populations, functional social support—including the emotional quality of relationships—might be less significant than in more socially isolated groups. On the other hand, in populations with lower social support, the availability of structural social support could play a more substantial role in determining mental health outcomes. This nuanced understanding suggests that social support's impact on prenatal depressive symptoms might be contingent on both the individual's social environment and the quality of support received. Women with high levels of social support feel less severe consequences of stress and illness (Awasthi & Mishra, 2007).

Numerous studies have explored the relationship between illness-related beliefs and health behaviors in women (Awasthi & Mishra, 2011, 2013; Awasthi et al., 2019) studied how illness-control beliefs and self-control influence well-being and found that greater self-efficacy beliefs are associated with better well-being. Avoidance coping or psychological disengagement from the disease was linked to poorer functioning, as evidenced by declines in physical health, heightened psychological distress, and difficulties with adjustment.

The findings of this study indicate that intrapersonal processes, such as experienced emotions and self-regulation, are more significant predictors of prenatal depressive symptoms than interpersonal factors like social support. Positive affect, in particular, may offer protection against depression by fostering greater psychological resilience and improving emotional regulation during pregnancy.

Given the limited literature on these factors in diverse populations, future research should explore whether similar patterns of association exist in other demographic groups, particularly among those who may face greater social or economic adversity. In these populations, social support, both functional and structural, might play a more pronounced role in mitigating prenatal depression symptoms. Expanding this research will provide valuable insights into the broader applicability of these findings and help tailor interventions to support maternal mental health across various social contexts.

Conclusion

This systematic review provides a comprehensive analysis of the literature surrounding birth satisfaction and post-partum depression (PPD), demonstrating a significant correlation between the two. The findings highlight that positive birth experiences are associated with a lower incidence of PPD, while negative experiences significantly elevate the risk of depression. This review underscores the importance of personalized and respectful maternity care in improving birth satisfaction and reducing the risk of post-partum mental health issues. By focusing on these aspects, healthcare providers can foster better maternal mental health outcomes and create a more supportive environment for mothers during the post-partum period. The findings suggest that addressing both the psychosocial and clinical needs of mothers during childbirth is crucial for preventing PPD.

In conclusion, improving maternal care practices, ensuring respectful and compassionate support during childbirth, and addressing the psychosocial factors that influence birth satisfaction are essential for reducing the risk of post-partum depression. The insights derived from this review provide a valuable foundation for developing targeted interventions aimed at supporting mothers and enhancing their post-partum experiences, thereby promoting better mental health and well-being for both mothers and their infants.

Limitations

- Heterogeneity of research: It can be difficult to draw unified conclusions from the included research due to their wide variations in design, demographic, and measuring methods.
- Publication Bias: Research with noteworthy results may have a higher chance of being published, which could distort the findings.

- Quality of Included Studies: The review contains certain studies that may have methodological flaws, such as small sample numbers or inadequate confounding variable control.
- Cultural Differences: The review's limited generalizability may stem from its failure to take into consideration cultural variations in post-partum depression and birth satisfaction perceptions and reporting.
- Temporal Factors: The consistency of the results may be impacted by the timing of the post-partum depression and birth satisfaction surveys.

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Conflict of Interest

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