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Modern Motherhood Between Fulfillment and Vulnerability: Mothers' Perceptions and Needs—An Observational Study in Romanian Population

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Abstract

Motherhood is a profoundly transformative stage, associated with both emotional fulfillment and psychological and physical vulnerability. The aim of this study was to assess the perceptions, difficulties and resources needed by mothers in the experience of motherhood. We conducted an exploratory cross-sectional observational study, based on an online questionnaire administered to 172 mothers. We analyzed socio-demographic data, experiences related to pregnancy and childbirth, perceived level of support, emotional difficulties, and resources considered useful in the role of motherhood. Most participants were women aged 30 to 45, with university or postgraduate education, married and with one or more children. Although motherhood was predominantly described in positive terms such as "fulfillment", "love" and "joy", a significant percentage of mothers reported increased fatigue, lack of personal time and emotional difficulties. The resources considered essential for maternal balance were family support, personal time, emotional support and access to clear and empathetic medical information. In conclusion motherhood is perceived as a complex experience, in which fulfillment frequently coexists with emotional overload and vulnerability. This exploratory study highlights the complex emotional and psychosocial dimensions of motherhood among Romanian women. The findings suggest the need for accessible emotional and social support resources. A comprehensive approach addressing both emotional and practical needs may contribute to improved maternal well-being.

Keywords: motherhood; breastfeeding; maternal health; general practitioner; emotional support

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1. Introduction

The postpartum period, also known as the puerperium and the "fourth trimester," refers to the weeks after birth when the physiologic changes related to pregnancy return to the nonpregnant state. In addition to physiologic changes and medical issues that may arise during this period, obstetric health care providers should be aware of the mental health needs of the postpartum mother and be sensitive to different cultural practices related to childbirth, which may involve eating particular foods and restricting certain activities [1,2]. Lastly, obstetric providers can help patients to transition to primary care providers. Before discharge, the patient should be educated about the expected normal postpartum changes and how to care for herself (breasts, perineum, etc.) and the newborn. The multidisciplinary team—obstetrician, neonatologist, pediatrician, general practitioner (GP), psychologist—has an important role in supporting the mother. She has many challenges related to both the transformations in her own body and the care of the newborn [2]. A systematic review of studies on maternal expectations in the postnatal period found that they wanted to achieve positive motherhood (maternal self-esteem, competence, and autonomy), successfully adapt to the changes in intimate and family relationships, and (re)gain health and well-being for their child and themselves [2,3].

The World Health Organization (WHO), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP) generally recommend exclusive breastfeeding for approximately the first six months and continued breastfeeding, based on both short- and long-term benefits for mother and child [4–7].

Expectant parents often make decisions about how they will feed their infant very early in pregnancy or before conceiving. Understanding which factors affect parental choices about infant feeding is essential to providing appropriate education and support. In addition, counseling is enhanced by recognizing common misconceptions and barriers about breastfeeding and how to overcome them. Similarly, public resources and policy should be directed at removing and addressing the common obstacles to breastfeeding in a population [8,9].

Although the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend immediate, continuous, uninterrupted skin-to-skin contact after birth, newborn infants are still separated from their mothers during this period in many settings [10].

Maternal–fetal attachment represents a well-documented psychological construct, referring to the emotional bond that develops between the mother and the fetus during pregnancy. The permanent connection of the pregnant woman with her fetus during pregnancy, the emotions of the pregnant woman and the mother, the verbal and nonverbal communication of the mother with her child influence the child's evolution in the short and long term, being an imprint for the rest of their life [11–13].

As such, motherhood is a challenge for the entire family, but especially for the mother, who needs both physical and emotional support. The multidisciplinary team, but also society, has a role in supporting the mother-child couple and in promoting and supporting breastfeeding, which is not only a personal choice, but a collective responsibility with profound implications for the physical and emotional health of future generations. The involvement of a multidisciplinary team, including obstetricians, pediatricians, general practitioners, and mental health professionals, has been associated with improved maternal and neonatal outcomes, particularly in the context of perinatal mental health and breastfeeding support [14–17].

Despite increasing attention to maternal mental health globally, there is limited data regarding Romanian mothers' perceptions of motherhood, particularly in relation to maternal–fetal bonding, emotional experiences, and perceived support needs. Given

the high rates of cesarean section and changing socio-cultural dynamics in Romania, understanding these aspects is essential for developing targeted maternal support strategies [18,19]. The aim of this exploratory cross-sectional study was to evaluate Romanian mothers' perceptions of motherhood, including emotional experiences, maternal–fetal bonding, perceived maternal burnout, and the types of support resources they consider necessary for maternal well-being.

2. Results

A total of 172 responses were collected during the two-month data collection period (December 2025–January 2026).

2.1. Sociodemographic Characteristics

In Table 1, the sociodemographic characteristics of the respondents can be found. Age of the respondents had a non-normal distribution ($p = 0.003$) and a median of 40 (33–46) years old. Participants were predominantly highly educated, with 86.0% having university or postgraduate studies. The majority of them had one or two children (72.1%), whereas 27.9% reported having three or more children. Most respondents were married (87.8%). A smaller proportion reported being in a stable relationship (6.4%), while 4.1% were divorced or widowed. Only 1.7% of participants reported being single. Most of them had the youngest child at over 6 years old (41.9%). The vast majority of respondents reported a desired pregnancy (94.8%), with only a small minority reporting an undesired or partially desired pregnancy. The majority of the pregnancies were naturally conceived (93.6%). Over half of them (57%) were delivered through c-section. Most participants reported that they breastfeed their child (91.9%).

Table 1. Respondents characteristics.

Variable	*n* (%)	Median (IQR)
Age of the mother		
		40 (33–46)
Education level		
Secondary education or below	24 (14.0%)	
University degree	80 (46.5%)	
Postgraduate education (Master/PhD)	68 (39.5%)	
Number of children		
One	59 (34.3%)	
Two	65 (37.8%)	
Three	29 (16.9%)	
More than three	19 (11.0%)	
Marital status		
Married	151 (87.8%)	
In a stable relationship	11 (6.4%)	
Divorced/Widowed	7 (4.1%)	
Single parent	3 (1.7%)	
Age of the youngest child		
Under 1 year old	31 (18.0%)	
1–3 years old	49 (28.5%)	
4–6 years old	20 (11.6%)	
Over 6 years old	72 (41.9%)	

Table 1. *Cont.*

Variable	*n* (%)	Median (IQR)
Desired pregnancy		
Yes	163 (94.8%)	
No	2 (1.2%)	
Partially desired	7 (4.1%)	
Method of conception		
Natural	161 (93.6%)	
Assisted reproductive techniques	11 (6.4%)	
Type of delivery		
Vaginal	74 (43.0%)	
C-section	98 (57.0%)	
Breastfeeding		
Yes	158 (91.9%)	
No	14 (8.1%)	

2.2. Maternal–Fetal Bonding During Pregnancy

Most participants reported a strong emotional connection with their unborn baby, with 46.5% reporting feeling very connected and 30.2% reporting feeling much connected. Communication with the unborn baby was frequent among respondents, with 62.8% reporting frequent communication and 34.9% occasional communication. More than two-thirds of participants perceived that the baby sensed maternal emotions, with 33.7% and 31.4% reporting much or very much perception, respectively. 70.9% of respondents reported using rituals, music, or voice to connect with their unborn baby (Table 2). A significant association was observed between pregnancy intention and perceived maternal–fetal bonding during pregnancy (p = 0.003), mothers who reported a desired pregnancy were more likely to report a strong emotional connection with their unborn baby, with 46.0% indicating they felt "very connected" and 31.3% reporting they felt "much connected." In contrast, respondents with partially desired pregnancies reported lower levels of connection, including 28.6% who reported no connection and 14.3% who reported feeling only slightly connected.

Table 2. Maternal–fetal bonding during pregnancy.

Variable	Response	*n* (%)
Feeling connected to the unborn baby	Not at all	2 (1.2%)
	Slightly	7 (4.1%)
	Moderately	31 (18%)
	Much	52 (30.2%)
	Very much	80 (46.5%)
Communication with the unborn baby	No	4 (2.3%)
	Occasionally	60 (34.9%)
	Frequently	108 (62.8%)
Perceived that the baby sensed maternal emotions	Not at all	3 (1.7%)
	Slightly	17 (9.9%)
	Moderately	40 (23.3%)
	Much	58 (33.7%)
	Very much	54 (31.4%)
Used rituals/music/voice to connect	No	38 (22.1%)
	Yes	122 (70.9%)
	Do not remember	12 (7%)

Most respondents agreed that the baby exists as a being before birth (80.2%), while 14.0% were neutral and 5.9% disagreed. Regarding the perceived influence of maternal emotional experiences on the baby, 60.4% of participants reported much or very much influence, whereas 14.0% reported no or slight influence (Table 3).

Table 3. Maternal beliefs about prenatal life and emotional influence.

Variable	Response	*n* (%)
Baby exists as a being before birth	Agree	138 (80.2%)
	Neutral	24 (14%)
	Disagree	10 (5.8%)
Mother emotional experiences influenced the baby	Not at all	12 (7%)
	Slightly	12 (7%)
	Moderately	44 (25.6%)
	Much	52 (30.2%)
	Very much	52 (30.2%)

2.3. Birth Experience and Early Postnatal Bonding

Almost half of the mothers, 47.7%, perceived the moment of birth as a natural transition, but 11% of respondents perceived the moment of birth as a sudden separation. Most of them agreed that birth represents a continuation of the prenatal bond (69.8%). The majority of mothers reported an immediate emotional connection with their newborn (75.6%), while 24.4% reported a delayed connection (Table 4). A significant association was observed between the mode of delivery and mothers' perception of the birth experience ($p = 0.003$). Among women who delivered via cesarean section, 37.8% perceived birth as a natural transition, 22.4% as a predominantly physical experience, 22.4% as a spiritual experience, and 17.3% as a sudden separation. In contrast, vaginal deliveries were most frequently perceived as a natural transition (60.8%), followed by a predominantly physical experience (18.9%), a spiritual experience (17.6%), and a sudden separation (2.7%). The emotional connection after birth was not influenced by the type of delivery ($p = 0.858$) or by breastfeeding ($p = 0.109$). The timing of first holding the newborn after birth varied among participants. The largest proportion of mothers (35.5%) held their baby immediately after birth, followed by 35.5% who held their child after several hours, 15.1% at 5 min, 8.1% after one hour, 3.5% after 30 min, and 2.3% who did not remember.

Table 4. Birth and Early Postnatal Bonding.

Variable	Response	*n* (%)
Perception of birth	Natural transition	82 (47.8%)
	Physical experience	36 (20.9%)
	Spiritual experience	35 (20.3%)
	Sudden separation	19 (11%)
Birth as continuation of prenatal bond	Agree	120 (69.8%)
	Neutral	47(27.3%)
	Disagree	5 (2.9%)
Emotional connection after birth	Immediately	130 (75.6%)
	No	42 (24.4%)

2.4. Maternal Identity and Psychosocial Experience

Most participants reported that motherhood transformed their self-perception (83.1%), with only a small proportion disagreeing (2.3%). Nearly half of the respondents reported a significant change in personal identity (45.3%). Maternal burnout was commonly reported, with 58.1% indicating experiencing burnout sometimes and 18.0% frequently. Most

mothers reported often or almost always understanding their child without words (84.9%). Emotional support from partners or family members was reported by 65.1% of participants, while 29.7% reported partial support. Only 14.5% of respondents reported participating in psychological counseling or support groups; however, an additional 15.7% expressed interest in such services, resulting in an overall interest rate of 30.2% (Table 5). A significant association was found between the number of children and the experience of emotional exhaustion ("maternal burnout") ($p < 0.001$). Among mothers with two or more children, 64.6% reported experiencing emotional exhaustion sometimes, rarely, or frequently, with 21.2% indicating "often," 10.6% "sometimes," and 3.5% "rarely." In contrast, among mothers with only one child, 45.8% reported experiencing emotional exhaustion, with 11.9% indicating "often," 22.0% "sometimes," and 20.3% "rarely." Regarding the marital status or being in a relationship with the child's father and the experience maternal burnout no significant association was found ($p = 0.069$), but the number of single mothers in the sample was very small ($n = 10$), limiting the ability to detect statistically significant differences.

Table 5. Maternal Identity and Psychosocial Experience.

Variable	Response	*n* (%)
Motherhood transformed self-perception	Agree	143 (83.1%)
	Neutral	25 (14.6%)
	Disagree	4 (2.3%)
Change in personal identity	Not at all	10 (5.8%)
	Slightly	9 (5.2%)
	Moderately	29 (16.9%)
	Much	46 (26.7%)
	Very much	78 (45.4%)
Maternal burnout	Never	16 (9.3%)
	Rarely	25 (14.5%)
	Sometimes	100 (58.3%)
	Frequently	31 (18%)
Understanding child without words	Never	1 (0.6%)
	Rarely	6 (3.5%)
	Sometimes	19 (11%)
	Often	90 (52.3%)
	Almost always	56 (32.6%)
Emotional support from partner/family	No	9 (5.2%)
	Partially	51 (29.7%)
	Yes	112 (65.1%)
Psychological counseling/support groups	No	120 (69.8%)
	No, but would like to	27 (15.7%)
	Yes	25 (14.5%)

2.5. Emotional Experiences Associated with Motherhood

Regarding emotional experiences associated with motherhood, joy was the most frequently reported emotion, with 97.1% of participants indicating its presence. A high proportion of respondents also reported feelings of fulfillment (87.2%) and fatigue (75.6%). Negative emotional experiences were also common: anxiety was reported by 34.3% of participants, guilt by 33.1%, and frustration by 23.8% (Table 6).

Table 6. Emotional experiences associated with motherhood among participants.

Emotional Experience Associated with Motherhood	*n* (%)
Joy	167 (97.1%)
Fulfillment	150 (87.2%)
Fatigue	130 (75.6%)
Anxiety	59 (34.3%)
Guilt	57 (33.1%)
Frustration	41 (23.8%)

2.6. Perceived Support Needs

Regarding perceived support needs, most respondents indicated that personal time would help them feel more supported in their maternal role (76.2%). Nearly half of participants reported that help from family members would be beneficial (47.1%). Psychological support (25.6%), access to educational information (23.8%), and community support (22.7%) were reported by approximately one-quarter of respondents (Table 7). Among mothers with two or more children, 30.1% reported the need to receive psychological support, compared with 16.9% of mothers with only one child ($p = 0.047$).

Table 7. Perceived support resources that would help mothers feel more supported in their maternal role.

Support Resources Needed	*n* (%)
Personal time	131 (76.2%)
Help from family members	81 (47.1%)
Psychological support	44 (25.6%)
Educational information	41 (23.8%)
Community support	39 (22.7%)

3. Discussion

As an exploratory study, the findings should be interpreted as hypothesis-generating rather than confirmatory, and the reported associations require validation in larger, adequately powered studies.

Fetal movements are one of the earliest and most salient ways the fetus interacts with the environment, providing the pregnant person reassurance of the fetus's health and development [20,21]. Through fetal movement, the fetus not only signals its presence but also fosters a sense of awareness and connection in the mother, contributing to the emotional bond that forms during pregnancy—referred to as maternal-fetal attachment [22,23]. When asked "how connected did you feel with your child during pregnancy?" more than half, 76.7% of respondents answered "a lot" and "very much", which indicates mothers' awareness of the formation of this strong bond even during intrauterine life. Maternal prenatal attachment has been shown to predict early postnatal maternal involvement, with higher prenatal attachment associated with more engaged and stimulating mother–infant interactions [24]. Prenatal anxiety, depression, and maternal-fetal attachment are associated with postpartum bond formation [25]. The high levels of reported maternal–fetal attachment in our study suggest that emotional bonding during pregnancy is a central component of the maternal experience. This finding is consistent with previous research indicating that prenatal attachment plays a crucial role in shaping postnatal maternal behaviors and early mother–infant interactions, even being theorized that it has a role in the cognitive development of the child, including ADHD or autism [22–24,26–30]. Importantly, neurodevelopmental conditions in children have been shown to significantly impact family functioning and quality of life, influencing maternal well-being and the

overall experience of motherhood [31]. This result highlights the importance of considering prenatal bonding as a potential target for early interventions, particularly in populations at risk of impaired attachment, such as mothers with unintended pregnancies or elevated psychological distress.

In our study, 70.9% of mothers reported using music, voice, or rituals to connect with their unborn child, suggesting an active and intentional engagement in prenatal bonding. While previous studies have demonstrated the neurodevelopmental relevance of prenatal auditory stimulation, our findings highlight that such behaviors are already widely adopted in the general population, even outside structured interventions [32–34]. This may reflect an intuitive maternal tendency to establish early communication with the fetus, rather than solely an evidence-based practice. Therefore, music exposure during pregnancy may represent both a cultural behavior and a potential avenue for low-cost interventions aimed at enhancing maternal–fetal attachment.

The majority of mothers in our study, 91.87%, understood the importance of breastfeeding in the development of the child and the mother-child relationship. Although the nutritional and physical health benefits of breastfeeding are well established, accumulating research demonstrates the far-reaching psychological effects of breastfeeding on infants and their mothers. A non-exhaustive review of the empirical evidence shows that breastfeeding impacts children's brain, cognitive, and socio-emotional development. In the case of mothers, research is presented indicating that breastfeeding influences mood, affect, stress, and maternal care [35]. Another study conducted in Romania shows that the main cause of newborn readmission to pediatrics is poor nutrition, due to maternal age under 18 years and the lack of breastfeeding promotion and support for mothers [36]. The very high prevalence of breastfeeding in our cohort (91.9%) likely reflects the specific characteristics of the study population, particularly the high educational level [37,38]. While breastfeeding is widely promoted, such high rates are not typically observed at the population level, suggesting a potential selection bias. Therefore, this finding should not be interpreted as representative for the general Romanian population but rather as indicative of a subgroup with increased health awareness and access to information.

More than half, 57%, of mothers gave birth by cesarean section (CS), and only 43% of respondents gave birth vaginally. Almost half of the mothers, 47.7%, perceived the moment of birth as a natural transition, but 11% of respondents perceived the moment of birth as a sudden separation. Although the World Health Organization has stated that the optimal rate of cesarean section (cesarean section) should be between 10 and 15% of all births, in the United States cesarean section rates have hovered around 32% since the late 2000 s, while some countries report rates of up to 50% or more, such as in our country, Romania. This trend has raised concerns about the potential health implications of cesarean sections for both mothers and infants. While cesarean sections can certainly save lives, they have been associated with adverse developmental and behavioral outcomes in children, as well as negative effects on mothers' mental health, including postpartum depression, reduced likelihood of initiating breastfeeding, and impaired attachment to their babies [39,40]. Levels of each of the 'birth signaling hormones' (oxytocin, arginine vasopressin, epinephrine, norepinephrine and the glucocorticoids) are lower following CS compared to vaginal delivery, and there is substantial evidence for each, that manipulations in early life result in long-term neurodevelopmental consequences. We draw from the research traditions of neuroendocrinology and developmental psychobiology to suggest that the perinatal period is a sensitive period, during which hormones achieve organizational effects [41]. The higher proportion of mothers perceiving birth as a spiritual experience following cesarean section may be explained by the emotional context in which these births occur. Previous studies have shown that cesarean delivery, particularly when unplanned or medically indicated,

can be associated with heightened emotional responses, including stress, vulnerability, and the need for psychological meaning-making [42–44]. In this context, some mothers may interpret the birth experience in more existential or spiritual terms, as a way of integrating the intensity of the event into their personal narrative.

Despite the high rate of cesarean section (57%), the prevalence of breastfeeding was also very high (91.9%). This finding may reflect increased awareness and education regarding breastfeeding benefits among the studied population, which was predominantly highly educated. Although cesarean delivery has been associated with delayed initiation and lower rates of early breastfeeding in some studies, it does not preclude successful breastfeeding, particularly in the presence of adequate support and maternal motivation [39,40,45,46]. In this cohort, cesarean delivery did not appear to significantly hinder breastfeeding initiation, possibly due to supportive hospital practices or increased maternal awareness.

The vast majority of mothers, 93.6%, achieved pregnancy naturally and only 6.4% achieved pregnancy through assisted reproductive techniques. The high prevalence of maternal burnout observed in this study highlights a significant psychosocial burden associated with motherhood. This finding aligns with existing literature linking parenting stress and burnout to increased risk of depression, impaired parent–child relationships, and negative child outcomes. Investigators have pointed out that long-awaited pregnancies, such as those after in vitro fertilization (IVF), are emotionally vulnerable. In addition, higher pregnancy-related distress has been found among women pregnant after in vitro fertilization compared with women with "naturally" achieved pregnancy [47]. A study conducted in Stockholm shows that in vitro fertilization mothers are attached to their unborn children to the same extent as other mothers. Prenatal attachment increases during pregnancy. Significant factors that contribute to prenatal attachment are marital satisfaction, age, ambivalence, and detachment [47].

In our study, a third (35.4%,) of the mothers held their baby in their arms several hours after birth. Strong scientific research exists about the importance of skin-to-skin contact (SSC) in the first hour after birth. This unique time for both mother and infant, individually and in relation to each other, provides vital advantages to short- and long-term health, regulation and bonding. However, worldwide, clinical practice lags [48]. Although the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend immediate, continuous, uninterrupted SSC after birth, newborn infants are still separated from their mothers during this period in many settings. WHO recommends continuing immediate skin-to-skin contact and early and exclusive breastfeeding during the COVID-19 outbreak, as the benefits substantially outweigh the potential risks of transmission and illness associated with the disease [49–51].

We found a high prevalence of maternal burnout, with 58.1% of mothers reporting experiencing burnout sometimes and 18.0% frequently. This finding is particularly significant given that maternal burnout has been associated with a decrease in parenting quality, impaired mother-child bonding, and an increased risk of maternal depression and child abuse [52–55]. The strong association between the number of children and maternal burnout ($p < 0.001$) may suggest that mothers with multiple children face increased challenges in managing household responsibilities, childcare demands, and personal well-being. Mothers with 2 or more children were significantly more likely to report emotional exhaustion, highlighting the cumulative effect of parenting demands. These findings point the need for targeted interventions and support systems for mothers with multiple children, including accessible childcare service and mental health resources [56].

In this study 76.2% of mothers identified personal time as the most important resource needed to feel more supported in their maternal role. This finding aligns with existing literature demonstrating that maternal self-care and personal time are protective factors

against burnout and depression [57–59]. Our data also showed that 47.1% of mothers valued help from family members, while 25.6% recognized the importance of psychological support. Only 14.5% of participants reported having participated in psychological counseling or support groups, despite 30.2% expressing interest in such services. This gap between need and utilization suggests barriers to accessing mental health support, which may include stigma, lack of awareness, financial constraints, or limited availability of services [60,61]. Healthcare providers, particularly GPs, should routinely screen for maternal mental health concerns and facilitate referrals to appropriate psychological support services. The identification of personal time and family support as key resources reflects the fundamental role of social and relational factors in maternal well-being. Rather than being solely an individual responsibility, motherhood emerges from our findings as a socially embedded experience, shaped by the availability of support systems. The relatively lower emphasis on professional support services may indicate either limited access or cultural preferences for informal support networks. These findings suggest that interventions aimed at improving maternal well-being should not only focus on individual resilience but also on strengthening family and community support structures.

The majority of mothers (83.1%) reported that motherhood transformed their self-perception, with 45.3% indicating a very significant change in personal identity. This finding reflects the profound psychological reorganization that occurs during the transition to motherhood, often referred to as "maternal identity development" in the literature. While this transformation is a normal developmental process, it can be accompanied by feelings of loss of one's pre-motherhood self, role confusion, and identity conflict [62–64]. The coexistence of positive emotions (joy: 97.1%, fulfillment: 87.2%) with negative emotions (anxiety: 34.3%, guilt: 33.1%, frustration: 23.8%) reflects the complex and multifaceted nature of maternal experience. This duality is well described in the literature as a normal aspect of maternal identity development, rather than a pathological state [65–67]. Recognizing this complexity is essential for healthcare providers, as it challenges idealized representations of motherhood and supports a more realistic and compassionate approach to maternal care.

An important finding was the significant association between pregnancy intention and maternal-fetal bonding during pregnancy ($p = 0.003$). Mothers with desired pregnancies were more likely to report strong emotional connections with their unborn babies, while those with partially desired pregnancies reported lower levels of connection. This association has important clinical implications, as prenatal bonding has been shown to predict postnatal maternal involvement and the quality of early mother-infant interactions [68,69]. Healthcare providers should assess pregnancy intention early in prenatal care and provide enhanced emotional support and counseling to mothers with ambivalent feelings about their pregnancy.

The mode of delivery also had an impact on mothers' perception of the birth experience ($p = 0.003$). Women who delivered via cesarean section were more likely to perceive birth as a sudden separation (17.3%) compared to those who delivered vaginally (2.7%). A smaller proportion of cesarean mothers perceived birth as a natural transition (37.8%) compared to vaginal deliveries (60.8%). These findings are consistent with research suggesting that cesarean delivery, particularly when unplanned or emergency, may disrupt the physiological and psychological processes of birth and early bonding [42–44,70]. Healthcare providers should provide additional emotional support to mothers delivering via cesarean section, facilitate early skin-to-skin contact when medically appropriate, and address any feelings of disappointment, trauma, or disconnection that may arise from the birth experience.

Study Limits

The achieved sample size (n = 172) was lower than the estimated minimum required sample size of 196 participants, which may have reduced the statistical power of the study. As a result, there is an increased risk of type II error, meaning that some true associations may not have been detected. In addition, the limited sample size requires cautious interpretation of statistically significant findings, as these may be unstable and not generalizable. Therefore, the results should be considered exploratory and hypothesis-generating. The questionnaire was specifically developed for this exploratory study and was not previously validated; therefore, psychometric properties such as internal consistency (e.g., Cronbach's alpha) were not assessed. The convenience sampling method and online distribution of the questionnaire may have introduced selection bias, as the study predominantly reached educated, urban mothers with internet access, potentially excluding mothers from lower socioeconomic backgrounds or rural areas with limited digital literacy; therefore the findings cannot be generalized to the broader Romanian maternal population. The questionnaire did not collect data on important health-related variables, including maternal chronic conditions (such as diabetes, hypertension, or autoimmune disorders), pregnancy complications, postpartum health problems, maternal mental health history, pregnancy complications, socioeconomic status, or urban/rural residence, or child health status and chronic conditions. These factors may significantly influence maternal experiences, emotional well-being, and perceived support needs. The study relied on self-reported retrospective data, which may be subject to recall bias. Their recollections of birth experiences, early bonding, and breastfeeding practices may be influenced by current relationships with their children and subsequent life experiences. A substantial proportion of participants had children older than 6 years (41.9%), which increases the risk of recall bias. Mothers' recollections of pregnancy and early postpartum experiences may be influenced by time and subsequent experiences. This limitation was not controlled for and should be considered when interpreting the findings. Future studies should consider stratified analyses based on the age of the youngest child to better capture temporal differences in maternal perceptions. Another important limitation of this study is the overrepresentation of highly educated women (86%), which may introduce a significant bias. Higher educational level is associated with increased health literacy, greater access to healthcare resources, and different perceptions of motherhood and support needs [71,72]. Consequently, the findings may not be representative of mothers with lower educational attainment or from disadvantaged backgrounds.

4. Materials and Methods

4.1. Study Setting

We conducted a cross-sectional observational study, based on an online questionnaire administered to 172 Romanian mothers. A self-administered online questionnaire was developed specifically for this study and distributed between December 2025 and January 2026. The survey was conducted in Romanian and included both multiple-choice and single-choice questions. The completion time was approximately 7 min.

The questionnaire included 33 items structured across several thematic domains: (1) sociodemographic characteristics, (2) perinatal factors, (3) maternal–fetal bonding during pregnancy, (4) early postnatal bonding and birth experience, (5) maternal identity and psychosocial experience, and (6) perceived support needs (Appendix A Table A1). Most items used ordinal response scales, predominantly Likert-type formats (e.g., "not at all", "slightly", "moderately", "much", "very much" or "never", "rarely", "sometimes", "often", "always"), while some questions were dichotomous or multiple-choice. For statistical analysis, categorical variables were analyzed as reported, and in selected cases, response

categories were grouped to ensure adequate cell sizes for inferential testing (e.g., combining adjacent Likert categories).

Participants Were Instructed to Respond with Reference to Their Youngest Child

The questionnaire was developed by the research team based on a review of existing literature on maternal–fetal attachment, maternal identity, and perinatal mental health. Items were designed to cover key domains relevant to the study objectives [73,74]. Prior to distribution, the questionnaire was pilot-tested on a group of 10 mothers to assess clarity, comprehension, acceptability, and completion time. Participants were asked to provide feedback regarding question wording, ambiguity, and ease of response. Based on this feedback, minor revisions were made, including rephrasing unclear items, improving the order of questions, and refining response options to enhance clarity and usability. However, the instrument was not formally validated, and its psychometric properties were not assessed, which represents a limitation of the study. Given the exploratory nature of the study, all statistical analyses were considered hypothesis-generating. *p*-values should be interpreted with caution, and no causal inferences can be drawn from the observed associations.

4.2. Study Population

The target population consisted of Romanian mothers aged ≥18 years
Inclusion Criteria:

- Romanian mothers aged ≥18 years.
- Consent to participate and completion of the full questionnaire.

Exclusion Criteria:

- Incomplete questionnaire responses.

All the respondents meet the inclusion criteria and none was excluded.

4.3. Statistical Analysis

The data was then exported in Microsoft Excel 2013 and the statistical analyses were performed using IBM SPSS Statistics, Version 26, with a significance level set at $p < 0.05$. Continuous variables were tested for normality of distribution the Shapiro–Wilk test. Non-normally distributed variables were written as medians with interquartile ranges (IQR). Fisher's exact test was used to determine the nonrandom associations between categorical variables with Bonferroni method used for correction. The minimum required sample size was calculated using Cochran's formula for cross-sectional studies:

$$n = Z^2 p(1 - p)/e^2,$$

where Z = 1.96 for a 95% confidence level, p was set at 0.5 to maximize sample size, and e was set at 0.07. The estimated minimum sample size was 196 participants. A total of 172 respondents were included in the final analysis, which was considered acceptable for an exploratory study.

4.4. Ethical Considerations

Informed consent was obtained from all subjects involved in the study. The study was approved by the Ethics Committee of the Pediatric Clinical Hospital, Ploiesti, Romania, under approval number 4/17.12.2025 and was conducted in compliance with the Helsinki Declaration of Human Rights.

5. Conclusions

Motherhood is perceived as a complex experience, in which fulfillment frequently coexists with emotional overload and vulnerability. This exploratory study highlights the complex emotional and psychosocial dimensions of motherhood among Romanian women. The findings suggest the need for accessible emotional and social support resources. Further research is needed to better define the role of healthcare providers and integrated care approaches in addressing maternal needs. These findings should be interpreted in light of the exploratory design and sample limitations.

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Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

GP General practitioner

Appendix A

Table A1. Questionnaire on Maternal Experience and Identity.

Question	Response Options
1. What is your age (years)?	Open numeric response
2. What is your level of education?	Secondary education; University degree; Postgraduate studies (Master/PhD)
3. How many children do you have?	1; 2; 3; More than 3
4. What is your current marital status?	Married; Cohabiting; Single; Divorced; Widowed
5. What is the age of your youngest child?	Under 1 year; 1–3 years; 3–6 years; Over 6 years
6. Was your pregnancy planned/desired?	Yes; No; Partially desired
7. How was the pregnancy achieved?	Natural conception; Assisted reproductive techniques.
8. During pregnancy, how connected did you feel to your unborn child?	Not at all; Slightly; Moderately; Very much
9. Did you talk or communicate with your unborn child during pregnancy?	Yes, frequently; Yes, occasionally; No
10. How would you describe your emotional bond with your child?	Weak; Moderate; Strong; Very strong
11. In the first months after birth, how confident did you feel in your maternal role?	Not at all confident; Slightly confident; Moderately confident; Very confident

Table A1. *Cont.*

Question	Response Options
12. How did you perceive yourself as a mother in the first months after birth?	Insecure; Rather insecure; Confident; Very confident
13. How did you learn to care for your child? (multiple answers allowed)	From my own mother; From healthcare professionals; From books/online resources; From personal experience (trial and error); From partner/family support
14. How did your relationship with your partner change after the birth of your child?	Improved; Remained the same; Worsened
15. How did your relationship with your parents change after becoming a mother?	Improved; Remained the same; Worsened
16. Did you feel pressure to be a "perfect mother"?	Not at all; Slightly; Moderately; Very much
17. Did you experience feelings of guilt related to motherhood?	Never; Sometimes; Often; Always
18. "I believe motherhood has transformed the way I relate to myself."	Strongly disagree; Disagree; Neutral; Agree; Strongly agree
19. What helped you most to feel like a mother? (multiple answers allowed)	Physical contact with the child; Partner support; Family support; Own maternal experience (trial and error); Own mother's experience/model; Prenatal education/reading; Healthcare professionals
20. To what extent has motherhood changed your personal identity?	Not at all; Slightly; Moderately; Very much
21. Which emotions do you most frequently experience in your role as a mother? (multiple answers allowed)	Joy; Fulfillment; Guilt; Fatigue; Anxiety; Sadness
22. Have you experienced emotional exhaustion ("maternal burnout")?	Never; Sometimes; Often; Always
23. To what extent do you feel you understand your child without words?	Never; Sometimes; Often; Always
24. Do you receive constant emotional support from your partner or family?	Yes; Partially; No
25. Have you sought psychological counseling or support groups for mothers?	Yes; No; No, but I would like to
26. What resources would help you feel more supported in your maternal role? (multiple answers allowed)	Family help; Community support; Personal time; Professional psychological support; Parenting education programs
27. Do you feel that motherhood has increased your sense of purpose in life?	Not at all; Slightly; Moderately; Very much
28. Do you consider motherhood an essential part of your identity?	Not at all; Slightly; Moderately; Very much
29. How satisfied are you with your experience as a mother?	Very dissatisfied; Dissatisfied; Neutral; Satisfied; Very satisfied
30. In a few words, how would you describe what motherhood means to you?	Open-ended response
31. Did you intend to breastfeed during pregnancy?	Yes; No
32. Did you initiate breastfeeding after birth?	Yes; No
33. Did you breastfeed your child?	Yes; No

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