Portfolio Volume 1: Major Research Project

Exploring the Impact of COVID-19 on the Postnatal Period for First-time Mothers Experiencing Postnatal Depression: a Thematic Analysis

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Abstract

Research has identified the negative impact that postnatal depression has on new mothers' wellbeing and that of their family. With mothers in the postnatal period facing unique challenges during the COVID-19 pandemic, there is an increased need to explore the effects of the pandemic on mothers experiencing postnatal depression to understand where support may be needed. A systematic literature review highlighted a gap in this area of inquiry. This study employed a qualitative approach to explore the impact of COVID-19 on the postnatal period for first-time mothers experiencing postnatal depression. Using semi-structured interviews, this research sought to understand the experiences of 12 first-time mothers who experienced postnatal depression during the pandemic. Five main themes were identified through analysis: 'fear of COVID-19', 'being alone', 'relationship with services', 'impact on partner relationships' and 'coping strategies'. Nine respective subthemes were constructed, which identified that COVID-19 had a predominantly negative impact on the wellbeing of new mothers experiencing postnatal depression, however, there were some advantages to their partner being home for several participants. Findings are discussed in relation to the wider literature and the implications are presented, alongside a critical appraisal of the research. Recommendations for future research will also be outlined.

1. Introduction

1.1 Chapter overview

This study used thematic analysis to explore the impact of coronavirus (COVID-19) on the postnatal period for first-time mothers experiencing postnatal depression (PND). To ground the reader in my approach to this research, I will start this introductory chapter by detailing my position and epistemological stance. I will focus on presenting the literature concerning the transition to motherhood and PND more specifically, including the definition, prevalence and the impact of PND on mothers and their family. I will then highlight the impact COVID-19 has had on the postnatal period for new mothers.

1.2 Personal and epistemological position

1.2.1 Interest in the research topic

My interest in the topic of perinatal mental health became heightened when people close to me began their journey into motherhood. I was curious about the transition that occurs for both the mother and family. Witnessing the difficulties some encountered during the transition to parenthood further increased my curiosity and the focus of my thesis started here in October 2019. Fast forward to the beginning of COVID-19, in March 2020, I wanted to explore the new phenomena and impact the lockdown restrictions may have on mothers at a significant point in their transition to motherhood, particularly as friends shared the negative impact lockdown had had on their maternity experience.

1.2.2 Epistemological stance

This research assumes a critical realist approach. Critical realism is ontologically realist (i.e., there is an assumption that there is an external reality that exists and operates

independently of our awareness or knowledge of it) and epistemologically relativist (i.e., human knowledge is socially produced, historically transient and fallible). Critical realism views reality as an 'open system' where causative processes are always contextually determined (Sword et al., 2012). It aims to uncover the hidden mechanisms that explain the empirical phenomena (Sword et al., 2012). The subjective nature of definitions of PND lean towards it being a socially constructed phenomenon. A critical realist approach recognises the way the broader social context will influence the way participants make sense of their experience of PND, whilst also recognising the limit of this reality (Willig, 1999). The approach accepts that the way people perceive this reality is dependent upon their beliefs and expectations, thereby recognising an inherent subjectivity in the construction of knowledge (Bunge, 1993; Madill et al., 2000). Critical realists do not view the data as directly mirroring reality but assume it can inform us about reality (Harper, 2011). This approach also acknowledges how a researcher's experience, beliefs and values will shape their perception of the phenomena being studied, in this case PND, and the way they approach the research more generally. Consequently, although the aim of this research is to share the voices of participants, it does not subscribe to a "naïve realist" (Braun & Clarke, 2006, p.80) view of qualitative research, where the research simply "gives voice" (Fine, 2002, p.218) to participants, as the approach is premised on the assumption that how we experience reality is shaped by our lens and context (Braun & Clarke, 2006; Fine, 2002). Reflexivity is therefore key when undertaking qualitative research to ensure that the researcher acknowledges their role in the shaping of the research. These concepts and their application to this research will be expanded upon in the method chapter.

1.2.3 Relationship with the research

In relation to the critical realist stance I am adopting and the need for reflexivity around all aspects of this research, it is important to begin by acknowledging my context, which I will partly share here. My identity, undoubtably, will have influenced my relationship with the research topic and my participants. As a White British middle-class female, I have often reflected on the impact this has on my clinical work in perinatal services and the perceived visible sameness I share with service users. Similarly, I have wondered upon the impact of meeting with a researcher similar in appearance and with whom they share parts of their identity. Could being an insider (a White British woman at a childbearing age carrying out research on other White British women during their motherhood journey) have contributed to an increased level of trust, from which participants feel able to share more (Bhopal, 2001; Haniff, 1985)? Alternatively, as suggested by Chavez (2008), perhaps the feeling of 'sameness' may make the discussion of key topics uncomfortable for participants. While it is important to be mindful of this, research has suggested that participants would be unlikely to participate in a study if they did not feel some level of trust (Clingerman, 2008). The implications of this for recruitment in this research will be outlined in the method chapter.

I have also considered how meeting with mothers with shared identities to myself (both clinically and in research) has contributed to my assumptions and biases regarding the impact of emotional difficulties in the perinatal period, and how these could be challenged by working with mothers with different identities. My understanding of the perinatal period has stemmed from my family context and the reflections and discussions that have occurred around the challenges that have been experienced during the perinatal period from a White British lens. Difference, however, has been observed in class status between different family

members, which in turn has impacted their reality of the postnatal period and how they perceive and manage these challenges. Nevertheless, these discussions contributed to the start of my interest in the perinatal period.

Furthermore, I am mindful of the interplay between my context and the inherent power I am afforded in the role of researcher, with the potential to amplify certain voices or stories due to my personal lens (Råheim et al., 2016). One way of attending to this is through reflexivity; remaining cognisant of my identity and how this intersects with the research. Reflexivity has been increasingly recognised as a crucial strategy in the process of generating knowledge by means of qualitative research, as it supports the researcher to contemplate and reflect on the numerous ways their position may impact on research outcomes (Berger, 2015; Elliott et al., 1999). I will therefore now outline my position to the research topic.

1.2.4 Being an 'insider' and 'outsider' researcher

Within the context of this research, I consider myself to have both an insider and outsider position. As highlighted by Dwyer and Buckle (2009), occupying this position offers a possibility to explore the richness of the space between perspectives, within which qualitative researchers are uniquely equipped for this challenge. Furthermore, although the researcher's position influences their knowledge and biases, qualitative researchers also hold an appreciation for the fluidity of the human experience (Dwyer & Buckle, 2009; Maykut & Morehouse, 1994; Mullings, 1999). My insider position included being subjected to the same COVID-19 restrictions imposed by the UK Government in March 2020, including only shopping for essentials, only engaging in one form of outdoor exercise a day and only

travelling for work where necessary. Within my work role, I am also currently supporting mothers in the perinatal period. Consequently, my clinical experiences have afforded me the opportunity to support mothers with similar experiences to the participants being recruited for this research. This has amplified my passion to undertake research that can have implications in clinical practice. In some respects, I am also an outsider, I have not experienced a transition into the postnatal period and I have not experienced PND. These opposing positions therefore allow me to take a middle position, thereby widening the range of my experience and understanding (Dwyer & Buckle, 2009).

1.3 Setting the scene

The remainder of this chapter will outline the literature around a woman's transition to motherhood, the definition and prevalence of PND and highlight the impact of PND and recommended interventions drawing on the current evidence base. I will then move on to discuss COVID-19 and its impact on new mothers' experiences of the postnatal period.

1.3.1 Transition to motherhood

To understand why some mothers experience depression in the postnatal period, it is essential to understand mothers' reported experiences of the transition to motherhood. However, to do this, it is helpful to first define the term 'mother'. There are many definitions available but for the purpose of this research, the term 'mother' is based on Naka's (2020) suggestion that a 'mother' is a person who forms a close connection with a child through the role of motherhood. 'Motherhood' being the "role of being the primary responsible caretaker for a dependent child" (Ridgeway & Correll, 2004, p.384).

Research describes the transition to parenthood as a major developmental period that significantly affects parents, the infant-parent bond and the infant's development (Deave et al., 2008). Literature has described this transition as a stressful life event and one that causes more intense changes than any other developmental stage of the family life cycle (Cowan & Cowan, 1995; Priel & Besser, 2002). Indeed, whilst research has highlighted many positives associated with this transition, including mothers expressing overwhelming feelings of joy and love for their baby and enjoying their company (Cronin & McCarthy, 2003; Deave et al., 2008; Kalinowski et al., 2012), new mothers have also spoken about coping with extreme fatigue, adapting to new routines and adjusting to their new body image (Kurth et al., 2016). The challenges associated with the transition to motherhood have been demonstrated in both Western and non-Western cultures, suggesting that this experience, to some extent, is universal (Cronin & McCarthy, 2003; Javadifar et al., 2016; Kurth et al., 2010).

Studies have also found that a mother's expectations of motherhood play an important role in this transition (Glass, 1983; Wise & Grossman, 1980). Mothers who have realistic expectations of motherhood in the antenatal period tend to demonstrate a healthy adjustment in the postnatal period to motherhood (Glass, 1983; Wise & Grossman, 1980). A positive adaptation to motherhood has been linked to preparing for the challenging aspects of motherhood and an awareness of the positive outcomes associated for caring for their baby (Glass, 1983). By contrast, a postnatal period that does not match or exceed prenatal expectations can contribute to the development of PND (Lazarus & Rossouw, 2015). Furthermore, research has demonstrated that new mothers may not disclose struggling to adjust, due to motherhood being perceived as a happy event (Copeland & Harbaugh, 2019). New mothers may feel shame over negative thoughts about becoming a mother and, as a

result, avoid seeking help (Barclay et al., 1997; Nicolson, 1999). Indeed, feelings of guilt and concern about stigma are contributors to mothers who experience PND not seeking support (Manso-Córdoba et al., 2020).

1.3.2 Policy and services

Historically, there has been a lack of specialist perinatal mental health support for expectant and new mothers. In 2013/14, 40% of England had no access to perinatal health care (Health Education England, 2016). It is estimated that perinatal mental health problems cost the NHS and social services £6.6 billion a year, with a substantial part of this cost relating to the impact on the child (Bauer et al., 2016; Howard & Khalifeh, 2020). In 2019, the NHS long-term plan demonstrated a renewed commitment to transforming specialist perinatal mental health services to ensure that all mothers who need support have access to care. The plan included increasing the number of community perinatal teams and mother and baby units so that mothers can be treated closer to home, and an increase in the length of care, from preconception to two years. The ambition of the long-term plan is to provide care concordant with the Antenatal and Postnatal Guidelines developed by the National Institute for Health and Care Excellence (NICE) (Howard & Khalifeh, 2020; NICE, 2014).

1.4 Postnatal depression

As highlighted, the transition to motherhood represents a critical experience in a mother's life and is characterised by profound change at both an individual (physical and psychological) and interpersonal level (Guzzo & Hayford, 2020; Lawrence et al., 2008). These changes include taking on a new maternal identity, increased demands and navigating new roles, including relationships with partners, wider family and healthcare professionals (Clout

& Brown, 2015; Feinberg et at., 2019). These major changes in motherhood can negatively impact on a new mother's wellbeing, leading to the development of emotional difficulties, potentially including PND (Lupton, 2000).

Literature, to date, has demonstrated several protective and risk factors linked to new mothers developing PND in the postnatal period. Risk factors for new mothers include unplanned pregnancy, experiencing prenatal depression, the occurrence of stressful life events, experiencing difficulties in the relationship with their partner and a lack of social support, including from their friends and parents (Della Corte at al., 2022; Kettunen & Hintikka, 2017; Oppo et al., 2009). In contrast, strong emotional and physical support from a partner has been found to play an important role in reducing the emergence of PND in the postnatal period (Della Corte et al., 2022). Alongside wider social support from partners, family and health care professionals, new mothers feeling confident in their parenting abilities and experiencing high social economic status has been identified to offer a protective role (Abdollahi et al., 2014; Smorti et al., 2019).

1.4.1 Definition of postnatal depression

PND is currently defined in the Diagnostic and Statistical Manual of Mental Disorders (5th edition) and the International Statistical Classification of Diseases (11th edition) as a major depressive episode occurring within the first 4- or 6-weeks following childbirth (DSM-5; American Psychiatric Association, 2013; ICD-11; World Health Organisation, 2019). The symptoms of PND include depressed mood, loss of enjoyment and energy, anxiety, guilt, low self-esteem, disturbed sleep, and restlessness. There are various difficulties with the definition of PND, however, including the established cutoff between when mothers are experiencing postnatal blues or PND and the features of PND and how they may be

experienced by new mothers. The current definition of PND is therefore lacking and consequently the diagnosis of PND is complex.

1.4.2 Prevalence

Research has highlighted that approximately 18% of new mothers will experience PND (Hahn-Holbrook et al., 2018). The inception rate is greatest in the initial 12 weeks and whilst residual depressive symptoms are common, up to 50% of mothers diagnosed with postnatal depression will remain clinically depressed at six months postpartum (Cooper & Murray, 1998; Kumar & Robson, 1984; Vliegen et al., 2014). Recent research has also demonstrated an increase in the prevalence of PND, with new mothers twice as likely to experience PND compared to before COVID-19 (Davenport et al., 2020; Myers & Emmott, 2021; Spinola et al., 2020). The guilt around experiencing negative thoughts in motherhood, the concerns around the stigma associated with PND and the inadequate diagnostic criteria, however, may mean the prevalence rates are higher than this (Barclay et al., 1997; Manso-Córdoba et al., 2020; Nicolson, 1999). Furthermore, literature has highlighted how lockdown has impacted on new mothers' access to mental health support, therefore, although a large proportion of new mothers may have met the clinically relevant criteria for a diagnosis of depression, many will not receive a formal diagnosis (Fallon et al., 2021).

1.4.3 Intervention

There are several psychological models that have been shown to be effective in the treatment of PND (Stephens et al., 2016).[1] In the UK, the NICE guidelines (NICE, 2014)

[1] It is important to note that these approaches are underpinned by Western cultural values. Adaptations of such approaches have been found to be beneficial to different cultures and populations (Naeem & Kingdon, 2002). Within these adaptations, however, the traditional rituals and practices that accompany the transition to motherhood in non-Western cultures need to be acknowledged and understood (Wittkowski et al., 2017).

suggest treating moderate to severe PND with a high intensity psychological intervention, such as Cognitive Behavioural Therapy (CBT). The central principle of cognitive behavioural theory is that our thoughts influence our emotional and behavioural responses to life situations (Pedro et al., 2019). For new mothers in the postnatal period, the expectations on being the 'perfect' parent, for example, can lead to the development of a vicious cycle (Button et al., 2017). CBT aims to explore the link between an individual's thoughts, feelings, physical sensations and behaviour to change the negative cycle and help improve how a new mother feels (Stamou et al., 2018). Research has identified the use of CBT to improve the symptoms and progression of PND (Huang et al., 2018).

Interpersonal therapy (IPT) has also been shown to be effective in the treatment of PND (Stuart, 2012). The lack of perceived support in new mothers' relationships can contribute to the occurrence of PND (Stuart, 2012). The interpersonal relationship between new mothers and their partners has often been shown to be negatively affected in PND (O'Hara, 1994). IPT aims to target the specific disruptions in the interpersonal relationships of new mothers to strengthen their relationships, thereby increasing social support and improving communication in the postnatal period (Stamou et al., 2018).

With research demonstrating the negative impact of PND on partner relationships and a new mother's relationship with their infant, a systemic approach has been highlighted as useful in the treatment of PND (Hunt, 2006). Systemic therapy can be used to reframe and externalise the problem so it is no longer a difficulty that lies with the mother, but instead is an external problem, whereby therapy can assist a "couple to explore how PND comes in between them", reducing the pressure on new mothers (Hunt, 2006, p.216). With psychological difficulties often arising during key moments in the life cycle transition, the approach allows the exploration of the roles and routines needed to adjust to a new family

life, alongside consideration of the broader social-economic context, including wider relationships and change in finances or job status, which are known to be affected in the postnatal period (Hunt, 2006).

1.5 Impact of postnatal depression

1.5.1 Impact on mother

Western society's constructed ideology of motherhood is one of happiness, excitement, and contentment (Buultjens & Liamputtong, 2007; Mauthner, 2002). Such depiction of new parents' ease at adapting has perpetuated the common myth that women can transition to motherhood easily and create a maternal bond effortlessly (Choi et al., 2005). Mothers experiencing PND who perceive themselves as failing to meet these ideological criteria are more likely to experience feelings of guilt, inadequacy and shame (Mauthner, 2002), and try to mask their difficulties, leading to withdrawal from others, thereby creating feelings of loneliness and isolation (Choi et al., 2005; Mauthner, 2002) and perpetuating symptoms of PND.

Mothers who experience PND are also more likely to experience anxiety (Vliegen et al., 2013). PND has a long-term impact with mothers more likely to experience future episodes of depression over a five-year period (Cooper & Murray, 1995) and has been known to impact on new mothers' physical health, their relationships and their perceived quality of life (Da Costa et al., 2006; Vliegen et al., 2013). Furthermore, the consequences of undiagnosed and untreated depression are serious. Nearly 20% of mothers with PND have contemplated harming themselves and in the UK, suicide is the leading cause of maternal death in the year following delivery (Knight, 2019).

1.5.2 Impact on family

The implications of PND include an impact on mother and infant bonding, which in turn can have adverse effects on an infant's behavioural, emotional and cognitive development (Bernard-Bonnin, Canadian Paediatric Society & Mental Health & Developmental Disabilities Committee, 2004; Madigan et al., 2007) that can persist beyond infancy (Beck, 1998; Cooper & Murray, 1998; Hipwell et al., 2000). PND also has an adverse impact on an infant's social abilities and on their parental attachments (Murray, 1992; Murray et al., 1999). A major tenet of attachment theory is the competence hypothesis, which demonstrates that a secure attachment in childhood prepares a child for other social challenges and sets them on a more positive developmental trajectory (Weinfield et al., 2008). [2] As PND can impact the way mothers behave towards their child, this can lead to the development of insecure attachments, which have been linked to infants developing externalising behaviours, including aggression, and internalising behaviours, such as depression and anxiety (Kerns & Brumariu, 2013; Madigan et al., 2007).

PND has been found to affect a child's sleep pattern and their physical health, with children more likely to experience physical illness (Gress-Smith et al., 2012; Pinheiro et al., 2011). These findings can be explained by attachment theory and its links to the theoretical work on affect regulation systems. The development of the threat, drive, soothe systems co-occur with the development of an attachment system, within which caregivers are expected to offer reassurance, thereby stimulating the soothing system (Gerhardt, 2014). Where caregivers are unable to meet the needs of their children, for example in environments

[2] There are several critiques of attachment theory, for example, it is a Westernised approach that privileges the maternal bond over the paternal bond or bond with siblings, when in fact, a father or sibling can have the same type of attachment (Lee, 2003). It is the focus on the maternal bond that may contribute towards maternal PND, with the pressure on mothers to be the 'perfect mother' (Brown et al., 1997; Meeussen & Van Laar, 2018).

where a mother is experiencing PND, this can have an adverse impact on the development of the infant's regulation system, leading to an increased threat drive and an underdeveloped soothing system (Carona et al., 2017; Doyle & Cicchetti, 2017). The difficulty to engage in behaviours that soothe can lead to an increase in stress levels (Carona et al., 2017). Research has long recognised the link between stress and physical illness and its contribution to sleep difficulties (Han et al., 2012; Slavich & Auerbach, 2018).

Furthermore, research has found that PND in mothers can contribute to their partner feeling low in mood (Carro et al., 1993; Webster, 2002; Zelkowitz & Milet, 1995). Studies suggest that this may be due to them caring for a depressed partner and a young baby whilst living in a tense environment, where they predominately manage family tasks and feel underappreciated (Meighan et al., 1999; Morgan et al., 1997; Roberts et al., 2006; Webster, 2002). Indeed, research has demonstrated that partners of mothers with PND view their lives as unpredictable, and this can have a long-lasting impact on their partner relationship (Meighan et al., 1999).

1.6 COVID-19

The COVID-19 pandemic caused a sudden and significant change of circumstances across the world. Many people have experienced a loss of livelihood and the loss of family and friends. The UK imposed restrictions on the 23rd March 2020 to reduce the spread of COVID-19. Measures included orders for people to stay at home (only leaving for essential travel), closure of businesses and prohibition of gatherings with individuals outside of their household. Until the end of 2021, the UK population was subjected to various restrictions, similar to those above.

1.6.1 COVID-19 and maternal mental health

Most of the studies on the impact of COVID-19 on maternal mental health have mainly been quantitative in nature. Nevertheless, it has identified that COVID-19 poses health risks to the whole population, including expectant and new mothers. When the vulnerabilities of the postnatal period are combined with the impact of the pandemic, psychosocial outcomes are expected to be affected further (Matvienko-Sikar et al., 2020). Key psychosocial stressors include an inconsistent organisational response to COVID-19 in postnatal care, a decrease in access to in-person support from services, absence of partners at birth and restrictions on mother-infant contact and infant feeding care (Horsch et al., 2020; McKinley, 2020; Thapa et al., 2020). A recent review of the psychological impact of quarantine on the general population found negative psychological effects, including anger, confusion and post-traumatic stress symptoms (Brooks et al., 2020). Furthermore, the pandemic has decreased access to mental health services for the general population, which is likely to impact further on psychological wellbeing (Davenport et al., 2020).

Research has also highlighted how some new mothers' experiences have been completely different from their expectations and that they and their family had missed out on important moments, such as access to mother and baby classes (Vázquez-Vázquez et al., 2021). It is important to acknowledge, however, the positive implications of the COVID-19 pandemic, including partners being able to work from home (thereby being able to support new mothers more), more time to adjust to the new family structure with the absence of visitors and not missing out on postponed social activities and events (Gray & Barnett, 2022).

1.6.2 COVID-19 and postnatal depression

Mothers in the postnatal period have faced unique challenges during the COVID-19 pandemic, which will have increased the need for emotional and psychological support for mothers experiencing PND (Basu et al., 2021). A recent study found that women who gave birth during the lockdown period scored higher on the Edinburgh Postnatal Depression Scale, compared to a control group of mothers who gave birth during the same time period in 2019 (Zanardo et al., 2020). Moreover, the pandemic has affected new mothers' access to health care and mental health support postnatally, which is likely to exacerbate their experience of PND and reduce the number of opportunities for PND to be diagnosed and treated (Takubo et al., 2021).

The impact of COVID-19, including isolation, reduced physical activity, and a lack of postnatal health care have all contributed to an increase in the prevalence of depression for new mothers (Basu et al., 2021; Davenport et al., 2020; Perzow et al., 2021) as lockdown periods designed to reduce virus transmission resulted in isolation from family, friends and wider support (e.g. baby classes) (Chivers et al., 2020).[3] Given that poor social support has been found to increase the risk of PND (Lakey & Cronin, 2008), it is important to further explore the way mothers with PND experienced social isolation due to the lockdown period.

1.7 Conclusion

Literature has emphasised the negative impact that PND can have on new mothers' wellbeing and the wellbeing of their partner and children, with lasting effects found. With the postnatal period being a vulnerable time for new mothers, it is not surprising that the restrictions implemented during COVID-19 have had mainly adverse consequences for new

[3] The impact of COVID-19 on the postnatal period for partners of mothers experiencing PND, however, is a largely under-researched area.

mothers and their families, including isolation from social support, a lack of postnatal care and reduced physical activity. It may not be unexpected that this has likely contributed to a negative impact on the psychological wellbeing of new mothers in the postnatal period and further intensified the symptoms of maternal PND. With mainly quantitative research being conducted to date, however, there is a gap in the literature and a need to increase the use of qualitative approaches to further explore the impact of COVID-19 on maternal mental health and the experiences of mothers with PND. The following chapter will build on the research presented in the introduction and identify gaps in the literature by presenting the systematic literature review that was undertaken.

2. Systematic review of relevant literature

2.1 Chapter overview

I will start by outlining the process completed as part of the systematic literature review (SLR), including detailing the databases that were searched and the inclusion and exclusion criteria applied. I will go on to present the results of the SLR and a critical evaluation and synthesis of the findings. Finally, I will offer the rationale for this investigation, including its aims and the specific research question.

The current study will focus on the impact of COVID-19 on the postnatal period for first-time mothers experiencing PND. The literature presented in the introduction indicated a negative effect of COVID-19 on the wellbeing of new mothers in the postnatal period. The aim of the SLR was to understand this further by exploring wider research about maternal mental health. Therefore, a systematic review of peer-reviewed empirical literature was undertaken to answer the following question:

What does the existing literature say about the impact of COVID-19 on the experience of new mothers' mental health in the postnatal period?

2.2 Search strategy

Four bibliographic databases were accessed through the University of Hertfordshire (UH) library. Searches were conducted in Scopus, PsycArticles, CINAHL and Pubmed. The UH library search planning tool was used to list the various terms relevant to the systematic review question (the final search terms are in Appendix A). The final search strategy was

informed by conducting several pilot searches within each database to capture the commonly used terms. Discussions also took place with two consultants to the research to integrate their reflections and thoughts on the terms used, before a final search was performed to capture relevant articles. The number of search terms used was reduced when searching through the Pubmed database due to the vast number of articles found (see Appendix A). This did not seem to compromise the search, as numerous articles were returned that had already been found through searching the Scopus and CINAHL databases. A search was also performed on Google Scholar using the phrase 'impact of COVID-19 on maternal mental health in the postnatal period' to try and identify any additional relevant articles. No new articles that were previously undiscovered emerged. The PROSPERO database was checked to identify if this SLR had already been undertaken, however, none were found. The final search across the databases and Google Scholar to capture relevant articles occurred between the 26th and 27th February 2022.

After conducting pilot searches of the broader literature, inclusion and exclusion criteria was established. Articles were included if they were written in English, so that the researcher could understand them fully.[4] Papers were included only if they focused on participants who had already given birth, as the SLR question concentrated on the postnatal period. The initial aim was to focus on research that had been conducted in the UK, as the restrictions that were imposed varied between countries and between different areas within a country (Wang et al., 2021). However, this criterion generated a limited number of articles and was excluded. This will be further discussed in section 2.3.3.

[4] No papers were excluded on this basis in the end.

Literature was excluded if participants had given birth more than 12 months prior to restrictions being imposed.[5] Research that focused on or included mothers who had a premature baby was also excluded. The imposed restrictions created additional challenges for the families of premature infants and would have caused heightened anxiety and stress during the postnatal period (Green et al., 2021). In addition, literature that concentrated on refugee mothers was excluded. Resettled refugee mothers are already at a substantially higher risk of experiencing adverse postnatal experiences compared to non-refugee mothers, particularly due to their existing obstacles to healthcare (Stirling et al., 2021).[6] A letter to the editor from Lim et al. (2021) that focused on mental health among postpartum mothers was also excluded, as whilst the article reported on some of their findings from interviews with postpartum participants, the information on their methods and findings was limited and this letter would not have been subject to peer-review (Falavarjani et al., 2016).

After exporting the relevant articles into Excel and exploring the literature, a later decision was made to only include research that focused on qualitative and mixed-methods findings to be able to explore the experiences of new mothers' mental health in the postnatal period during COVID-19. It was evident that utilising these methods allows a richer depth of understanding, which is a benefit that has been previously highlighted within the literature (Caruth, 2013). Table 1 below provides a summary of the inclusion and exclusion criteria.

[5] This time period was chosen, as mothers who gave birth 12 months prior to the pandemic would have experienced a typical postnatal maternity experience for some time before COVID-19 and the implementation of the restrictions.

[6] This is an area where further research is needed but it was beyond the scope of this thesis.

Table 1

Inclusion and exclusion criteria for SLR

Inclusion criteria	Exclusion criteria
Focused on the experiences of mothers in the postnatal period (within the last 12 months)	Focusing on mothers who had given birth a long time prior to the pandemic (more than 12 months)
Published in English	Conceptual, theory or letter to the editor
Reporting original peer-reviewed research	Focusing on refugee mothers
Published in any country	Focusing on mothers who gave birth to premature infants
Qualitative and mixed-methods research	Quantitative research
	Published in any language other than English

The method for the SLR is detailed below:

1. Search results were exported from the databases to an Excel spreadsheet
2. The title and abstracts were screened
3. Duplicates were removed
4. Articles meeting the exclusion criteria were removed
5. The remaining full-text articles were assessed against the criteria and were removed if they did not meet them

2.3 Results of the systematic literature review

Following the removal of duplicate articles, a total of 118 articles remained for screening. After screening for the inclusion and exclusion criteria, 13 articles remained for full-text screening. Of the 13 articles, 10 met the criteria for inclusion in the literature review. A summary of the papers included in the SLR is detailed in Table 2. The reference lists of these articles were searched to check for further articles that met the inclusion

criteria, but none were found. The flow chart detailing the procedure can be found in Figure 1.

Figure 1

PRISMA flow chart for the study selection procedure

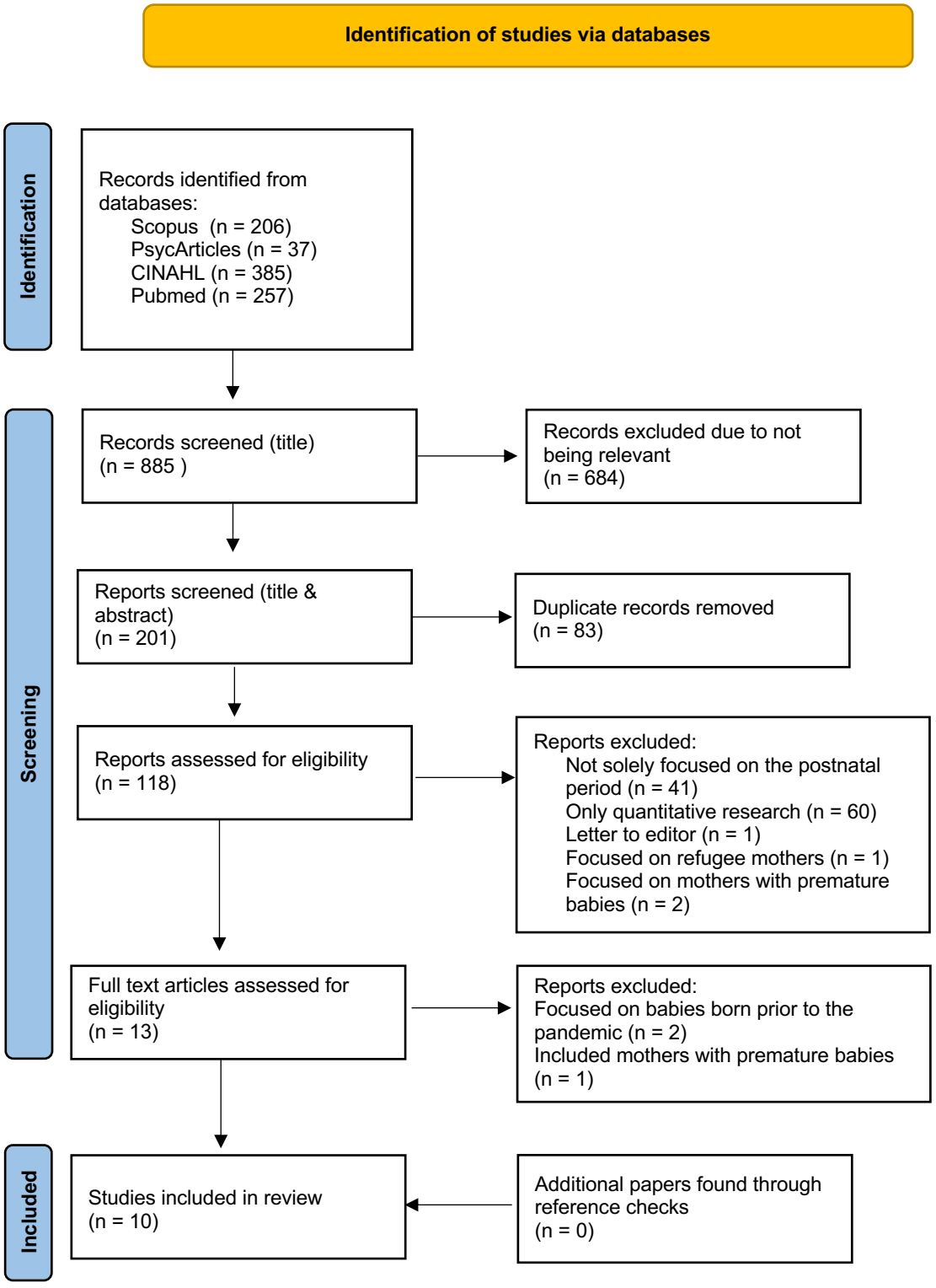

Table 2

Summary of studies included in SLR

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
1	Aydin, R. (2021).	Becoming a Mother in the Shadow of COVID-19	Turkey	The study aimed to explore the experiences and coping methods of first-time mothers during the COVID-19 pandemic.	Data collection: semi-structured interviews Data analysis: grounded theory	17 first-time mothers	One core theme emerged from the data – *Psychologically Worn Out Due to the Challenges of Becoming a Mother and Fear of Something Happening to the Baby* and five main themes (which were all affected by the core theme): - Postpartum mental health - Maternal adjustment - Maternal attachment - Baby care - Coping methods The study highlighted the difficulty in experiencing motherhood for the first time under the shadow of COVID-19. Maternal mental health, maternal adjustment and attachment were adversely affected by the fear that their baby would be infected with COVID-19. Participants spoke about being overprotective when caring for their baby. Mothers' mental health was also impacted by fractures in their relationship with their partner. Participants spoke about coping with these difficulties by adopting a fatalistic approach, crying and seeking social support from their partner, family, online support and peer support.	Strengths: The researcher commented on identifying the rigour of the study by using Lincoln and Guba's (1994) five criteria to validate the study. The coding process was cross-validated by another researcher not involved with data collection. Themes were checked by two external experts. The study reflects on the implications for clinical practice. Three pilot interviews conducted to confirm clarity of the interview questions. Reason for sample size provided (data saturation reached). Limitations: Interviews were conducted by telephone, therefore non-verbal cues which may have signalled distress from participants would not have been picked up.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
2	Joy, P., Aston, M., Price, S., Sim, M., Ollivier, R., Benoit, B., Akbari-Nassaji, N., & Iduye, D. (2020).	Blessings and Curses: Exploring the Experiences of New Mothers during the COVID-19 Pandemic	Canada	The aim of study was to explore the postpartum experiences of new parents during the COVID-19 pandemic.	Data collection: open ended online survey Data analysis: discourse analysis	68 new mothers	The findings highlighted that the public health orders imposed due to COVID-19 created experiences that were positive (blessings) and negative (curses). Being required to isolate was both emotionally stressful and emotionally rewarding for most participants. They described the blessings that came with the freedom of being able to enjoy their baby without expectations being placed on them. With this came positive experiences of quiet enjoyment, including time for themselves as a family, which allowed them space to bond with their baby. They highlighted the positives of being able to learn about their baby and themselves as a new parent. Participants also shared the sadness around being isolated from family and missing out on opportunities to do things with their baby. They reported their concerns that their baby would not be socialised properly due to limited contact with other people. Mothers also highlighted missing out on their alone time with their baby, as their partner was always present at home, which adversely impacted their relationship.	Strengths: Named that their feminist poststructuralism epistemology guided the qualitative research process. No interviewer due to using a survey reduces bias. Limitations: Online survey used; therefore, no follow up questions can be asked potentially reducing the richness of the data. No acknowledgement of the limitations of the study or areas for future research.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
3	Ollivier, R., Aston, M., Price, S., Sim, M., Benoit, B., Joy, P., Iduye, D., & Akbari-Nassaji, N. (2020).[7]	Mental Health & Parental Concerns during COVID-19: The Experiences of New Mothers Amidst Social Isolation	Canada	The aim of the study was to explore how the public health orders imposed during the COVID-19 pandemic impacted the way new mothers attended to their social, emotional and mental health needs and the needs of their babies.	Data collection: open ended online survey Data analysis: discourse analysis	68 new mothers	A predominant theme in the study was that mental health difficulties were at the forefront of the participants postnatal experience during the first wave of COVID-19. Although many participants reported positive experiences with their babies, their experience with their mental health was significantly negative, with participants sharing that they felt sad, angry, anxious, depressed, isolated and abandoned. Many participants shared that their mental health had been impacted for a number of reasons, including mourning the postnatal maternity experience they had imagined, feeling isolated from family, loss of social support and difficulties finding appropriate mental health support. Several participants spoke about connecting with people through online means e.g. groups to support their mental health. Some participants reported benefits of using online platforms, whereas others felt it did not offer the same benefits as face-to-face interactions.	Strengths: Subjective experiences captured through moving quotes from participants. Implications for future practice highlighted. Names its feminist poststructuralism epistemology. Limitations: Lack of transparency regarding the analysis process. As highlighted by the researchers, the study only focused on Nova Scotia, which experienced a different context to COVID-19 compared to other provenances in Canada, thus potentially lacking generalisability.

[7] Joy et al's. (2020) and Ollivier et al's. (2020) studies were two papers based on the same participants and survey; however, different questions were asked of the data, with two different aims and research questions focused on. Therefore, both papers were included in the SLR, as different findings were provided from the two papers.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
4	Goyal, D., Han, M., Feldman-Schwartz, T., & Le, H. N. (2022).	Perinatal Experiences of Asian American Women During COVID-19	United States	To explore the wellbeing, pregnancy, childbirth, and postpartum experiences of Asian American mothers who gave birth during the COVID-19 pandemic.	Data collection: semi-structured interview Data analysis: content analysis	38 new mothers	Two main themes emerged from the data: - *Unexpected perinatal journey* (responses encompassed two subthemes: restructured medical visits and silver linings) - *Emotional and psychological consequences of COVID-19* (responses reflected two subthemes: fear of COVID-19 and feeling sad and disappointed) Participants reflected on the benefits that had emerged from the pandemic. They also reported several negative effects of the pandemic, including feeling anxious about managing visitors due to the concerns around their baby being infected with COVID-19. They shared sadness at missing out on maternity experiences and family being unable to visit. Participants with other children at home also shared their concerns around their children not being able to socialise and feeling overwhelmed with managing demands.	Strengths: Recruitment took place over a long period of time (6 months). Limitations and implications for practice was presented. As noted by the researchers, the study included an underrepresented group in perinatal research. Limitations: Majority of participants were well-educated with a high annual income, limiting the generalisability of the results. As noted by the researchers, a limitation was that the participants were not asked about racist comments or incidents towards them during their perinatal care. Given the increase in racial attacks directed toward Asian Americans since the start of the pandemic, it was noted that future research should include questions regarding racism and discrimination.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
5	Jackson, L., De Pascalisa, L., Harrolda, J. A., Fallona, V., & Silveriob, S. A. (2021a).[8]	Postpartum women's experiences of social and healthcare professional support during the COVID-19 pandemic: A recurrent cross-sectional thematic analysis	UK	To explore UK women's postnatal experiences of social and healthcare professional support during the COVID- 19 pandemic.	Data collection: semi-structured interviews Data analysis: thematic analysis	24 new mothers – 12 participants interviewed approximately 30 days after initial social distancing guidelines were imposed (22 April 2020). A separate 12 participants were interviewed approximately 30 days after the initial easing of social distancing restrictions (10 June 2020).	Two main themes emerged at timepoint 1: - *Motherhood has been an isolating experience – (*exacerbated loneliness due to diminished support accessibility) - *Everything is under lock and key* – (confusion, alienation and anxiety regarding disrupted in-person healthcare checks). The two main themes at timepoint 2: - *Disrupted healthcare professional support* – (feeling burdensome, abandoned and frustrated by virtual healthcare) - *Easing restrictions are bittersweet* – (conflict between enhanced emotional wellbeing and sadness regarding lost postnatal time). At both timepoints, participants' psychological wellbeing was reportedly negatively impacted by restricted access to formal (healthcare professional) and informal (family and friends) support. Maternal mental health was also adversely affected by attending in-person appointments, with participants describing experiencing anxiety and feeling attending appointments was contradictory to social distancing guidance.	Strengths: Study offers unique insights into the impact of lockdown restrictions at two distinct time points. Data collection also aligned with changing social distancing restrictions. Participants were selected through a random number generator, reducing the potential for bias. Justification for sample size (saturation reached). Subjective experiences captured through quotes from participants. Clinical implications presented. Limitations: Lack of diversity amongst participants. There is a future need to address ethnicity-specific barriers to support.

[8] Jackson et al's. (2021a) and Jackson et al's. (2021b) papers were also based on the same participants and survey; however, different questions were asked of the data, with two different aims and research questions focused on. Therefore, both papers were included in the SLR, as different findings were provided from the two papers, which were relevant to the SLR question.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
6	Jackson, L., De Pascalisa, L., Harrolda, J. A., Fallona, V., & Silveriob, S. A. (2021b).	Postpartum women's psychological experiences during the COVID-19 pandemic: a modified recurrent cross-sectional thematic analysis	UK	To explore the postpartum psychological experiences of UK women during different phases of the COVID-19 pandemic and the associated lockdowns.	Data collection: semi-structured interviews Data analysis: thematic analysis	24 new mothers – 12 participants interviewed approximately 30 days after initial social distancing guidelines were imposed (22 April 2020). Another 12 participants were interviewed approximately 30 days after the initial easing of social distancing restrictions (10 June 2020).	Two main themes emerged from the data: - *Motherhood is much like lockdown* (responses encompassed two subthemes: lockdown exacerbates postnatal loss of independence and guilt beyond normal parenting) - *A self-contained family unit* (responses reflected two subthemes: lockdown has been a relief from social obligations and breastfeeding triumphs and tribulations) Similar themes arose at both timepoints, with an increase in emotional distress in relation to social distancing restrictions and parenting responsibilities at timepoint 2, thereby offering substantial evidence that maternal mental health has been adversely impacted by the lockdown restrictions. Alongside the negative impact of the restrictions, some of the women also reported positive experiences arising as a result.	Strengths: Researchers' reflexive statement highlighted their position to the research. Data collection was rapid in response to the imposed restriction and latter changes in the guidelines, which allowed for early exploration of the impact on maternal mental health. Collecting qualitative data at two time points allowed for richer insights. In-depth presentation of data collection and analysis allows replicability. Limitations: Lack of homogenous sampling at the two timepoints may have inadvertently compromised methodological rigour (however, allowed for time-sensitive influential factors related to maternal mental wellbeing to be identified and explored).

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
7	Kolker, S., Biringer, A., Bytautas, J., Blumenfeld, H., Kukan, S., & Carroll, J. C. (2021).	Pregnant during the COVID-19 pandemic: an exploration of patients' lived experiences	Canada	To explore pregnant and postpartum individuals' lived experience during the COVID-19 pandemic to better understand their psychological and emotional responses and behaviours, with a focus on strategies to ameliorate distress.	Data collection: semi-structured Data analysis: thematic analysis	12 new mothers – although the study was open to pregnant participants, only mothers who were in the postnatal period took part	Six main themes emerged: - *Childbearing-related challenges to everyday life* - *Increased worry, uncertainty and fear* - *Pervasive sense of loss* - *Challenges accessing care* - *Strategies for coping with pandemic stress* - *Reflections and advice to other pregnant and postnatal people and health care professionals* Participants reported experiencing psychological distress during their postnatal period. Some participants also described how having a new-born baby was a welcome distraction to the pandemic and the advantages of their partner working from home more. Participants advice to healthcare services included: the importance of offering mental health support and clear, up to date communication as well as more postpartum and breastfeeding support.	Strengths: Pilot interview conducted to refine interview guide. Participant experiences captured through quotes from participants. Unique addition to the literature with participants providing advice to other mothers in the same situation and to health care providers. Limitations: Small sample size and no justification of sample size was provided. Participants were from a similar background (well educated, high socioeconomic status, employed and partnered), therefore it is difficult to generalise the findings to other populations.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
8	Rice, K., & Williams, S. (2021).	Women's postpartum experiences in Canada during the COVID-19 pandemic: a qualitative study	Canada	To examine how mothers who gave birth during the pandemic in Canada were affected by policies aimed at limiting interpersonal contact to reduce COVID-19 transmission in hospital and during the early postnatal period.	Data collection: semi-structured interviews Data analysis: thematic analysis	57 new mothers	Four main themes emerged from the data: - *Poor postnatal mental health, especially in participants with underlying mental health conditions and those who had experienced medically complicated deliveries* - *Negative postnatal experience in hospital due to the absence of support* - *Seeking help despite public policies that prohibited doing so* - *Difficulties with breastfeeding due to a lack of in-person breastfeeding support and reduced in-person follow-up care*	Strengths: Named their Social Constructionist approach. Pilot interview conducted to refine interview guide. Identity and position of author presented. Data shared with peers and presented at a conference, coding then re-worked in response to feedback. Additional interviews completed beyond saturation to provide a broad representation of new mothers. Limitations: Interviews completed before participants were aware that pregnant women were at an increased risk for COVID-19, which may have affected new mothers' more recent experiences of care during pregnancy and when in hospital. Telephone interviews completed, therefore non-verbal cues which may have signalled distress from participants would have not been picked up.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
9	Saleh, L., Canclini, S., Greer, K., Mathison, C., Combs, S. M., Dickerson, B., & Collins, K. (2021).	Mothers' Experiences of Pregnancy, Labour and Birth, and Postpartum During COVID-19 in the United States	United States	To explore women's experiences of being pregnant, giving birth and parenting during COVID-19.	Data collection: surveys and interviews Data analysis: descriptive statistics and thematic analysis	32 new mothers	Of the participants, 46% experienced mild to moderate anxiety, 28% experienced severe anxiety symptoms and 34% experienced depression. The study found that COVID-19 had a negative impact on participants' mental health. Participants shared feeling supported by health care professionals but felt that COVID-19 had adversely impacted their support systems. Some mothers also reframed the negatives by describing how it had allowed them space to enjoy their baby and their time as a family. Four main themes emerged: - *Mental distress vs mental health* - *Expectations vs reality* - *Early versus late COVID-19 experience* - *Health care policy versus COVID-19 confusion*	Strengths: Recruitment occurred over a long period of time (12 months). Detailed presentation of data collection and analysis for replicability. Random selection of participants reduces bias. Themes counter checked by each member of the research team. Article presents how quality was ensured throughout the research. Limitation: Only a subset of data collected (February 2021 – April 2021) was addressed in the article. There was no comment on the full findings and any similarities or differences.

No	Authors (Year)	Title	Country	Aims	Methodology	Participants	Key Findings	Strengths and Limitations
10	Sakalidis, V. S., Rea, A., Perrella, S. L., McEachran, J., Collis, G., Miraudo, J., Prosser, S. A., Gibson, L. Y., Silva, D., & Geddes, D. T. (2021).	Wellbeing of Breastfeeding Women in Australia and New Zealand during the COVID-19 Pandemic: A Cross-Sectional Study	Australia & New Zealand	To investigate the effect of COVID-19 on breastfeeding and maternal wellbeing in Australia and New Zealand.	Data collection: mixed method approach with online surveys (questionnaires and open-ended questions) Data analysis: generalised linear models and thematic analysis	364 new mothers	The study found that participants who were pregnant for longer during the pandemic were found to have lower psychological wellbeing scores. Reduced mental health and wellbeing was associated with an increase in perceived stress, perinatal anxiety and reduced levels of family functioning. Partial breastfeeding was also associated with longer pregnancy duration during the pandemic and low milk supply. Participants' most significant concerns were related to the impact of COVID-19 health and safety. In addition, participants expressed concerns for their family's wellbeing and the impact on their ability to parent and their relationships. Participants' concerns around financial insecurity and the impact on their child not being able to socialise was also highlighted. Participants also noted positives of the pandemic, including the reduced pressure to socialise with visitors or leave the house. They reported enjoying a slower pace of life and more family time, resulting in an increase in family bonding.	Strengths: Quantitative and qualitative data provided a rich level of findings and were integrated well. Limitations of research acknowledged. Limitations: As acknowledged by the researchers, the rate of mothers exclusively breastfeeding at three months was higher than the usual rate in the Australian breastfeeding population, indicating that the sample may be biased towards mothers who are highly motivated to breastfeed. Therefore, the findings may not be transferable to all breastfeeding mothers.

2.3.1 Critical evaluation of the study quality

Due to the different methodological variations of the studies in the review, two different appraisal tools were employed to evaluate the quality of the studies. The qualitative studies were evaluated using the "Big Tent" criteria for qualitative quality (see Appendix B) (Tracy, 2010). This approach was preferred as it can be applied to a range of epistemological stances and various methods, from semi-structured interviews to surveys, which were captured in this review (Gordon & Patterson, 2013; Tracy & Hinrichs, 2017).

Two of the articles which utilised a mixed-methods approach were appraised using the Mixed Methods Appraisal Tool (MMAT) (see Appendix C) (Hong et al., 2018). The MMAT was used as it acknowledges the different methodological characteristics specific to each component of mixed-method research, such as quantitative, qualitative and mixed methods. As a result, both strands of the study could be evaluated and brought together to evaluate the whole approach. Originally, there was consideration of using the MMAT to evaluate all the studies, as the different strands of the tool can be drawn upon separately. However, as Tracey's (2010) "big tent" criteria offers a more comprehensive approach to evaluating qualitative research, this was chosen over the MMAT for studies that solely employed a qualitative methodology.

The articles included in the review were well written and made a significant contribution to a rapidly growing knowledge base. Each article was well presented, with the background, method, findings and discussion presented separately for easy reading. Relevant literature was drawn upon in each article to provide comprehensive background information, which would lead to the aims of the research. One paper at the start briefly

identified the current knowledge base and what their research would add to it, providing transparency from the beginning (Jackson et al., 2021a).

The findings of each paper were thoughtfully interpreted, and links made to the existing literature in the discussion. Within the mixed-methods papers, the results were broken down further into quantitative and qualitative findings before being integrated in the discussion. However, the mixed-method findings were not as well integrated in Saleh et al's. (2021) study, with the interpretation of the quantitative findings being presented, followed by the qualitative.

The methods used in each study were suitable for the research aims and most of the articles were transparent with their method. Across all the papers, however, no information was provided on any challenges that arose as part of the research. Several of the articles, particularly where grounded theory and thematic analysis methods were used, offered detailed information on how the data analysis was undertaken (Aydin, 2021; Jackson et al., 2021a; Joy et al., 2020; Kolker et al., 2021; Rice & Williams, 2021). Similarly, Saleh et al. (2021) offered comprehensive accounts of the quantitative and qualitative methods they utilised. In contrast, in Sakalidis et al's. (2021) mixed-method article, detailed information was provided for the quantitative arm of the study, but less transparency was provided about the qualitative strand. In addition, neither of the mixed-method studies provided a rationale for why both quantitative and qualitative approaches were utilised. Apart from four papers (Aydin's, 2021; Jackson et al., 2021a; Jacksons et al., 2021b; Rice & Williams, 2021), within which data saturation was given as a reason for the sample size, no other papers presented any details.

In articles where the researchers shared their epistemological stance (Joy et al., 2020; Ollivier et al., 2021; Rice & Williams, 2021), information was provided on how this

linked to the methodology chosen and how it was considered as part of the data analysis. Most of the papers, however, failed to display self-reflexivity. Goyal et al. (2022) acknowledged at surface level the need to keep their own biases and positionality in consideration during their analysis but did not delve deeper. Rice and Williams (2021) went further to convey sincerity by sharing their personal identity and disciplinary expertise and how this was addressed during data analysis. Jackson et al. (2021b) also presented a reflexive statement which included a comment on the researchers' disciplinary expertise and the first author's position as a childless researcher, which was viewed as an advantage for offering objectivity to data collection and analysis. Limited information, however, was provided on how this was managed throughout the research.

Detailed descriptions of participants' experiences were achieved in each article using quotes, with each theme incorporating numerous quotes from participants to offer rich accounts. Various articles went beyond the core themes, to present detailed subthemes (Jackson et al., 2021a; Jackson et al., 2021b; Kolker et al., 2021). Kolker et al. (2021) also added unique information to the knowledge base, with participants in their study offering advice to other mothers in the postnatal period and to healthcare providers, captured via quotes. None of the papers, however, engaged in member checking. It was therefore not known if participants found the findings and interpretations meaningful. Moreover, the articles only presented superficial acknowledgement of ethical considerations. All papers referenced approval from an institutional board, and most mentioned gaining informed consent (Goyal et al., 2022; Jackson et al., 2021a; Jackson et al., 2021b; Kolker et al., 2021; Ollivier et al., 2021; Rice & Williams, 2021; Sakalidis et al., 2021). However, no other ethical considerations were presented in any of the articles.

All the articles had an impact on the growing literature base, particularly as there is still limited qualitative literature on the impact of COVID-19 on maternal mental health. Nevertheless, numerous articles were transparent in their studies' limitations, alongside their strengths (Aydin, 2021; Goyal et al., 2022; Jackson et al., 2021a; Jackson et al., 2021b; Ollivier et al., 2021; Saleh et al., 2021). Several studies also presented clinical implications of the findings and gaps in knowledge that still exist (Goyal et al., 2021; Jackson et al., 2021a; Jackson et al., 2021b; Joy et al., 2020; Ollivier et al., 2021; Saleh et al., 2021). Common themes, however, were found across the papers, highlighting the transferability of the findings, particularly as research was conducted in several countries, where the restrictions imposed would have varied.

2.3.2 Synthesis of findings

To synthesise the information across the ten papers, the method of thematic synthesis was drawn upon (Thomas & Harden, 2008). Thematic synthesis follows a three-step process and draws on the established methods used in thematic analysis to formalise the identification of themes across papers. The first step involves line-by-line coding of text, followed by the generation of descriptive themes. The final step involves going beyond the primary studies to generate interpretive and analytical themes. A benefit of using this approach is the ability to integrate the information across papers in a transparent way, thereby facilitating the explicit development of new concepts (Thomas & Harden, 2008). A summary of the themes and subthemes can be found in the table below (Table 3), with a more detailed table of the synthesis included in Appendix D.

Table 3

Summary of themes and subthemes from SLR

Themes	Subthemes
Fear of COVID-19	Concerns for wellbeing of baby
	Concern around conflicting information
Missed opportunities	Missed postnatal experience
	Loss of traditions
	Robbed of sharing moments with family and friends
Unexpected postnatal journey	Diminished healthcare support
	Partner present at home
Isolation	Lack of social support
	Breaking restrictions

Fear of COVID-19.

A theme present across numerous papers was new mothers' fear of COVID-19, with two subthemes found: concerns for the wellbeing of their baby and concern around conflicting information.

Subtheme: Concerns for wellbeing of baby.

Several of the papers referenced new mothers' concerns about the fear of their baby becoming infected with COVID-19 and the adverse impact this had on participants' mental health, particularly due to the limited knowledge early in the pandemic (Aydin, 2021; Goyal et al., 2022; Kolker et al., 2021; Jackson et al., 2021a; Ollivier et al., 2021; Sakalidis et al., 2021). One participant's account highlighted the impact the fear of COVID-19 had on her mental health "I feel psychologically collapsed. It was a challenging period and it still is…Living with the fear that something will happen to the baby ruins my mental health"

(Aydin, 2021, p.3). Several papers captured participants' anxiety around exposure to the virus and how they avoided this, including banning visitors, avoiding clinic appointments or trying to avoid busy periods (Aydin, 2021; Goyal et al., 2022; Jackson et al., 2021a; Kolker et al., 2021). Papers also highlighted participants engaging in strict cleaning and hygiene practises inside and outside of the house to prevent their baby from becoming unwell, including sanitising objects and frequently changing their baby's clothes (Aydin, 2021; Kolker et al., 2021). Significantly, both partners and mothers were engaging in these routines. In Aydin's (2021) paper, one participant described how strict routines imposed by her husband negatively affected her mental health and their relationship: "My husband always ordered me to wash my hands, wipe the doors, and not touch the child.... Even though I am a meticulous mother, paying attention to everything, these warnings negatively influenced our relationship and my mental health" (p.3).

Subtheme: Concern around conflicting information.

Fear of COVID-19 had a major role in participants seeking information about COVID-19 (Ollivier et al., 2021). Research highlighted, however, that due to the novelty of the virus, there was often a lack of information and also misinformation, therefore, participants felt unsure of how to best proceed during the pandemic, causing increased anxiety (Aydin, 2021; Jackson et al., 2021a; Jackson et al., 2021b; Kolker et al., 2021; Ollivier et al., 2021; Saleh et al., 2021). Contradictory advice of being told to adhere to social distancing guidelines, whilst also attending health care appointments that held an increased risk of exposure to COVID-19, adversely impacted maternal wellbeing (Jackson et al., 2021a). One participant reflected on their experience with the following statement:

> You still have to go to hospitals or, you know, health facilities for your appointments, which don't feel as safe...it just sends a bit of a mixed message you know? Oh gosh, I'm having to go to the lion's den to have this appointment. (Jackson et al., 2021a, p.5).

New mothers' anxiety around the fear of COVID-19 and inconsistent information around the effects of COVID-19 infection on babies most likely contributed to participants avoiding attending health care appointments. A consistent message across numerous papers was the need for a central hub where new mothers could access information related to COVID-19 from health care professionals (Kolker et al., 2021; Ollivier et al., 2021; Saleh et al., 2021). This may have reduced the added stress participants felt trying to navigate the amount of information (Ollivier et al., 2021; Saleh et al., 2021). In addition, a notable mention in Aydin's (2021) paper was the conflicting information around breastfeeding and COVID-19. Participants expressed their concerns around exposing their baby to COVID-19 when suspected of being infectious.

Missed opportunities.

A common theme across all the papers was missed opportunities because of the pandemic. This was captured through three subthemes: missed postnatal experience, loss of traditions and robbed of sharing moments with family and friends.

Subtheme: Missed postnatal experience.

Research highlighted a profound sense of loss due to COVID-19. Participants' experience of their postnatal maternity period was significantly disrupted, with the reality of their experience far from their expectations (Jackson et al., 2021a; Jackson et al., 2021b; Joy

et al., 2020; Kolker et al., 2021; Saleh et al.,2021). Several papers highlighted how new mothers were excited about socialising in their postnatal period by developing friendships with other new mothers, attending coffee chats and joining mother and baby classes (Jackson et al., 2021a; Jackson et al., 2021b; Joy et al., 2020; Ollivier et al., 2021). A participant in Ollivier et al's. (2021) study reflected on the negative impact that being unable to share experiences with other mums had on their mental health, "I feel my mental health is suffering because of missing connection with other first-time moms" (p.8). This indicates the importance of shared experiences between new mothers. Participants were also disappointed that social distancing restrictions had constrained their postnatal experience and shared their frustrations that postnatal 'normality' had not resumed (Jackson et al., 2021a; Jackson et al., 2021b). A participant in Jackson et al's. (2021) study shared: "I felt like I'd been imprisoned. I was just, like, sick and tired of being in this living room. I think that was really hard." (p.8).

Subtheme: Loss of traditions.

An important theme across a few papers was the missed opportunity to engage in traditions (Aydin, 2021; Goyal et al., 2022; Joy et al., 2020; Kolker et al., 2021). This was particularly evident for first-time mothers, who had not previously had the opportunity to engage in traditions, such as baby showers (Goyal et al., 2022).[9] Mothers shared their disappointment of not being able to engage in baby showers, with one participant reflecting on feeling robbed of the celebrations for their baby: "Yeah, definitely felt robbed of that. My mom had planned on having a party for everybody, the baby, which of course couldn't

[9] A baby shower is a party held in the honour of a woman who is about to transition to the role of being a mother and involves other people coming together to gift the new mother objects that she will use in her new role (Fischer & Grainer, 1993).

happen and, yeah, those kind of things were kind of disappointing." (Kolker et al., 2021, p.5). For another new mother in Goyal et al's. (2022) study, this had enduring consequences, with the participant sharing that they are still unable to look at other baby shower photos on Facebook.

Two papers highlighted the significance of timing. A participant in Joy et al's. (2020) study spoke about wanting to capture a family portrait through a professional photographer, however, due to the pandemic this was cancelled. The participant reflected on how the opportunity to capture this was gone forever, as her baby will never be at this stage of life again. Similarly, a participant in Aydin's (2021) study shared their sadness at not being able to perform birth rituals important to their Turkish culture.[10] Research has demonstrated an inability to take part in traditional birth rituals during the postnatal period increases the risk of maternal mental health difficulties (Hoban & Liamputtong, 2013; Murray et al., 2010). This link was not explored within Aydin's (2021) paper.

Subtheme: Robbed of sharing moments with family and friends.

A notable reflection in numerous studies was the sadness of not being able to share their baby with family and friends (Goyal et al., 2022; Jackson et al., 2021a; Joy et al., 2020; Ollivier et al., 2021). Participants reflected on the sadness they felt that they could not "show off" their baby (Joy et al., 2020, p.213). In addition, papers highlighted how having a baby is not only an experience for new parents but is also an important experience for family and friends, therefore, new mothers reported feeling disappointed that precious

[10] Within this birth ritual, the mother does not go out for 40 days in the postnatal period, she is not left alone with her baby and social support is vital. At the end of this 40 days, the mother takes a bath, the house is cleaned and family and friends come together and pray. Later, visitors come and see the baby and bring gifts, and the mother feels special (Çevik & Alan, 2020 as cited in Aydin, 2021).

bonding time had been lost (Jackson et al., 2021a; Joy et al., 2020). New mothers also expressed sadness that they were unable to share their life transition of becoming parents with their family and friends (Jackson et al., 2021a). Family and friends missing out on the milestone was also noted as significant in two papers, with participants unable to share the joy of their babies first experiences (Jackson et al., 2021a Ollivier et al., 2021). Research noted that technology was used by participants as an alternative to face-to-face interactions to try and share their babies' milestones, however, it was felt that it did not offer the same level of connection (Jackson et al., 2021a; Kolker et al., 2021; Ollivier et al., 2021).

Unexpected postnatal journey.

An overlap across the papers was the unexpected impact that COVID-19 had on the postnatal journey of new mothers, with two subthemes found, including diminished healthcare support and an increase in their partner being present at home.

Subtheme: Diminished healthcare support.

A frequent acknowledgement in several papers was the impact the pandemic had on new mothers' postnatal care (Goyal et al., 2022; Jackson et al., 2021a; Jackson et al., 2021b; Joy et al., 2020; Kolker et al., 2021; Ollivier et al., 2021). Participants reported fewer appointments with health care professionals, particularly reduced face-to-face appointments, which often left them feeling confused and unsure whether their concerns warranted medical attention (Goyal et al., 2022; Jackson et al., 2021a; Ollivier et al., 2021). As a result, participants expressed worry that they may be putting the NHS under unnecessary pressure with their non-essential concerns (Jackson et al., 2021a).

While some papers highlighted the negative impact of the lack of in-person contact (Jackson et al., 2021a; Ollivier et al., 2021), participants in Goyal et al's. (2022) study were amenable to having fewer face-to-face appointments. This was perhaps due to the concerns raised by new mothers around an increased risk of being exposed to COVID-19 at face-to-face appointments, as documented by Jackson et al. (2021a). Participants in Ollivier et al's. (2021) study, however, shared struggling to understand what is normal post-birth due to the lack of in-person care: “I also feel as if moms are being treated as second class citizens as they no longer offer 6 weeks postpartum check-ups meaning that we are left to decide if things seem normal or not after giving birth” (p.4).

To bridge the gap, virtual support was offered. In some papers, new mothers' experience of virtual support was noted as enjoyable and healthcare professionals were praised for their attempts at offering virtual support (Jackson et al., 2021a; Kolker et al., 2021). In the same papers, however, the inadequacies of virtual support were also discussed. Various participants reflected on their experience of support feeling restricted and rushed (Jackson et al., 2021a; Kolker et al., 2021). Similarly, mothers in Kolker et al's. (2021) reflected on the shortfalls of virtual care: "I have not had a doctor look at me since I left the hospital ... you’re on a virtual call and you can’t really explain things, you’re taking pictures that aren’t clear, it’s really, it’s not helpful." (p.5).

In several papers, participants discussed the lack of concern they felt from virtual care, reporting it to feel like a "tick-box" exercise and feeling a burden for attending appointments (Jackson et al., 2021a, p.6; Jackson et al., 2021b; Kolker et al., 2021). It is therefore not surprising that participants shared feeling helpless and abandoned by health care services, leaving new mothers feeling anxious and stressed. This emotional strain adversely impacted participants’ mental health, with the following quotes capturing their

experience in Ollivier et al's. (2021) study, “almost enough to put you in a padded cell” (p.3) and feeling “emotionally empty with nothing more to give” (p.3). Those feelings, especially for a new parent, may impede overall health, wellbeing, and parental confidence, which can have a significant impact on the infant and family (Ollivier et al., 2021).

Notably, participants reflected on the impact of the pandemic on the lack of breastfeeding support from health care professionals, particularly in-person appointments (Jackson et al., 2021b; Kolker et al., 2021; Rice & Williams, 2021). It was documented as a reason for early breastfeeding cessation (Jackson et al., 2021b; Rice & Williams, 2021). Research suggested that virtual support did not bridge this gap, with a participant stating:

> I did it, virtually, once or twice and it was awkward and hard. I wanted someone right there with me. It’s just such a personal thing and they need to be right there to see so closely with the baby. (Kolker et al., 2021, p.5).

The cancellation of breastfeeding classes meant mothers had various queries around breastfeeding, which due to the diminished health care appointments left them with little or no support.

Subtheme: Partner present at home.

An unexpected positive outcome of the pandemic for many participants was an increase in the time their partner spent at home. Numerous papers reported on how lockdown measures and an increase in working from home meant more time for new families to spend together (Goyal et al., 2022; Jackson et al, 2021b; Kolker et al., 2021 Sakalidis et al., 2021; Saleh et al., 2021). Partners were able to offer more support, for example by cooking, cleaning, aiding the development of routines and offering childcare support (Jackson et al., 2021b; Kolker et al., 2021). Mental health was tied to support from

partners both emotionally and physically (Jackson et al., 2021b; Saleh et al., 2021). Participants shared feeling less guilty, as they were able to lean on their partners for support (Jackson et al., 2021b). This included being able to take naps during the day or having space to do something different (Jackson et al., 2021b). A participant in Jackson et al's. (2021b) study shared the following thought:

> My husband's working from home every day or was, which is great because it means that he can cuddle [baby] for 10 minutes and I can go off and do something for my sanity round the house, even if it's just hoovering a room. (p.7).

An increase in time spent with family also supported the development of positive coping strategies and the reframing of the negatives of the pandemic by some participants (Jackson et al., 2021b; Kolker et al., 2021; Saleh et al., 2021).

Positive findings were not found in every paper. Research has demonstrated that not all participants experienced the increased time their partners spent at home as a positive. Some mothers shared that the constant presence of their partner at home created a strain on their relationship, which in turn negatively affected their mental health (Aydin, 2021; Joy et al., 2020). Participants also reported an increase in stress from having their partners at home, with more mess and jobs required to be undertaken around the house (Joy et al., 2020).

Isolation.

A core theme across all the papers was the isolation new mothers experienced as a consequence of COVID-19. To quote a participant from Aydin's (2021) study, "You are all alone on an island in the ocean." (p.5). This theme was represented by two subthemes: lack of social support and breaking restrictions.

Subtheme: Lack of social support.

Research has highlighted that the lack of social support in the postnatal period had an adverse impact on participants' mental health and their adjustment to motherhood (Aydin, 2021; Jackson et al., 2021a; Jackson et al., 2021b; Joy et al., 2020; Ollivier et al., 2021). New mothers hoped for support from their family, friends and maternal social networks, including mother and baby classes (Aydin, 2021; Jackson et al., 2021a; Jackson et al., 2021b; Ollivier et al., 2021). In reality, new mothers felt isolated and alone, which impacted negatively on their mental health, as captured in the reflections of a participant in Rice and William's (2021) study,

> I know [that] a lot of women who gave birth around the same time as me, or during when the restrictions were at the heaviest, they suffered from postpartum depression. I know that I suffered big time from baby blues, and I thought, "For sure, I'm going to need to be medicated after this, 100%." (p.5).

An important aspect of social support was wanting support in adjusting to parenthood, including learning what is considered normal for their baby (Aydin, 2021; Joy et al., 2020; Ollivier et al., 2021). For instance, a mother in Aydin's (2021) study shared "We were so lonely...nobody was with us. We were already inexperienced... what is motherhood and fatherhood? We also needed help. We needed somebody experienced..." (p.5). Interestingly, two papers discussed the additional layer of concern for new mothers. This was in relation to their worries concerning the effect the lack of socialisation may have on their baby's development and their attachment (Joy et al., 2020; Ollivier et al., 2021). Ollivier et al. (2021) noted that this caused participants a lot of stress, as they worried not only about the impact on their own mental health but also on the effect this may have on their baby's long-term mental health.

Subtheme: Breaking restrictions.

The impact of the restrictions to stay at home had an impact on maternal wellbeing, as helpfully described by a participant in Saleh et al's. (2021) study: "Being cooped up in the house takes a toll on you mentally" (p.63). Consequently, a conflict for many participants considered in various papers was the decision to break restrictions to access the support they needed in the postnatal period (Jackson et al., 2021a; Jackson et al., 2021b; Kolker et al., 2021; Rice & Williams, 2021). In two papers, the risk of exposure to COVID-19 was deemed lower than the risk of their mental health further deteriorating (Kolker et al., 2021; Rice & Williams, 2021). As captured in Rice and Williams (2021) paper,

> At some point, you have to look at what's more important, your mental health or a risk, which [in our community] was so low. ... Are you sacrificing your mental health, which is, in my mind, just as serious as COVID? That's how we started to feel toward the end. ... The mental health thing was a big factor [in our decision to let someone in], for sure. (p.5).

However, for many participants, the concerns around the breaking of social distancing restrictions came with additional feelings of stress and anxiety (Rice & Williams, 2021).

2.3.3 Conclusion

This SLR on the impact of COVID-19 on maternal mental health in the postnatal period identified 10 research studies. It is important to note that only papers written in English and identified on four databases were included in the review. Although the initial aim was to focus on research conducted in the UK, due to the restrictions varying between countries (Wang et al., 2021), the inclusion of research conducted outside of the UK did not seem to impact the findings of the SLR, with similar experiences reported by new mothers in

the postnatal period across countries. Several themes were found across the papers. The fear of their baby becoming infected with COVID-19 had a significant impact on new mothers' mental health. This was particularly significant initially, when knowledge of the virus was limited. Unfortunately, as the knowledge base increased, this led to conflicting and misleading information causing anxiety for participants. This was further increased by the requirement to attend face-to-face appointments at health centres, where the risk of exposure to COVID-19 was increased.

Participants' mental health was significantly impacted by COVID-19 eradicating their planned postnatal maternity leave. New mothers reflected on the impact on their psychological wellbeing of being unable to make connections with other new mothers. The review also highlighted the impact of missing out on traditions, especially for first-time mothers. Participants shared that these were time-sensitive traditions that could not be recovered and also revealed their disappointment at being unable to share milestones with family. Although technology was used as an alternative, it was felt that this did not offer the same level of connection.

The SLR highlighted the negative effect the lack of support from healthcare professionals had on mothers' mental health. Mothers shared feeling abandoned by services, resulting in mothers feeling anxious, stressed and burdensome. The increased time partners spent at home also had a mixed impact on mothers' mental health. For some mothers, emotional and physical support from their partner had a positive impact on their wellbeing. However, for other mothers, the added strain on their relationship with their partner had a negative effect on their mental health. Finally, the SLR highlighted the impact of being isolated had on new mothers' mental health and their experience of motherhood. As a result, mothers spoke about breaking rules to access support.

2.4 Rationale for current research

With the recent emergence of COVID-19, there are still substantial gaps in the literature base. Although rapidly growing, the focus to date has been wide and has assessed the impact of COVID-19 on maternal mental health in general. There has been less focus on certain diagnoses, such as PND, and moreover, there has been no qualitative studies to date on the impact of COVID-19 on the postnatal period for mothers experiencing PND. It was also not possible to focus solely in the SLR on the impact of COVID-19 on the postnatal period for mothers in the UK, due to the limited research completed. With a lot still unknown with COVID-19, there are substantial opportunities for future research. This research would offer a valuable first insight into the impact of COVID-19 and may be used to provide vital information to inform clinicians, policymakers, funding bodies and researchers on PND care, including the psychological support required as part of this pandemic and future health crises.

2.4.1 Research aims and question

As we continue to live through the pandemic, it is vital to understand how COVID-19 has impacted new mothers' experiences of the postnatal period. There is growing evidence of the impact of the ongoing pandemic on maternal mental health and there is a picture of increased PND prevalence, with new mothers twice as likely to experience PND compared to pre-COVID-19 (Davenport et al., 2020; Myers & Emmott, 2021; Spinola et al., 2020). PND has a long-term impact with mothers more likely to experience future episodes of depression over a five-year period (Cooper & Murray, 1995). Moreover, research has highlighted how PND may not only have lasting effects for mothers, but it also has adverse impacts on the mother and baby relationship and on other family members, such as

partners (Carro et al., 1993; Myers & Johns, 2018; Webster, 2002; Zelkowitz & Milet, 1995). This study therefore looks at the impact of COVID-19 on the postnatal period for first-time mothers experiencing PND. The research aimed to answer the following question:

What is the impact of COVID-19 on the postnatal period for first-time mothers experiencing PND?

3. Method

3.1 Chapter overview

In this chapter, I outline the way in which I attempted to answer the research question. I will describe my rationale for undertaking qualitative research and my reasoning for choosing to undertake Thematic Analysis (TA) and how it is situated within my epistemological stance. I will then provide a description of my participants and recruitment strategy. Finally, I will explain the involvement from consultants and the ethical considerations of the research, before describing the process of data collection and analysis.

3.2 Epistemological position

My approach to the research was underpinned by my critical realist epistemological position. A critical realist approach assumes that there is an external reality that exists independently of our awareness and assumes that human knowledge is socially produced and fallible. The aim of this research is to gain knowledge of what is 'really' going on in the world but also consider that the data collected may not provide direct access to this reality and not straightforwardly mirror it, rather it is required to be interpreted (Willig, 2012). Additionally, critical realism recognises how the wider social context can affect how people interpret their own personal experiences, whilst continuing to concentrate on participants' reports and also acknowledging the limitations of this 'reality' (Willig, 1999). Furthermore, the approach recognises that the researcher's own beliefs, values and experiences shape the way they approach research. Reflexivity was important to keep this in consideration, alongside any personal biases and assumptions. Reflexivity was maintained by discussions with my supervisors and through keeping a research journal. These methods were important throughout the research and were particularly significant at key moments during

the research when difficulties arose in my personal life, which challenged my capacity to engage in the research.

3.3 Design

3.3.1 Qualitative research

Due to the recent emergence of COVID-19, there is a still a gap in research. As noted in the SLR, most of the research on the impact of COVID-19 in the postnatal period has employed a quantitative approach. Qualitative research is well suited for exploratory research where a subject has not been researched thoroughly before, as it provides an opportunity for hypotheses to be developed and highlights further gaps in the literature that can be researched in the future (Barker et al., 2015). In this way, the exploratory nature of the research question regarding the impact of COVID-19 on the postnatal period for mothers experiencing PND lends itself to a qualitative approach. Qualitative research explores and provides deeper insight into human experience, including how people make sense of their experiences (Tenny et al., 2021). This allows a researcher to examine phenomena from the viewpoint of participants (Harper & Thompson, 2012; Lapan et al., 2012) and privileges a participant's evaluation of their own experiences (Roberts & Boardman, 2014). Furthermore, a qualitative paradigm reflects the complexity of psychological phenomena, with a recursive method of data analysis providing an opportunity for feedback from participants to check the accuracy of the researcher's interpretation of their experience (Silverstein et al., 2006). Qualitative research also requires a researcher to be self-reflexive, to keep in mind their bias and assumptions, a skill that psychologists hold within their clinical practice (Silverstein et al., 2006).

3.3.2 Choosing thematic analysis

With COVID-19 being relatively new, as aforementioned, there remains a gap in the literature regarding the impact of the pandemic on the postnatal period for mothers experiencing PND. It was felt that TA would be the most useful method of analysis as it can be applied flexibly without being based on prior theoretical frameworks and allows for the exploration of data to remain broad (Braun & Clarke, 2006; Willig, 2013). TA is also useful in examining participants' perspectives of their experience, remaining close to their narrative (Braun & Clarke, 2006). Moreover, TA was chosen as it involves identifying, analysing and reporting patterns across data, thereby describing data in rich detail in a clear and coherent report (Braun & Clarke, 2006; King, 2004). Furthermore, the method of qualitative analysis needs to be compatible with the epistemological position (Willig, 2013). TA therefore lends itself to this study as it can be conducted from different epistemological positions, including a critical realist stance (Braun & Clarke, 2006).

3.3.3 Considering other approaches

Other approaches were considered for this research, including Interpretative Phenomenological Analysis (IPA). IPA is concerned with the detailed examination of an individual's personal lived experience, with the aim of understanding the meanings participants attach to their experiences (Eatough & Smith, 2017). IPA could have been a useful approach given the research question. With IPA largely focusing on the subjective experience of participants, however, this approach was dismissed in favour of TA, as the hope of the research was to identify patterns across interviews for the exploration of the data to remain broad to understand the impact of COVID-19 for mothers experiencing PND.

In addition, IPA is attached to a phenomenological epistemology, which was not in line with the critical realist approach used in this research (Smith & Osborn, 2008).

Grounded theory was also considered. Similar to TA, it is a flexible method and appropriate when little is known about an area of interest (Chun Tie et al., 2019) and like inductive TA, it aims to generate theory grounded in data (McLeod, 2001). However, while TA can produce conceptually informed interpretations of data, it does not attempt to develop a theory (Finlay, 2021).

3.3.4 Choosing interviews

As the interview may be emotionally distressing for participants, it was decided that individual interviews would be conducted. The use of a focus group was considered and there are many merits to this approach including, the potential for new mothers to have experienced this format as supportive and validating, particularly given the potential social isolation that mothers may have experienced due to COVID-19. Individual interviews, however, were utilised for several reasons; for example, it was felt that it would be more disruptive to stop interviews in a group format if a participant had become upset and the researcher was required to pause the interview. In addition to this, a group interview may have prevented certain issues from being discussed, such as participants sharing their experiences of anxiety as part of their experience of PND. Moreover, practical issues were more likely to arise using a group format, for example individual interviews provided flexibility for childcare to be arranged at a suitable time for participants. Furthermore, it was hoped that this type of research environment would feel containing to participants when discussing sensitive topics. Individual interviews provide space for participants to share their

experience and feel heard, which was a hope of this research (Robert Wood Johnson Foundation, 2008).

Semi-structured interviews were completed, as they allowed for the optimum use of interview time. As these interviews are more conversational, it was felt that participants would feel more comfortable sharing sensitive information using this format. Interview guides were used to support the exploration of participants responses more comprehensively (Dicicco-Bloom & Crabtree, 2006) and it was hoped that this would offer flexibility to hear participants' experiences but also offer a containing environment, with participants able to predict the structure of the conversation to some extent (Jamshed, 2014).

3.3.5 Interview schedule

The interview schedule was developed considering existing literature and the aims of the research question, and in consultation with the supervisory team, and experts by experience who consulted to the project. The topics covered can be found in Table 4.

Based on guidance by Braun and Clarke (2013), the questions were open and clustered into topic areas. Follow-up questions were included to expand on participants answers depending on their responses. Pilot interviews were completed with two consultants and another consultant gave their feedback on the questions. Pilot interviews have been demonstrated to be helpful to identify questions that may need amending or where procedures may inhibit appropriate responses, thereby affecting the richness of the data collected from interviews (Gudmundsdottir & Brock-Utne, 2010). The pilot interviews were helpful to reflect on the flow of the questions. During the first pilot interview, for example, I felt the questions did not seem to have a logical flow and I felt asking about

participants' maternity experience should have occurred earlier, as it felt that some of the information shared in the answer to this question was then built on in response to other questions. A similar consideration was shared by a consultant, who felt that it would have been helpful to have been asked about her maternity experience earlier in the interview before covering the more sensitive topics such as her bond with her baby, as she felt this order "eased" her into what could have potentially been a difficult topic. The benefit of undertaking a second pilot interview was that the new order of questions could be appraised before the interviews with participants.

Table 4

Topics covered as part of the interview

Topics
- Participants' experience of PND - The impact of COVID-19 on their psychological wellbeing - How their maternity experience was during COVID-19 - The impact of COVID-19 on their relationships - The bond to their baby in the postnatal period and how COVID-19 may have affected this - How COVID-19 affected support from social support/networks - How COVID-19 affected their access to services e.g. mother and baby classes - Any financial impact of the pandemic - Their access to outdoor space and physical activity - Any positive experiences they had as result of the pandemic - Any other experiences that may have been missed but participants felt had important implications for their experience of PND

3.3.6 Virtual interviews

Virtual interviews were conducted. This method was deemed favourable, as it would not be impacted by changes to Government guidelines during COVID-19. Moreover, new mothers have found virtual contact to be more convenient, as it does not require them to travel with their baby (Saad et al., 2021). Within the context of this research, this also served a function of allowing mothers to have their baby present if they wished, and to pause the interview to attend to their baby.[11] Conducting interviews online allowed for participants to come from anywhere in England.

COVID-19 had also contributed to participants becoming more familiar with video software. Nevertheless, I checked whether participants felt comfortable using virtual platforms and enquired which platform they would prefer. As part of using virtual platforms, it was important to check that participants had a confidential space to talk, so they felt able to share their experience.

3.4 Experts by experience

Involving experts by experience was a priority in this research. Four experts by experience had a consultation role. An advertisement for the role of consultants for the research was displayed on the social media platforms of PANDAS (PND Awareness and Support). The researcher's email address was provided so that mothers interested in the role could email to express their interest or to find out more information. A summary of the consultants' demographic information, obtained from a questionnaire, can be found in

[11] Nevertheless, all participants arranged for baby to be looked after.

Table 5. The experts by experience were aged between 18 and 39. Most of the experts by experience were from a White background, on maternity leave and had one child. All were married, living in a house with access to outdoor space and had accessed psychological support for PND and had been prescribed medication. Many of the experts by experience had also accessed support from maternity services.

Table 5

Experts by experience demographics table

Demographics	N	%
Age		
18-29	2	50
30-39	2	50
Ethnicity		
White	3	75
Asian or Asian British	1	25
Relationship Status		
Married/Civil partnership	4	100
Employment status		
Employed (including self-employed)	1	25
Employed (on maternity)	3	75
Living conditions		
House with access to outdoor space	4	100
Number of children		
1	3	75
2	1	25
Support		
Maternity services	3	75
Mother & baby classes	1	25
Psychological support	4	100
Medication	4	100

Each consultant played an active role in shaping and progressing the research from sharing their thoughts about the research proposal and ethics proposal to sharing their reflections on feedback from the ethics board and taking part in pilot interviews.

Consultants also shared their reflections on recruitment and data collection and provided feedback on the initial themes and subthemes as part of the analysis. Having four consultants was beneficial, as it meant being able to hear reflections from different lenses. It also meant being able to receive feedback at different points of the research whilst providing consultants with flexibility, allowing them to give as much or as little as worked for them. Being able to draw on the wealth of experience held by my consultants and research team was helpful at times, when being immersed in the research obstructed the process. For instance, when visually mapping out the themes and subthemes to immerse myself in the data was not helpful. Specific examples will be provided in section 3.8.3.

3.5 Participants

3.5.1 Inclusion criteria

With the research on COVID-19 being limited, it felt important to keep the inclusion and exclusion criteria open as possible to ensure the results are generalisable to a broad population. At the same time, it was important to ensure that relevant participants with meaningful contributions were able to take part to answer the research aims. Participants were asked at the start of the interview if they met the inclusion or exclusion criteria and if required, were reminded of the criteria. To be included, participants had to fulfil the criteria below (see Table 6):

Gave birth in the pandemic.

Participants were included if they had given birth in the pandemic from the onset of the first lockdown period (23rd March 2020 when restrictions started) to 23rd March 2021 (when restrictions were first lifted). This was important to ensure that participants'

postnatal period had been affected by the restrictions imposed by the Government to reduce COVID-19 transmission.

Identifying as experiencing PND.

Participants who self-identified as having suffered PND were invited to take part. Research has highlighted how lockdown has impacted on new mothers' access to mental health support and how there is a large proportion of new mothers who meet clinically relevant criteria for depression but have not received a formal diagnosis (Fallon et al., 2021). Therefore, participants were not required to have a formal diagnosis of PND.

Table 6

Inclusion and exclusion criteria of participants

Inclusion criteria	Exclusion criteria
Mothers who gave birth during the pandemic (between 23rd March 2020 to 23rd March 2021)	Mothers under the age of 18 years old
Mothers who self-identify as having experienced or currently experiencing PND	Mothers who have had more than one child
First-time mothers	Mothers living outside of England
Mothers based in England	Mothers who cannot speak English
Mothers who speak English	Mothers who have experienced high risk pregnancies and/or births (experienced complications)
	Mothers currently involved in a child protection case or where there are concerns for the child's wellbeing
	Mothers with current drug or alcohol dependency
	Mothers expressing current suicidal ideation with plans to end their life, currently engaging in self-harm behaviours

3.5.2 Exclusion criteria

Exclusion criteria were important to establish homogeneity of the sample and to ensure that participants had similar experiences. As such, potential participants were excluded if they met the criteria detailed below.

Mothers under the age of 18 years old.

Research suggests that younger mothers are at a heightened vulnerability when transitioning to motherhood and are more likely to face challenges (Erfina et al., 2019; Mangeli et al., 2017). Consequently, it was felt that younger mothers would have additional difficulties associated with the postnatal period and therefore they were excluded.

Mothers who have had more than one child.

Mothers who have had more than one child were excluded from taking part, as it is likely that they would have experienced the traditional and expected maternity experience with other children. Mothers with multiple children may have also faced different challenges to first-time mothers during the COVID-19 pandemic (Molgora & Accordini, 2020), which should be researched further.

Mothers living outside of England.

Mothers living outside of England were excluded from taking part. This was due to the lockdown restrictions varying across parts of the UK, which may have altered new mothers' experiences of the postnatal period.

Mothers who cannot speak English.

Participants who cannot speak English were excluded from the study. Literature has previously highlighted the difficulties of using interpreters when completing analysis (Harper, 2007). An exclusion on this basis, however, has discriminatory implications. Nevertheless, it was decided that mothers who cannot speak English would be excluded, as

this is likely to have caused additional difficulties during their postnatal experience. For example, language barriers have been demonstrated to impact mothers' accessibility to services (Schmied et al., 2017). As such, it was felt that this should be researched separately to fully understand their experience.

Mothers who have experienced high risk pregnancies and/or births (experienced complications).

Research has highlighted that the transition to motherhood is impacted by the experience of a high-risk pregnancy and/or birth and that it is likely to cause extra challenges (Molloy et al., 2021). Therefore, mothers who had experienced this were excluded.

Mothers currently involved in a child protection case or where there are concerns for the child's wellbeing.

Participants were excluded if there were concerns around the child's wellbeing, as this was likely to impact their experience of the postnatal period. Previous research has demonstrated new mothers who are involved in child protection services are mistrusting of support from postnatal services for fear of having their child removed (Kenny et al., 2018). Moreover, new mothers have viewed the child protection process as stigmatising and traumatic (Kenny et al., 2015).

Mothers with current drug or alcohol dependency.

Participants who were drugs or alcohol dependent were excluded, as typically they would experience different challenges in the postnatal period (Canfield et al., 2017). Moreover, there can be challenges to obtaining informed consent when alcohol or drugs are consumed (McCrady & Bux, 1999; Nordentoft & Kappel, 2011).

Mothers expressing current suicidal ideation and engaging in self-harm behaviours.

Due to the sensitive nature of the research topic and the possibility of participants becoming distressed, mothers who were expressing current suicidal ideation and/or engaging in self-harm behaviours were excluded from taking part to prevent further psychological harm.[12] Moreover, unsurprisingly new mothers who experience suicidal ideation and PND are more likely to experience enhanced difficulties in their postnatal period (Paris et al., 2019).

3.5.3 Sample size

The study aimed to recruit between 12 to 15 participants and 12 participants were recruited. A sample size of 12 has been demonstrated to be sufficient for TA and for data saturation, as was the case for this study, with no new data or themes found during the last interviews conducted, a point of "thematic exhaustion" (Ando et al., 2014; Clarke & Braun, 2013; Guest et al., 2006, p.65).

3.5.4 Participant recruitment

A purposive sampling approach was used to recruit participants. This technique was utilised as it ensures participants are knowledgeable or experienced in the area of interest (Cresswell & Plano Clark, 2011). It also ensures that suitable participants, who meet the stated inclusion criteria are interested and willing to participate (Bernard, 2002).

Initially, the study was advertised on the social media platforms of PANDAS (PND Awareness and Support) and the Maternal Mental Health Alliance (MMHA), using a research advertisement poster (Appendix E). There was a good response rate from advertising on

[12] This criteria did not apply to any of the participants that came forward to take part in the study. If this had occurred, resources would have been shared around where support could be accessed.

these platforms, however, many mothers who reached out met the exclusion criteria (see Table 6) and therefore, were unable to participate. Moreover, some participants initially expressed an interest, however, following receiving the participant information sheet and consent form chose not to proceed. An email was sent to enquire about any questions, but further attempts to communicate were ceased when no response was received. PANDAS and MMHA both re-advertised the study on their platforms, however, there was a reduced interest the second time. It is likely that this is because the same audience was viewing the advert and those who might participate in the research had already expressed an interest. To reach a new audience, an amendment was made to the existing approved ethics protocol, requesting for the research advert to be posted on the social media pages of several other organisations who provide support to women experiencing maternal mental health difficulties (Appendix F). The organisations included: Light Pre and Post Natal Support, Cedar House Support, and Acacia. This led to a further increase in participant interest. Advertising the research on these organisations platforms not only allowed the research to reach a wide audience, but it also ensured that participants were aware of services that they could access for support if needed.

3.5.5 Participant information

Of the 34 mothers that expressed an interest in taking part in the research, 14 were eligible to take part and 12 first-time mothers consented to being interviewed as part of this research. A summary of their demographic information, obtained from a questionnaire provided to the participants prior to the interview, can be found in Table 7. Most of the participants were aged between 30 to 39 and were from a White background, married, living in a house with access to outdoor space and had returned to work following maternity

leave. Many participants had received psychological support, and several had received support from maternity services. Half of the participants had been prescribed anti-depressant medication.

Table 7

Participant demographics table

Demographics	N	%
Age		
18-29	3	25
30-39	8	66.7
40-49	1	8.3
Ethnicity		
White	10	83.3
Any other White background	1	8.3
Asian or Asian British	1	8.3
Relationship Status		
In a relationship	2	16.7
Married/Civil partnership	10	83.3
Employment status		
Employed (including self-employed)	10	83.3
Employed (on maternity)	1	8.3
Unemployed	1	8.3
Living conditions		
Flat with access to outdoor space	3	25
House with access to outdoor space	9	75
Support		
Maternity services	7	58.3
Mother & baby classes	2	16.7
Psychological support	10	83.3
Medication	6	50
Other support:		
Doula	1	8.3
Online support groups	2	16.7

It is important to note the lack of diversity in this sample. Most participants were from a white background. Black mothers have been disproportionately affected by the

pandemic (Gur et al., 2020) and it has specifically worsened Black mothers' maternal mental health (Lemke & Brown, 2020). This may not be considered surprising, with research highlighting the barriers that ethnic minority mothers experience when accessing mental health care in the first postnatal year (Jankovic et al., 2020; Smith, 2019; Watson et al., 2019), including feeling unable to disclose their feelings due to differences in ethnic background of health care professionals, not being able to receive perceived culturally appropriate support and difficulties with language barriers (Edge, 2011; Edge & MacKian, 2010; Wittkowski, 2011). It may be that mothers from minority ethnic background did not feel able to come forward due to their experience of seeking support and my whiteness as a researcher. As aforementioned, a feeling of 'sameness' can contribute to a feeling of trust (Bhopal, 2001; Haniff, 1985), perhaps increasing my ability to gain access to White mothers within the research (Wray & Bartholomew, 2010).

It could be hypothesised that the research advert may have reached mainly White mothers due to the barriers highlighted above. To try and hear from Black mothers about their experience during COVID-19, I approached two organisations that are dedicated to supporting Black mothers during the perinatal period. Unfortunately, I received no response. One potential reason for this may be the pressure that organisations were under during COVID-19. There were several other organisations I had reached out to during the research, who I did not hear back from or who shared they were overstretched because of COVID-19 and would be unable to help currently. Although research has found similarities in the experiences of Black and White mothers during the pandemic, they have also noted differences (Gur et al., 2020). It is therefore important to note the limitations of the generalisability of the data and acknowledge where there are gaps in the research that should be addressed in the future.

3.6 Ethical Considerations

3.6.1 Ethical approval

The study was granted ethical approval from the Health, Science, Engineering and Technology Ethics Committee at UH. Ethical approval was received on the 27th July 2021 with the protocol number: LMS/PGR/UH/04650. An amendment was made to the ethics protocol (see section 3.5.4 for details). Approval was granted on the 29th November 2021 with protocol number aLMS/PGR/UH/04650(1) (see Appendix F for ethical approval notices).

3.6.2 Informed consent

Potential participants who expressed an interest in taking part in the research were sent a participant information sheet, which offered detailed information about the study and the exclusion criteria (Appendix G). Participants were encouraged to ask any questions that would help them to make an informed decision on whether they wanted to take part. A consent form and a demographics questionnaire were also sent to participants (Appendix H). Most participants completed these forms and sent them back prior to interview. A small number struggled to fill in the forms due to technical difficulties, and in these instances the forms were completed at the beginning of the interview. In these cases, the consent form was shared on the screen and read to participants and recorded verbal consent was received, with the form being signed with their name by the researcher electronically as consented to verbally by participants. For the demographic questionnaire, participants stated which box they wanted to be ticked. At the start of the interview, the participants' understanding of the participant information sheet and the consent form was checked. This included a discussion of the inclusion criteria and the exclusion criteria.

Both the participant information sheet and consent form informed participants that they had the right to withdraw from the study at any point until data analysis began (which was stated to be December 2021). Participants were unable to withdraw once data analysis had commenced, due to the nature of TA. This involves developing codes based on individual interviews and searching for themes across the data, thereby the nature of TA makes it difficult to extract the data of any one participant (Nowell et al., 2017).

3.6.3 Confidentiality

Confidentiality was maintained throughout the research process. Participants were provided with written information within the participant information sheet around how confidentiality was maintained. All sensitive data including consent forms, audio and video recordings and typed transcripts were securely saved to the UH OneDrive, in line with the UH data management policy and General Data Protection Regulations (GDPR). As the principal researcher, only I had access to identifiable data. Pseudonyms were used and any identifiable information was removed in data shared with the supervisory research team. The interview recordings were only accessed by myself and one professional transcriber, who signed a non-disclosure agreement (Appendix I). Consent forms, demographic data and audio and video recordings will be deleted on completion of the study. Anonymised transcripts will be kept on the UH OneDrive for five years following completion of the study. The data will not be used beyond this study.

3.6.4 Risk of distress to participants

The research team did not foresee any risk of harm to participants, however, there was a chance that the interview could have been emotionally distressing, as participants

were talking about challenging experiences. Participants were made aware that they could take a break at any point. The interview was paused for three of the participants, as they became upset when talking about their experience. At this point, the recording was stopped, and I checked on the participant. Participants were reminded of their right to withdraw and were provided with as much space as needed. Two of the participants commented on being "emotional" people and that although they cried, they were okay. For all participants, after taking a break, they consented to continuing. A debrief was completed at the end of the interview, whereby participants had the opportunity to discuss how they found the interview and whether it bought up any difficult emotions for them. Prior to and at the end of the interview, participants were made aware of a resource sheet which included the contact details for organisations who offer support to mothers experiencing postnatal depression. This was also emailed to participants at the end of the interview (Appendix J). To maintain ethical standards throughout the interviews and as lead researcher, I engaged in self-care practices and utilised supervision from my primary supervisor when needed.

3.6.5 Ethical responsibilities as a researcher

Through holding my ethical responsibilities in mind as a researcher, I found my values aligned with the position shared by Naidu and Sliep (2011) for the need to preserve a reflexive ethical position throughout the research process, rather than believe ethical responsibility is complete once ethical approval has been obtained. Maintaining ethical reflexivity involves researchers holding their position to account and how they conduct their research (Bhattacharya, 2007; Gerwirtz & Cribb, 2006). This involves going beyond procedural ethics, for example following guidelines and applying for ethical approval and

applying ethics in practice (Guillemin & Gillam, 2004). This is important considering procedural ethics cannot provide all that is needed when faced with ethically important moments in research and this is where reflexivity can be drawn upon as a resource to ensure ethics in practice (Guillemin & Gillam, 2004).

3.6.6 Reflexivity during the research process

Reflexivity involves the researcher taking a critical stance to how they construct knowledge during the stages of research, to reflect on how this may impact the process and write-up of a study (Dodgson, 2019). Reflexivity is also important to remain aware of any assumptions, prejudice, biases that may impact the research through interviews to analysis (Braun & Clarke, 2013). Key resources for incorporating reflexivity throughout the research process was the use of a reflexive journal, discussions with my research consultants and supervision with my research team. This helped me to be mindful of my position to the research, including when breaks from the research were necessary for personal reasons, to reflect on the feelings that arose from undertaking the research and to think about what informed my decision making throughout the research journey.

3.6.7 Statement of position by the researcher

Prior to and throughout the research, I have kept my own experience on my journey to motherhood at the forefront of my mind. As highlighted by Willig (2013), to ensure the credibility of the research process, transparency and reflexivity about pre-existing relationships with the subject matter are important, so the researcher's subjectivity is acknowledged. I was aware of the emotional risks that are taken as a qualitative researcher and at times, this meant dealing with complex and difficult emotions and taking a step back

from the research (Hofmann & Banks, 2017). Supervision with my research supervisors, keeping a reflexive diary, prioritising self-care and feeling empowered by my conversations with participants were invaluable experiences from which I was able to draw strength. In addition, my experiences have contributed to my choice of wanting to work in perinatal mental health services. It has enhanced my understanding of mental health in the perinatal period, and I am passionate about hearing people's experiences and advocating for change through research and clinical work.

3.7 Data collection process

3.7.1 Data collection

Participants were recruited and interviews took place between September and December 2021. Participants interested in taking part in the research emailed me after seeing the research advertised on one of the social media platforms named above (see section 3.5.4 for further details). Participants were then sent the participant information sheet, consent form and demographics questionnaire to return if they wished to take part and were encouraged to ask any questions they had about the forms, the interview, or the research in general. A convenient time to undertake the interview was then arranged.

All interviews were conducted through MS teams. A meeting link was sent to participants prior to our session. At the start of the interviews, participants were asked if they had any questions about the participant information sheet. At this point, it was confirmed that they met the inclusion criteria and that they did not meet the exclusion criteria. Participants were also reminded that the interview could be paused at any point if

they needed to attend to their child.[13] For participants who were unable to fill in the consent form or demographics form prior to the interview, these were then completed. The resource sheet (see 3.6.4 for details) was then shared via my laptop screen with participants. Participants were provided with an opportunity to ask any questions they had and following providing verbal consent, the interview started. At the end of the debrief, participants were reminded of the right to withdraw up until data analysis began. Participants were reminded of the resource sheet and were asked if they would be happy for me to keep in touch about the study and/or whether they wanted to take part in member checking.

3.7.2 Further involvement of participants

Often within qualitative data, the researcher both collects and analyses the data, giving potential for researcher bias (Miles & Huberman, 1994). One way of reducing researcher bias is by involving participants in the checking of the data (Birt et al., 2016). Returning analysed data to participants is known as member checking and it is used to verify the trustworthiness of qualitative results and to ensure "that the participants' own meanings and perspectives are represented and not curtailed by the researcher's own agenda and knowledge" (Tong et al., 2007, p.356). Ten participants provided verbal consent to take part in member checking. A visual map representing the data and a more in-depth table highlighting the initial themes and subthemes alongside quotes that captured these were shared with participants to get their feedback. It has been highlighted that this method of providing analysed data from the whole sample is helpful when the purpose of

[13] However, all participants had arranged for someone to look after their child while they took part in the interview.

member checking is to discover whether the results resonate with the participants' experience (Birt et al., 2016).

Six participants responded and provided feedback. Participants shared feeling that the themes and subthemes resonated with them. None of the participants recommended any changes or strongly disagreed with the themes and subthemes that were identified. Several participants expressed feeling sadness that other mothers had similar experiences to them. One participant shared their reflections on how they felt nervous to read what was written in case they did not agree with the results and alternatively, in case they were accurate and this in turn would bring the negative feelings back. Three participants shared that reading through the analysis had transported them back to how they had felt when things were very difficult, with one participant stating that it demonstrated how the results resonated with them. Two participants also thanked the researcher for reflecting their views so eloquently.

3.8 Data analysis

TA was used as the main method of analysis in the research. The six-phrase process outlined by Braun and Clarke (2006) was drawn upon to undertake the analysis. Although the six phases are organised in a logical sequential order, the process itself is not considered to be simply linear but rather a recursive and iterative process, whereby the researcher moves back and forth as necessary through the phrases (Braun & Clarke, 2020). This was an accurate reflection of the process through the analysis of the data. Outlined below is a more detailed description of each step of the six-phrase process.

3.8.1 Phase 1: Familiarisation with the data

This phase entails becoming intimately familiar with the data, which is essential to discover pertinent information relevant to the research question (Byrne, 2022). I transcribed one of the interviews and the remainder were sent to a professional transcriber. Whilst the interviews were being transcribed, I listened to the audio recording to start the process of becoming familiar. The first playback required 'active listening'; therefore, no notes were taken to be as present as I could be with the data. In a second listening of the recordings, notes were made of my initial thoughts of the data, including moments I found interesting, moments where I found myself having an emotional reaction to the recording and times where I found myself feeling curious. See Appendix K for preliminary notes.

Once the transcripts were received from the transcriber, the audio was relistened to in order to check the accuracy and make any amendments necessary. I then read each transcript in an active way and noted down the patterns that were coming up, as suggested by Braun and Clarke (2006).

3.8.2 Phase 2: Generating initial codes

The second phase involved working systematically through each transcript to code, line by line. The NVIVO 12 system was utilised to code the transcripts. An inductive, data driven approach was drawn upon, which fits within a critical realist stance. As a result, the codes were unrestricted to pre-conceived theory and were instead reflective of the content of the data, representing meaning as communicated by participants (Byrne, 2022). Both semantic and latent coding were employed. Semantic codes are aimed at solely presenting the data as communicated by the participant (Braun & Clarke, 2006). Latent coding goes beyond descriptive analysis, to also identify hidden meanings or assumptions that may

inform the semantic content of the data (Braun & Clarke, 2006). This dual level of coding ensures context remains throughout (Bryman, 1998). An excerpt from a coded transcript is located in Appendix L.

As the interviews were rich in data, this resulted in numerous codes across the interviews (887 in total). A significant amount of time was spent assessing the codes to confirm they accurately represented the data and to merge and delete duplicate codes. In addition, to aid reflexivity during the coding process, as proposed by Braun and Clarke (2019), one of my supervisors cross-coded subsections of an anonymised transcript. This helped me to think about the codes I had used, where my curiosities were and my reflections on the data.

3.8.3 Phase 3: Initial theme generation

The main aim of this phase was to shift the focus from individual codes to finding shared meanings across the dataset. To begin with, I printed out all the codes created on NVIVO onto paper and cut them into strips to map them out visually and explore where clusters were forming (see Appendix M). At first, I found myself separating the clusters into 'usual experiences of PND' and 'impact of COVID-19'. A conversation with my supervisor helped me to step back and reflect on why I had taken this approach. I noticed this had felt a more manageable way of navigating the number of codes there were, particularly due to the large number of paper slips and realised that this had become unhelpful to exploring meaning across the dataset. As a result, I stepped back from visually mapping out the clusters on paper and went back to using NVIVO, using the node functions to look for emerging patterns. This seemed to feel a more manageable way of immersing myself into the data again. From this, initial subthemes and themes were generated.

3.8.4 Phase 4: Reviewing potential themes

This phase involved going back to the data to check the codes against the subthemes and themes to ensure meaningful interpretations of the data had been made. At this point, key questions proposed by Braun and Clarke (2012) were drawn upon to review themes. Through focusing on their question "If it is a theme, what is the quality of the theme?" (Braun & Clarke, 2012, p.65) the themes that were not providing information that addressed the research question were removed. Alongside this, critical conversations with my supervisors and with consultants were helpful to step back and reflect on the development of the themes and move from initial themes to final themes.

3.8.5 Phase 5: Refining, defining and naming themes

In this phase, the themes, subthemes and quotes that captured each of these were pulled into a table in preparation for the write-up. The naming of some themes was also amended to ensure that they provided the first indication to the reader of what was captured from the data (Byrne, 2022).

3.8.6 Phase 6: Producing the report

The final phase is the write up of the analysis. Within this phase, there was consideration of the order in which the themes should be reported to connect them in a logical order, whilst also ensuring each theme was able to communicate their own narrative (Braun & Clarke, 2012). The write-up of the analysis is presented in the next chapter.

4. Analysis

4.1 Chapter overview

I will present the themes and subthemes that were generated in the analysis. An overview of these can be found in Table 8. Five main themes were found: *fear of COVID-19, being alone, relationship with services, impact on partner relationships* and *coping strategies*.[14] Within the five themes, nine subthemes were identified.

The aim of the analysis was to answer the research question outlined in the introduction: *What is the impact of COVID-19 on the postnatal period for first-time mothers experiencing PND?* The themes were selected due to their relevance to the research question. The aim of analysis therefore was not to provide an exhaustive list of themes that covered all aspects of what participants shared as part of the interview.

The write up of the research will involve weaving together an analytic narrative using quotes from participants (Braun & Clarke, 2006). As an inductive approach was utilised, with themes reflective of the content of the data, links to existing theory will be focused on separately in the discussion (Byrne, 2022; Clarke et al., 2015). The use of participant quotes is also important to ensure the analysis is "grounded in the account of participants" (White et al., 2014, p.375). This ensures that the data represents the experience of participants to which the researcher has been allowed temporary and privileged access to (Parkin & Kimergård, 2022). As aforementioned, a critical realist approach is premised on the assumption that how we experience reality is shaped by our lens and context, therefore the themes are based on my interpretation of the meaning that participants have attributed to their experience. It is therefore possible that alternative themes may have emerged from

[14] The naming of themes and subthemes was derived from the language used by participants in interviews and through discussions with consultants.

another researcher. Examples of self-reflexivity will be included at important points of the analysis.

Table 8

Themes and subthemes from analysis

Themes	Subthemes
Fear of COVID-19	Psychological impact of the fear of their baby catching COVID-19
	Minimising risks
Being alone	Feeling isolated
	Difficulties masked
Relationship with services	Difficulties dismissed
	Fighting for support
	Feeling like a burden
Impact on partner relationships	Silver lining of partner being home
	Strained relationship with partner
Coping strategies	

4.2 Theme 1: Fear of COVID-19

With COVID-19 being a new virus, with unknown effects at the start of the pandemic, it is understandable that the first theme captures how all participants shared their experience of being *fearful of COVID-19*. There were two subthemes: *the psychological impact of the fear of their baby catching COVID-19* and *minimising risks.*

4.2.1 Subtheme: Psychological impact of the fear of their baby catching COVID-19

All of the participants shared their concerns about the fear of their baby becoming infected with COVID-19 and spoke of the adverse impact this had on their psychological wellbeing in the postnatal period as they attempted to protect their baby through fluctuating waves of COVID-19 cases.

> *We were risking like exposing him… so, you feel like he's not able to do as much even now because COVID cases are still on the rise, etc., and I think all of that had a HUGE impact on me psychologically… it's been really, really stressful.* (Lucy)[15]

In particular, the majority of participants shared how the fear of their baby catching COVID-19 resulted in them feeling anxious, low in mood, fearful and nervous during the postnatal period. Alice also reflected on the added pressure this caused in motherhood, a time already recognised for being tiring.

> *Then when Grace came along, that kind of fear transferred to HER… being really, really worried tha… that SHE would catch COVID and die.* (Lisa)

> *And COVID JUST… just COVID… just… just the fear… just the constant anxiety of catching her COVID… you know, it was just exhausting.* (Alice)

[15] Pseudonyms have been used to replace participant names, their babies' names and the names of their partners.

Several participants also reflected on the added anxiety that COVID-19 created on top of becoming a mother for the first time and the worries this caused when their baby was in contact with people. For participants, this left them ruminating over the different opportunities where their baby may be exposed to other people and therefore potentially COVID-19.

> *Yeah, I think the pandemic did just add a load more anxieties onto my plate, so you know, yeah, I was worried about when people could come, or when we could see people outside, you know, I was worried about people touching her.* (Jenny)

> *I didn't want anyone touching the baby because of COVID and all that kind of stuff, and I think I just yeah, I just felt really worried and really down.* (Hannah)

Many of the participants shared concerns relating to their experience of the unknown effects of COVID-19, with a lack of knowledge of the effects of the pandemic on babies, particularly at the beginning. Understandably, this caused first-time mothers' anxiety, with participants guessing whether what they wanted to do in the postnatal period was safe in the context of COVID-19.

> *She was born at the beginning of the pandemic, so we didn't really know things, about how contagious it was, or how dangerous it would be for babies, or you know, it was very, very unknown… so that caused lots of worries.* (Laura)

I guess it was just a question of whether it was safe to… you know, in the first few weeks, whether it was safe to take my daughter out for a walk, you know, during normal times, of course you'd take her out but with COVID, you know, what do you do? I think there was just a lot of… we just didn't… you just don't know whether it's safe or not safe. (Bethany)

A small number of participants who gave birth later in the pandemic, when more was known about the effects, also reflected on their experience of feeling worried about their baby catching COVID-19.

…well, we'd lived with it for quite a while by the time I gave birth – it was January - so we'd been through obviously quite a lot… it wasn't so new but, obviously, I was still… I still felt fearful of it in terms of I didn't want my baby to get it. (Michelle)

Furthermore, a participant shared their experience of the dilemma between wanting to be active with her baby outside of the house, as she was aware this would be beneficial for her mental health but also struggling due to feeling concerned about COVID-19. This reaction tied into the description that participants felt of loneliness during the pandemic (this will be the next theme presented in the analysis), which participants shared had exacerbated their experience of PND in the postnatal period.

That was a really difficult time because I was torn between wanting to go out and do things, because I kind of knew that it would be good for my mental health to see people, to eat out, to just go to a park, all of these things, so I was struggling with

that, but also still being very cautious, and very aware that the virus was still there. (Lisa)

Overall, this subtheme was one that stood out from the beginning of interviews; participants were sharing frequently the psychological impact of the fear of their baby catching COVID-19 had on them. This had clear implications for the steps participants took to protect their baby.

4.2.2 Subtheme: Minimising risks

The fear of COVID-19 was reflected in participants sharing their experience of the steps they took to minimise the risk to their baby including an increase in cleaning and checking that other people were following the restrictions, adding to an increased pressure on partners to be following the restrictions. This added extra stress during the postnatal period when participants were required to complete essential tasks, such as shopping or attending the usual postnatal appointments for their baby. The need to undertake extra precautions appeared to increase with their baby growing, with participants recognising the potential for their baby to be exposed to more germs.

Constantly sanitising which just… that I would literally undress her when we got home and we'd been out, but she hadn't even touched anyone but I would like undress her in the hallway, just lay her on the floor and then just take her… everything off and put it in the wash… and just the same, like coming back from the hospital or any appointments, you know, just undressing and just putting everything in the wash and… just that CONSTANT fear of what has she touched? (Alice)

> *Just constantly checking "Are you wearing a face mask at work? You know, are others wearing their face masks?"… but yeah, the fear when he went back to work*. (Alice)

By contrast, Hannah shared having mixed feelings about the lockdown measures and restrictions. On the one hand, she shared feeling relieved that lockdown measures were in place, so her baby was protected.

> *I don't have to worry about people, germs, touching my newborn, and I remember being like verbally thankful we were in lockdown because people can't touch my baby*. (Hannah)

At the same time, she also reflected on the impact the lockdown restrictions had on her psychological wellbeing and the effect of being unable to see family and friends during the winter months, as they did not want people to come into the home due to the fear of catching COVID-19. Hannah's experience demonstrates the conflicting feelings created by COVID-19 that participants had to navigate during the postnatal period.

> *…we didn't see anyone in winter because we couldn't sit at the park cause it's freezing cold and I don't want anyone in my house and so we didn't really start seeing anyone again until this summer so it was kind of 3 months each year where we really spent time with anyone other than John's parents really so a massive impact.* (Hannah)

Several participants also spoke about how the worry around COVID-19 restricted their activities, as they did not feel safe. This increased the tasks that their partners were required to undertake. At the same time, the lockdown restrictions resulted in participants being confined to the house, as the only alternative was to be outside.

> *I wouldn't go to the supermarket with Mia because I didn't feel it was safe, so Daniel would go mask on and he would – that's my husband – and he would then bring the shopping back and put it all away… and then sanitise his hands and stuff, and being very cautious but then it meant that Mia and I never got to go out really… because it was the sort of place you could only go other than outdoors…* (Laura)

For Lucy, minimising the risks of her baby catching COVID-19 meant stopping classes they had started with their baby due to services not following COVID-19 guidelines and feeling this posed a risk to her baby. Lucy's quote demonstrates how participants continued to experience an impact on their postnatal period beyond the initial lockdown restrictions being lifted.

> *And then even things like the classes he has gone to, we've actually stopped taking him to one because they just weren't following COVID guidelines… so, we were risking like exposing him… so, you feel like he's not able to do as much even now.* (Lucy)

A small number of participants also reflected on being in lockdown beyond the restrictions lifting. Lisa described experiencing an increased sense of danger, which COVID-

19 exacerbated. It is well known that new mothers often experience a heightened feeling of risk in the postnatal period around the safety of their baby. Participants understandably wanted to minimise the risk, thereby further isolating themselves for longer.

> *I think the anxiety part of my brain just linked, if we caught COVID we were all gonna die including the baby. So just anybody visiting it was just going to be a big no no because it just isn't worth the risk. And I was like obsessively clean and like we didn't have any takeout food or anything like it would. So we was full on lockdown way longer than anyone else was.* (Hannah)

> *I don't think we went into a shop, like just a local shop for well beyond when we were legally allowed to – we just didn't, so… yeah, and it was even though I knew logically how unlikely I was to catch COVID from just somebody walking past me, my mind just told me "You can't take the risk"… and everything seemed so much more dangerous than it was.* (Lisa)

A few participants also touched upon the enduring nature of trying to continue minimising the risk to their baby by taking precautions.

> *Then things like the swings and stuff I'm a bit more mindful now cause babies touch things and lick things or like if I do take him to the supermarket, you know, I make sure I sanitise the trolley before he puts his hands all over it and… you know things like that. I will sanitise the swings, sometimes his hands after he's been on the swings.* (Lucy)

> *…because even when things were back open, I didn't feel comfortable or safe going to places and seeing people.* (Clara)

Overall, the majority of participants shared taking steps to minimise the risk to their baby. This appeared to have implications on their daily activities. There were also enduring effects described by participants, including spending longer in lockdown following restrictions being lifted.

4.3 Theme 2: Being alone

In view of the fears of COVID-19 and the efforts the participants felt they needed to take to minimise the risks to their baby, it is perhaps unsurprising that being alone was something that participants spoke about frequently and was a theme that was constructed in its own right. The second theme therefore captures how all the participants shared their experience of *being alone* because of COVID-19 and the restrictions. There were two subthemes: *feeling isolated* and *difficulties masked*.

4.3.1 Subtheme: Feeling isolated

It is well known that social support changes in the postnatal period. For mothers who gave birth during the pandemic, this was further heightened by the lockdown restrictions, which confined all people to their homes, except for very limited purposes. It is therefore not unexpected that most of the participants reflected on the impact that being isolated and alone had on their psychological wellbeing in the postnatal period, with this contributing to their PND and their experience of not being able to receive support.

…then my mood was just low because of the loneliness and like I said just feeling isolated. (Zoe)

It was very lonely… lots of anxiety, no one to really help… I'd probably… I'd probably say that… (Alice)

Jenny reflected on how the pandemic left her feeling isolated in the postnatal period, intensifying her feelings of anxiety and depression, which in turn led her to struggle to leave the house with her baby, resulting in further isolation. This reflected the "double isolation" that participants experienced during the pandemic.

I felt very anxious as it was, and depressed I think and everything I did, I thought I was doing it wrong, I had no confidence at all in what I was doing and I was scared to leave the house with the baby and, yeah, I think the… I just… the pandemic just kind of expanded more of those feelings by just yeah, making me feel more isolated… (Jenny)

Most participants shared how the restrictions limited their access to family and friends, at a time when social support is known to be crucial, heightening their feelings of loneliness.

…everything shut down… so… it was quite lonely so, I didn't have family or friends nearby or checking in because they live far away or because they weren't allowed to. (Laura)

Hannah shared a sense of conflict around wanting her mother's support but not wanting her parents to visit their home due to her fear around COVID-19, resulting in her feeling more isolated.

> *I guess if there wasn't a lock down, my mom would have just turned up and then 'I haven't heard from you properly. I'm here. What can I do?'. But because of the lockdown and we didn't want them to, because of COVID. We kind of got double isolated.* (Hannah)

Several of the participants shared feeling doubt around whether they would have felt isolated without the context of COVID-19 impacting their ability to have a normal postnatal experience. For Hannah, there was uncertainty around whether she felt lonely because of COVID-19 or whether it was because of her character and how she would have engaged with other people in the postnatal period.

> *And just the general like loneliness of it and so obviously it's something that I'm never going to know whether or not, if it was COVID or if it was, just me, that I felt super lonely, but yeah, just physically nobody being around, not being able to go and do the normal things that everyone else did.* (Hannah)

Furthermore, a few participants queried whether they experienced PND because of the pandemic and subsequent isolation, which exacerbated their difficulties. Participants shared feeling that they would have been less isolated experiencing their postnatal period

outside of the context of COVID-19, possibly because participants would have been able to draw upon more resources for support.

> *I felt like my probably postnatal depression started and mine was definitely more like to do with anxiety so, I just became like very anxious about things and I think it sort of came from being so isolated from everyone with a newborn baby.* (Zoe)

> *I don't know if… it's hard to tell isn't it… if I would have developed depression without the background of the pandemic, it's hard to tell but I think I would have certainly been less isolated.* (Katie)

For Laura, she reflected feeling that maybe the isolation had not affected how she was feeling but resulted in her being unable to open up and share how she was feeling to get the support she needed for her PND.

> *It felt very lonely… and yeah, like I didn't really have any support, and, obviously, at that point as well, there was very strict like lockdown… so, you couldn't have any family support, because the family support didn't kind of come on till much later that year when we could have bubbled up with one other household. Yeah, so, initially, there was definitely lots of things that then impacted… not necessarily how I was feeling maybe, but definitely impacted the way I wasn't able to share how I was feeling, or get support for how I was feeling*. (Laura)

Within the context of feeling isolated, participants reflected on how the lack of support heightened their experience of PND and contributed to their difficulties of bonding with their baby. Being unable to take a break also contributed to the postnatal period being more intense for participants than they had anticipated, resulting in the experience feeling relentless.

> *I think it impacted it by sort of enhancing the post-natal depression and just enhancing that whole postnatal period because it is an intense time anyway if you're not in COVID but I think… it just became more intense. It was just like groundhog day every day… so, I think it just made it so much worse.* (Zoe)

> *I had no one to… to come and watch her for an hour while I did something – I was here all the time so, I think maybe if… if the pandemic hadn't happened, maybe I wouldn't have… the feelings wouldn't have got to that level… because I'd have had some space maybe from her. So, maybe the bond would have come quicker perhaps*. (Jenny)

Overall, this theme represented participants' experience of feeling isolated because of the pandemic and lockdown restrictions. For participants, the lack of support heightened their experience of PND and impacted their ability to feel able to open up to others and access vital support.

4.3.2 Subtheme: Difficulties masked

Many of the participants described feeling that if they had been less isolated and had the opportunity to meet with people including other new mums, then they would have been able to recognise sooner that they were findings things difficult. Indeed, without the opportunity for social comparison it seemed it was difficult for participants to know whether the feelings they were experiencing were to be expected during the postnatal period.

> *I would have gone to things and been able to talk to people and I think I would have realised much sooner that I was struggling more than I should have been and that some of the feelings I was having weren't normal. (Jenny)*

> *I think if I'd have… if I'd have been able to talk to other mums, I might have found out that was a really normal thing and everyone feels like that about their weird, alien baby.* (Clara)

For a few participants, being alone meant there were no expectations or pressure on them and as a result, they struggled to notice they were experiencing the symptoms of PND.

> *I didn't have family or friends nearby or checking in because they live far away or because they weren't allowed to… there weren't like baby groups or things like that… that you could go along to even like health visitors or things like that was all stopped as well… so, for a long time, it was me and her… so, it's almost like, for a long time, it was not easy, but, yeah masked because I didn't have any expectations on me, I*

didn't have any pressure on me, I didn't have anybody visiting, or just checking in on me. (Laura)

A small number of participants also described how being alone made it easier for them to mask their difficulties from people, particularly as communication with their family was by phone calls. For participants, the "ease" of hiding their feelings resulted in them further isolating themselves from support from family and friends.

It could have been picked up sooner, I guess and I think because I wasn't seeing anyone else, it was easier for me to hide, so whereas if I was seeing, you know, like my mum would have been round all the time, but obviously she wasn't because of lockdown… because I was… I could hide it… so, it would just be a phone call and I could get through a phone call without… without like showing my true feelings. (Zoe)

For Bethany, the persona that everything was fine was something she actively tried to maintain daily in front of her family.

I mean I was trying to act fine in front of everyone… because my mom stayed with us. (Bethany)

Furthermore, some participants felt their experiences would not have been as heightened in the postnatal period and similarly, felt that their PND would have been noticed sooner, if they had not been isolated.

> *I also think if we had the support of people, if people had been able to come over, close people, then I probably wouldn't have gotten so high strung. And again the depression may have been picked up a lot earlier.* (Hannah)

Overall, this theme captured how being alone contributed to participants' difficulties being masked at several levels. Some participants struggled to notice their difficulties due to being isolated. A few participants actively masked their difficulties from their support network. Numerous participants also felt their PND would have been noticed sooner by family, friends and professionals if they had been able to receive support.

4.4 Theme 3: Relationship with services

Participants feeling that their difficulties would have been picked up sooner if they had been seen by professionals ties into their *relationships with services,* which was identified as a third theme. There were three subthemes: *difficulties dismissed*, *fighting for support* and *feeling like a burden.*

4.4.1 Subtheme: Difficulties dismissed

Several of the participants described how their difficulties related to PND were dismissed by family, friends and health professionals as being related to COVID-19, with the stock phrases used to offer reassurance having the opposite effect.

> *…it was just dismissed as "You've had a bad time. It's a bad time. You'll be alright." But I wasn't alright.* (Clara)

> *It was kind of the… err… the stock response was "Well, kind of … of course. You've just had a baby in a pandemic. You don't have any support, so, of course you feel off."* (Lisa)

For a small number of participants who had tried to seek help for their PND, they described their experience of being dismissed and their reflections on how the pandemic had impacted this experience. For Laura, the isolation of COVID-19 and concern around being dismissed, contributed to her ruminating on a script she could say to services when she sought help, to reduce the probability of this happening.

> *…because when I was just at home in my own head, then it can be worrying to think "If I go in and say this, they might be like "Oh no. No."… like they did originally "Oh no. Everyone feels like that." "You're kind of like making a big deal of it." Um… so, yeah, the pandemic definitely impacted that as well.* (Laura)

Hannah described how she accepted a professional's viewpoint when they suggested her difficulties were related to COVID-19. She shared how her experience of PND led her to accepting the professional's opinion before retreating into herself. This appeared to be a new experience for Hannah who shared how she is usually able to assert herself.

> *I was kind of explaining and she was like I think that's just a COVID thing that like it's kind of COVID and I was like, OK, fine. Like, I'm usually quite strong-willed person, but during that… if I asked a question and someone just answered, I was like OK, fine, I'll just accept that and then just kind of go into my shell.* (Hannah)

Overall, this theme represents how participants experienced having their difficulties dismissed by services as being related to COVID-19. Participants who actively tried to receive support for their PND also described a similar experience of their difficulties being dismissed.

4.4.2 Subtheme: Fighting for support

Participants feeling dismissed by services closely relates to the subtheme of participants being required to *fight for support* from services for their difficulties. This was seen as a subtheme in its own right, as most participants strongly voiced needing to "fight for support" for both physical check-ups and for mental health support for PND.

> *…well, during COVID it wasn't very good. I would say that I had to fight for anything that I wanted, so I had problems trying to get people to look at like my stitches and to check that I was healing OK and things like that, like no one would come and see you.* (Zoe)

> *I had to beg my GP for a mental health referral. I had to beg my GP to look at my stitches because I felt like things were wrong there.* (Lisa)

There was a level of understanding from some participants about why it was difficult to get support from their GP because of COVID-19, however, this did not make the experience easier to navigate.

I think the main thing for me is that the access to sort of the GP has been so like tough and I completely get it on most… but it is such a fight. (Katie)

Fighting for support was not only for participants' wellbeing but also for their baby to be seen, including for the normal health checks required, creating additional stress in the postnatal period.

You know, you're having to fight to get your child a GP appointment, when he's clearly got something wrong with his skin that needs something, you know. Or you're having to fight to… to get a… you know, an appointment to get him weighed. (Lucy)

For a few participants, there was an added layer of being influenced by the perceived experiences of other new mothers attempting to access support from healthcare professionals during the pandemic. Hannah described how hearing other people's experience of struggling to be seen for support led her to wonder what the point was of trying to get support for her PND was if "nobody's listening". The difficulty accessing support and the comparison to other people appeared to be a shared experience for participants.

A lot of other people I've spoken have had to really fight to even get the appointments because they're just kind of being fobbed off for weeks and weeks and then… what is even the point of me trying to get help if nobody's listening kind of thing. (Hannah)

Services feeling stretched because of COVID-19 had important implications for participants feeling able to access support, including *when* they accessed support. Clara described how she had to reach a critical peak to get support for her PND and, like other participants, described needing to fight to get support.

> *…because I said "I need to speak to a doctor because I'm at breaking point. I need… I'm depressed… I'm panic-attacking. I need someone NOW!"… that I got someone… it… it was… I had to use… I had to be SO forceful to get… some attention.* (Clara)

Furthermore, a few participants described the impact of the lack of face-to-face support by healthcare professionals and the effect this had on their psychological wellbeing. Clara shared feeling that if she had been seen in-person, the health visitor may have reacted differently. Perhaps for participants being seen in-person would have resulted in less of a "fight" for support. The lack of feeling "seen" by participants understandably had a huge impact on their access to services and ultimately on their mental health.

> *…the lack of medical attention and eyes on me… in the early days, I did tell my health visitor I wasn't feeling OK, but if she'd have SEEN me when I said that with tears in my eyes, she would have done something… I think. But you can only kind of say "I'm struggling" so many times before you just give up saying it. I just… I feel there was just so much… so much impact on my mental health.* (Clara)

It seemed that what was represented by this subtheme was the need to fight for support from services for themselves and their babies, including for the follow up postnatal appointments usually completed, adding additional stress in the postnatal period.

4.4.3 Subtheme: Feeling like a burden

A small number of participants described needing to push to get support but finding this difficult, as they did not want to burden services. For some participants, an awareness of the pressure on services prevented them from striving for support. Participants shared feeling this would have been easier without the context of COVID-19.

> *I didn't push enough to get support because I didn't want to bother anyone that was already over-worked. I would have been much more happy… if it wasn't in COVID times.* (Clara)

Several participants expressed feeling like a burden when required to use NHS services, due to them being overwhelmed, which heightened their experience of being dismissed. This led to participants feeling guilty for accessing the necessary services in the postnatal period. The response from services of being "panicked" appeared to heighten these feelings for participants.

> *I felt quite dismissed to be honest by people – I think they were really overwhelmed.* (Lucy)

> *…but everything felt… in terms of NHS services, felt so stretched and so panicked, that as a patient felt… my feeling was like "I'm so sorry that I'm here" … like feeling very much like a burden.* (Lisa)

In addition, many of the participants described the impact that COVID-19 had on their experience with healthcare professionals. Participants described feeling like a burden to services and consequently felt unsupported by them, which impacted on their willingness to open up. Participants also shared feeling like a burden when accessing the necessary postnatal appointments for their children.

> *I would try and be open with it but I didn't really… I didn't feel like I had much support from midwives or health visitors. They didn't… I mean they functionally came, stayed a minimum amount of time, then left. And I guess because of COVID that was limited. The clinics… weigh-in clinics and things like that were all like appointment, you know, it just seemed like it was almost a burden to participate in those things…* (Lucy)

For Laura, feeling like she was bothering healthcare professionals and that she would be pushed away by services, left her feeling apprehensive that she could access those services when she needed them. The idea of needing to be at breaking point for support to be offered was a powerful reflection of her experience.

> *Yeah, I didn't feel comfortable… I didn't feel confident I COULD access those services. I did definitely have the feeling like "If I called them, I'd be bothering them" and I*

> *would be kind of pushed away because they didn't want to see anyone unless it was an ultimate emergency, and I didn't feel like I was an emergency.* (Laura)

Furthermore, feeling like a burden impacted participants' access to mental health support. This extended beyond NHS services to charity organisations too, with participants left wondering whether they should seek help.

> *I know from like following Pandas, they were completely overwhelmed and things like that which makes… makes you not want to use them. I never did. I followed them on Twitter and things, but I… I think I started writing an email once and then didn't.* (Clara)

Within the context of feeling like a burden, participants referenced services seeming stretched and overwhelmed as a result of COVID-19, reducing the likelihood of participants seeking support. It is well known that COVID-19 has had an impact on the resources of services, with healthcare professionals feeling burnt out from the demands that the pandemic created (Leo et al., 2021).

4.5 Theme 4: Impact on partner relationships

With participants describing the negative impact that COVID-19 had on them feeling isolated and on their relationship with services, it may be expected that participants would describe having their partner at home during lockdown periods as beneficial. For many participants, however, having their partner at home brought up mixed feelings. The fourth theme therefore captured the impact COVID-19 had on participants' relationships with their

partner. There were two subthemes: *silver lining of partner being home* and *strained relationships with partner*.

4.5.1 Subtheme: Silver lining of partner being home

Many of the participants described the positives of having their partner work from home during lockdown and being present beyond the traditional paternity leave period.[16] For Michelle, this meant her husband could help with childcare and reduced the feeling of being alone.

> *…my husband was working at home for a long time, so, even when his paternity leave finished, he was still working at home, so that was a positive because I had someone else in the house. Obviously, he was working, but I just wasn't completely alone and he was able to come and help at lunchtime and when he finished work, there was no commute, so he was, you know, with us straight away and things, so that was actually positive.* (Michelle)

> *…my husband worked from home once there was a lockdown, so that was like amazing. It was like it was such like a silver lining. It was "Well we're going into lockdown, but Liam's going to be at home." And whilst he was working, you know, just having him in the house was like a massive relief.* (Anna)

[16] The current statutory paternity leave in the UK is either one week or two consecutive weeks' leave.

A few participants reflected that having their partner work from home supported their psychological wellbeing during lockdown. Indeed Anna, expressed concerns around what would have happened if her partner had been required to return to work whilst she was experiencing PND.

> *…because having him here was just… and he was home until April/May… so, he was working from home that whole time then yeah, which was massive, like I don't really know how it would have been if that hadn't happened…* (Anna).

Interestingly a small number of participants reflected on wondering whether they would have experienced PND without the context of COVID-19 and therefore whether the support from their partner would have been needed. This further demonstrated the uncertainty felt by participants, as they tried to distinguish whether their experience was due to the lockdown or whether they would have experienced mental health difficulties outside of the context of COVID-19.

> *Obviously my husband was working from home, whereas before he would have been in the office. I mean the problem is that I don't know whether I would have had postnatal depression if it wasn't a lockdown or COVID, so I don't really know if there was a positive experience… like a positive thing from it, but I guess the only thing was that I had him at home, so… um… I had more support than I would have from him.* (Zoe)

> *…my husband having more time… and being around more… that meant you know, that I had additional support. But, I'm not sure I'd have needed it if it hadn't been COVID, so it's swings and roundabouts.* (Lucy)

Overall, this theme captured the positive impact participants experienced due to their partner being at home. This included feeling less alone during lockdown with their partner being present and being able to share childcare duties for longer than the typical paternity leave period.

4.5.2 Subtheme: Strained relationship with partner

An overlap of the sample of participants who spoke about the silver lining of their partner being home, also described the negative impact that COVID-19 had on their relationship with their partner. Many participants reflected on the added pressure this caused at a time recognised for being hard as they adjusted to having a newborn baby. In particular, it was reported that the lockdown measures had the biggest impact on participants' relationship with their partner.

> *The relationship with my husband it was so hard. Definitely the hardest time of our marriage… I think, obviously, having a baby is a hard time anyway. But, just the pressure and the intensity of it, just being the two of you trying to figure out what you're doing with… with this newborn baby with no one else to like bounce off was really difficult and we definitely both found it really hard.* (Zoe)

A small number of participants also shared how the pandemic meant they and their partners were unable to rely on their usual coping strategies, creating more difficulties which resulted in a further strain on their relationship, even for the "strongest of marriages".

> *…it has caused difficulties, it has caused strained relations, and then I think… just you know, even if you have the strongest marriage or relationship in… you know, you're the kind of most laid back, chilled people, which neither my husband and I are… but you know but if you were living, you know, under the same four walls, not being able to escape, not being able to, you know, see other friends and do things, it is really hard, like you do need to learn to cope in a whole different way to how you did before, and then you throw in a baby it… it is hard, it's been really hard I think, really impactful. (Lucy)*

Some of the participants spoke of the impact on their partners' wellbeing. Jenny shared suspecting that her partner was also suffering from PND and how it was hard for them both not being able to lean on their wider support network. As a result, they struggled to support each other.

> *Well, my relationship with my husband is very strained… I suspect that he also suffered from postnatal depression possibly… I know a lot of the feelings I had, he had as well, so, we were both struggling so, you know, and we had no one else, so… yeah, we weren't able to really support each other… and we were both suffering at the same time.* (Jenny)

Furthermore, the quote below highlights how the pandemic exacerbated participants' experience of PND, which then led them to blame themselves for the strain on their relationship, creating a vicious cycle of difficult feelings.

> *I think it probably exacerbated my depression and low mood, and it made me feel like it was my fault because I was depressed so, I was maybe like contributing to the strain on the relationship more and… yeah. It definitely affected me…* (Katie)

It seemed that what was represented by this subtheme was the negative impact that their partner being home had on participants' wellbeing. For participants, being confined to their home had a negative impact on the relationship with their partner, with this amplifying their experience of PND by causing added pressure in the postnatal period. It was interesting that there were mixed experiences for many participants, with both positive and negative experiences highlighted of their partner being home.

4.6 Theme 5: Coping strategies

There was a lot of back and forth during discussions with my research supervisors as to whether the final theme of coping strategies should be included. Although the theme resonated with my experiences of lockdown, I wanted to ensure it represented participants' experiences. Ultimately, through discussions with consultants and having conducted member checking, I received sufficient feedback to suggest that this theme was a salient aspect of their experience and one which should be reported in the results. Furthermore, I felt that the theme spoke to the research question, as the impact of COVID-19 effectively

denied new mothers the opportunity to use coping strategies that may have benefited their mental health in the postnatal period.

Turning to consider the theme of *coping strategies*, as highlighted in the previous subtheme, participants described how the pandemic left them and their partner unable to rely on their usual coping strategies. The quotes below demonstrate the impact COVID-19 and the lockdown restrictions had on participants' coping mechanisms, in particular the limits it had on their physical activity with their baby and alone. In turn, this affected participants' abilities to have time away from motherhood responsibilities.

> *…definitely with walking only being able to do like an hour, you couldn't like spend a day in the park, or a morning at the park or something like that and then there were no classes like swimming classes that you could do with your baby and things like that… and there was no chance for activities like that and even activities that you could do by yourself which I guess would have given you more like some mental space to yourself, so like going for a run or doing an exercise class, there was no option for that either.* (Zoe)

> *…I think it affected my day-to-day in a sense of like not wanting to exercise or eat well, and just wasn't, you know, in the mind-set to do that. In terms of practically speaking, even though I wanted to go because I wanted to do something, I didn't because of COVID.* (Lucy)

For Laura, COVID-19 had an additional oppressive effect on her mental health during winter, a time when people commonly struggle with motivation.

Yeah, it probably had quite a negative impact, once it moved into winter, it had quite a negative impact on our physical exercise and it definitely felt like there were times where we'd just been indoors for ages. (Laura)

Many of the participants described the impact that COVID-19 and their PND had on their ability to exercise both outside and inside their home and the affect it had on their levels of motivation.

I wasn't able to go for a walk or a run, my only chance was to do like videos in the house, like exercises videos in the house and with like the depression there was no motivation to anything really, so yeah it was bit the depression and a bit COVID that affected it yeah. (Hannah)

Not being able to engage in their usual coping strategies exacerbated participants' PND. For some participants, this was a time where their usual coping strategies could not be drawn upon and it was difficult to develop new ones due to the restrictions.

I think there would have… there was a lot of… yeah, a lot… I missed going to the gym because that's where I felt it really helped with my depression in general and I feel like not being as active as I normally had definitely had an effect. (Bethany)

Overall, this theme captured the negative effect that COVID-19 had on participants' physical activity, a coping strategy relied on by several participants. This prevented

participants from engaging in activities that may have positively impacted their psychological wellbeing in the postnatal period.

4.7 Chapter summary

This chapter has presented the five main themes and associated subthemes that have been identified through TA of the impact of COVID-19 on the postnatal period for first-time mothers experiencing PND. The next chapter will provide a summary of the analysis, exploring how the findings of this study speak to the research question, and going beyond this to highlight how they might contribute to the existing evidence base.

5. Discussion

5.1 Chapter overview

I will begin by summarising the findings of this study in relation to the research question. I will then focus on relating the findings to existing literature, before discussing the implications for clinical practice. I will move on to offer a critical appraisal of the research including the strengths and limitations, followed by the plans for dissemination and areas of future research. Finally, my reflections on the research will be offered, followed by my closing remarks.

5.2 Summary of findings

The aim of the research was to answer the question: *what is the impact of COVID-19 on the postnatal period for first-time mothers with PND?* The analysis presented five themes summarising participants' perspectives. The first theme, *fear of COVID-19,* highlighted the impact that COVID-19 had on participants' mental health. Participants experienced a range of negative emotions related to their fear of their baby catching COVID-19, which resulted in an increase in stress during the postnatal period. The anxiety experienced by participants went beyond the typical anxiety experienced in this period, with participants expressing uncertainty around what it was safe to do with their baby, even down to going out for a walk. Participants shared their dilemmas around wanting to go out for their mental health but being fearful of exposing their baby to COVID-19. The fear of their baby catching COVID-19 was felt by participants throughout the pandemic, even when it was understood that the impact of COVID-19 on infants was likely to be minor. The theme also incorporated the efforts by participants to minimise the risk to their baby, including an increase in sanitising.

For some participants, there was an appreciation of the lockdown as they saw it as protecting their baby from COVID-19.

The measures undertaken by participants to minimise risk to their babies, including living in lockdown beyond the restrictions lifting, led many to experience prolonged isolation. The was explored in the second theme, *being alone,* which highlighted the negative effects of isolation on participants' mental health in the postnatal period and the ways in which this exacerbated their experience of PND, or as was the case for some participants, was seen as a primary cause of PND. Nevertheless, the theme also captured the doubt that participants shared around whether they would have felt isolated without the context of COVID-19 impacting their ability to have a normal postnatal experience or whether feeling lonely was due to the nature of their personality. They also identified the practical implications of isolation as they shared how having no-one to support with parental duties meant they were unable to take a break. This contributed to the experience of motherhood being more intense than anticipated, and the postnatal period being described by many as relentless. The challenges of being isolated included participants struggling to notice that they were findings things difficult, as there was no pressure or expectation on them during the day whilst in lockdown. It was also identified how being alone made it easier for participants to mask their difficulties to family and friends. Furthermore, participants described feeling their PND would have been noticed sooner, if they had been able to see people. It may therefore not be surprising that participants identified being isolated as a barrier to them accessing support for their PND.

The third theme highlighted participants *relationships with services.* Participants gave examples of being dismissed by services, with their difficulties being related to the pandemic. Participants shared comparing their experience to other new mothers who had

reached out for support, leaving them to wonder what the point of accessing support was if other mothers had not been listened to by services. This was highlighted by participants who reflected feeling the need to fight for support for their PND, alongside fighting for the support typically experienced in the postnatal period for both themselves and their babies, creating additional stress. Participants also acknowledged the internal conflict they experienced between needing support but not wanting to burden services that were overwhelmed during the pandemic. Participants described feeling that asserting their needs would be easier without the context of COVID-19. Many participants shared that this left them feeling unable to access support for their PND, particularly as they did not feel like an "emergency".

The fourth theme captured the *impact on their partner relationships.* The postnatal period was identified by participants as a stressful time which can place strain on even the "strongest" of marriages, which was exacerbated by COVID-19. Some participants shared suspecting that their partner was also suffering from PND. As a result, couples struggled to provide support to each other whilst also being unable to access support from wider social networks. In contrast, participants also identified the silver lining of their partner being home, including a positive impact on their psychological wellbeing. However, there was an acknowledgement that outside of the context of COVID-19 they may not have experienced PND and so might not have required additional support from their partner in the postnatal period.

The final theme, *coping strategies,* demonstrated the impact COVID-19 and the lockdown restrictions had on participants' coping mechanisms. In particular, the limits placed on their physical activity affected participants' abilities to have time away from motherhood responsibilities. As such, participants identified how being unable to engage in

their usual coping strategies amplified their PND. Participants reflected that it was also difficult to develop alternative coping strategies during the pandemic due to the restrictions.

5.3 Links with existing literature

5.3.1 Theme 1: Fear of COVID-19

Literature has highlighted the adverse effect that the fear of COVID-19 has had on new mothers' mental health in the postnatal period, with the risk for depression increased (Iyengar et al., 2021; Zanardo et al., 2020). In particular, research has demonstrated a link between a fear of COVID-19 infection for their baby and higher scores on the Edinburgh Postnatal Depression Scale, with mothers who were scared of their baby catching COVID-19 reporting higher depressive symptomatology (Spinola et al., 2020). These findings are consistent with research that has highlighted how stressful life events can negatively affect mental health levels (Clout & Brown, 2015).

As in this study, several of the papers in the SLR referenced new mothers' concerns about the fear of their baby becoming infected with COVID-19 and the adverse impact this had on participants' mental health (Aydin, 2021; Goyal et al., 2022; Jackson et al., 2021a; Kolker et al., 2021; Ollivier et al., 2021; Sakalidis et al., 2021). In Aydin's study (2021), new mothers reported feeling psychologically worn out because of the fear of their baby becoming unwell. They also shared experiencing uncertainty of how best to care for their baby in the pandemic. The implications of this will be discussed later in the chapter. Similarly participants in Ollivier et al's. (2021) study also reflected on the added stress the fear of their baby catching COVID-19 caused during an already stressful time, as they attempted to navigate motherhood. For participants in this study, it went beyond this, as

they reflected on the difficulty of not knowing whether the usual activities mothers engage in during the postnatal period was safe for their baby. Previous research has also highlighted the fear participants experienced in relation to the lack of knowledge about the virus and its effect on their baby's health (Goyal et al., 2022; Kolker et al., 2021). This was a sentiment echoed by participants in this study and interestingly, this was felt by participants who had given birth later in the pandemic too, when more was known about the effects of the virus on infants. This might suggest that, for some new mothers, having more information does not reduce the fear of their baby becoming unwell with COVID-19.

Given the finding that participants were fearful of their baby catching COVID-19, it is unsurprising that participants spoke of taking precautions to minimise the risk to their infant. This corroborates earlier findings indicating that owing to concerns about COVID-19 new mothers would avoid hospital appointments and would not allow visitors, nor let people hold their baby (Aydin, 2021; Goyal et al., 2022; Jackson et al., 2021a; Kolker et al., 2021). Participants in this study also shared engaging in strict hygiene routines both inside the house and when required to go outside. Likewise, papers in the SLR also highlighted participants' practices in engaging in strict cleaning and hygiene routines, such as sanitising objects and frequently changing their baby (Aydin, 2021; Kolker et al., 2021). Participants checking that their partners were following guidelines, however, appears to be a relatively novel finding within the wider literature. In contrast, previous research has referred to the strict routines imposed by partners on new mothers (Aydin, 2021).

5.3.2 Theme 2: Being alone

The isolating effects of the pandemic were highlighted by all participants, with the lockdown restrictions limiting the support new mothers could receive from family and

friends having a negative impact on their mental health. Similar experiences of new mothers feeling isolated were highlighted in several papers in the SLR (Aydin, 2021; Jackson et al., 2021a; Jackson et al., 2021b; Joy et al., 2020; Ollivier et al., 2021; William & Rice, 2021). Research has previously demonstrated the vast changes that occur in social support in the postnatal period, with the effects on mothers' mental health being well recognised (Leigh-Hunt et al., 2017; Nolan et al., 2012; Strange et al., 2014). It is therefore unsurprising that the findings in this study demonstrate the adverse impact a reduction in support has on new mothers' psychological wellbeing, with there being a need to ensure there is sufficient support for new mothers, rather than a reduction, during lockdown periods. The further implication of this will be discussed in section 5.4.5.

Research has demonstrated that low social support for new mothers in the postnatal period has been found to increase the risk of PND (Lakey & Cronin, 2008). It may therefore not be surprising that participants in this study described wondering if they would have experienced PND without the context of being cut-off from their social networks by the restrictions imposed in the wake of the pandemic. Feeling isolated also heightened participants’ experiences of PND and contributed to participants struggling to bond with their baby, as participants described feeling that with support, perhaps the bond with their baby would have come sooner. Attachment theory has often been drawn upon in PND literature to highlight the effects of maternal attachment on a baby's development (Bowlby, 1958). An "attachment bond" describes the how an infant will seek a protective relationship from a caregiver (Ainsworth, 1989, p.711). The early bond with a caregiver has been demonstrated to have a tremendous impact throughout a child's life, with a secure attachment setting a child on a more positive developmental trajectory (Ainsworth, 1989; Weinfield et al., 2008). Previous research has demonstrated that maternal PND can

influence the affective state of an infant, leading to the development of insecure attachments, which have been shown to have adverse consequences for children beyond infancy (Śliwerski et al., 2020). Support for mothers experiencing PND is therefore crucial.

Within the context of COVID-19, participants described struggling to notice they were experiencing difficulties, as there were no expectations on them and no opportunity to speak to other new mums about their experiences. This reflected the findings in Ollivier et al's. (2021) study, as new mums spoke about the need to share their experience to find out if what they had felt was normal. Mothers struggling to distinguish between the normal emotional and psychological adjustment associated with motherhood and when they were experiencing PND has been demonstrated as a barrier to seeking support (Bilszta et al., 2010). For many participants in this study, however, there was a belief that being less isolated would have resulted in their PND being noticed sooner, thereby being able to access support for their difficulties.

5.3.3 Theme 3: Relationships with services

Most participants shared feeling dismissed by services. For some participants, this led them to retreat further 'into their shell'. The debilitating effects of PND have been highlighted in research, with PND being significantly associated with low self-esteem and confidence (Stamp & Crowther, 1994). In previous research, where attempts have been made by health professionals to normalise feelings and offer reassurance, rather than actively treat their PND, mothers have reported how this has intensified their feelings of low self-esteem (Bilszta et al., 2010). Literature has emphasised the importance of not minimising distress, to ensure that new mothers experiencing PND feel validated, and to ensure that support is offered (Bilszta et al., 2010). This can have important implications,

particularly as previous literature suggests that mothers are reluctant to disclose symptoms of PND (Chew-Graham et al., 2009) and the consequences of undiagnosed and untreated depression are serious, with suicide being the leading cause of maternal death in the year following delivery (Knight, 2019). Furthermore, with many health care professionals in perinatal health services redeployed during the pandemic and at a time where there were increased systemic pressures on these services, it may have contributed to health visitors being quicker to pass off difficulties as normal in the context of COVID-19 as a way of reducing demands on their time (Brown & Shenker, 2020).

Like new mothers in Jackson et al's. (2021a) study, a few participants shared an appreciation for the unprecedented circumstances of the pandemic. This, however, did not diminish the difficulties associated with fighting for support from services, with participants in this study feeling that they needed to be an "emergency" to access the support they needed. These findings support previous literature outlining new mothers' confusion around whether their concerns warranted attention and a sense of apprehension that their concerns were "non-essential" and placing unnecessary strain on the NHS (Jackson et al., 2021a). It is well known that COVID-19 has put a substantial strain on the NHS and the wellbeing of healthcare workers (Ham, 2020; Liberati et al., 2021).

Similarly to new mothers in several of the papers in the SLR, participants shared feeling like a burden when attending appointments for themselves and their baby and when accessing mental health support (Jackson et al., 2021a; Jackson et al., 2021b; Ollivier et al., 2021). This had a negative impact on participants in this study, as they felt unable to be open about their mental health difficulties. This is significant considering the pandemic has reduced the number of opportunities for PND to be diagnosed and treated, thereby intensifying new mothers experience of low mood, anxiety and hypervigilance (Takubo et

al., 2021). It is therefore likely that the prevalence rates of PND during COVID-19 are much higher than predicted (Manso-Córdoba et al., 2020). As evidenced in the wider literature, this can also have adverse consequences, as new mothers who feel they are a burden to services are more likely to seek information from the internet, raising concerns around exposure to misinformation, particularly during the pandemic (Jackson et al., 2021a).

5.3.4 Theme 4: Impact on partner relationships

Most participants shared mixed feelings related to their partner being at home. For many, this was a positive experience, with support from their partner benefiting their psychological wellbeing in the postnatal period. This correlates with previous research which has found partner support to reduce depressive symptoms in mothers experiencing PND (Misri et al., 2000). For participants, there was the added benefit of partners being able to provide support beyond the typical paternity leave provided, resulting in the continuation of support with childcare responsibilities and in participants feeling less alone during lockdown. This sentiment was echoed by new mothers in several of the papers in the SLR, who described the benefits of their husband being home (Goyal et al., 2022; Jackson et al., 2021a; Jackson et al., 2021b; Sakalidis et al., 2021; Saleh et al., 2021).

In contrast, akin to the “blessings and curses” reported by Joy et al. (2020, p.207) the same participants also spoke about the negative impact that their partner being home had on their wellbeing. For participants, the pandemic created a strain on their relationship with their partner, heightening their experience of PND, as they described being confined to their home without breaks from their partner or support from other people. Similarly, the strain the pandemic had created on partner relationships was identified by two papers in the SLR (Goyal et al., 2022; Joy et al., 2020). This finding contrasts with the viewpoint that family

togetherness is critical in the postnatal period (Wright & Leahey, 2005). However, the difference for the participants in this study is there was a lack of control of how much time they spent with their partner, due to lockdown measures enforcing people to stay at home.

A few participants described the impact that the postnatal period had on their partner's wellbeing, with participants voicing their thoughts that their partner may also be experiencing PND. This is likely to have been further impacted during COVID-19 as partners were experiencing the same lockdown restrictions, which have been shown to negatively affect adults' mental health (Chandola et al., 2020). Support for partners of mothers experiencing PND is therefore vital, particularly as aforementioned, a father may be a child's primary attachment figure, demonstrating the paternal-infant bond to be as important as the maternal-infant bond and subsequently, speaks to the protective value of ensuring both parents are able to access support (Lee, 2003). The clinical implications of this will be discussed later in the chapter.

5.3.5 Theme 5: Coping strategies

Participants describing the importance of using coping strategies was previously identified in Aydin's (2021) study, where mothers spoke to the significance of drawing on coping mechanisms to manage the difficulties related to becoming a mother during the pandemic. In this study, participants described the impact on being unable to engage in physical activity due to the lockdown restrictions and the negative effect this had on their mental health, heightening their experience of PND. It has long been recognised that there is a link between physical activity and a reduction in symptoms of PND (Kołomańska-Bogucka & Mazur-Bialy, 2019). Recent research has highlighted a substantial increase in levels of depression and significant reductions in physical activity in postnatal women

(Davenport et al., 2020). In addition, the pandemic's adverse impact on activity has been previously demonstrated in papers within the SLR. In Kolker et al's. (2021) study, participants described being unable to exercise at home and feeling too scared to leave the house for fear of COVID-19. Interestingly in the wider literature, opposing effects were also found. In Kolker et al's. (2021) study, new mothers shared developing creative ways to stay active during the pandemic, with reported positive benefits on their psychological wellbeing. This finding was also supported in Sakalidis et al's. (2021) study, with new mothers noting the increased time at home to have positive effects on their opportunity to exercise. In contrast, participants in this study shared struggling to exercise or find alternative coping strategies, especially as their usual exercise routine consisted of being outside of the house, for example visiting the gym or swimming.

5.4 Clinical implications

The current research has clinical implications for different levels of practice and covers a range of professionals, from those working to alleviate psychological distress in the realm of psychology to those working in a supportive capacity within the NHS and the charity sector. It also has implications at a wider level, in relation to the NHS long term plan, government policies, the dissemination of research and potential future lockdowns.

5.4.1 Implications for agencies supporting new mothers

The findings in this study emphasise the importance of professionals helping to facilitate disclosure, by not minimising new mothers' distress or dismissing their difficulties as solely related to COVID-19. That is not to say professionals should not explore the impact of COVID-19 on new mothers' experiences, as the findings clearly demonstrate that the

pandemic has exacerbated mothers experience of PND. Rather, it is important for mothers to have their experiences validated, with prompt support being offered, particularly as PND has wider effects than exclusively affecting new mothers, with implications for partners and their children being widely recognised. Furthermore, the findings highlight the significance of services and professionals providing consistent and dependable support to new mothers to reduce the burden felt by new mothers and to ensure the necessary support is offered, including the usual postnatal appointments. Whilst COVID-19 has placed extreme pressure on the NHS, the funding for perinatal services has continued to increase in line with the NHS long-term plan. It is therefore vital that the necessary referrals are made for new mothers to receive mental health support in a timely manner. Furthermore, the findings clearly demonstrate that the pandemic has exacerbated new mothers' experiences of PND. The effect of COVID-19 is something that should be thoughtfully reflected on in clinical work with mothers in the postnatal period, particularly as we continue to live with COVID-19.

It is important to acknowledge, however, that mothers who experienced PND during the pandemic (and did not receive support from specialist perinatal services) are likely to miss out on support if sought now. Although the long-term NHS plan aims to increase the availability of perinatal mental health support for mothers up until 24 months after giving birth, this is something that is yet to be fully rolled out in services. Furthermore, mothers who experienced PND at the start of the pandemic would not meet the criteria for support, as they would have given birth over two years ago. There are, however, several organisations in the charity sector which provide support for mothers experiencing PND who are not bound by the same restrictions as the NHS, to which mothers could be signposted if support is needed. Moreover, with the long-term effects of PND, adult mental health services may see an increase in women coming forward with depression, highlighting

the need for professionals to explore the possibility of maternal PND if they are working with mothers who had a child during the pandemic. It is also important for healthcare professionals to be aware that support can be provided by specialist perinatal services within the NHS at the point of preconception if mothers who have experienced mental health difficulties (current or past) are considering having another child, to minimise the risks to mothers' mental health during pregnancy (NHS England & NHS Improvement, 2018). Although not a theme or subtheme of this research, two participants shared feeling that due to their experience of PND during the pandemic, they would be hesitant to have any further children. Support from perinatal services could therefore be a valuable resource for families considering expanding their family.

5.4.2 Implications for agencies working with partners

The findings within this study highlighted the impact on participants' partners, as new mothers questioned whether their partner was experiencing PND. The adverse impact of PND on partners has been documented in the literature. It is therefore not surprising that an aim of the NHS long-term plan is to improve access to psychological therapies in perinatal service for mothers and their partners. Research has previously demonstrated the positive impact of offering support to couples in the treatment of PND, with an improvement in wellbeing found for both the mother and their partner (Misri et al., 2020). Furthermore, partner support has been found to protect against depression and anxiety in the postnatal period (Pilkington et al., 2015). This has important clinical implications for clinical psychologists (CP), as it demonstrates the need to offer joint interventions such as, systemic therapy (the benefits of which were discussed in section 1.4.3), where possible, to mothers experiencing PND and their partners. This research also identifies the need for

partners to be signposted for their own support, as required, in line with aims of the NHS long-term plan.

5.4.3 Implications for agencies working with children

Although participants' bond with their baby did not come through as a main theme in the research on its own, there was an acknowledgement of the indirect impact. As previously highlighted (section 5.3.2), participants spoke about how feeling isolated as a result of the lockdowns contributed to them struggling to bond with their baby. In addition, a few participants described how the inability to engage in their usual coping strategies, such as going to the gym, which would have allowed them to have time for themselves away from their baby, had a negative impact on their bond with their baby. Similar findings were found in Aydin's (2021) study, with new mothers voicing how feeling isolated, alongside restrictions being placed on their freedom and usual activities, negatively impacted the bond they had with their baby. It is possible that the impact of COVID-19 on participants' bond with their baby did not come through as a main theme due to the focus of the interview questions or because participants did not feel there was a direct impact. Nonetheless, as highlighted above there was an acknowledgment by participants of the indirect impact.

The implications of maternal PND on infants, including the impact of PND on a mother and child's bond has been well established. Within the wider literature, attachment theory has often been utilised to highlight the negative effect of PND on a child's development, with lasting effects demonstrated (Ainsworth, 1989; Bowlby, 1958; Madigan et al., 2007), including an increase in mental health difficulties for children (Kerns & Brumariu, 2013; Madigan et al., 2007). This has important implications for services offering

support to children, including nurseries, schools and child and adolescent mental health services (CAMHS). With COVID-19 increasing the prevalence of maternal PND and the findings in this study highlighting the negative impact the pandemic has had on participants' relationships and access to services, including a reduction in support, it is anticipated that this will increase the number of children experiencing attachment difficulties and mental health difficulties. In turn, this is likely to lead to an increase in referrals to CAMHS for support. Attachment-based family interventions, such as video interaction guidance, have previously been found to help promote secure attachments between parents and children and can be utilised by CPs to promote parental and infant mental health within CAMHS services (Kennedy et al., 2010). With the limits of CAMHS services, however, such as a lack of early intervention and reduced access to community-based services, there is a need for preventative steps to be taken to support families in the early years, as an alternative to waiting for a referral to a mental health service, which can lead to an increase in pressure for urgent care (Vusio et al., 2021). Interventions could be offered, for example at nurseries or by 0 to 19 teams to support parents who have experienced challenges in the early years of their child's life, in turn improving a child's developmental outcomes and potentially reducing the pressure on CAMHS services.

5.4.4 Implications for change at a wider level

CPs are in a privileged position to actively use research and evidence from clinical practice to inform policy literature and provide evidence for where further change is needed, such as within the NHS long-term plan and NICE guidelines. The current NICE Antenatal and Postnatal Guidelines (2014) have not been updated since before the pandemic. With literature in the area rapidly expanding at the same time as the increase in funding for perinatal services, now is a key time for CPs to lobby political structures to

advocate for change for mothers experiencing mental health difficulties in the postnatal service and beyond, with an anticipated ripple effect for services supporting mothers beyond the perinatal period and for children's services. The limitations of how the findings may inform policy and procedure will be discussed in section 5.5.3, however, from the findings the following recommendations have been provided. A specific suggestion from this research would be a need for the NICE (2014) guidelines to recommend specific support to new fathers in the postnatal period, for example for perinatal services to offer individual psychological interventions to ensure new fathers' needs are met. An additional recommendation would be for the NICE (2014) guidelines to identify the role that health professionals could take in supporting services working with children in the early years, to engage in preventative measures, such as undertaking parent interventions for children at nursery. Furthermore, an additional supplement should focus on the recommendations for new mothers and their partners if future lockdowns are required. This will be discussed next.

5.4.5 Implications for future lockdowns

The findings in this study have demonstrated the adverse consequences that COVID-19 has had on maternal mental health, with a significant impact on the wellbeing of mothers experiencing PND in the postnatal period. It highlights the need for several recommendations to be implemented if future lockdown periods are required. A priority should be for the use of support bubbles (which occurred later in the pandemic) to reduce the isolation felt by new mothers in the postnatal period and to provide the much-needed support required during a crucial life transition, including being able to speak to others about whether what they are experiencing is to be expected. Although the findings in this study highlighted that new mothers stayed in lockdown beyond restrictions lifting due to

concerns around the safety of their baby, there was an acknowledgement that the support bubbles would not need to be a wide network but rather support from their parents would make a huge difference. This would also allow new mothers to have a break from their responsibilities at times, potentially helping to support the bond between mother and baby, as suggested by participants in this research.

The importance of physical activity on psychological wellbeing in the postnatal period has also been found in this study. The need for new mothers to access gyms or facilities that support engagement in physical activity will therefore be crucial if future lockdowns are necessary.

5.5 Critical appraisal

5.5.1 Quality appraisal

Research integrity and robustness is important to evaluate in all qualitative studies (Hammarberg et al., 2016). This research has been evaluated using Tracy's (2010) "Big Tent" criteria to assess the quality of the inquiry. This criterion was chosen as it offers a comprehensive evaluation of qualitative research. As outlined in Table 9, application of the criteria highlighted strengths in the rigor and ethics of the study and the offering of sincerity. It is also a worthy topic to be researched, with the recent emergence of COVID-19, there are gaps in the current literature. In relation to resonance, the findings are transferable, however, as the findings are based on 12 participants, further research is needed to confirm similar findings. Alongside the quality appraisal undertaken, further exploration of the strengths and weaknesses of the research are considered in section 5.5.2 and 5.5.3.

Table 9

Quality appraisal of research

Quality criteria	Appraisal of this research
Worthy topic: The topic of the research is: - Relevant - Timely - Significant - Interesting	The research is relevant, timely and significant considering the recent emergence of COVID-19 and the gap in the current literature. It is interesting to those working in perinatal services including mental health services and healthcare services that support women in the postnatal period. It is also interesting to the stakeholders engaged in policy development.
Rich rigor: The study uses sufficient, abundant, appropriate, and complex: - Theoretical constructs - Data and time in the field - Sample(s) - Context(s) - Data collection and analysis processes	For research to be rigorous, rich description and explanations are required. I have attempted to meet this criterion by detailing the research process at length. I have also attempted to take care in the collection and analysis of the research. Practices were undertaken to check the accuracy of transcripts. Close line-by-line coding was completed to ensure rigor. I also incorporated many rich quotes from participants in the write-up. Recruitment and interviews were undertaken over multiple months to ensure meaningful and substantial data was captured.
Sincerity: The study is characterized by: - Self-reflexivity about subjective values, biases, and inclinations of the researcher(s) - Transparency about the methods and challenges	The research incorporates self-reflexivity, with my position and epistemological stance shared. Challenges to the research were highlighted. The process of completing the research was outlined in detail to promote transparency.
Credibility: The research is marked by: - Thick description, concrete detail, explication of tacit (non-textual) knowledge, and showing rather than telling - Triangulation or crystallization - Multivocality	For readers to be able to draw their own conclusions from the data, a process of 'show' rather than 'tell' was employed, through the use of participant quotes, as suggested by Tracy (2010). Likewise, the credibility concepts of ‘multivocality’ and ‘member reflections’ were utilised by collecting member checking feedback and

- Member reflections	feedback from consultants, increasing the collaboration and partnership with those researched.
Resonance: The research influences, affects, or moves particular readers or a variety of audiences through: - Aesthetic, evocative representation - Naturalistic generalizations - Transferable findings	Considering the nature of the topic, it could be reasoned that the research is evocative and has the power to transform the emotional disposition of the reader given participants' reflection of the distress that was experienced. The findings of the research are transferable across multiple disciplines, services and professionals. They are also transferable to wider agencies, involved in supporting mothers and families who have experienced PND including, at policy level.
Significant contribution The research provides a significant contribution: - Conceptually/theoretically - Practically - Morally - Methodologically - Heuristically	The research aims to apply existing theory and concepts to a previously unresearched area. It also offers significant moral and heuristic contributions, through the discovery of new findings by highlighting participants' experiences, which in turn offers a significant contribution to the practical changes required at ground and policy level. The research also offers methodological significance, by extending what is already known about the impact of COVID-19 on PND beyond quantitative findings to a qualitative approach.
Ethical The research considers: - Procedural ethics (such as human subjects) - Situational and culturally specific ethics - Relational ethics - Exiting ethics (leaving the scene and sharing the research)	The research has strived to maintain and uphold procedural and relational ethics at each stage of the process, as have been detailed in this report. Situational and culturally specific ethical issues were held in mind and shared using a self-reflexive stance in the research. Ethical considerations will also continue beyond data collection and the write up of this report, to the dissemination of the findings. This will include consideration of how the findings are represented in written documents and verbal presentations. A

	priority is to also ensure participants' contributions are continually honoured.
Meaningful coherence The study: - Achieves what it purports to be about - Uses methods and procedures that fit its stated goals - Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other	The research has achieved its stated purpose and reflects the aims of the study. The methods and procedures utilised fit with the aims of the study. In addition, the findings are interconnected with literature to ensure meaningful coherence. The findings and recommendations also add meaning to ongoing practice.

5.5.2 Strengths

The study has made a significant contribution to an area that has not been previously researched using a qualitative approach and where relatively little is known. This research contributes to the rapidly expanding wider literature around the effect and impact that COVID-19 has had, from which further research can be conducted. The findings lead to several implications for clinical practice within the discipline of psychology and the wider healthcare system. The interest exhibited by new mothers to consult to and participate in this study indicates the importance of this research to those impacted. This was further demonstrated by participants who shared their thanks around the research being undertaken.

A strength of this research was the utilisation of TA, a method that is useful when conducting research in an area that is under researched (Braun & Clarke, 2006). This enabled an inductive approach to be undertaken whereby themes could be strongly linked to the data itself, rather than tied to pre-conceived theories, concepts, or models (Byrne, 2022). An inductive approach to TA has also been demonstrated to offer rich descriptions of data (Braun & Clarke, 2006). Furthermore, within this study, a detailed account of the process of TA was outlined, providing transparency in the process. The use of member

checks as part of the research also helped to ensure the trustworthiness of the research (DeCino & Waalkes, 2019).

Reflexivity was integral to the research, with my position and epistemological stance outlined at the beginning. A reflexive diary and conversations with supervisors and consultants were helpful to hold in the forefront of my mind my context and how this influences my relationship with the research (Dodgson, 2019). This was particularly helpful during times in the research where personal challenges arose.

5.5.3 Weaknesses

As aforementioned, there is a lack of diversity in the sample recruited, with most participants identifying as White British. Research has found differences in the experiences of Black and White mothers during the pandemic (Gur et al., 2020). Although attempts were made to expand recruitment methods to recruit mothers from diverse backgrounds, more research is needed to understand how best to reach this community. It is possible that my whiteness as a researcher and the challenges that ethnic minority mothers have likely experienced when accessing mental health services may have been potential barriers to ethnic minority mothers coming forward (Edge, 2011; Edge & MacKian, 2010; Wittkowski, 2011). The perspectives and experiences from participants from minority backgrounds, therefore, are not represented in the findings. Moreover, all participants were English speaking. Mothers of a non-English speaking background have notably poorer perinatal outcomes (Yelland et al., 2015), and this is likely to have been impacted further by COVID-19. Research is therefore required to understand their experiences of the postnatal period in the context of COVID-19. All the mothers within this research were also in a relationship or married. Little is known about the impact of COVID-19 on single mothers or mothers

living in non-traditional family structures experiencing mental health difficulties such as, PND. There is therefore lots of scope for future research.

The interviews varied in length, from 42 minutes (shortest) to 1 hour 43 (longest). There were several reasons for this, including participants becoming distressed during the interview, participants requesting time to think before answering and the researcher becoming more accustomed to the interview process as time progressed. It has been previously highlighted that although interviewers may have a guide, there are times where the researcher may need to deviate from it, because each participant is unique and therefore each interview is unique (deMarrais & Lapan, 2003). Questions can therefore be tailored to fit comfortably into the experience of each interview; however, this could have also influenced the data collected, with more information collected from some participants that may have been missed in other interviews (deMarrais & Lapan, 2003).

There is also a limitation of how the findings from this research can be used to inform intervention and policy, as the results are based on 12 participants. Although the findings can inform where change may be needed, there is a need for further research to confirm similar findings.

5.6 Dissemination of the research

In the UK, CPs are primarily trained in the 'scientist-practitioner' model, meaning they have the skills to deliver psychological interventions and undertake and interpret research (Holttum & Goble, 2006; Stricker, 2002). With the research into the impact of COVID-19 on the postnatal period rapidly expanding, it is essential for these skills to be drawn upon by CPs to undertake and disseminate research that may add to the growing literature and improve interventions for mothers experiencing PND.

Dissemination is an important part of this research and the process of sharing the findings has started. The research was recently presented to the Community Perinatal Team within which I am based on placement. It was felt by the team that it was helpful to be aware of research exploring the effect of COVID-19 on new mothers experiencing PND as they continue to discuss the impact of the pandemic with mothers in their work. It was voiced that the research is important to keep in mind when working with mothers who are referred to the team for support when they are considering expanding their family, but are concerned due to their previous perinatal experience, for example for mothers who previously experienced PND during COVID-19. The importance of involving the partner in these discussions and in interventions was spoken to, with the findings highlighting the negative impact on partners. Furthermore, ideas were shared around recommendations for where the research could be disseminated moving forward such as, with midwives who work in perinatal mental health services.

The plan is to present the research at the annual Doctorate in Clinical Psychology research day in September and to liaise with organisations (including the charities who advertised the research) to explore how the findings can be made available to the population impacted. The next step in the journey is to write up and publish the research within a relevant academic journal to be able to share the research more broadly and add to the growing research base.

5.7 Future research

The research and findings have identified several future research areas of qualitative inquiry. As aforementioned, there is a need for research to be completed with participants

from diverse backgrounds, including mothers from minority backgrounds and mothers living in non-traditional family structures, to understand the impact that COVID-19 has had on their experience of the postnatal period.

With the long-term impact of maternal PND demonstrated in previous literature (Cooper & Murray, 1995), there is a need for research to be conducted on the long-term impact of maternal PND, as experienced by mothers in the pandemic. As highlighted in the findings of this study, the pandemic has also had adverse consequences for partners, with mothers suspecting that their partner may be experiencing PND. Partner support has been found to be crucial in improving maternal PND (Pilkington et al., 2015). However, as noted in the introduction this is a largely under-researched area. Therefore, further research into the impact of COVID-19 on the postnatal period for partners of mothers experiencing PND is essential to better understand how best to tailor support to meet their needs.

With research demonstrating the adverse effect of maternal PND on the wider system, it will be important for research to be conducted on the short and long-term effects of maternal PND on child development, particularly as research has previously highlighted the long-term negative effects (Ainsworth, 1989; Madigan et al., 2007). With the likely ripple effect this will place on referrals to CAMHS, research may offer important recommendations for clinical practice and the best way for families to be supported.

Furthermore, with the pandemic being a recent emergence there is a need for more research to be completed into the effects of COVID-19 on children, including the long-term effects, particularly as we continue to learn to live with COVID-19. With participants in this research sharing their fears around the effects of COVID-19 on their baby, this may potentially help reduce new mothers' concerns in the postnatal period, thereby reducing the anxiety and isolation felt by new mothers and the steps taken to protect their baby.

5.8 Final reflections

Looking back to the beginning of this research, I could not have predicted the journey it would take me on. Becoming an 'insider' to the research on several levels was unexpected and with the demands of clinical psychology training, this has created challenges at times, but also feelings of great privilege. To be able to engage with an area of interest both within my clinical practice and through research has allowed me to connect to the study on a deeper level and, as I come to the end of this journey, has reminded me of the passion I have for the area of perinatal mental health. It has also further strengthened the values I aim to take forward as a CP working within the NHS; this includes being inspired to continue engaging in research to complement clinical practice and to prioritise dissemination to services and at a wider level.

6. Conclusion

This research aimed to explore the impact of COVID-19 on the postnatal period for first-time mothers experiencing PND. Twelve first-time mothers were interviewed as part of this inquiry. Five main themes were identified: 'fear of COVID-19', 'being alone', 'relationship with services', 'impact on partner relationships' and 'coping strategies'. The findings are consistent with the research that has been conducted on the impact of COVID-19 on maternal mental health more widely. This study also adds to the growing evidence base on the impact of COVID-19 on maternal PND. The implications of the findings are wide reaching, both on the ground for services that support mothers in the postnatal period and at a broader level, with the continued increase in funding in perinatal services to align clinical practice to policy. Overall, the findings offer important contributions to the area of perinatal mental health and the potential for future research is extensive.

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Zelkowitz, P., & Milet, T. H. (1995). Screening for post-partum depression in a community sample. *Canadian Journal of Psychiatry, 40(*2), 80-86. https://doi.org/10.1177/070674379504000205

8. Appendices

8.1 Appendix A

UH Search Planning Form

Question:
What does the empirical literature say about the impact of COVID-19 on maternal mental health in the postnatal period?

Search terms used in Scopus, CINAHL, Psycarticles (no limits used):

(COVID* OR COVID-19 OR coronavirus) AND (mental health OR psychological* OR emotional*) AND (postnatal OR postpartum OR perinatal OR fourth trimester OR maternal OR mother* OR mum)

Search terms used in Pubmed (no limits used):

(COVID* OR COVID-19 OR coronavirus) AND (mental health OR psychological* OR emotional*) AND (postnatal OR postpartum)

Identify the main concepts of the question (use as many as you need)

Concept 1	**Concept 2**	**Concept 3**
COVID*	Mental health	Postnatal

List alternatives keywords, terms and phrases below

Concept 1	**Concept 2**	**Concept 3**
OR COVID-19	OR Psychological*	OR Postpartum
OR Coronavirus	OR Emotional*	OR Fourth trimester
OR	OR	OR Perinatal
OR	OR	OR Maternal
OR	OR	OR Fourth trimester
OR	OR	OR Mother*

OR	OR	OR Mum
OR	OR	OR

Step 1: Use OR to combine ALTERNATIVE search terms together.

Step 2: Use AND to combine different concepts together.

8.2 Appendix B

Appraisal of qualitative research using Tracey's (2010) "big tent" criteria

	Qualitative Studies Assessed Using "Big Tent" Criteria for Qualitative Quality (Tracey, 2010)							
Author/ Authors & Year	Aydin. (2021).	Joy, Aston, Price, Sim, Ollivier, Benoit, Akbari-Nassaji & Iduye. (2020).	Ollivier, Aston, Price, Sim, Benoit, Joy, Iduye, & Akbari-Nassaji. (2020).	Goyal, Han, Feldman-Schwartz & Le. (2022)	Jackson, De Pascalisa, Harrolda, Fallona & Silveriob. (2021a).	Jackson, De Pascalisa, Harrolda, Fallona & Silveriob. (2021b).	Kolker, Biringer, Bytautas, Blumenfeld, Kukan & Carroll. (2021).	Rice & Williams. (2021).
Worthy Topic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rich Rigor	Yes	Yes	Limited	Yes	Yes	Yes	Yes	Yes
Sincerity	Some – Transparency of method but no evidence of self-reflexivity	Yes	Some – no evidence of self-reflexivity	Some – a brief note of the need to attend to their biases and positionality	Some - Transparency of method but no statement of self-reflexivity, compared to the researchers' other article	Yes	Some – Transparency of method but no evidence of self-reflexivity	Yes
Credibility	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Resonance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Significant contribution	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ethical	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Meaningful coherence	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

8.3 Appendix C

Appraisal of mixed-method papers using the MMAT

Table C1

MMAT for Saleh et al's. (2021) study

Category of study designs	Methodological quality criteria	Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			
2. Quantitative randomised control trials	2.1. Is randomization appropriately performed?				N/A
	2.2. Are the groups comparable at baseline?				N/A
	2.3. Are there complete outcome data?				N/A
	2.4. Are outcome assessors blinded to the intervention provided?				N/A
	2.5. Did the participants adhere to the assigned intervention?				N/A
3. Quantitative non-randomised	3.1. Are the participants representative of the target population?				N/A
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				N/A
	3.3. Are there complete outcome data?				N/A
	3.4. Are the confounders accounted for in the design and analysis?				N/A
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				N/A
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			
	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?		X		

5. Mixed methods	5.2. Are the different components of the study effectively integrated to answer the research question?		X		
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?		X		
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	X			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	X			

Table C2

MMAT for Sakalidis et al. (2021)

Category of study designs	Methodological quality criteria	Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			
2. Quantitative randomised control trials	2.1. Is randomization appropriately performed?				N/A
	2.2. Are the groups comparable at baseline?				N/A
	2.3. Are there complete outcome data?				N/A
	2.4. Are outcome assessors blinded to the intervention provided?				N/A
	2.5. Did the participants adhere to the assigned intervention?				N/A
3. Quantitative non-randomised	3.1. Are the participants representative of the target population?				N/A
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				N/A
	3.3. Are there complete outcome data?				N/A
	3.4. Are the confounders accounted for in the design and analysis?				N/A
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				N/A
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?		X		
	5.2. Are the different components of the study effectively integrated to answer the research question?	X			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	X			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	X			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	X			

8.4 Appendix D

Results of thematic synthesis

Descriptive	**Analytic**
Fearing baby will get ill Strict hygiene Worried about baby being infected Negative effect of husband's virus-related warnings	**Fear of COVID-19** - *Concerns for wellbeing of baby* - *Concern around conflicting information*
Lack of social support Unable to take part in traditions Overprotective of baby Cleaning everything Changing clothes frequently Lack of freedom	**Missed opportunities** - *Missed postnatal experience* - *Loss of traditions* - *Robbed of sharing moments with family and friends*
Isolation Conflicting information about safety of breastfeeding Preference for private hospitals to reduce exposure Avoiding hospital at busy times Avoiding follow up visits	**Unexpected postnatal journey** - *Diminished healthcare support* - *Partner present at home*
Freedom to enjoy baby as a family Partner having more time with baby Increased time as a family Not able to share moments with family Quiet time to enjoy being a family Online support not the same Missed postnatal experience Concerns of impact on baby's socialisation Overattachment with Mother Disrupted support Fear of spreading COVID-19 Information frequently changing Lack of in-person health care visits Anxiety attending appts due to exposure Virtual healthcare tick-box exercise Feeling abandoned Lack of health care professional support Breaking rules for support Increased support from partner Lack of breastfeeding support Able to establish routines Changes to medical appts Mental health at forefront of postnatal experience	**Isolation** - *Lack of social support* - *Breaking restrictions*

Anxiety due to lockdown Emotionally exhausted COVID-19 challenging for mental health Conflicting information	

8.5 Appendix E

Research poster

University of Hertfordshire

PARTICIPANTS NEEDED

Research exploring the impact of COVID-19 on the postnatal period for women experiencing postnatal depression

WHAT IS THE STUDY ABOUT?

The study is being carried out by Rachel Barnes, a DClinPsy trainee from the University of Hertfordshire.

It aims to explore the impact of COVID-19 on the postnatal period for women experiencing postnatal depression.

The study is being supervised by Dr Rebecca Adlington, Clinical Psychologist and Senior Lecturer on the Doctorate in Clinical Psychology course at the University of Hertfordshire. It has been approved by the University of Hertfordshire Ethics Committee – protocol number LMS/PGR/UH/04650.

WHAT WOULD IT LOOK LIKE IF I TOOK PART?

You would be invited to take part in an interview with the main researcher, Rachel Barnes, about your experiences of the impact of COVID-19 on your postnatal period.

Interviews will take place via telephone or video call. The interview will last around 90-120 minutes. Interviews undertaken by telephone will be audio recorded. Interviews undertaken by video call will be audio and video recorded. Only the audio recording will be used for the purpose of analysis.

You can decide to withdraw at any time during the interview and up to when data analysis begins.

If you are interested in taking part, please contact Rachel for more information about what to expect.

WHAT IS THE CRITERIA FOR TAKING PART?

First time mothers who gave birth during the COVID-19 pandemic (between 23rd March 2020 to 23rd March 2021) and experienced postnatal depression. You do not need a formal diagnosis to take part. You may also no longer experience symptoms of postnatal depression.

There are exclusion criteria to taking part for example, women who have had more than one child or who cannot speak English will be unable to take part. The full exclusion criteria will be included in the participant information sheet, which will be shared once you contact Rachel. If you meet any of the exclusion criteria, you will be unable to take part in the research.

INTERESTED IN PARTICIPATING OR WANT TO ASK A QUESTION?

Email Rachel Barnes:

rb19act@herts.ac.uk

8.6 Appendix F

Ethical approval notices

First approval – 27/07/2021.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Rachel Barnes
CC	Dr Rebecca Adlington
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE	27/07/2021

Protocol number:	**LMS/PGR/UH/04650**
Title of study:	Exploring the impact of COVID-19 on the postnatal period for women experiencing postnatal depression

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Kelly Abraham-Smith (External/Secondary Supervisor)
Dr Jacqui Gratton (Project mentor)

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 01/08/2021

To: 28/02/2022

Approval following amendment – 29/11/2021.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	**Rachel Barnes**
CC	**Dr Rebecca Adlington**
FROM	**Dr Rosemary Godbold, Health, Science, Engineering and Technology ECDA Vice Chairman**
DATE	**29/11/2021**

Protocol number: aLMS/PGR/UH/04650(1)

Title of study: Exploring the impact of COVID-19 on the postnatal period for women experiencing postnatal depression

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Modification:

- **Additional workers Dr Jennifer Heath (Senior Lecturer and Senior Research Fellow) to replace Dr Jacqui Gratton as Project Mentor, as Jacqui has left the Doctorate in Clinical Psychology programme.**
- **An application to extend the recruitment process, with the advert for the research being shared on the social media platforms for several organisations that support women with postnatal depression.**

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 29/11/2021

To: 28/02/2022

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

8.7 Appendix G

Participant information sheet

University of Hertfordshire UH Ethics Committee

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEET

1 **Title of study**

Exploring the impact of COVID-19 on the postnatal period for women experiencing postnatal depression

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us about anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part.

If you wish to you can also look at the document which highlights the University of Hertfordshire's regulations that apply to any study involving the use of human participants. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via the link below. It is a link that you may wish to look at, but it is not an expectation that you need to read it.

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs
(after accessing this website, scroll down to Letter S where you will find the regulation)

3 **What is the purpose of this study?**

The purpose of the study is to explore the impact of COVID-19 on the experience of the postnatal period for women experiencing postnatal depression. Specifically, it will focus on several areas including: the individual's experience of postnatal depression, psychological wellbeing, relationships, bond to baby, social support/networks, access to services e.g. mother and baby classes, financial impact, maternity experience, access to outdoor space, physical exercise and any positive experiences.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage of the interview without giving a reason. You can also withdraw from the study up until data analysis begins (it is expected that data analysis will start in December 2021).

5 **Are there any age or other restrictions that may prevent me from participating?**

There are restrictions that will prevent you from being able to participate. The restrictions include:

- Women under the age of 18 years old
- Women who have had more than one child
- Women living outside of England
- Women who cannot speak English
- Women who have experienced high risk pregnancies and/or births (experienced complications)
- Women currently involved in a child protection case or where there are concerns for the child's wellbeing
- Women with current drug or alcohol dependency
- Women expressing current suicidal ideation with plans to end their life, currently engaging in self-harm behaviours.

If, during the research, information comes to light that you are ineligible to take part in the study, due to meeting any of the exclusion criteria, we will conclude our meeting and you will be offered a list of support services.

6 **How long will my part in the study take?**

If you decide to take part in this study, the interview will take between 1.5 to 2 hours.

7 **What will happen to me if I take part?**

The first thing to happen will be Rachel Barnes, principal investigator, contacting you to arrange an interview at a date and time which is convenient for you. Prior to the interview, a demographic questionnaire will be sent to you to be filled in prior to the interview. The demographic questionnaire will include questions on age, ethnicity, relationship status, employment status, living conditions (e.g. flat/house) and whether you had formal support for your postnatal depression. It will be your choice as to whether the interview takes place via telephone or video call (e.g. Zoom / MS Teams). If you would prefer, your child can be present for the interview. The interview can also be paused, for example, should you need to feed or change your baby.

Prior to the interview, there will be a pre-interview discussion with Rachel. This will be an opportunity for Rachel to discuss with you the potential benefits and risks of taking part in this research. You will also be able to ask any questions you have regarding the participant information sheet and the consent form. If through taking part in the

study, it is felt that you may require advice or support, you will be advised to speak to your GP or to contact one of the services (who offer support to women experiencing postnatal depression) noted on the resource sheet. The resource sheet will be provided on the day of the interview and discussed as part of the pre-interview and debrief.

At the end of the interview, you will be asked whether you would like to take part in member checking. This is when a copy of the findings is sent to you so that you are able to review the themes that have arisen from the analysis across all the interviews and check for accuracy and resonance with your experience. Member checking helps to establish the credibility of the results. Taking part in member checking is optional. You will also be asked whether you consent to Rachel contacting you should the expected date (December 2021) for data analysis change, so you are aware of the new date up to which you can ask for your data to be withdrawn.

8 **What are the possible disadvantages, risks or side effects of taking part?**

There are no known risks, however, there is a chance that the interview may be emotionally distressing (e.g. during or after the interview). Rachel has experience in providing emotional support to people who are experiencing distress and will be sensitive to this in her interview technique and delivery. For example, if Rachel feels you are becoming distressed, she may ask you to pause for a moment and check how you are feeling. As stated above, Rachel may ask clarifying questions but not questions which will involve asking details about specifics of an event. You will be reminded that you should only talk about the experiences that you feel willing to talk about and in a way that feels manageable for you.

You can withdraw during the interview at any time and you can also withdraw from the study up until data analysis begins.

9 **What are the possible benefits of taking part?**

There are not any direct benefits of taking part, but we hope to provide a space where you can share your story of your experience of the postnatal period whilst experiencing postnatal depression during the COVID-19 pandemic. Talking about your experience with someone who is impartial may be helpful in making meaning from the experience. Also, it will contribute to a growing area of research, which may have implications for women in their postnatal period in the future. This may include psychological benefits.

10 **How will my taking part in this study be kept confidential?**

All information collected (consent forms, demographic questionnaire) is strictly confidential and will be stored securely online on the University of Hertfordshire OneDrive. Only Rachel will have access to this information. Information that could identify you, such as your name and other details, will be removed or changed and a pseudonym used for the analysis and the writing up of the research.

The interviews will be audio recorded if undertaken by telephone. The interviews will be audio and video recorded if undertaken using an online platform (e.g. Zoom/MS Teams). This is because it is then transcribed for analysis later on in the research. Only the audio recordings will be used, however. These recordings will only be accessed by Rachel and the transcription service. The interview audio recording will be sent to an independent transcription company. A transcription service with a

General Data Protection Regulation (GDPR) policy in place will be used to ensure confidentiality (GDPR is a legal framework that sets guidelines for the collection and processing of personal information). The service will also be asked to sign a confidentiality agreement. Audio and video recordings and typed transcripts will be securely saved to the University of Hertfordshire OneDrive.

11 **Audio-visual material**

Interviews will be audio and video recorded. The audio recording will be transcribed by a transcription service with a GDPR policy in place to ensure confidentiality.

12 **What will happen to the data collected within this study?**

- Consent forms, demographic data and audio recordings will be deleted on completion of the study.
- Anonymised transcripts will be kept for 5 years on the University of Hertfordshire OneDrive following completion of the study.
- You will be given a pseudonym for the write up of the study.
- The thesis which will include anonymised data and extracts of transcripts will be made publicly available via a research repository (database).

13 **Will the data be required for use in further studies?**

The data will not be used in further studies, however transcripts will be stored for 5 years on the University of Hertfordshire OneDrive before being destroyed under secure conditions.

14 **Who has reviewed this study?**

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is LMS/PGR/UH/04650

15 **Factors that might put others at risk**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch by emailing me at: rb19act@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

8.8 Appendix H

Demographics questionnaire

Age: 18-29 ☐
30-39 ☐
40-49 ☐
50-59 ☐

Ethnicity:

White

- English, Welsh, Scottish, Northern Irish or British ☐
- Irish ☐
- Any other White background (please state) _____

Mixed or Multiple ethnic groups

- White and Black Caribbean ☐
- White and Black African ☐
- White and Asian ☐
- Any other Mixed or Multiple ethnic background (please state) _____

Asian or Asian British

- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Chinese ☐
- Any other Asian background (please state) _____

Black, African, Caribbean or Black British

- African ☐
- Caribbean ☐
- Any other Black, African or Caribbean background (please state) _____

Other ethnic group

- Arab ☐
- Any other ethnic group (please state) _____

Relationship status: Single ☐
In a relationship ☐
Married/Civil partnership ☐
Separated ☐
Divorced ☐
Widowed ☐

Employment status: Employed (including self-employed) ☐
Employed (on maternity) ☐
Unemployed ☐

Living conditions: Sharing a flat/house ☐
Sharing a flat/house with access to outdoor space ☐
Flat ☐
Flat with access to outdoor space ☐
House ☐

House with access to outdoor space ☐
Other type of housing (please state) _____

Support: Have you received any formal support/help for your PND (please tick all of the ones relevant to you)

- Support from maternity services (e.g. midwife/health visitor) ☐
- Mother & baby classes ☐
- Psychological support ☐
- Medication ☐
- Please state if you received any other support not included above: _____

Consent form

University of Hertfordshire UH Ethics Committee

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

……..…
of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……
hereby freely agree to take part in the study entitled

Exploring the impact of COVID-19 on the postnatal period for women experiencing postnatal depression

(UH Protocol number LMS/PGR/UH/04650)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw at any time during the interview and up to when data analysis will commence (expected date December 2021) without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that video and voice-recording will take place (if interviewed using an online platform) and voice-recording if completed by telephone and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including anonymised data and extracts of transcripts included in the thesis being publicly available via a research repository which has open access.

5 I understand that my participation in this study may reveal findings that could indicate that I may require advice or support. In that event, I will be informed and advised to consult my GP. I will also be offered a resource list, which includes information on services who offer support to women experiencing postnatal depression. If, during the study, evidence comes to light that I am not suitable to take part in the study, due to meeting part of the exclusion criteria I understand that I will not be allowed to take any further part in the study and my interview will be removed. I am aware that the researcher has a duty of care and that in the event of a serious and immediate risk to myself or others, they will need to act to keep people safe.

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

7 I do / do not (please circle as appropriate) wish to be contacted regarding the findings of this study.

Signature of participant……..…

Date……

Signature of (principal) investigator……

Date……

Name of (principal) investigator ……

8.9 Appendix I

Non-disclosure agreement

Transcriber non-disclosure agreement

Research Title	Exploring the impact of COVID-19 on the postnatal period for women experiencing postnatal depression
Principle Researcher	Rachel Barnes
Department	Doctorate in Clinical Psychology, University of Hertfordshire
Transcriber	[redacted]
Transcriber Organisation	

As a transcriber of this research, I, [redacted], understand that I will be hearing recordings of confidential interviews. The information on these recordings has been revealed by interviewees who agreed to participate in this research on the condition that their interviews would remain strictly confidential. I understand that I have a responsibility to honour this non-disclosure agreement.

I, [redacted], agree not to share any information on these recordings with anyone except the Researcher of this project. Any violation of this and the terms detailed below would constitute a serious breach of ethical standards and I confirm that I will adhere to the agreement in full.

I, [redacted], agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the content of the interviews in any form or format with anyone other than the Researcher.
2. Take reasonable technical and non-technical measures to keep all research information in any form or format secure while it is in my possession.
3. Not keep the research information in any third party cloud storage service, unless the files are in encrypted format and this is agreed by the Researcher.
4. Return all research information in any form or format to the Researcher, in a secure method, when I have completed the transcription tasks.
5. After consulting with the Researcher, securely erase or destroy all research information in any form or format regarding this research project that is not returnable to the researcher (e.g. information stored on my computer hard drive).
6. Inform the Researcher if we are aware of, or suspect there might be, a data breach while the data is in our possession.

[redacted]

8.10 Appendix J

Resource sheet

Resource sheet

You can access support from your GP. Please also find below the details of some registered organisations which can provide support to individuals suffering from postnatal depression.

- **PANDAS Foundation** (PND awareness and support)
  Website: https://pandasfoundation.org.uk
  Telephone: 0808 1961 776

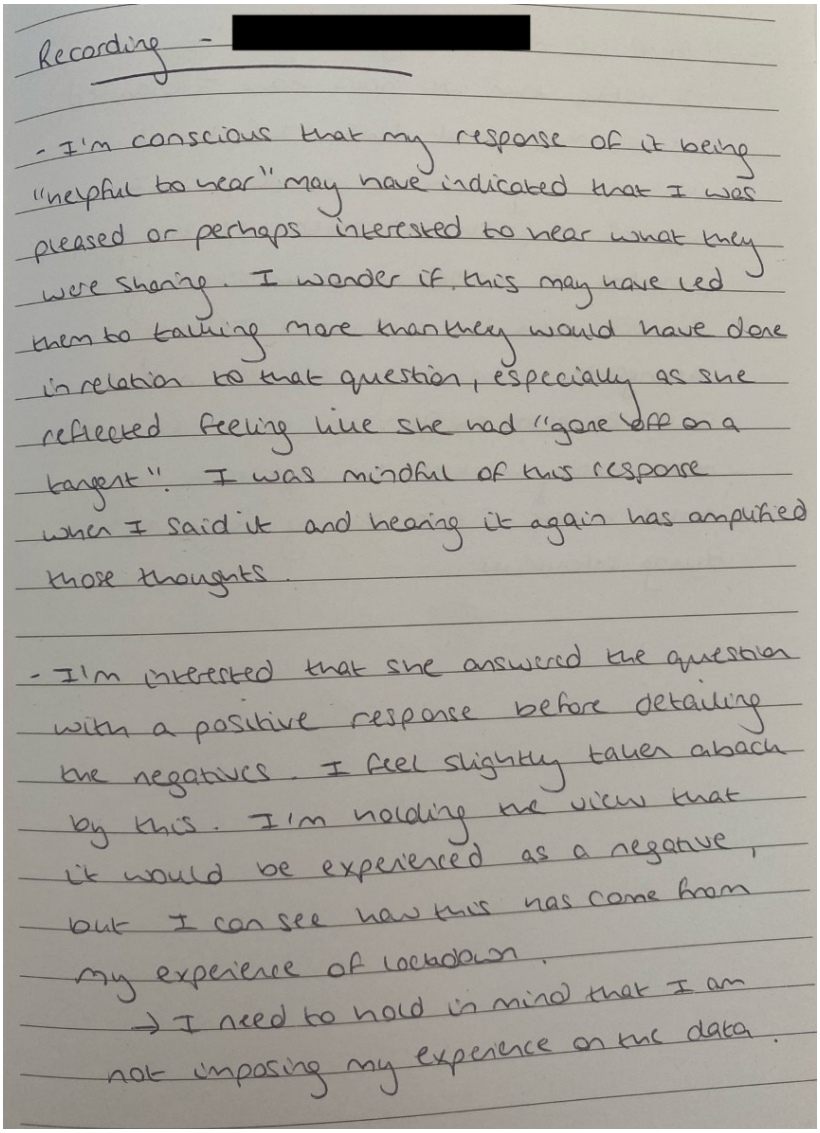
- **Association for Post Natal Illness (APNI)** (The Association has a countrywide network of phone and e-mail volunteers, who have had, and recovered from post-natal illness)
  Website: https://apni.org/
  Telephone: 0207 386 0868
  Email: info@apni.org

- **Mothers for Mothers** (A network of women with lived experience who offer support, advice and information)
  Website: https://mothersformothers.co.uk/
  Telephone: 0117 9359366

- **House of light** (A service offering support and counselling to women and their families)
  Website: https://pndsupport.co.uk/
  Telephone: 0800 043 2031
  Email: help@pndsupport.co.uk

8.11 Appendix K

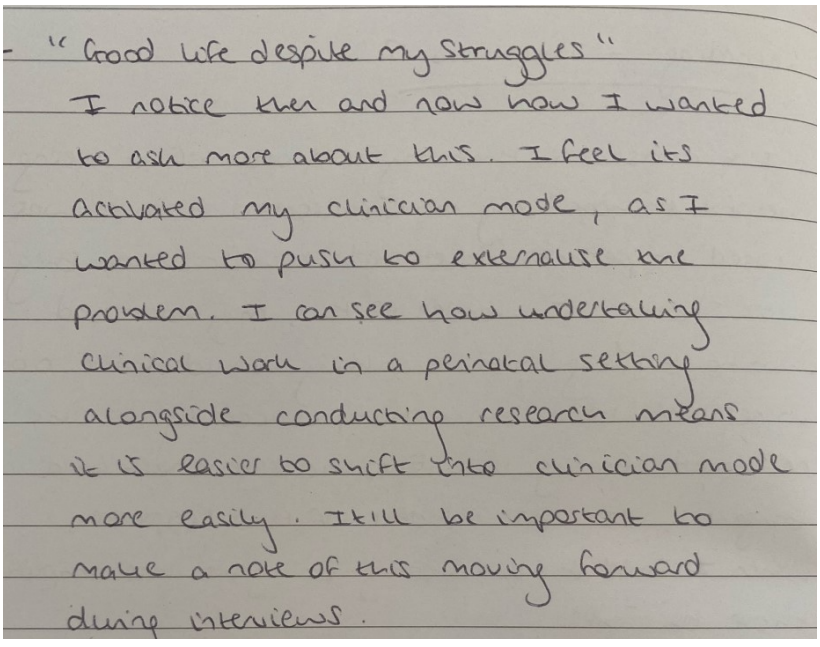
Preliminary notes from listening to recordings from reflexive diary



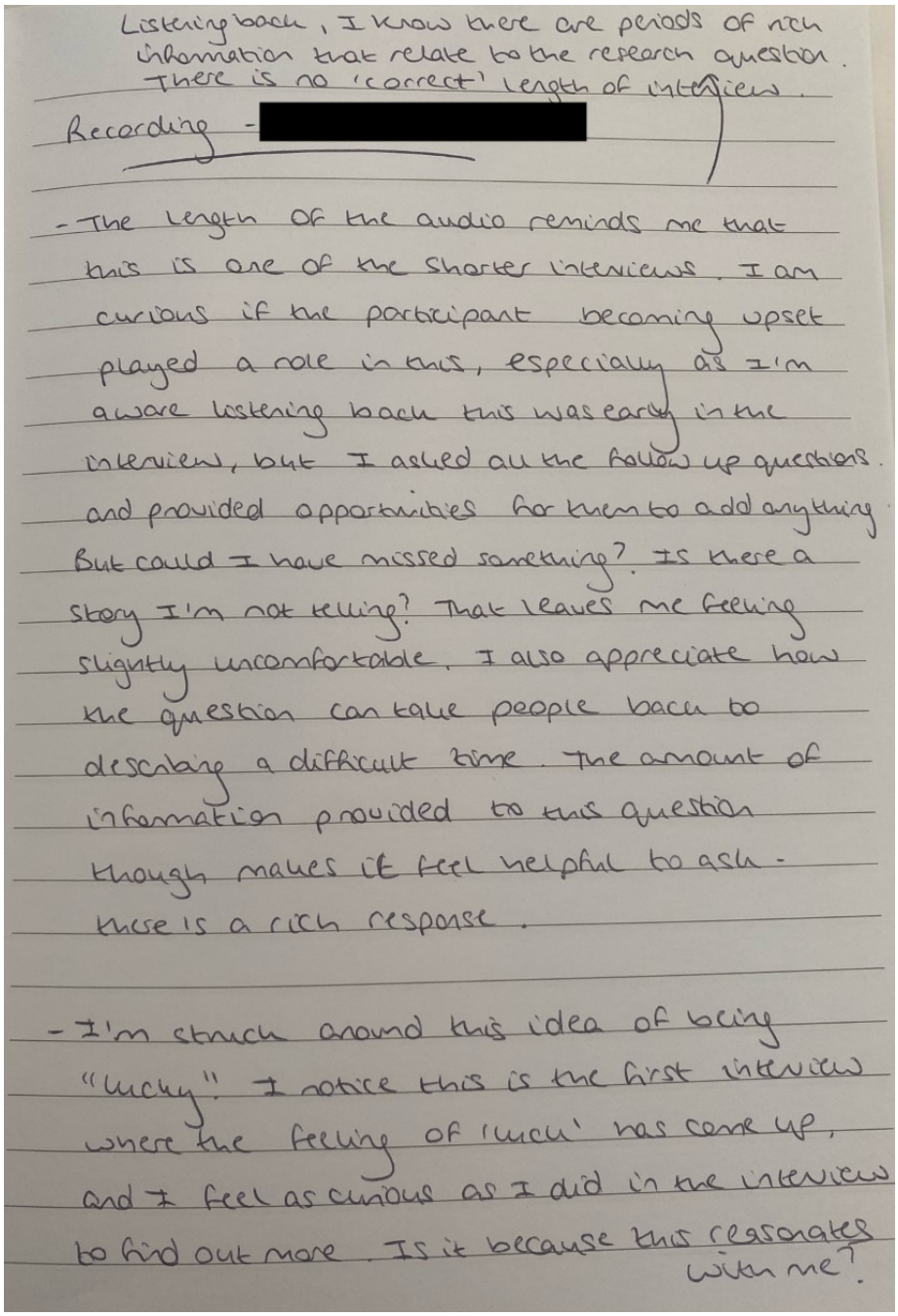
Recording - [redacted]

- I'm conscious that my response of it being "helpful to hear" may have indicated that I was pleased or perhaps interested to hear what they were sharing. I wonder if this may have led them to talking more than they would have done in relation to that question, especially as she reflected feeling like she had "gone off on a tangent". I was mindful of this response when I said it and hearing it again has amplified those thoughts.

- I'm interested that she answered the question with a positive response before detailing the negatives. I feel slightly taken aback by this. I'm holding the view that it would be experienced as a negative, but I can see how this has come from my experience of lockdown.
→ I need to hold in mind that I am not imposing my experience on the data.



- "Good life despite my struggles"
I notice then and now how I wanted to ask more about this. I feel its activated my clinician mode, as I wanted to push to externalise the problem. I can see how undertaking clinical work in a perinatal setting alongside conducting research means it is easier to shift into clinician mode more easily. It'll be important to make a note of this moving forward during interviews.

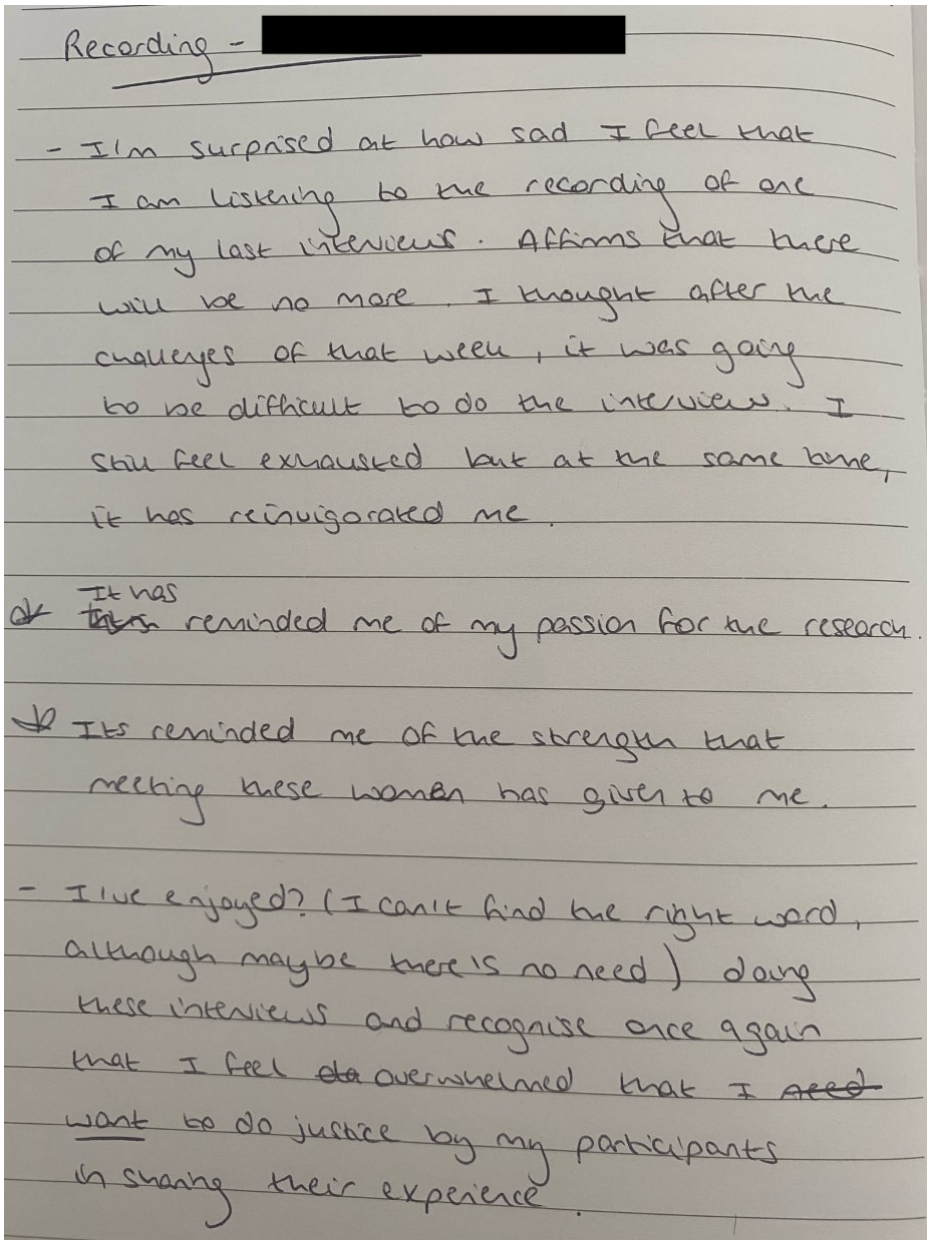


Listening back, I know there are periods of rich information that relate to the research question. There is no 'correct' length of interview.

Recording - [redacted]

- The length of the audio reminds me that this is one of the shorter interviews. I am curious if the participant becoming upset played a role in this, especially as I'm aware listening back this was early in the interview, but I asked all the follow up questions and provided opportunities for them to add anything. But could I have missed something? Is there a story I'm not telling? That leaves me feeling slightly uncomfortable. I also appreciate how the question can take people back to describing a difficult time. The amount of information provided to this question though makes it feel helpful to ask - there is a rich response.

- I'm struck around this idea of being "lucky". I notice this is the first interview where the feeling of 'luck' has come up, and I feel as curious as I did in the interview to find out more. Is it because this resonates with me?



Recording - [redacted]

- I'm surprised at how sad I feel that I am listening to the recording of one of my last interviews. Affirms that there will be no more. I thought after the challenges of that week, it was going to be difficult to do the interviews. I still feel exhausted but at the same time, it has reinvigorated me.

It has
~~It~~ reminded me of my passion for the research.

Its reminded me of the strength that meeting these women has given to me.

- I've enjoyed? (I can't find the right word, although maybe there is no need) doing these interviews and recognise once again that I feel ~~do~~ overwhelmed that I ~~need~~ want to do justice by my participants in sharing their experience.

8.12 Appendix L

Coded transcript

[redacted]

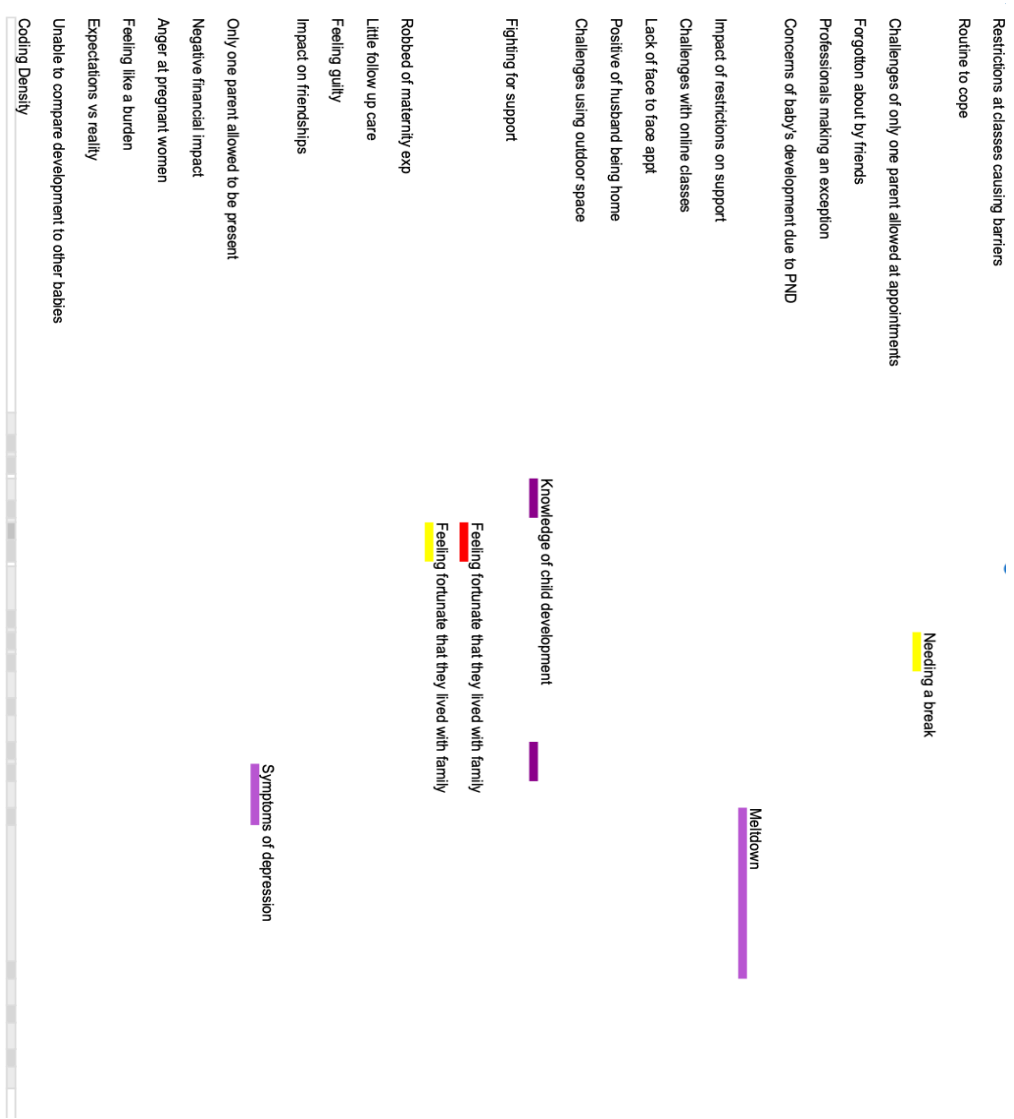
P = Participant
I = Interviewer
… = linking different thoughts/interruption/talking over each other/going off on a different tangent
(pause) = hesitation/short silence/gathering thoughts
(long pause) = long silence without either person saying anything
(?0.00) = listen again please!
(comment) = flavour of the interaction e.g. clears throat, stumbles over words, cries, etc.

Child's name changed to pseudonym - Chloe

PART ONE

I: Please could you tell me about your experience of post-natal depression?

P[redacted]
b[redacted]
um … part of that perhaps was because of the hospital, part of it was because she was a strange, newborn … um … I knew from my kind of history of kind of child development … how important it is for babies to bond with their mothers early on … um …and I was VERY conscious that I wasn't bonding. Um … and that was kind of added pressure … um … I (short pause) … kind of (pause) … I was very lucky in some ways because I had my partner, and my parents were practically living with me at the time, and so I had a small support network. Um … I also had an online group of friends … we … we'd been … we were all due at the same time, so we kind of had tracked … you know, we met online, tracked each other throughout … um … that I could talk to … (slight [redacted] got worse … she didn't sleep very well, so I was tired … um … there was no respite. There was no going out anywhere …there was just me and the baby … and because my parents were living with us, and my husband was working from home or furloughed, there was very few places, even in my house, I could go it was just … quite … claustrophobic, isolating … um … I kind of put in perhaps poor self-coping strategies, so I'd have lots of schedules and routines, and kind of built … I'm quite a scheduled person anyway … I … I …didn't … I live on schedules anyway but extreme schedules …I did lots of kind of reading about child development and things to make sure that she was OK … um … and I was doing everything right. I had this real pressure that I put on myself with the depression to do everything right, to the point where I was looking after her, I wasn't particularly looking after myself but she was OK. Um … and it came to … I kind of broke down – it was December … um … we'd taken Chloe to see Santa … and we'd gone shopping afterwards and I realised I'd lost the ticket … for Santa … but it was afterwards, so I didn't need the ticket but I wanted to put it in a box of like memories, and I'd lost it in the shop, and I kind of COMPLETELY had a panic … had a full-blown panic attack, kind of melt down … um … and my husband was like "It doesn't matter. You … we've seen Santa. We've got photos of her …" … you know … "It … it's just a ticket. It really doesn't matter." But it mattered to me. Um … and I got home, and I was … like that wasn't right … and then she didn't eat the food that I'd provided for her, and …then I just like lost it. I didn't (stutters) … with myself, kind of going down on myself … um … and I called the doctor and said "I need help NOW!" (gives a bit of a laugh) … and that was the first time I'd openly … no, it wasn't the first time I'd ASKED for help, but it was the first time I kind of said "I need it NOW." Um … I was given anti-depressants that I did not respond well to so I came off them very quickly. Um … I … yeah, I didn't like how they were making me feel at all … um …and then I did talking therapies and I had … err … trauma-focused CBT … um … and (slight pause) … I'm a lot better than I was …



P: … but I'm not … I'm not the person I was before and there's definitely that … it's all centred around Chloe, and the baby … even there, I … I refer my daughter as different from the baby I had at the beginning …because I had that real disconnect from her.

I: Yeah. Thank you. Thank you for sharing that. Could you tell me a bit more about what post-natal depression looks like for you … um … because you mentioned a bit about mood, could you tell me what you felt during that period, or what you didn't feel?

P: So, I didn't feel … especially at the beginning, I didn't feel very much … um … of anything. I felt very, very numb … um … very much (gives a big of sigh/laugh) … I'd kind of go between like feeling everything was pointless to then feeling that EVERYTHING was incredibly important and that kind of just but again not centred around me, so it didn't matter if I didn't kind of brush my hair, or it didn't matter if my clothes weren't ironed at all … and, I guess part of that's being a mum … new mum anyway and in a lockdown, when you're not allowed out anywhere, it doesn't matter if you're (laughs) … in the same clothes … um … but it was very … I was … it was very yo-yo-ie for me. Between that real … there's no point in anything to everything has to be perfect … um … I kind of distanced myself from my partner …um … was quite snappy and short-tempered with him … um (pause) … with Chloe I would (slight pause) … be quite relaxed again about some things, and then other things would be really tense, and (Pause) … really, just really uneven not kind of (sighs as she says it) … not normal … I … um … stopped doing anything I had pleasure in …everything was centred around Chloe … um … and that still is the case to be honest. I have found it really difficult to put anything back, you know, doing things for joy kind of … um … things I (pause) … I never had any kind of suicidal thoughts or anything like that … um … I had … I wanted to kind of run away but …then I didn't want to leave as well … um … but … but that kind of (pause) … really, really being unhappy with how my life was …really (pause) …it (voice stumbles) … just not … sorry (gives a bit of a laugh) … um …

I: … No, that's OK …

P: (gets her voice back) … just … yeah, really, really wishing things had been different.

I: Yeah. Thank you. And you spoke some of the things that you didn't feel during the postnatal period, and I was wondering was there anything that you didn't feel that you expected you should feel during that time?

P: I … I would have expected to bond with the baby … um …even to … now, that I can't even call that … the newborn baby is a different …child to the … the one that I have. I expected to feel happy and proud and (slight pause) … and I didn't. Um … I didn't get that kind of boost that …I … I … I'd go out shopping as much as possible with her in the hopes that I bumped into someone so that I could be like "LOOK! LOOK what I did!" Um … because I really wanted that (sighs) (pause) … that kind of … I don't know … someone to say "Well done! You did it!" or … you know, it sounds really pathetic but that kind of …

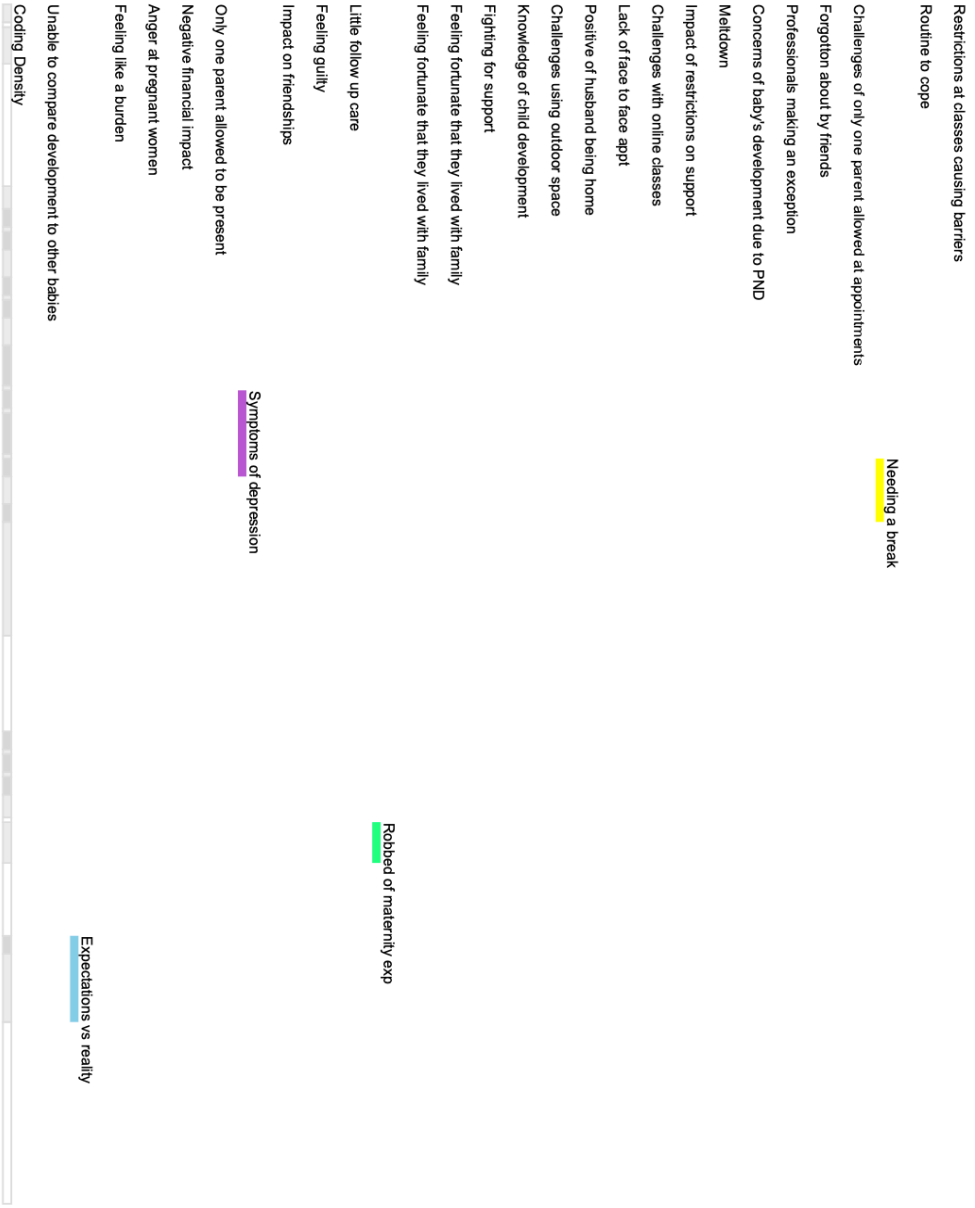
10.00

P: … you know … I've posted pictures online but it's not the same. Um … and I expected (slight pause) … I expected to be busy, and … and I wasn't busy … so, a lot of the time it … what was the point in getting up because there's nowhere to go … we're not going anywhere, we're not doing anything, we're not meeting anyone, and … just really pointless.

I: Mmm … thank you. I just want to check you're OK?

P: Yeah, yeah …

I: (P coughs) … Thank you. And you spoke a bit about the thoughts during that post-natal period, and you mentioned kind of thoughts about running away and wanting to stay, and I was wondering were there any other thoughts that you experienced during your post-natal period that were coming up quite a lot for you?



P: (Pause) … um … I had some kind of things that were linked to the PTSD … more … um …I know we're not focusing on that, but I had like real aversions to certain things being mentioned … the hospital … um … or anything to do with the first lockdown I couldn't even think about, so banana bread, Joe Wicks, all those … you know clapping for the NHS … all of those things, I mean, really, really I couldn't deal with at all … driving past NHS signs, which is … hor… …horrible, because, you know, but … um … a lot of those, I (short pause) … I never had any thoughts about harming myself or the baby … um … but I was very conscious that I didn't have those thoughts …but they were obviously … it was bouncing around in my mind I think, because I remember talking to my mid-wife and the health visitor and saying "No!" and you know and "I'm not angry with her, I'm fine." … and so, obviously there was something underlying that (fidgets a lot – pauses and struggles to speak) … I … yeah, I just wanted to get away, go somewhere away from my house … kind of that runaway kind of … start again somewhere else … um … where everything is good … kind of feelings … um … I … I didn't have any kind of … it wasn't myself … I didn't feel angry at myself, or sad about myself, it wasn't a low self-worth, it was … everything around me was bad … um … and I couldn't fix it, and I couldn't make it better. So, I guess I did have a feeling of "I can't fix this." That disappointment I should be feeling certain ways, and I'm not, and why am I not? Is there something wrong with me? That kind of thing. Um … yeah.

I: Thank you. Um … and you spoke about the impact that post-natal depression had on your behaviour and your your activities, you mentioned kind of stopping activities, or having activities that were very centred around Chloe, and you also spoke about extreme schedules, and I wondered if there was anything else during your post-natal … or your experience of post-natal depression in terms of your behaviour, or your actions … um … or how these might have been different?

P: Err … yeah. So, extreme scheduling and getting quite upset if things didn't go to schedule and … um … I did … I stopped kind of reading, playing on the computer … err … watching TV I didn't do any of that … um … I did read but it was research in child development and … um … feeding schedules, and sleeping schedules … um … quite obsessive over like keeping track of … you know, nappy changes, and how long we slept for, and those kind of things … Um … I put together menus. I cooked everything from scratch. Now, I don't cook – that's my husband's thing … um … but I cooked … I cooked all her food from scratch. She wasn't getting any jars and that was … that wasn't what I … what my plan was … well, I was always going to do a bit, but … I was never that (slight pause) … anti jars and pouches and things … but I was … I had a really strict plan … you know, I planned a month in advance with all the recipes, cooked, pre-made, put in the freezer to pull out … um …
15.00

P: … we had scheduled activities, and if she wasn't feeling up for it, if I wasn't feeling up for it, I got VERY frustrated … um … teary … I'd snap at my husband over something stupid … um (slight pause) … just really (pause) … unhappy. Um … because, inevitably, it didn't go to plan because she was a baby (takes a breath and gives a laugh) and they don't follow schedules (I chuckles) … um (long pause) … I'm trying to think if there's anything else … sorry …

I: … No, no. That's OK.

P: (Long pause) … no, I think that's everything.

I: Thank you. And you mentioned feeling like immediately, very early on that there were some difficulties for you and I wondered was it just you that noticed that or was there someone else that noticed this had started for you?

P: Yeah. Um (slight pause) … my mum noticed, and my husband noticed … um … that I wasn't right. I was very … err … I was very teary … um … and quick to get frustrated like I said … um … and they noticed that (slight pause) … things weren't right … and as it progressed and my behaviours … my coping mechanisms …

Restrictions at classes causing barriers
Needing a break
Challenges of only one parent allowed at appointments
Forgotton about by friends
Professionals making an exception
Concerns of baby's development due to PND
Meltdown
Impact of restrictions on support
Challenges with online classes
Lack of face to face appt
Positive of husband being home
Challenges using outdoor space
Routine to cope
Fighting for support
Feeling fortunate that they lived with family
Feeling fortunate that they lived with family
Robbed of maternity exp
Little follow up care
Knowledge of child development
Feeling guilty
Impact on friendships
Symptoms of depression
Only one parent allowed to be present
Negative financial impact
Anger at pregnant women
Feeling like a burden
Expectations vs reality
Unable to compare development to other babies
Coding Density

got more abnormal I guess … um (slight pause) … you know, they'd kind of say, you know "Why don't you just relax?" And I was like "Oh no, no I can't relax." So (coughs) … it was my husband that prompted me to get help …um … because he was like "No. This is (gives a bit of a laugh) … this isn't right … you're not … you not healthy … you're not like looking after yourself" … um … "This is no way to live. You're not enjoying being a mum … you know, you're not … having fun" … um … yeah.

I: Thank you. And do you remember when they had noticed that … that you were struggling?

P: It was … yeah, it was very early on …um … but then it is very normal, they say the baby blues comes …in very early on, so … um … and then maybe it was about a month later …

I: OK. Thank you. Um and, for you, is your experience of post-natal depression is it still continuing? Does it feel like it's continuing but improved or does it feel like it's no longer a problem?

P: It's continuing but improved.

I: Mmm … hmm … thank you.

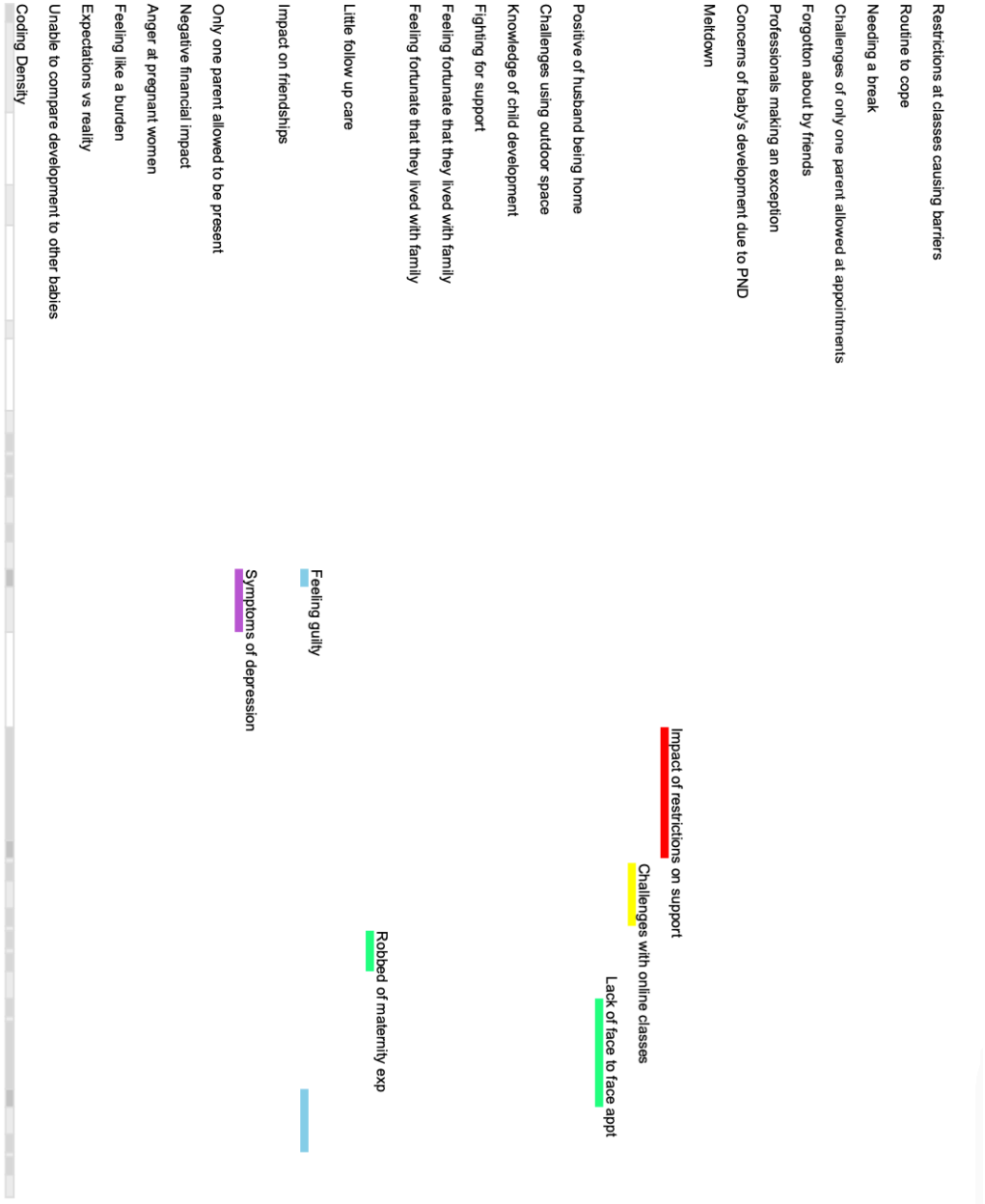
P: Um … I don't feel … I feel it's self-managed now … rather than … um … needing support … um … but it definitely still has an impact … no doubt still … there is pretty much no way I'd ever have another baby because of (gives a bit of a laugh) … how this went. And I think … um … so, it definitely has an impact and there are still … I'm still having to de-train myself from some of those coping mechanisms … that I had … um … having to take a deep breath if it goes wrong and kind of "No, I'm not going to do a schedule because it's fine, I can cope" … and that kind of thing … but it's definitely still having an impact, but I know that I've now bonded with Chloe … you know, that … that's definitely still there … um … or THERE … that's not how it was … but the … the guilt that came with it is still there and I still feel guilty. I feel like I missed the first three months of her life …um (pause) … completely … I can't … I can't remember much …photos, I look at and I don't feel anything for that period … it's just …kind of a blur.

I: Thank you. Thank you for sharing that. Please could you tell me the ways in which Covid-19 has influenced your psychological wellbeing in the post-natal period?

P: So … not being able to go anywhere, no baby groups had a MASSIVE impact …it wasn't … I didn't realise the impact …

20.00

P: … until we were then able to meet up with people … um … and because when … because I had a nice online community that I could ask questions but (short pause) … you don't have … when you're sat there nattering over a cup of coffee while the kids are playing, things come up a lot more naturally … and I didn't realise (coughs) … how much I was missing until I experienced that … um … I never got that kind of serotonin boost of "Look at my new baby" … you know, you're meant to have people come round and give you presents and make you dinner, and (slight pause) … you … err … didn't get that. There was no reason to go out … yeah, we could have our daily walks … but that was just difficult and if, you know, the baby was crying, then … I don't want to be out on the street, I'd rather be at home … so, that had a really kind of negative impact … um … and it was really that lack of people …there was the fact that … um … the health visitor didn't come round. Um … I had my health visitor appointments via phone, not even via video call, so … um … there was … there was a [redacted] colleagues were really struggling and I wasn't there, so I had that kind of guilt …um … my husband was furloughed, thankfully kept his job, but … so, there was that money worry as well …um … it really added a lot of negative things to what should have been a nice time … being part of a new family … it was (sighs) …



thinking back to that time just waiting for announcement after announcement …and now you're allowed to see people, and my … um … in-laws live three and a half hours away, so they couldn't do a drive-by, look through a window visit … um … which meant that it was a long time before they got to see Chloe at all, which … really, all of these things just added stress after stress …um … worry, and the temptation to break the rules comes in and then the guilt about "No, we need to follow the rules … and … um … we can't break them" … and there's no point … I didn't want to take Chloe, you know, shopping … into a supermarket … although, I did, because I wanted to see people … at the same point, I didn't because I was worried about what she might pick up … (Coughs heavily) … um … yeah (short pause) … it … I genuinely think it caused so many … or it prevented so many positive things. And then caused a couple of negative things and people obviously were dying and it was quite scary … the thought of going back into hospital for check-ups and what-not was scary … I mean, when she was born, that was before masks were mandatory …but … um … health workers were wearing PPE but the rules were weird. (Coughs heavily) … so, they'd wear PPE in the room, but when they were taking me from one room to another, they'd take it off when they left the room, so they'd be wheeling me around without PPE, and then put it on in another room. So you … err … anyone … err … they could see the flaws in the system then … so, the thought of needing to go back in was …

25.00

P: … terrifying (slight pause) … um … but, for me, I think the biggest thing was the lack of social … kind of bond … I … I was part of an NCT group and we had our final session online and then we did the follow up once the babies were born online …and we never built that bond and I mean you pay a fortune for those classes TO build the bonds with the other parents …it's not really for the education – it's for that, and that just never really happened because it's so difficult to do it via a video call …and it's very easy, you know … I've got to go because the baby's crying … well, if we were in a room, I'd just deal with the baby there and then … um … for me, it was the peer support I really missed out on, and (sighs) … everyone was so busy medical-wise …that I didn't want to keep bothering them … Um … we had some problems with feeding and developing a latch … um … and then she was under weight for a little bit – nothing too serious – but … um … and I didn't push enough to get support because I didn't want to bother anyone that was already over-worked. Um … yet, I would have been much more happy … (gives a bit of a laugh) … if it wasn't in covid times … um … so, the lack of medical attention …and eyes on me … err … you … in the early days, my h… … I did tell my health visitor I wasn't feeling OK, but if she'd have SEEN me when I said that with tears in my eyes, she would have done something … I think. But you can only kind of say "I'm struggling" so many times before you just give up saying it. And that's … sorry, I've waffled on there (laughs) …

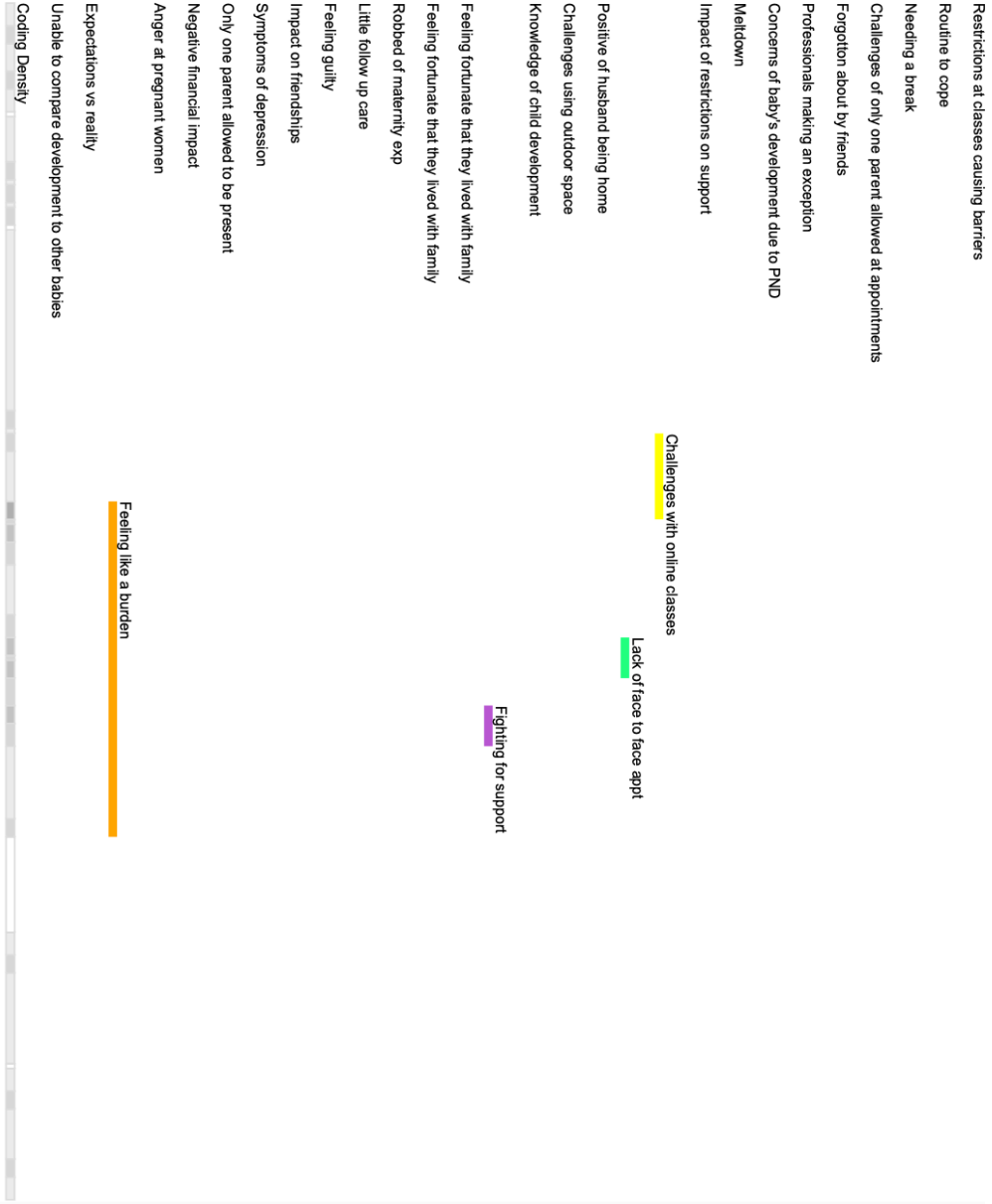
I: Oh no, no …

P: Yeah, I just … I feel there was just so much (slight pause) … so much impact on my mental health.

I: Thank you. Is there anything else that you'd like to add … um … in terms of the impact Covid-19 had on your psychological wellbeing, or does it feel like what you've shared covers the experience?

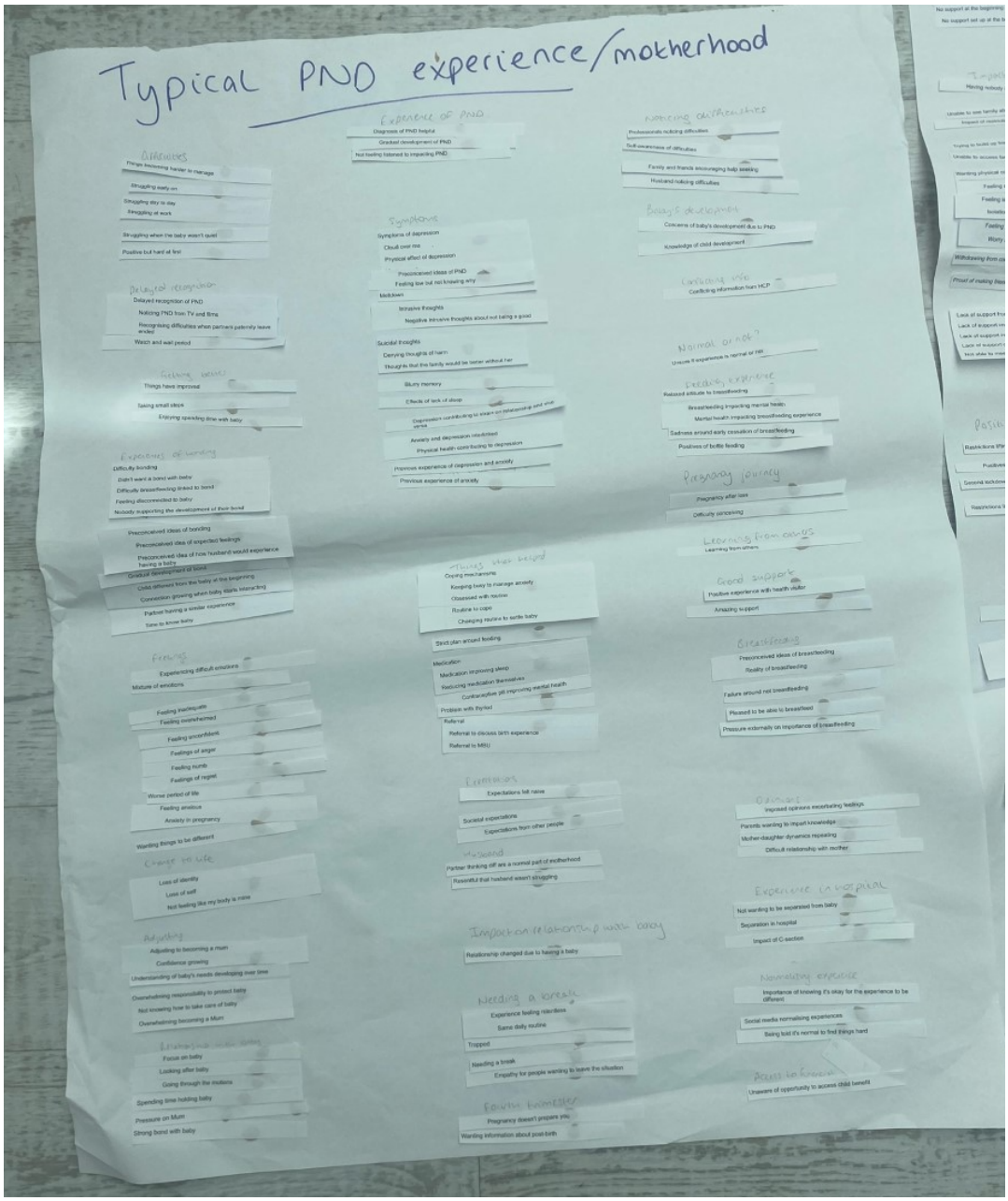
[redacted]

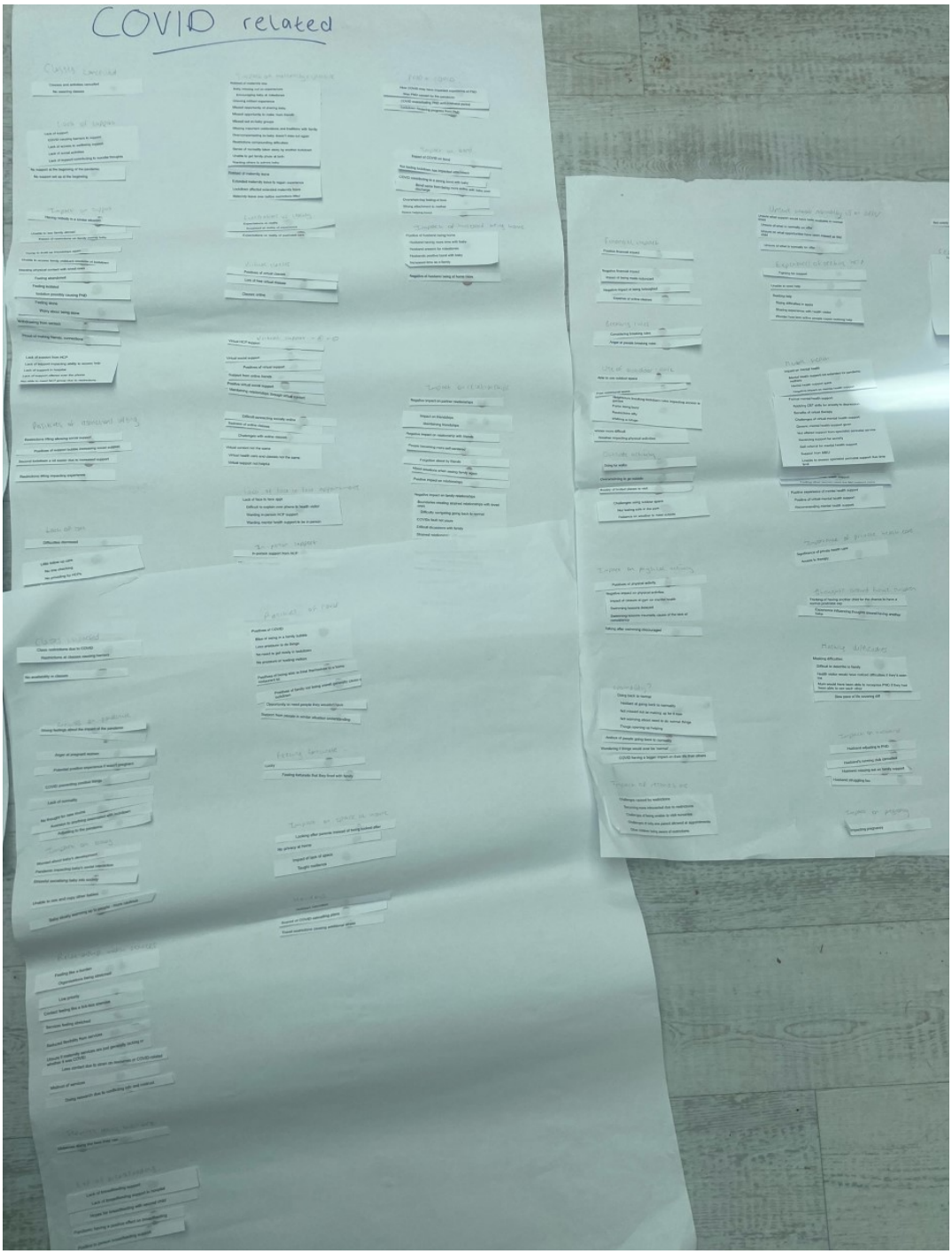
(short pause) … it caused … it just (sighs) … it caused so many problems, and it's still going on … um … I don't think … I don't think I can truly be better until (gives a little laugh) … it's stopped and gone away … um … even … I mean, Christmas last year, my in-laws were meant to be coming to stay, it was going to be really nice, and then it got cancelled because they were in Tier 4 I think. This year, we're meant to be going to them … and I'm not packed. I'm not excited … we're meant to be going … in a couple of days, and I'm not because I'm so scared it's going to be taken away … um … which I know everyone is feeling like that, but I do feel … I feel like I'm feeling it worse than the people around me …um … and I was quite proactive in getting support and I have a … I … I (sighs) … I have a worry about other people that were less proactive …and … and



8.13 Appendix M

Visual map of codes




COVID related